ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

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skills, such as budgeting, shopping, paying bills, and working at appropriate levels of functioning.

By July 1, 1986, the State intends to build or purchase a six-unit block of apartments, with four units for clients, one unit for the live-in resident managers, and one unit for a family hostel (a place for out-of-town family members to stay while visiting with and/or participating in the treatment of any client receiving state supported mental health services. All the apartments will have double-occupancy bedrooms. The apartments must be able to house a minimum of sixteen chronically mentally ill clients. For this RFP however, the respondent must find and lease space and be responsible for all programming. The respondent must budget for lease payments and related fixed costs. The respondent is expected to serve a minimum of sixteen clients and must locate space which will support the services outlined under this RFP.

The respondent shall incorporate the following ideas into the program plan:

1. The apartments should encourage social interactions among residents.

2. Residents of any one apartment should plan meals and eat together regularly.

3. A live-in manager should serve as the case manager for residents unless residents have designated case managers within the multi-purpose center or elsewhere in the mental health system. In the latter case, the live-in manager should work closely with the case manager. The apartment manager should maintain daily contact with each resident; assist residents in "normalizing activities" (e.g., paying bills, shopping, pursuing jobs or training, etc.); counsel residents with routine problems and projects; and, schedule occupancy of the family hostel. The manager should also coordinate closely with other mental health services and programs.

4. The manager should be a paraprofessional- or professional-level mental health worker.

5. A manager or a designated alternate should be available 24 hours per day.

6. Residents/clients should be assisted as needed to obtain the range of services necessary from a variety of agencies to enable them to maintain viable functioning in

the community. The respondent must show proof that clients are eligible for services provided by all other components of the services continuum for chronically mentally ill adults (see Part III, Section 3-5 below).

B. Multi-Purpose Center

The multi-purpose center shall provide on-going assessment and treatment for chronically mentally ill adults in order to allow them to maintain themselves in the community. This center, envisioned as the hub for services for chronically mentally clients, will eventually be built and owned by the State and operated by the grantee. It will be located adjacent to the Adult Group Home, which will also eventually be built and owned by the State. In this grant award, however, the respondent must locate appropriate space and budget for lease payments and related fixed costs.

Services shall include day treatment, group therapy, case management, individual counseling, psychological and psychiatric evaluations, and day respite. Average client load should be a minimum of thirty clients per day or fifty clients per week. In other words, although approximately fifty individuals clients will receive service each week, only about thirty clients will be served on any given day. While some clients may attend daily, others may come to the center only once or twice a week.

Respondents shall include provisions for ordering, storage, and dispensing of psychotropic medications, as well as protocols for drug monitoring.

Activities shall be planned for each individual client in accordance with his intelligence, functional, skill, and interest levels. The program must be flexible enough to accommodate differences between clients, as well as differences within clients over the course of time.

The respondent should plan to provide all but the most specialized services with in-house staff. The core team of in-house professionals should be supplemented through consultation or contractual services on a case-by-case basis. Because of the diverse treatment and therapy needs anticipated in the target population, the respondent should consider a multi-disciplinary team approach as generally the most effective treatment mode.

Grantees are encouraged to cultivate team management relationships with a variety of private practice professionals.

While the Department is currently planning the center to be a forty-hour-per-week operation, respondents are encouraged

to extend hours as much as possible. It is widely recognized that there is a need for this facility to provide 24-hour services. Around-the-clock operation is the goal, when and if additional funds become available.

The respondent shall incorporate the following ideas into the program plan:

1. The multi-purpose center should be the location of the case management team for the entire service delivery system for chronically mentally ill adults in Fairbanks.

2. The multi-purpose center should be the hub of services for chronically mentally ill adults.

3. Programming should encourage social interaction but also provide for various degrees of privacy.

4. All programming should be client centered, with individualized treatment plans.

5. One of the main functions of the multipurpose center should be to evaluate psychological functioning of the clients. Assessments should be done both formally and informally.

6. Possible staff for the multi-purpose center include: 1) a clinician/director; 2) an administrator; 3) case managers: 4) a psychiatric nurse; 5) social workers; 6) other professional staff as needed; and 7) support staff as needed.

7. Day treatment activities should include group therapy, recreation, skill building, group meetings, and occupational therapy. Provision should also be made for crisis intervention.

8. A typical therapeutic regimen for a client might include one hour per week with a case manager, one hour per month with a psychiatrist, and one hour per day with a case manager or psychiatrist during a crisis.

9. Although clients may spend some of their free time at the center, the facility is not to be merely a drop-in center. Therapy and group activities shall be scheduled.

C. Group Home with Crisis Beds

Like the multi-purpose center, the group home will eventually be built and owned by the State. In this grant award, however, the respondent must locate appropriate space and must budget for lease payments and related fixed costs. Respondents should be mindful of the State's intention to co-locate the group home and multipurpose center when these facilities are constructed. Proposals in response to this RFP should aim toward this eventuality to the extent possible.

The adult group home shall provide intensively supervised voluntary residential services for five chronically mentally ill adults. Residents should be encouraged to participate under supervision in household activities such as cooking, cleaning, self-care, and other activities of daily living. The group home should emulate a family-like lifestyle in accordance with the philosophy of normalization. Both sexes should live in the home and should be encouraged to participate in activities that promote self esteem.

As a place of residence, the group home must be designed to incorporate normal features of community living. For example, provision could be made for residents to have pets and/or a garden. Residents should also be encouraged to participate in appropriate recreational activities.

In addition to normal residential pursuits, residents should be involved in structured therapy and vocational programs, as appropriate, which are to be provided through other components of this RFP and which are otherwise provided in the community. The proximity to the multi-purpose center will help to ensure use of therapy by group home residents. The respondent should design other measures to ensure client involvement in community services and social and vocational opportunities.

Within the group home but structurally separate from the main residential areas, two crisis beds shall be available on a 24-hour basis for persons who have short-term problems which require immediate, intensive care but which can be managed outside of a hospital setting. Although group home residents may use the crisis beds periodically, these beds should be available primarily for the larger community. Group home staff should cover the crisis component but should have a plan to call for additional help as needed. Memoranda of agreement with other community services, including Fairbanks Memorial Hospital, are essential for this component. Proposals must include admission and discharge criteria and protocols for these crisis beds.

Group home staff might include a program coordinator on all shifts and a program aide during the evening and night shifts. Since some residents will be participating in activities at the multi-purpose center or other locations

during the day, one program staff member at the group home will probably be sufficient during the day time. Additional staff may be needed for extra coverage during times of the day when intensive activity occurs. The respondent should develop and justify an appropriate staffing pattern. The respondent shall incorporate the following ideas into the program plan:

1. Residents must not be discharged until such time as they no longer need the help of this facility. Programming should be flexible enough, with individual case planning, to accommodate the varying needs of individual clients within the larger parameters of group home capabilities.

2. Because of the nature of the clients' disabilities, staffing and programming should be planned to provide almost constant supervision.

3. Adequate staffing is very important to client outcome and stability. It will probably be necessary to have at least two staff on duty at all times when clients are present.

4. Protocols should be developed to ensure back-up for group home staff when crises occur or the client mix requires higher staff-to-client ratios.

5. Clients, with appropriate supervision from staff, should plan, shop for, and prepare their own meals. Residents should eat together family style.

6. Programming should attempt to integrate clients into the mainstream of community life as much as possible.

D. Vocational Education Workshop

Vocational services shall be provided in space leased or owned by the grantee; the respondent must include costs for any lease(s) in the proposed budget, along with maintenance, utilities, insurance, and other such costs.

This component shall serve a minimum of fifteen clients at a time. The grantee must develop placements in community businesses and other work sites to accommodate clients for whom such placements are appropriate. Proposals must include plans for developing and supervising these placements.

Vocational educational workshop services, as envisioned under this RFP, should help chronically mentally ill adults maintain, transition, or retransition into the labor market. The overall goal for this component is to provide meaningful employment appropriate to the individual's level of functioning, in a sheltered workshop environment and through on-the-job assistance and support. Coordination with existing services as well as integration with community businesses is encouraged. The program shall complement existing community programs and should provide new options and opportunities for clients on a "no failure" basis.

The vocational program shall feature individual assessment of client needs and capabilities and development of tailor-made training programs. The program shall attempt to create or enable as normal a work environment for the client as possible. The respondent should recognize that clients will have widely differing capabilities and needs and should plan accordingly.

Education and training opportunities shall be provided to every client at his or her own pace and within his or her own level. The educational/training experience should be meaningful. It should be a learning experience which will provide income as well as give a feeling of personal achievement.

For a client who would benefit from academic education instead of or as an adjunct to vocational training, the program shall assist the client to participate in existing community-based programs and college courses.

The vocational training environment and services shall be specific for people with chronic mental illness. However, the respondent should explore opportunities to share some services, purchasing, or facilities with existing agencies or businesses in ways which will promote cost savings.

The respondent shall incorporate the following ideas into the program plan:

1. Chronically mentally ill adults with all levels of disability should be incorporated into vocational training if they are in need of such service. Program planning should allow for a great diversity of abilities and interests.

2. Work is a normal activity for adult Americans. Therefore, this program should provide vocational and training opportunities that will constitute real work and preparation for real work, not "make work."

3. The program should be decentralized into existing businesses and other normal work sites as much as possible and on an individual basis.

4. The staff of the vocational program should have both psychology skills and workshop/vocational training experience. Anyone providing academic instruction should be trained in adult education as well as his or her subject matter.

E. Case Management Services

Respondents shall make provision for case management services, whether they propose to provide one component under this RFP or all four. Because many of the clients will be involved with services beyond those offered by the grantee the respondent shall develop relationships with other providers which will enable non-duplicative, comprehensive services and continuity of care and follow-up for each client.

For clients from communities outside of the immediate Fairbanks area, provisions should be developed for case managers to provide follow-up to clients and their support systems when the clients return to their home communities.

F. Management/Administration

All four components under this RFP require administrative/management support services. However, because of the State's intention that programs be client centered and because of the desire to provide the most direct services possible with limited funds, the Department encourages respondents to keep the number of administrative and support staff as low as possible while maintaining quality. Respondents should make every attempt to promote cost savings in the administrative area. Respondents proposing to provide more than one component should document cost savings in administrative areas that would accrue as a result of providing more than one component.

G. Program Evaluation

All proposals shall include a description of the client populations or sub-populations to be served under the proposed component(s) and an analysis of expected benefits for these populations. In addition, all proposals must detail a plan for program evaluation.

3-4. SUPPORTING FACILITIES, EQUIPMENT, AND SUBCONTRACTORS

Each proposal shall describe where services will be offered and how such a facility will be obtained. Proposals must address any anticipated problems in obtaining a facility and discuss alternative solutions to these problems. Any planned subcontracts must be defined as a part of the proposal.

3-5. EVIDENCE OF COORDINATION

All proposals shall demonstrate development, expansion, or direct linkage to existing mental health and counseling programs and providers and to existing social rehabilitation programs such as day treatment programs, social clubs, or other models for social rehabilitation that are demonstrated to be effective for chronically mentally ill persons. Proposals shall demonstrate efficient utilization of existing treatment and rehabilitation resources. If new programs are proposed or existing programs expanded, evidence must be provided that there are direct linkages among existing components of the system and that need exists to expand services.

It is of utmost concern to the State that services provided in accordance with this RFP complement rather than duplicate existing programs and services. The four components to be provided under this RFP must fill gaps in community services and promote comprehensiveness and continuity of care for clients.

In the case that a respondent is a consortium of agencies and organizations, written memoranda of agreement between the consortium members must accompany the proposal. Written memoranda of agreement with unaffiliated agencies and organizations with whom close working relationships and transfer arrangements are essential to continuity of care should also be included to the extent possible. The respondent shall include a plan for developing formal relationships and memoranda of agreement which are essential but which have not been practical to date. These memoranda must document agreements regarding criteria of admission and eligibility for services. The criteria shall be designed to ensure that clients of each component of the continuum of services for the chronically mentally ill are eligible for services provided by all other components, whether or not particular components are operating in response to the RFP. Finally, the respondent may wish to attach letters of support from more "peripheral" service providers, agencies, organizations, and consumers.

During proposal evaluation, a heavy weighting will be given to interagency coordination and avoidance of unnecessary duplication.

ALASKA-GENERATED STANDARDS FOR COMMUNITY SUPPORT SERVICES FOR THE CHRONICALLY MENTALLY ILL

Based on Oregon and Federal Standards

(These standards are not promulgated in regulation but are used by Department of Health & Social Services, Division of Mental Health and Developmental Disabilities in determining grant awards)

CSS PROGRAM STANDARDS

COMMUNITY SUPPORT SERVICES FOR CHRONICALLY MENTALLY ILL PEOPLE

Purpose

These rules prescribe minimum standards and procedures for community support services for chronically mentally ill persons. Community support services programs may appropriately develop more intense and specific services. All programs must address all of these minimum standards.

The grantee agrees to provide services for chronically mentally ill (CMI) people as required in 7 AAC 71.135 (a) (2). A community support services plan as outlined below must be submitted to your Regional Administrator. Standards for minimum community support services for the CMI population follow:

Definition

A. "Chronically mentally ill person" means a person who is 18 years of age or older and who satisfies both of the following criteria:

1. Must be diagnosed as having a Schizophrenic, Major Affective or Paranoid Disorder (DMS III diagnosis of 295.1, 2, 3, 4, 6, 7, 9; 296.2, 3,4, 5, 6,; or 297.1, 3), or another severe mental disorder with a documented history of persistent psychotic symptoms other than those caused by substance abuse; and

2. Impaired role functioning, consisting of at least two of the following:
   a. Social role: an inability to function independently in the role of worker, student, or homemaker;
   b. Daily living skills: an inability to engage independently in personal care (grooming, personal hygiene, etc.) or community living activities (handling personal finances, using community resources, performing household chores etc.); or
   c. Social acceptability: an inability to exhibit appropriate social behavior, which results in demand for intervention by the mental health and/or judicial system.

Minimum Standards

A Community support services plan: Each community mental health center shall submit an acceptable community support services plan to the Division identifying the number of clients to be served, and the arrangement and intensity of community support services to be provided. An acceptable plan will identify the number of staff who will provide community support services, their degrees, fields of study and hours per week spent working in the community support program. The plan will identify the average number of clients maintained in the program throughout the year. Also, the plan will address the community support services listed below:

1. Case management service to include:
   a. Screening and evaluation of potential clients to determine the client's eligibility for services, and providing a fixed point of entry into the services of the community support unit;
   b. Individualized Treatment Plans for each client accepted for services. The plan will include the client's history; an assessment of the client's personal strengths and weaknesses; and a plan of action to meet the client's basic life needs and enhance or maintain the client's level of functioning. The plan will identify outcomes, persons responsible, and target dates for staff action. These plans will be updated as appropriate, but not less often than once every six months. To the extent possible the plan will be prepared with the participation of the client and, as appropriate, significant others in the client's life;
   c. Assistance in applying for aid for which the client is entitled. Staff will routinely help clients secure resources such as Social Security, general assistance, vocational rehabilitation, and housing subsidies. When needed, staff will go with clients to help them in applying for these benefits;
   d. Assume a leadership role in coordinating services with other agencies and resources. Resources other than agencies include: landlords, employers and volunteers. When necessary, staff will organize and conduct case staffings with other agencies and resources; and
   e. Emotional support and counseling to clients throughout the provision of all other services listed in these rules; and
   f. Assure that clients are informed about the 24-hour per day services that are available through the community mental health program, and are trained in their use.

2. Outreach services to include:
   a. contact with psychiatric hospitals to identify appropriate clients and to offer services to potential clients. With the cooperation of the hospitals, staff will participate in hospital discharge planning; and

3. Medication management to include: Coordination with the client's physician to assure that the client's medication needs are met. Program staff will routinely observe and collect observations on the client's behavior and provide ongoing feedback to the client's physician.

4. Daily structure and support to include:
   a. The provision or arranging for skill training. Skill training will as needed include, but not be limited to, household skills, money management, personal hygiene, and self-managment of medications.
   Some of this training will be provided in the client's living situation. When appropriate volunteers will provide skill training; and

b. Socialization activities for clients. These activities will be provided in informal settings where clients can develop communication skills and friendships.

5. Vocational skill development to include:
a. Referral of clients to vocational rehabilitation services, and working with those services to develop individual programs to meet the special needs of each client. Whenever possible, staff will develop supportive work arrangements to prepare clients for vocational rehabilitation services.
b. Outreach contact to clients who are working in community settings. Staff will provide backup support to clients and their employers.

6. Residential resource development to include:
a. Assisting clients to find an appropriate (e.g., safe, sanitary) living situation.
b. Providing independent living skill training (cooking, hygiene, etc.) in the client's residence.
c. Using program funds to pay for rent deposits and basic housing needs when no other funds are available. The funds may be considered as loans to clients and mechanisms will be established to accept reimbursement from clients.

7. Throughout the provision of community support services, staff will observe and help secure the client's rights to confidentiality and treatment with human dignity.

TERROR STRIKES EUROPE'S AIRPORTS

Newsweek

January 6, 1986 $1.95

Abandoned

They are America's castoffs—turned away from mental institutions and into the streets. Who will care for them?

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Abandoned

Well-meant reforms have shattered our system for treating the chronic mentally ill–and left thousands of them to scrape by in the streets

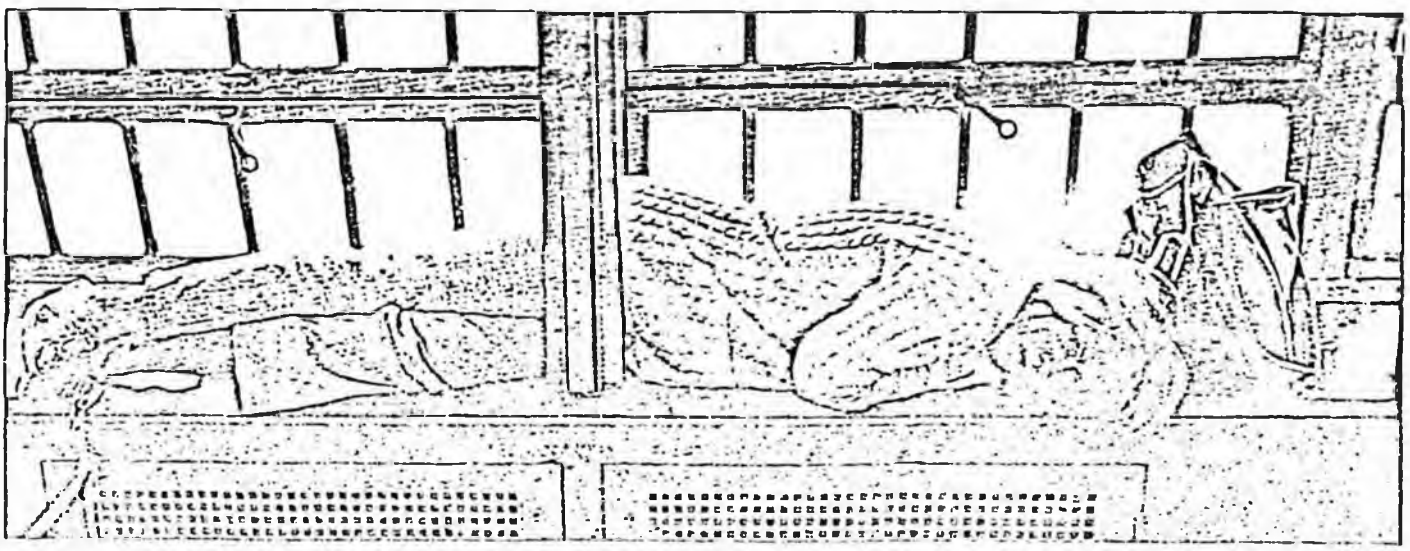
It's a typical night at the Pine Street Inn, a privately run shelter for the homeless in downtown Boston. One guest is quietly threatening suicide. Another has carved a three-inch gash in his cheek; the inn staff and a city policeman coax him into an ambulance as blood spatters the floor. Two women schizophrenics sit nearby, muttering disconsolately. Around them nearly 600 lost souls are settling in for the night—shuffling, snoring, murmuring, restlessly rearranging their meager possessions. As usual, the Pine Street Inn is overcrowded—and as usual many of its guests are mentally ill. "Our old alcoholic guests think it's too crazy to come here," sighs Ralph Hughes, the inn's director. "We've become the state's largest mental institution."

And yet, strange as it seems, the denizens of the Pine Street Inn are luckier than some. This winter a number of homeless persons around the country will undoubtedly succumb to the effects of exposure on city streets. More often than not, these men and women will be found to have a history of chronic mental illness and to have spent at least some time in psychiatric hospitals. To mental-health professionals, their deaths will be yet another example of America's mentally ill "dying with their rights on"—which is one way of saying, as many in the field now believe, that the nation's primary-care system for chronic mental patients is in utter chaos. That this is so is a monstrous irony, for the current plight of America's chronic mentally ill is the direct result of the nation's 20-year flirtation with the seductive optimism of reform.

That reform is broadly known as "deinstitutionalization," a term that refers to the hopeful goal of releasing most chronic mental patients from state-run asylums and returning them to the community. The goal was and is praiseworthy: the residential population at state and county mental hospitals has dropped by nearly 450,000 since 1955, and the level of care for those who remain in long-term confinement has generally improved. It is also true that up to 65 percent of the liberated mental patients have successfully adapted to life outside—though as any psychiatrist can testify, "success" among the long-term mentally ill is very much a sometime thing.

But for the rest—for hundreds of thousands of former inmates and younger mental patients for whom long-term institutional care has never been available—deinstitutionalization is a brutal hoax. Even longtime advocates of mental-health reform, like Dr. Leona Bachrach of the University of Maryland, concede a "failure in implementation" because very little of the hoped-for community psychiatric support was ever provided. That shortfall, she says, has created "a big mess" for the mentally ill. Others are less charitable, and some critics, mindful of the staggering neglect that many chronic mental patients now endure, are very angry. "Let's stop playing games—deinstitutionalization *stinks*," says one psychiatrist, Dr. Stephen Rachlin of the Nassau County, N.Y., Medical Center. "Liberty to be psychotic is not 'freedom' in any responsible sense of the word."

"Tovid" had his first psychotic episode at 20, after a prep-school career marked by precocious brilliance in science, baseball and the piano. His family spent his college



STEVEN HANSEN

A question of freedom: *A patient at New York's Creedmoor Psychiatric Center, later released to live in a halfway house*

MARIO RUIZ—PICTURE GROUP

New York, a troubled man huddles in a doorway

when their savings ran out . . . ferred him to a state mental institution. In and out of hospitals for years, Todd, now 37, recently was released to a boarding home in Worcester, Mass. Three weeks later he was mugged—an event which precipitated yet another psychotic breakdown. "He tried so hard to make it," his mother says. "They all try so hard, and they fail because they receive no care. It's torture for the families to watch that. These people are too sick to be let out into the community without any help. It's a national disgrace."

There are two reasons why deinstitutionalization has failed. The first is that government has fallen far short of providing the kind of community-based mental-health care that chronic schizophrenics like Todd so desperately need. To be sure, spending by state government on mental-health programs seems adequate: in 1981, the most recent year for which figures are available, that spending totaled $6.2 billion. But the dollars, as mental-health professionals say, have not "followed the patients."

Although 63 percent of the nation's chronic mentally ill are at large in the community, two-thirds of all state and local mental-health funding still goes to mental institutions that now house only a fraction of their former inmate population. The result: a staff-to-patient ratio (chart, page 16) that currently exceeds 1.5 to 1 in public and private hospitals nationwide—and a catastrophic shortage of psychiatric care for those who are struggling, in the streets of hundreds of cities and towns, with the crushing burden of liberty.

The constitutional right to liberty—and the 20-year trend toward a much broader assertion of mental patients' civil rights—is the other reason why deinstitutionalization has failed. Liberty is a primary value in American society and in its legal system: for the past decade the courts have consistently held that no one—not psychiatrists, not police, not even family members—may arbitrarily abridge a mentally ill person's right to freedom.

Legal standards: As a result, long-term involuntary commitment has been abolished in most states for all but the most dangerous mental patients—and even short-term commitment can be extremely difficult to achieve. The common legal standard is that a patient must be "a danger to himself or others"—a phrase that, in practice, often means the patient must commit some overt act of violence before the courts will intervene. "The rights of patients are important, but as things stand now, everything but his *illness* is being taken into account," says Dr. Sara Warren, vice president of the Pennsylvania Association of State Mental Hospital Physicians. "In the end," says Dr. Bertram S. Brown, one of the architects of

deinstitutionalization, "it may be the legal profession that will largely determine the fate of the chronic mentally ill."

The result of these twin trends, one within the mental-health profession and the other in the courts, has been nothing short of catastrophic. It is, of course, a furtive, whispering catastrophe that most Americans have ignored—much as they ignore the shabby, muttering, homeless crazies who haunt their streets. How many of the mentally ill are homeless and how many of the homeless are mentally ill? No one really knows—and the debate, which now preoccupies officialdom and academic researchers alike, is largely beside the point. Nevertheless, recent surveys indicate that approximately a third of the nation's homeless are mentally ill—although the total number of homeless Americans, which is variously estimated from 350,000 to 3 million, itself is in dispute.

The number of chronic mental patients is easier to come by. The National Institute of Mental Health estimates that 2.4 million Americans should be classified as chronically mentally ill and that approximately 1.5 million of them (chart, page 19) now live "in the community." That broad category includes those who live in halfway houses, those who live with their families or by themselves in rooming houses and cheap hotels and those who have been referred for short-term stays in the psychiatric wards of local hospitals—and those who simply live on the streets.

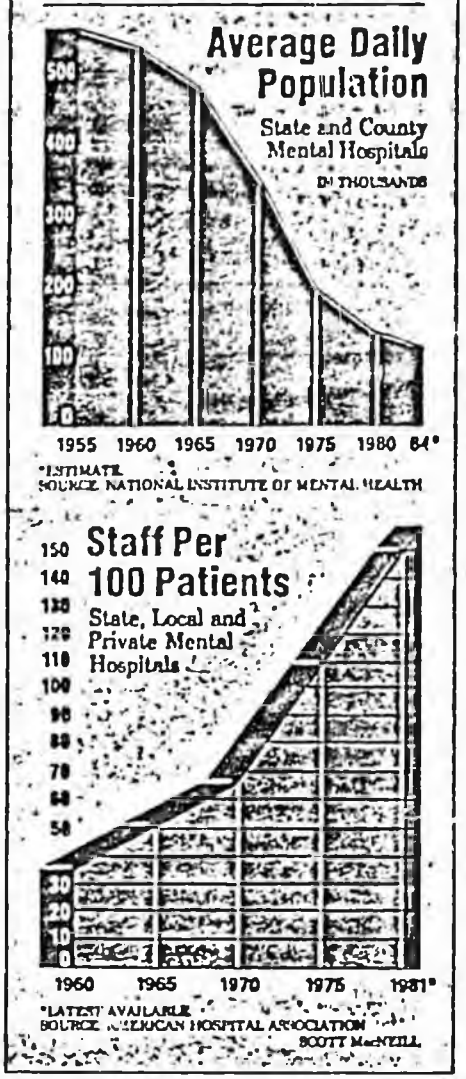
In truth, virtually any of those 1.5 million patients can be "homeless" at one time or another, for a chronic disease like schizophrenia tends to be cyclical, and its victims usually veer from periods of fragile stability to intermittent breakdowns all their lives. "Almost everyone in the organization can say that at some time, their loved one has been homeless," says Laurie Flynn, director of the National Alliance for the Mentally Ill, a self-help organization for the families of mental patients.

Earl Ruth is 47, partly deaf and schizophrenic. He heard voices for the first time at the age of six, spent most of his childhood in a foster home and an orphanage and has lived much of his adult life in mental hospitals—sometimes voluntarily, sometimes not. Normally a gentle, apologetic man, Ruth is capable of violence: he once told a psychiatrist he was "fighting something evil, something powerful." He is both homeless and rootless. Although he spends most winters at church shelters in New York City, he usually heads across country each spring in a solitary and always fruitless search for a better life. This year, he says, he may take a trip to Houston.

They call it "Greyhound therapy," and it is the opposite of "three hots and a cot"—

the Hospitals

Most funding still goes to institutions that house a fraction of their former population. Result: a high staff-patient ratio—and a shortage of care outside the wards.



mental-health workers' slang for long-term institutionalization. For Earl Ruth and thousands like him, the days of three hots and a cot are long gone, probably never to return: life consists of aimless wandering from city to city, a pattern that is interrupted only by random encounters with the police and periodic short-term visits to the psychiatric wards of local hospitals. It is a dreary, nomadic and dangerous existence. Violence is not uncommon, and the mentally ill are more frequently the victims of crime than its perpetrators. The young tend to be involved with drugs: according to some experts the underlying psychiatric problems of many younger patients are often mistakenly dismissed as the effects of chronic drug abuse.

Housing is where you find it—in an alleyway, a vacant building, a bus station or a flophouse. Food is in the garbage can or at the mission. Nightmares are everywhere—but only the mentally ill know the real pain of their hallucinations and their dark dreams. "It all boils down to these people who follow me around and take my boyfriends and so on," says "Lena," a paranoid schizophrenic at the Pine Street Inn. "They live in empty buildings, they kill my family members, they jeopardize me, too! I want to speak to President Carter and warn him to stay away from these people." "Kathy," another Pine Street Inn regular, says she has seen three friends die in the streets, one of them last October. "I'm gonna tell it to you straight," Kathy says. "All the pain, the suffering, the craziness—it hurts, *it hurts*." (Shortly before Christmas, Kathy was barred from the Pine Street Inn after staging a suicide attempt. No one knows where she is now.)

Minimal care: What is missing from their lives is effective community care—and without exception, mental-health professionals say the nation has reneged on that promise. The age of mental-health reform really began in 1963, when John F. Kennedy signed into legislation a network of community centers to support deinstitutionalized patients nationwide; though 2,000 are needed, only about 700 were ever built. There are, to be sure, a handful of highly praised outreach programs, like The Bridge in Chicago (page 18), which offer intensive caseworker support to chronically disturbed people. But the norm in most state or local agencies is a level of care so minimal as to approach official negligence—and in city after city, despairing mental-health workers concede that the system as a whole fails abysmally.

One problem is that reformers have greatly misjudged the difficulty of caring for the most severely disturbed patients. Hard-core street crazies are notoriously tough to deal with: they are often paranoid, manipulative and deeply resistant to treatment, and many deny they are disturbed at all. Deinstitutionalization was largely predicated on the therapeutic power of modern pharmacology. Even chronic schizophrenics, it was widely believed, could be released to the community if they were given regular doses of tranquilizers or antipsychotic drugs. But many patients resist taking their prescriptions, just as they resist any direction. "This is a system that leaves it up to the patient to keep up with his medication and psychiatric care," says Gloria Harrell, a mental-health coordinator in Detroit. "A few get help, but the majority won't."

Even with cooperative patients, the usual combination of drugs and a little counselling is far from adequate. Many are simply too disoriented, too volatile, too isolated to cope with modern society. A recent study of the chronic mentally ill in Boston, for example, showed that 75 percent had no con-

tact with anyone—family member, friend, doctor or counselor—who could help them in a crisis. "They can't name one person they can call or talk to," says Ellen Bassuk, an associate professor of psychiatry at Harvard Medical School. "It's a hideous existence that shoves them further into craziness."

The consequence, for many, is what professionals call the revolving-door syndrome. Getting only minimal support from the local mental-health agency, the patient gradually loses his grip on reality. In the jargon of psychiatry, he "decompensates": stops taking his medication, loses touch with his caseworker and eventually gets into trouble.

In many cases, his next contact with civil authority is through a patrolman on the beat: the San Francisco police department, for example, handles 18,000 calls involving emotionally disturbed citizens every year. The police may make a "mercy arrest," sending the patient to jail for a minor offense like disturbing the peace. Or they send the patient to a local psychiatric ward to cool out. Then the cycle begins all over again. "These patients are pushed back and forth in circles," says Dr. Iqbal Ahmed of Boston City Hospital.

Daniel Thornton is a 34-year-old schizophrenic with a long history of violence who lives in San Francisco. In and out of mental institutions for years, he has recently been under the care of a state mental-health counselor and a psychiatrist; during that time he received the usual regimen of antipsychotic drugs. Last fall, however, his case management broke down: the psychiatrist retired and his counselor could not see him because of illness. Daniel began to deteriorate. In desperation, his brother took him to San Francisco General Hospital, where he received more medication and was released. It didn't help. On Dec. 1 Daniel stabbed a 76-year-old woman to death. He told police it was the only way he knew to get the psychiatric care he needed.

MARIO RUIZ—PICTURE GROUP

Lifeline: *Medication at a church shelter*

There have been dozens of cases like Daniel Thornton's since the advent of deinstitutionalization, and each case inflames the public, alerting them to the policy's risks. In New York last November a 44-year-old paranoid schizophrenic named Lois Lang walked into the offices of Deak-Perera, a leading currency broker, and allegedly shot and killed the firm's president, Nicholas Deak, and his receptionist. In Springfield, Pa., 25-year-old Sylvia Seegrist was charged with gunning 10 people in a suburban shopping mall on Oct. 30, killing three of them. Seegrist's mother had tried to have her committed for months. In Onalaska, Wis., last February, Bryan Stanley, 30, was arrested for the murders of a priest, a lay minister and a church custodian; he had recently been discharged from a state mental-health center.

The pattern in all these cases is nearly identical: although the suspect had a history of mental disorder and a known propensity for violence, the system failed to protect either the patient or the public. Daniel Thornton, for example, had been proposed for long-term commitment in 1982; on the recommendation of state mental-health officials, a California court turned the commitment petition down. "The Thornton case says everything that's wrong with the mental-health system," says Thornton's public defender, Jeff Brown. "We have an all-or-nothing proposition in the system. A person is either in an institution or not in one—and if he's out, we operate on a hope and prayer that he's not going to do harm to himself or another person."

The obvious conclusion is that the system has failed. But the real issue runs deeper: the law's bias in favor of the rights of the mentally ill has significantly raised the barriers to involuntary commitment. The law works on the presumption that liberty is the highest value, and psychiatrists, who can never predict a patient's behavior with total certainty, must work within that libertarian bias.

Smoking gun: Dr. Darold Treffert, chairman of the board of the Wisconsin State Medical Society, says that conflict was fundamental in the Bryan Stanley case. "The guy was crazy—and after the smoking gun everybody said, 'Oh, my God, he should have been committed.' The fact is, under our laws he *couldn't* be committed because he wasn't considered a danger." Or as a study by the American Psychiatric Association puts it, "Clinicians believe it is better that 10 persons be hospitalized unnecessarily than one suffer serious harm unnecessarily. The judiciary believes, however, that it is better for 10 people to go free than for one 'innocent' person to be confined."

It usually takes a splashy murder case to raise these questions for laymen—but the issues of protecting the public and caring for the mentally ill are really one and the same. The law inhibits psychiatric intervention at many levels. There is the basic stipulation that a mentally ill person must be a demonstrable danger to himself or others; in most states that standard is applied rigorously and narrowly. There is also a widespread recognition of a patient's right to refuse medication. According to the American Psychiatric Association, 25

STEVEN HAMBERG

Her own space: *A former mental patient in her apartment kitchen*

states have such laws. And finally, there is the tradition of aggressive advocacy on behalf of the mentally ill. Legal ethics do not encourage an attorney to ignore his client's wishes—which means that a mental patient's lawyer must normally fight for his client's release even if that decision stymies treatment.

In New York City, where authorities are struggling to cope with thousands of homeless mental patients, the tension between liberty and care has become almost bizarrely politicized. The city's goal is modest: preventing street crazies from freezing to death. City hall has advised the police that state law allows them to round up anyone who appears to be mentally ill and refuses shelter, and transport that person to a hospital for observation when the temperature drops below 32 degrees. The police are doing so, but the program has prompted bitter criticism from the New York Civil Liberties Union, which has mounted its own "freeze patrol" to advise the homeless of their right to resist this minimal form of treatment. An NYCLU spokesman likened the city's roundup to kidnapping and insisted that the basic issue was housing—an assertion Mayor Ed Koch labeled "idiocy."

Legal absolutes: In many respects the current fracas in New York is a microcosm of the whole era of mental-health reform nationwide. Over the years, says Joel Klein, counsel to the American Psychiatric Association, advocates for the rights of the mentally ill have "had an agenda they succeeded in implementing. Then they said, 'It's *your* responsibility to put the pieces back together'." Getting people out of hospitals is "the easiest thing in the world," Klein adds. "The hardest thing is to get them alternative care, and that's what hasn't happened." The result is a mental-health system that tends to define the wide range of patients' needs in terms of legal absolutes. But mental illness "is a disease like any other," says Anita Pyatt of the Massachusetts Alliance for the Mentally Ill. "You don't have to be in a coma to be hospitalized for diabetes—and our people shouldn't have to become suicidal to get help."

There is now a growing recognition that deinstitutionalization may have gone too far, too fast—and if there is as yet no firm consensus on the remedy, the seeds of some limited counterreform seem to be taking root. The American Psychiatric Association has proposed changes in mental-health law to make involuntary treatment easier. Says Klein: "We need intelligent programs—not programs that appeal to some civil-rights lawyer's sense of where people ought to be."

The legal profession has begun to rethink the issues as well. The broadest approach is to amend the prevailing "danger to himself and others" standard in the law—a proposal that is already controversial among mental-health professionals. Dr. Darold Treffert, for example, is pushing for new language in Wisconsin law to allow involuntary commitment for the "obviously mentally ill"; others urge the use of wording such as "gravely impaired." Although Treffert insists there would be no revival of the bad old days of indefinite incarceration, no one doubts that such changes in the law would result in a substantial increase in the number of institutionalized patients.

The memory of the bad old days—of mammoth state asylums packed with infantilized, ill-treated patients—still figures powerfully in the debate. Some professionals insist there is no alternative for the most severely ill patients. Others, like Thomas Romeo, director of Rhode Island's Department of Mental Health, are "terrified" by the possibility—though proponents say the worst abuses are unlikely to recur.

Footing the bill: There is no dispute whatever that the quality of community-based care must be improved. But there is ample doubt whether the taxpayers are ready to foot the bill. The verdict of 20 years' experience is that deinstitutionalization, if it is ever to succeed, will require at least as much staff and at least as much spending as long-term institutional care. The "aggressive case-management" approach used by The Bridge program, for example, relies on low caseloads and young, energetic staffers. Federal funding, as always, is a major problem—though the Department of Housing and Urban Development has now joined hands with private philanthropy to improve housing and other services for the mentally ill. The program, sponsored by the Robert Wood Johnson Foundation, will provide $28 million to eight of the nation's largest cities. Those cities will then be eligible for HUD rent subsidies of up to $75 million over 15 years.

The greatest need of the mentally ill, of course, is to overcome the public's continued indifference. Everyone "accepts the need," says Associate Prof. Thomas McGuire of Boston University, "but nobody accepts the responsibility." The wretched quality of their lives is an affront to civilized society—and so far, at least, society mostly has tried to look the other way.

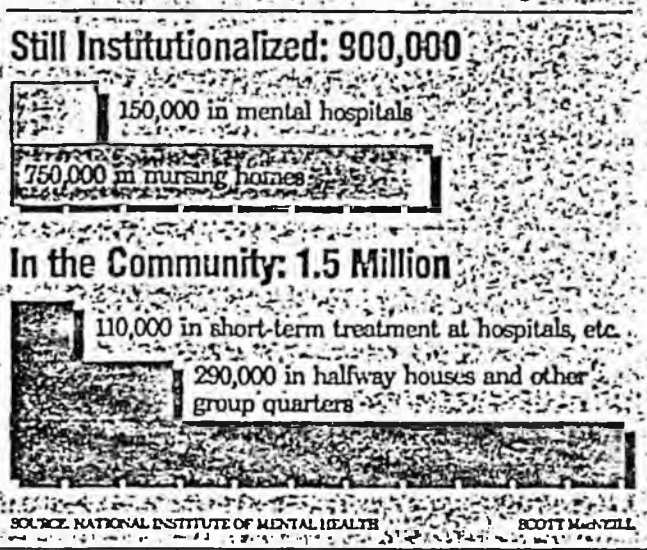
TOM MORGANTHAU *with* SUSAN AGREST *in New York*, NIKKI FINKE GREENBERG *in Washington*, SHAWN DOHERTY *in Boston and* GEORGE RAINE *in San Francisco*

The Mentally Ill Among Us

ROBERT R. McELROY—NEWSWEEK

Last resort: *A short-term haven run by New York City*

Estimates of the nation's homeless population range from 350,000 to 3 million, and many experts think that the chronic mentally ill make up about a third of the total—moving on and off the streets from a variety of neighborhood residential settings.



Bridge to a Normal Life

A neighborhood agency helps fragile souls survive

On a blustery Christmas Eve in Chicago, businesses were closing their doors early so employees could dash out for last-minute shopping. But 31-year-old Jim Sajdak, in boots and corduroys, was still making his rounds in the late afternoon on the city's north side, visiting members of the community he treats like a family. Sajdak is one of 25 social workers at The Bridge, a citywide agency that enables 200 mentally ill men and women to lead near-normal lives outside an institution.

The Bridge is just what its name suggests—a link to reality for the most difficult to treat of the mentally ill. Its clients are sometimes inadequately housed, often resistant to standard therapy, reluctant to visit most social-service agencies, hospitalized over and over again. Started eight years ago as a pilot program by Thresholds, a social-service agency, The Bridge takes on people only after they've landed repeatedly in mental wards. All or most are supposed to take medication to keep their equilibrium. Nearly all rely on federal disability checks. Bridge clients may have lived on the street or in shelters before The Bridge put them under more permanent roofs. But all live on the edge, and the dedicated cadre of caseworkers does everything it can to make sure that nothing will push them over.

Routine activities: The goal is to keep clients out of psychiatric wards and to cut tax-supported hospital costs in the bargain. To do it, Bridge staffers go where their patients live, using four unpretentious offices around the city more as message centers than counseling rooms. They often suggest clients sign over their various social-security and welfare checks; then Bridge counselors manage their money and help them buy clothes and food. They also help the mentally ill navigate bureaucratic shoals for their fair share of Medicaid, to find an apartment or other proper accommodations—reconnecting them with normal social goals and functions. "A great success for one of our members can be that he finally took a bath," says program director Tom Witheridge. Without help, routine activities can pose insurmountable hurdles for Bridge clients, unhinging their grip on reality.

In a story with too few happy endings, The Bridge has reduced both the number of times clients are confined to hospitals and the length of their stays. "The success pattern is clear," says Michael Belletire, an Illinois mental-health official. "This works for some of the most difficult clients." And the approach, program advocates contend, is not simply more humane but more cost-effective. Hospitalization costs for the first 41 participants in the program dropped $242,000 in the first year. With a relatively small budget—$1.3 million yearly, all of it from state funds—The Bridge needs patients to make it work. "The members themselves really deserve the credit," says David Zagorski, a three-year veteran of the The Bridge staff. "They really do the hard work."

But the lives redeemed by The Bridge are measured in more than dollars. Take Marie, a heart patient abandoned by her family who now has a place of her own to live in. Or Millie, who had been struggling with private demons in institutions for over a third of her 62 years. When caseworkers found her six years ago, Millie was wearing three hats at once, hearing conspiratorial voices in the television, brawling with hospital personnel. Staffers gently took over the daily tasks that used to defeat her. Now they manage her finances and take her to the hospital regularly for medication. Whether or not Millie's mental illness is ever cured, she has the semblance of a normal life. With the security of The Bridge solidly behind her, she reports, "I can handle my problems myself."

Rich resource: Sometimes, of course, The Bridge fails. About 5 percent of its 350 clients since 1978 have walked away from the help. But its triumphs are so impressive that many other communities are considering similar programs. The Bridge makes a difference largely because it is rich in a resource all too scarce among those who help the disadvantaged: caseworkers who are flexible, willing to help patients bathe or kill roaches—or just listen to their problems.

Those who do that work—for annual salaries starting at $13,000—are streetwise and dedicated. Sajdak, a Bridge worker for little more than a year, worked earlier in a psychiatric lockup and once studied for the priesthood; now his office is sometimes a park bench. There is a former VISTA volunteer and a paralegal worker who used to help the elderly. "We are not successful because we've stumbled over some new school of psychotherapy," says Witheridge. But by giving clients gifts they're not accustomed to—encouragement, patience, respect and firm guidance—they may have stumbled on something better.

COLLEEN O'CONNOR *with* PATRICIA KING *in Chicago*

Where the problems are: *Zagorski on the street with client*

J. T. LOWENTHAL—NEWSWEEK

(3) assessment of community and client reaction to services, which may include questionnaires, surveys, or board reports; and

(4) the center's evaluation of the degree of achievement of the annual plan. (Eff. 9/1/82, Reg. 83)

Authority: AS 47.30.530

7 AAC 71.125. QUALITY ASSURANCE. (a) A center must have systematic procedures for the review of the quality of care and the use of services and facilities.

(b) There must be a written description of current quality assurance procedures that is reviewed and revised annually.

(c) At least two utilization reviews must be completed each year as described in 7 AAC 7.155(g). (Eff. 9/1/82, Reg. 83)

Authority: AS 47.30.530

7 AAC 71.130. PLAN OF SERVICES. A center must have a written plan of services which

(1) the center staff reviews annually and revises as necessary to reflect changing community needs;

(2) includes the center's annual goals, the steps and resources necessary to implement the goals;

(3) includes a review of compliance with or reasons for exceptions to relevant regional and state planning documents; and

(4) includes a five-year plan for development and delivery of mental health services to the service area. (Eff. 9/1/82, Reg. 83)

Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.135. TYPES OF SERVICES AND POPULATIONS TO BE SERVED. (a) A center must serve, to the extent that mental health services are not available to them from other providers, the following populations in prioritized order:

(1) acutely disturbed persons;

(2) chronically, severely disturbed persons;

(3) children and adolescents;

(4) other persons or agencies requiring direct mental health intervention; and

(5) other persons or agencies requiring non-direct mental health services such as consultation or education.

(b) A center must provide the following services to the above listed populations in prioritized order:

(1) evaluation services, including

(A) diagnosis using the DSM-III classification; and

(B) evaluations for persons being considered for involuntary commitment under AS 47.30.700 – 47.30.915; this service is to include both court-ordered screening investigations and evaluations for commitment, if the necessary facilities and personnel are available; and

(2) treatment services, both voluntary and involuntary, which emphasize a brief therapy and crisis intervention model, including

(A) 24-hour inpatient psychiatric treatment for both voluntary and involuntary patients as close to the patient's home as possible; for involuntary patients, this service must include a written cooperative agreement with the Alaska Psychiatric Institute or other state-designated inpatient psychiatric facility; and

(B) outpatient care, including

(i) 24-hour direct emergency services for crisis intervention;

(ii) individual counseling/psychotherapy;

(iii) group counseling/psychotherapy;

(iv) case management and supportive care for chronic patients;

(v) referral services to other agencies; and

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2239 N. Jordan Avenue
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(907) 789-5912

January 27, 1986

The Honorable Max Gruenberg
Co-Chairman
House Health, Education and
Social Services Committee
Pouch V
Juneau, Alaska 99811

Re: HB 412
Sponsor: M. M. Miller
Cosponsor: D. Clocksin
Community Support System
for the Mentally Ill

Dear Representative Gruenberg:

I believe this bill should be passed with very few changes. I suggest two amendments:

1. Include case management in types of services;

2. Include a maintenance of effort clause so new money is not just used to replace existing programs.

I understand questions have arisen as to the need to have the state pay 100% of the cost. There are several reasons:

1. Virtually none of the chronically mentally ill have health insurance.

2. The chronically mentally ill are disabled and although they can sometimes qualify for Social Security the nature of their illness interferes with their application. For example, when asked if they are mentally ill they answer "no" because massive denial of reality is a hallmark of their illness.

3. Social Security has been administered in a manner which discriminates against the mentally ill.

4. Health insurance does not pay for the types of services they need (such as those defined in the bill.) Health insurance will pay for a doctor visit but even this is on a discriminatory basis. A visit to the psychiatrist is paid at a rate lower than a visit to a family doctor (50% vs. 90% for office visit in the State Employees

health insurance program. However, the actual amount of physician time in the care of a chronic mental patient represents a small part of their treatment.

5. The Community Mental Health Program started in every state as a matching program with the state paying 50% to 75% of the cost and up to 90% in poverty areas. It was believed that community mental health services would prevent patients from being admitted to state hospitals. After a short time it became apparent that the clinics were exercising their local options and the difficult seriously mentally ill were being neglected.

   In 1978 in California and in 1975 in Oregon mental health services for chronic mental patients were funded 100%. This has led to considerable progress in these states because the states are able to exercise complete control over these programs. In fact, it could be designated as contractual services rather than grant services.

6. Some third party reimbursement can be collected for portions of these services. These funds could be returned to the general fund in the same manner as at the Alaska Psychiatric Institute.

Thank you for your thoughtful consideration.

Sincerely,

Jerry L. Schrader, M.D.

**** exerpts from Report on Northern Region Mental Health Program submitted to 14th Legislature on SB 520

Table 3

SIX MONTH PREVALENCE RATES FOR GENERAL U.S. POPULATION[1]

Disorder by Gender by Age (Percent)

	MEN					WOMEN				
	0-17[2]	18-24	25-44	45-64	65+	0-17[2]	18-24	25-44	45-64	65+
Major Depression w/o bereavement	0.20	1.97	2.39	1.39	0.31	0.60	4.67	5.66	3.10	1.30
Bereavement	---	0	0.07	0.13	0.26	---	0.19	0.16	0.20	0.91
Manic	0.[illegible]	0.88	0.92	0.25	0	0.85	1.17	0.96	0.33	0
Dysthymia	0.29	1.81	2.38	1.92	0.92	0.57	2.27	5.13	4.72	1.89
Panic	---	0.65	0.70	0.71	0	---	0.83	1.70	0.84	0.23
Obs. Comp.	---	1.53	1.42	0.99	0.80	---	2.70	2.47	1.14	1.00
Alcohol Abuse	0.86	9.98	12.21	6.72	3.30	0.16	3.37	1.77	0.93	0.19
Drug Abuse	3.82	7.75	3.49	0.06	0	2.40	4.78	1.35	0.03	0.05
Antisocial Personality[3]	2.57	2.24	2.37	0.27	0.32	0.45	0.76	0.50	0	0
Cogn. Impair. Severe	0.23	0.35	0.28	0.89	5.58	0.11	0.53	0.30	1.07	4.31
Cogn. Impair. Mild	---	2.82	1.73	7.07	14.53	---	1.44	1.88	5.71	14.73
Schizophrenia/ Schizophreniform	0.50	1.30	0.94	0.61	0	0.80	1.01	2.10	0.63	0.34

1 Data are combined incidence rates for three reporting sites in NIMH (Oct. 1984). Combined rate has been weighted proportional to number of respondents per site.

2 Data for ages 0-17 are hybridized estimates as reported in Table 10 of the University of Alaska's report. These numbers are highly speculative.

3 For ages 0-17 these figures reflect all personality disorders. For ages 18+, only antisocial personalities are reflected.

Table 4

ESTIMATED SIX MONTH PREVALENCE RATES: DISORDER BY GENDER BY AGE

FOR NORTHERN ALASKA (Using differential national rates for age by gender by disorder)[1]

		0-17[2]	18-24	25-44	45-64	65+	TOTAL
	F	16,056	7250	15,559	5520	1386	45,771
N	M	17,492	8850	19,908	6838	1581	54,669
Major Depression w/o Bereavement	F	96	339	881	171	18	1505
	M	45	174	476	95	5	795
	TOTAL	141	513	1357	266	23	2300
Manic	F	136	85	149	18	0	388
	M	149	78	183	17	0	427
	TOTAL	285	163	332	35	0	815
Dysthymia	F	92	165	798	261	26	1342
	M	51	160	474	131	15	831
	TOTAL	143	325	1272	392	41	2173
Alcohol Abuse	F	26	244	275	51	3	599
	M	150	883	2431	460	52	3976
	TOTAL	176	1127	2706	511	55	4575
Drug Abuse	F	385	347	210	2	1	945
	M	668	686	695	4	0	2053
	TOTAL	1053	1033	905	6	1	2998
Antisocial Personality[3]	F	72	55	78	0	0	205
	M	450	198	472	18	5	1143
	TOTAL	522	253	550	18	5	1348
Severe Cogn. Impairment	F	18	38	47	59	60	222
	M	40	31	56	61	88	276
	TOTAL	58	69	103	120	148	498
Schizophrenia & Schizophreniform	F	128	73	327	35	5	568
	M	87	115	187	42	0	431
	TOTAL	215	188	514	77	5	999

1 Incidence rates for disorders by gender and age (Table X0, are multiplied by population figures, also broken down by gender and age (Table X3 and X5). As those figures are based on six month estimates, totals for disorders can be compared to column 3 of Table 13 of the University of Alaska's report.

2 Estimates for ages 0-17 are highly speculative, based on estimated incidence rates of Table W2 of the University of Alaska's report. The rates likely reflect lifetime rather than six month prevalence.

3 For ages 0-17 this includes any personality disorder, for 18+ it refers only to antisocial personality disorder.

Table 5 - Conversion of lifetime disorder prevalence to six-month Utilization rates.

	Lifetime disorder prevalence per 100 population	Chronicity ratio [1]	Six-Month prevalence per 100 population	Disorder to primary diagnosis expectancy [2]	Estimated six-month incidence for primary diagnosis/100	Six-Month utilization coefficients [3]	Six-Month utilization rates per 100 population
Alco Abu	13.63	.369	5.0	.818	4.115	.138	0.568
Drug Abu	5.63	.358	2.01	.323	0.651	.138	0.090
Sczphnia	1.51	.604	0.91	1.000	0.911	.463	0.422
Sczpform	0.17	.813	0.14	1.000	0.136	.463	0.063
Manic Ep	0.92	.670	0.62	.329	0.203	.314	0.069
Maj Depr	5.23	.561	2.93	.614	1.801	.314	0.612
Dysthym	2.99	1.000	2.99	1.000	2.986	.314	0.938
Anxiety [4]	16.11	.610	9.82	.790	7.762	.201	1.56
Antisoc	2.66	.319	0.85	.126	0.107	.231	0.025
Cogn Imp	1.21	1.000	1.21	.790	0.952	.061	0.059

1 Chronicity ratio is based on reported lifetime prevalence rates and six month prevalence rates from NIMH (Oct. 1984).

2 Disorder to Primary Diagnosis Expectancy is based on interpolation from co-occurrence coefficients reported in NIMH (Oct. 1984) and on ranking of disorders according to composite chronicity coefficient (Table 20 - of the UAF report). Assumption is that more recurrent disorder is the one which will attract diagnosis.

3 Utilization coefficients are based on mental health visits for disorder types as reported in NIMH (Oct 1984). Figures here are averages for reporting sites weighted by respondents per site. Subdisorders are given same coefficient of general category to which they belong.

4 Anxiety includes phobia, panic, obsessive compulsive and somatization. Expectancy for anxiety and severe cognitive impairment is based on simple overlap factor of .21 found for mean DIS disorders.

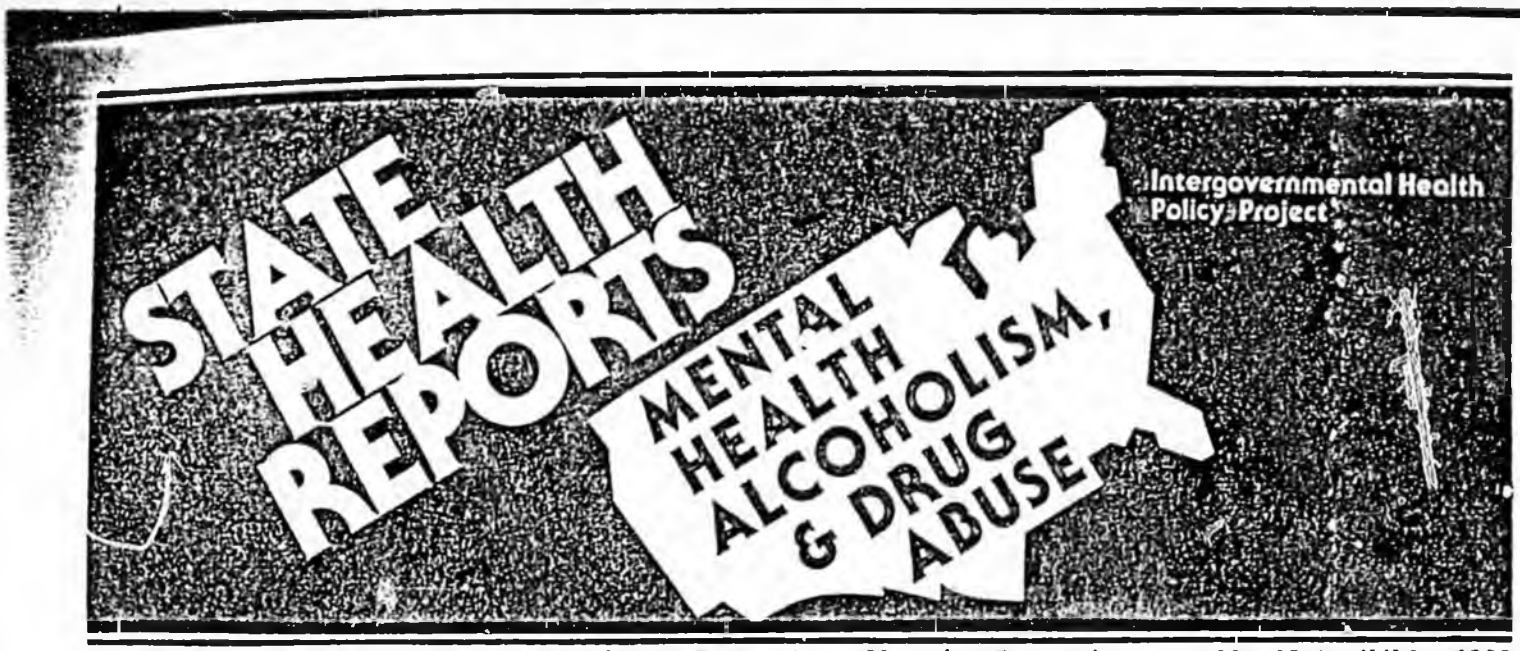
Table 5.1

Northern Alaskan Estimates:
Disorder, and Diagnosis Prevalence and
Anticipated Demand for Mental Health Services

	Estimate of Lifetime Disorders Northern Alaska	Chronicity Ratio	Estimated Six Months Prevalence	[2] Primary Diagnosis Coefficient	Estimated Prevalence by Primary Diagnosis	[2] Six Month Utilization Coefficient	Anticipated Demand for Six Month Period For Mental Health Services if Accessible
Alcohol Abuse	15,259	.369	5631	.818	4606	.138	636
Drug Abuse	5,303	.358	1898	.323	613	.138	85
Schizophrenia	1,465	.604	885	1.000	885	.463	410
Schizophreniform	136	.813	111	1.000	111	.463	51
Manic Episodes	121o	.670	815	329	268	.314	84
Major Depression	3664	.561	2055	.614	1262	.314	396
Dysthymia	2,153	1.000	2153	1.000	2153	.314	676
Anxiety Disorders	13,566	1.000	8275	.790	6537	.201	1314
Antisocial Personality	4225	.319	1348	.126	170	.231	39
Severe Cogn Deficit	536	1.000	536	.790	423	.061	26

[1] From Table 7

[2] Coefficients for chronicity, diagnosis and utilization come for Table 22 of the UAF report.



In This Issue: • California and Texas Reform • Prevention • Homeless Research *No. 15 April/May 1985*

Dramatic Reforms to California's Mental Health System

Major bipartisan legislation to help thousands of homeless CALIFORNIANS has been introduced into the CALIFORNIA Assembly (AB 2541). The bill, known as the CALIFORNIA Mental Health Services Reform Act of 1985, establishes a system of priorities and creates innovative ways to serve the most severely ill adults and children. In addition to the homeless, the bill provides for programs to mentally ill children, mentally ill petty offenders who are often inappropriately placed in local jails, mentally ill criminal offenders after release from prison, and mentally ill elderly.

The legislation is the product of the Assembly Select Committee on Mental Health's year-long study of mental health care in CALIFORNIA. Even though the population has declined in CALIFORNIA's state hospitals from 35,000 to under 5000 today, state funding for county mental health programs has not increased. In fact, state officials note that state funding for county mental health programs has dropped from an average of $16 per resident in 1978 to $13 today, a decrease of $150 million.

In a unique departure from current practices, the bill proposes to create social support agencies in communities plagued with large numbers of the homeless mentally ill. State officials estimate that approximately 40 percent of the state's homeless are severely mentally ill.

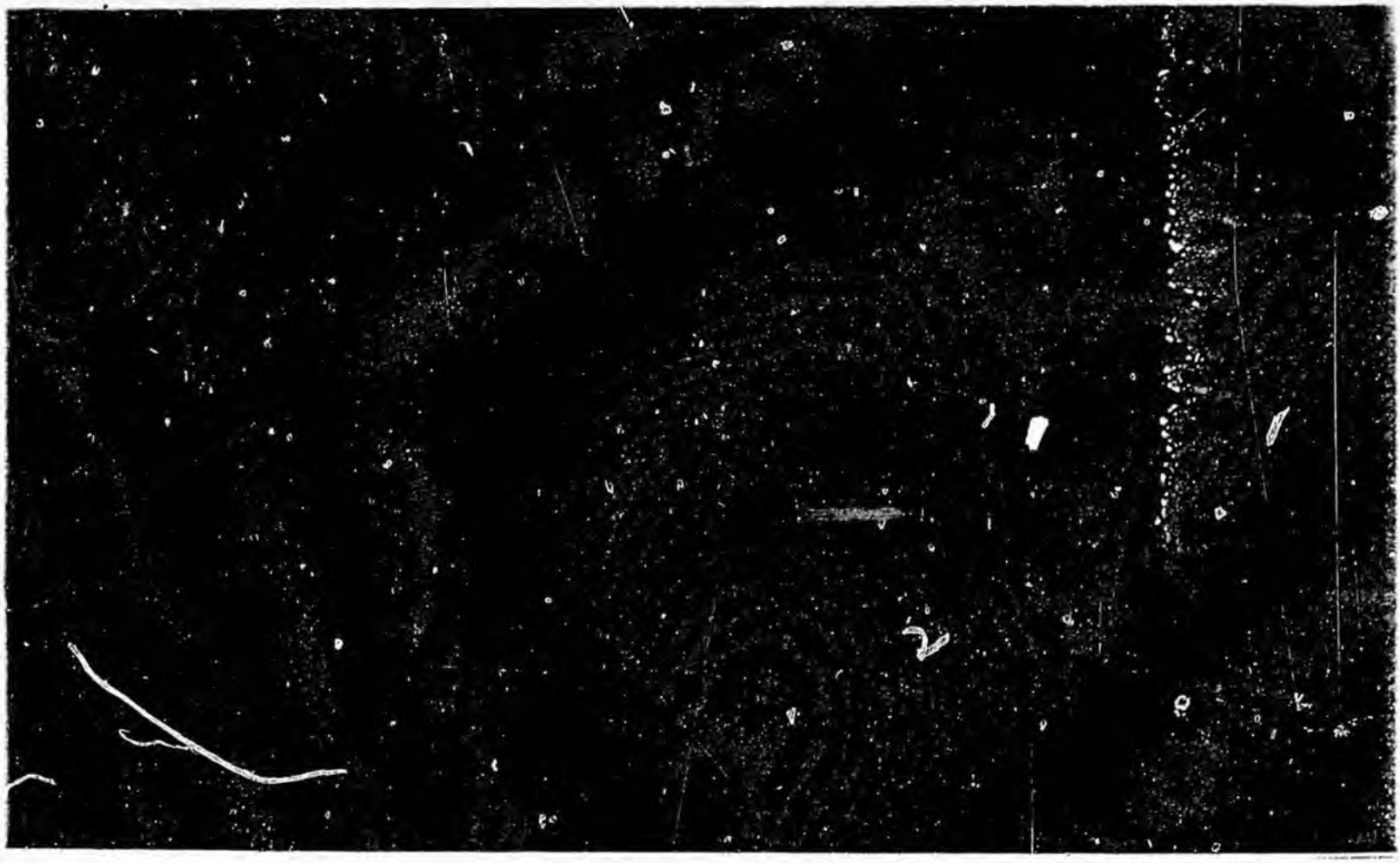
AB 2541 creates an innovative program to provide basic social services (housing, food, clothing) to the chronically mentally ill. The goals of these new "social support agencies" would be achieved through active local outreach to these people (many of whom are now homeless), redesigned financial structures to collect the Federal and state monies due these people, and ongoing advocacy on a continuous basis to help the clients survive in the community and to help them obtain mental health and other social services as appropriate for their individual needs.

Counties interested in developing these programs for the homeless mentally ill would submit a plan to the state detailing who they would serve, what programs or organizations would be involved, and what services would be provided clients. A county plan may include a central role for a private or nonprofit community organization as well as for existing public agencies or programs. The state would review these plans based on the ability to deliver food, shelter, and clothing to clients and the ability to stabilize community living for the people who are served.

Once a plan has been approved by the state, the local social support agency would directly receive state and federal income benefits for all the clients they serve.

With this money—which includes a $504 per month SSI/SSP payment for each client—the agency would purchase or arrange for services needed by particular clients. In addition to basic living needs, these may include counseling and teaching in independent living skills, transportation to medical or mental health appointments, and recreational and other activities for clients based on individual needs.

AB 2541 also provides for programs



for mentally ill children and places the county mental health officials at the center of decision-making concerning how and where to care for seriously emotionally disturbed children and adolescents. Currently, when a child is identified as being seriously emotionally disturbed and in need of some special placement, a multi-agency tug-of-war takes place, often without the input of mental health officials. This measure requires the county mental health director to be notified whenever a child is first identified as having a serious mental health problem, whether the child was first seen in the schools or was a ward of the courts, juvenile justice, or social services.

AB 2541 further requires the county to assign a mental health case manager to follow each child from the start, through his or her treatment and back to the family or other appropriate placement. The bill also requires county mental health departments to work with the schools in their county to arrange for more non-hospital treatment options for the emotionally disturbed children they serve. Up to $20 million has been requested for the childrens programs.

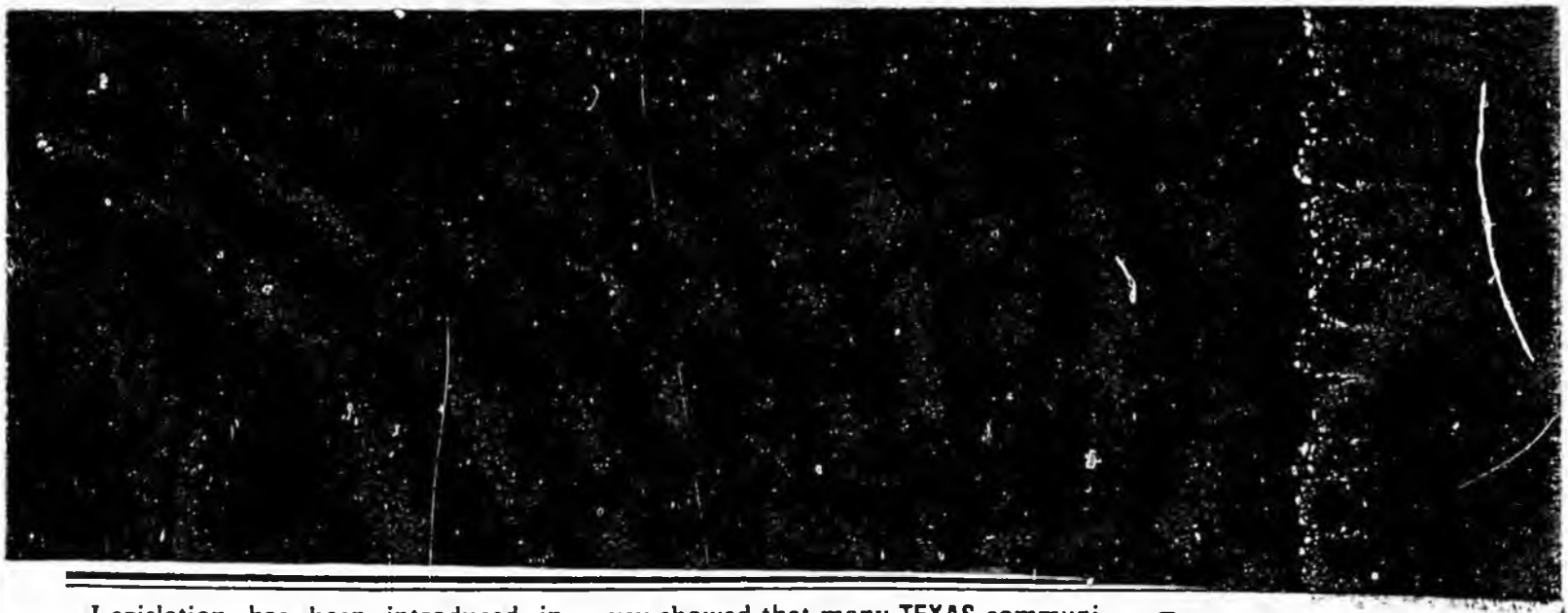
Other measures included in the proposal include the following:

- provides $12 million to counties to divert the mentally ill petty offenders from inappropriate placement in local jails and to expand the mental health treatment being provided in the jails;
- allows the Department of Corrections to place mentally ill parolees in an intensive mental health program to help them make the transition back to the community and to reduce the threat of danger to the community;
- provides the courts and mental health facilities the option of requiring someone to receive outpatient mental health treatment when they are being held involuntarily for treatment under CALIFORNIA's civil commitment act. Currently, people are either held in a locked, inpatient hospital setting or completely released, with no placement options available between these two extremes;
- provides $2 million in funding to counties to develop outreach and services to the isolated elderly; and
- expands Medi-Cal coverage of outpatient care.

In total, the bill appropriates just over $53 million for three years.

COLORADO is considering a measure (HB 1046) that would require that the

NEW YORK is considering a measure that would require the Director of the



State Authority and Local Accountability Strengthened in Texas

Legislation has been introduced in **TEXAS** that amends the Mental Health and Mental Retardation Act to incorporate statutory changes recommended by the Legislative Oversight Committee on Mental Health and Mental Retardation, established in June 1984. The Committee was formed to help resolve a crisis facing the mental health delivery system. **TEXAS'** system has been plagued by several concommitant problems: a federal court order to improve the care and treatment in state hospitals; the absence of basic services in most communities that assist individuals to avoid inappropriate hospitalization and to function optimally in the community; the failure of the service delivery system to keep pace with the growth of the population of the state; and the most severe budget limitations that has faced **TEXAS** in decades.

Volume I of the committee's final report makes over seventy recommendations related to planning, management, funding, quality control, accountability, and service delivery for the mental health system. Some of the more significant findings include:

- The first dollar spent for mental health services in **TEXAS** must be for screening and emergency services. A survey showed that many **TEXAS** communities are lacking in this capability.
- Case management must be implemented as a fundamental method of service delivery for clients with long term and multiple needs.
- The organization and management of the mental health service delivery system must be strengthened to encourage coordination and accountability at all levels. Specific recommendations in this regard include replacing the current state grant-in-aid system of funding community mental health and mental retardation centers with legally binding contracts, increase coordination with substance abuse providers and stronger quality assurance monitoring.
- There is a lack of community residential alternatives throughout the state. A goal of 60 alternative care beds per 100,000 population must be pursued.
- There is no operational long range strategic plan that enables compliance with provisions of the Settlement Agreement in the R.A.J. vs. Miller federal lawsuit. The **TEXAS** Department of Mental Health and Mental Retardation must implement such a plan by August 31, 1985. Included in the plan must be the setting of priority populations to insure that those in greatest need receive ser-

of their own funds to the disease over the last three years, including monies appropriated specifically for AIDS (in only eight states) and monies from health department budgets.

CALIFORNIA's concentration on the disease skews the totals, however. Of the $40 million earmarked specifically for AIDS, for example, **CALIFORNIA** accounted for an estimated $27 million, with about half—$13.5 million—going for research. Together, the states spent about $20 million for research.

Most of the rest of the money was spent for surveillance activities, laboratory services, public education and testing. Funding requests totalling more than $8.5 million will be pending in at least 10 states when their legislatures convene in January.

Copies of the report are available from IHPP for $10 prepaid. There is no charge to government officials.

Model Community Programs In Maine, Rhode Island

Two new programs in **MAINE** and **RHODE ISLAND** aim to prevent institutionalization of chronically mentally ill persons. **RHODE ISLAND's** program provides a subsidy to parents or guardians who care for their friends or relatives at home, while **MAINE's** program has set up respite, crisis stabilization apartments in the community to prevent unnecessary psychiatric hospitalization.

The **MAINE** Department of Mental Health and Mental Retardation, under the auspices of the Office of Community Support, has launched a pilot crisis stabilization program in three counties. The basic objective of the Crisis Intervention Program is to prevent or reduce the frequency of inpatient hospitalization for individuals undergoing a psychiatric or situational crisis. In addition to the client being served, the family, friends, or neighbors who are involved in the crisis may avail themselves of the program.

The Crisis Intervention Program extends the numerous psychiatric emergency services available during regular business hours into evening and weekend hours, and supplements existing services with staff and respite beds. The program provides a viable and reasonable option for people who are being considered for admission to Augusta Mental Health Institute or, who without this service, may very soon present themselves for admission.

The services in the program include a respite apartment in each of the three areas being served, used as an alternative to hospitalization; homemaker services available through the respite apartment, for the care and support of the person in crisis; care and treatment from two crisis intervention staff members; family support for the relatives of the patient; information and referral to various community agencies; and follow-up services and support. Screening, assessment and referral take place at the primary point of access, which could be an emergency on-call person at the area mental health center, the medical center emergency room, or the program's local office.

The Crisis Intervention Program strives to offer the maximum amount of treatment in the least restrictive setting possible. The targeted, priority clients are the young adult chronic population. They are 18 to 40+ years old, have a history of two or more admissions in the last 12 months, have a recent history (within the last 24 months) of psychiatric hospitalizations with a major mental health illness, or have had multiple emergency psychiatric contacts in the community in the past 12 months. Other indicators for involvement of the Crisis Intervention Program are that the person is experiencing a situational crisis, combined with an exasperation of psychiatric symptoms, and needs either security (but not hospitalization) or emergency housing supports; the person displays a need for help but is unable or unwilling to obtain it; the person may not be currently involved with a mental health agency, private provider, or other involved agency or the provider is unable to respond. Other considerations for referral to the program are that the person is free of acute medical problems or infectious diseases, is ambulatory, capable of self-preservation, able to care for his own physical needs, not seriously under the influence of alcohol or nonprescription drugs, and voluntarily accepts referral and the limitations for residency in the respite and transitional services.

The legislature has appropriated $200,000 for the program, which state officials anticipate will help decrease inappropriate and unnecessary admissions and readmissions to psychiatric inpatient units. In addition, they believe the program will lead to greater access to ser-

vices for chronically mentally ill young adults, and improved appropriateness, continuity and quality of community-based services and supports.

RHODE ISLAND taking a somewhat different approach, has established a program that aims to reduce admissions to state facilities as well as encourage discharges from state facilities into the community. **RHODE ISLAND's** law (Sec. 40.1-1-10.—40.1-1-10.1) will permit parents or guardians of mentally disabled persons to receive up to $75 a week, including training, to prevent admission or allow discharge from any state institution operated by the Department of Mental Health, Retardation, and Hospitals. This legislation was fully supported by the executive and legislative branches of government and does not require an additional appropriation since the director of MHRH can shift funds from the state institutions to this program.

The subsidy program makes available care, treatment and training to eligible people in family homes rather than in public institutions. The subsidy program thereby furthers the provision of home- and community-based care, treatment, and training to eligible individuals.

When the law was first enacted in 1978, only mentally retarded residents were eligible. A series of amendments has broadened eligibility to include patients in other public institutions (including the mentally ill) as well as certain people who have not yet been institutionalized.

A "parent" is defined as a relative, friend, court-appointed guardian or other person willing to care for a disabled person. The purpose of this program is to help defray expenses involved in caring for a disabled person within a community setting. The fiscal subsidy is in addition to any other payments the applicant or disabled person may be receiving.

A "home evaluator" determines eligibility of the "parent applicant" and the suitability of placement of the disabled person. The placement is supervised with monthly visits for the first three months and quarterly visits thereafter. There is no "means test" for "parent applicants" except in the case of natural parents where annual income cannot exceed 400 percent of the federal poverty guidelines (approximately $21,000 per year for a family of one).

Eligibility requires that the disabled person has been a resident or patient in a state institution for more than 90 days, or would likely be eligible for such placement lasting more than 90 days. An annual contract is established between the parent applicant and the Department of Mental Health, Retardation and Hospitals. Geriatric, Alzheimer's, mental health, mental retardation, developmental disabilities, and substance abuse populations are eligible.

New Commitment Standard Proposed

WISCONSIN legislators have recently introduced a bill SB 350, that would create a new commitment standard for people who are not quite dangerous, but yet require care to prevent further deterioration. Under **WISCONSIN's** current law, as well as under the laws in most other states, a person may be involuntarily committed for treatment only if it is found that the person is mentally ill, drug dependent or developmentally disabled, and the person is found dangerous to himself or others.

SB 350 would enable a person to be involuntarily committed if it is found that, due to mental illness, drug dependency or developmental disability, there is substantial probability that the person will suffer serious mental deterioration or develop chronic mental illness unless he or shereceives immediate treatment, as manifested by evidence of specific overt behavior or conduct that indicates the person suffers from a significant disorder that substantially impairs his or her behavior or judgment.

SB 350 also creates a new standard for emergency detention, including transfer of certain children from juvenile correctional facilities, taking a child into custody, or admission of a minor to an approved inpatient facility. Under this standard a law enforcement officer or other person authorized to take a child into custody under the Children's Code may take an individual into custody if, due to mental illness, drug dependency or developmental disability, there is a substantial probability that the person will suffer serious mental deterioration or develop chronic mental illness unless he or she receives immediate treatment, as manifested by evidence of specific recent overt behavior or conduct that indicates the person suffers from a significant disorder that impairs substantially

STUDIES

HEALTH
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July 1982

FUNDING CRITERIA FOR COMMUNITY MENTAL HEALTH SERVICES

States can be divided into four groups according to the methods they use to fund community mental health programs:

I. States with no formal criteria; allocations are made directly by the state legislature.

II. States with minimum qualifying criteria in the form of administrative rules and grant application forms.

III. States that use service and program goals of the state mental health agency as the principle criteria for distributing funds among providers or sub-state regions.

IV. States that make use of a formula to determine the allocation of funds among counties, regions, or individual community mental health programs.

The methods used by states in the last two groups have been described briefly wherever possible. For more complete information on the practices of these states, copies of sections of documents from selected states have been attached.

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Executive Director

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Program Administrator

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NATIONAL ASSOCIATION MENTAL HEALTH PROGRAM

FUNDING CRITERIA FOR

COMMUNITY MENTAL HEALTH SERVICES

State	I. No Formal Criteria	II. Minimum Criteria	III. Services and Program Goals	IV. Formulas
Alabama				x
Alaska				x
Arizona			x	
Arkansas				x
Colorado				x
Connecticut				x
Dist. of Col.		x		
Georgia		x		
Illinois			x	
Indiana			x	
Iowa			x	
Kansas		x		
Kentucky		x		
Maine				x
Maryland			x	
Massachusetts			x	
Michigan			x	
Minnesota				x
Missouri			x	
Nebraska		x		
Nevada			x	
New Hampshire				x
New Jersey			x	
New Mexico				x
New York				x
North Carolina				x
North Dakota	x			
Ohio			x	
Oklahoma			x	
Oregon			x	
Pennsylvania				x
Rhode Island				x
South Carolina			x	
Tennessee				x
Vermont		x		
Virginia				x
Washington				x
West Virginia				x
Wyoming		x		

Group I. COMMUNITY MENTAL HEALTH SERVICE FUNDS ARE ALLOCATED DIRECTLY BY THE STATE LEGISLATURE WITH NO FORMAL CRITERIA:

(1) North Dakota

Group II. MINIMUM QUALIFYING CRITERIA AS THEY ARE SET OUT BY ADMINISTRATIVE RULES, STATE LAWS, AND GRANT APPLICATION FORMS:

(2) Georgia
(3) Kansas
(4) Kentucky
(5) Nebraska
(6) Vermont
(7) Wyoming
(8) District of Columbia

Group III. ALLOCATIONS MADE TO PROVIDER GROUPS OR REGIONAL BODIES BASED ON SERVICE PRIORITIES DETERMINED BY THE STATE MENTAL HEALTH AGENCIES:

(9) Arizona
(10) Illinois
(11) Indiana
(12) Iowa*
(13) Maryland
(14) Massachusetts
(15) Michigan
(16) Missouri
(17) Nevada
(18) New Jersey
(19) Ohio
(20) Oklahoma
(21) Oregon
(22) South Carolina

Brief Descriptions of State Funding Methods**

Indiana:

The Department of Mental Health allocates funds to the State's 30 CMHCs through an intensive review of each center's budget, which involves a careful analysis of the services provided and a comparison of costs among centers.

Iowa:

The Department of Mental Health has separated into 8 categories the kinds of services it will consider funding. The agency and its board determine which of these categories are high priority areas, and programs are funded on the basis of how successfully

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* Copies of documents describing the methods of these states are attached.
** Based on state-provided documents.

they will provide the desired services. In addition, three other factors are considered in allocating funds:

- the unique needs of individual CMHCs;
- the quality of the proposals;
- the degree to which the proposals will involve close coordination with the state agency and/or two or more CMHCs.

Massachusetts:

Allocations are made to catchment areas within the State through a central budgetary process requiring legislative action. After the budget is approved, the directors of each catchment area allocate funds based on the extent to which:

- the services provided are needed to complete a balanced network of residential and non-residential services to citizens at risk in the catchment area;
- the services provided are needed to prevent admission and readmission to state-operated inpatient units;
- the services and service providers have demonstrated in the past a high degree of efficiency and effectiveness.

Missouri:

The Department of Mental Health contracts directly with individual community service providers. The Department has divided CMHCs into three groups according to the range of services offered. The three categories are: "core services," "intermediate services," and "full services." The Department establishes its priorities based on the general goal of funding all 26 service areas at the "intermediate" or "full" services level.

Nevada:

The Division of Mental Hygiene and Mental Retardation allocates funds on the basis of a needs assessment and budget review for each CMHC.

Ohio:

Through line items in the budget the State Legislature appropriates funds to be spent both on general mental health services and on specific services, populations, and service providers. The Department of Mental Health further defines how these appropriations are to be distributed by establishing "Eligibility Guidelines" and "Allocation Guidelines," which are based on the Department's service and program priorities.

Oklahoma:

The Department of Mental Health awards funds for alcohol services to local agencies based on budgets that are developed by community-based programs and submitted to regional planning bodies and then a state advisory council. State funds for drug abuse services are allocated in a similar way, but most of the money for these services comes from federal programs.

Funds for mental health services are allocated in much the same way as alcohol services are with the exception that the Department requires each CMHC to provide a minimal level of care for the Department's highest priority population group--the seriously mentally ill. A second priority of the Department is outpatient services for 6 other specified dependent or disadvantaged groups.

South Carolina:

The Department of Health is striving to base its allocation of funds on a one-to-one matching ratio of state-to-local money. Currently, however, money is apportioned to individual centers on the basis of need. Maintaining established programs and providing services for the chronically mentally ill are the main priorities of the Department.

Group IV. A FORMULA IS USED TO DETERMINE THE FUNDING LEVEL FOR REGIONS AND INDIVIDUAL COMMUNITY PROGRAMS:

(23) Alabama
(24) Alaska
(25) Arkansas
(26) Colorado
(27) Connecticut
(28) Maine
(29) Minnesota
(30) New Hampshire
(31) New Mexico
(32) New York
(33) North Carolina*
(34) Pennsylvania*
(35) Rhode Island
(36) Tennessee*
(37) Virginia*
(38) Washington
(39) West Virginia

Brief Descriptions of State Funding Methods

Alabama:

The Department of Mental Health allocates funds on a per capita basis to individual CMHCs.

Alaska:

Funds are allocated on the basis of three criteria:

- grant application (program proposal and budget request);
- evaluation of previous year's performance;
- recommendations of the State Mental Health Advisory Council.

In addition, there is a matching fund requirement for the mental health districts. The matching funds ratios are:

- 90% state funds to 10% local funds for poverty districts;
- 75% state funds to 25% local funds for non-poverty districts.

Colorado:

The legislature usually allocates the same amount of funds to individual CMHCs each year, except for a small cost-of-living increase and, occasionally, an additional amount to help make up for declining federal funds for certain centers. Whenever there are more funds than there were the previous year Colorado uses a formula--which changes periodically--along with other criteria to apportion them.

The factors used--some as parts of a formula--in determ funding levels have been: spending per capita, identified need, declining federal funds, and political intervention by individual legislators.

Connecticut:

When there are more funds available than there were the previous year, the additional funds are distributed to each of the State's five regions on the basis of four criteria:

Needs Indicators	Assigned Weights
Population	85%
Per capita income (inverse need factor)	7%
Unemployment	5%
State hospital admissions	3%

Maine:

The following formula is used to allocate funds to CMHCs:

- 30% of the budget is allocated on the basis of population (adjustments are made to allow for disproportionate concentrations of priority populations and for the increased costs of serving large geographic areas with low population density;
- 20% of the Bureau of Community Mental Health Services' budget is allocated on the basis of total mental health resources existing in each area;
- 50% of the Bureau's funds are allocated at the discretion of the Director, who bases his decisions on the criteria of high quality, cost effectiveness, and the qualifications of the providers.

Minnesota:

Using a formula, funds are awarded to counties in the form of a block grant for the areas of mental health, mental retardation, alcoholism, drug abuse, and day care services. The counties are limited in their use of these funds only by very general guidelines established by the state legislature and the Department of Public Welfare.

The formula is designed to provide greater funds for counties with a disproportionately high number of dependent citizens. It is based on three factors, all of them weighted equally:

- average number of people in the county who are recipients of: AFDC, state general assistance, and state medical assistance;
- county population;
- per cent of people in the county over 65 years of age.

New Hampshire:

The Division of Mental Health and Developmental Services uses two formulas to determine funding levels for each CMHC, one for allocating state funds and one for distributing federal block grant money:

- State funds are allocated on what is essentially a per capita basis except for the condition that no center receive less money than it did the year before.

- Federal block grant funds are allocated according to a formula which rewards centers for reducing hospital admissions and treating more patients at the centers.

New Mexico:

A formula is used by the Bureau of Mental Health to determine which proposals to provide services are to be funded. The following factors are part of the formula:

- projected level of utilization of services;

- expenditure rate;

- program performance as measured by:

  - service to target populations;

  - standards compliance;

  - contract reporting requirements.

- successful planning and budgeting as indicated by:

  - proposal documentation;

  - appropriateness of the budget level to the proposed services level;

  - consistency with Bureau priorities.

New York:

State funds: In general, after careful review of their programs and budgets, the Office of Mental Health allocates state funds to county governments on a one-to-one matching basis of state-to-local funds. The highest priority for the Department in allocating

both state and federal funds is adequate services for the chronically mentally ill.

Federal block grant funds: For the present, federal block grant funds are distributed by the State in much the same way that they were under the CMHC Act. Federal funds are allocated to three areas:

1. CMHCs that at one time received a grant from NIMH and would have been eligible to receive a continuation grant had the CMHC Act remained in existence.

   - The application and budget of each of these mandated CMHCs will be carefully reviewed. However, funds will generally be allocated on the basis of the old CMHC Act funding methodology.

2. CMHC's that, whether or not they were ever funded by NIMH, now meet the new CMHC definitions.

   - Allocations will be based upon the needs and priorities as identified in the ADM block grant and state and local plans.

3. Administrative costs.

North Carolina:

After exploring a number of different options, a state task force on area program funding recommended that new mental health funds be distributed to area programs on the following basis:

- 50% of new funds on a per capita basis to help defray costs caused by inflation and salary increases;
- 50% on a per capita basis to programs which are below the per capita statewide mean in order to provide funds toward equalization;
- certain special pilot projects should continue to be funded with categorical funds.

Pennsylvania:

A complex formula, which provides two separate scores, is used to allocate funds to the counties.

1. The performance score is used to determine cost-of-living increases.

2. The needs score provides the basis, together with each county's annual plan and budget, on which new program money is allocated.

Rhode Island:

The general priorities of the Department of Mental Health, Retardation and Hospitals are set forth in the State Mental Health Plan. However, the funding process for community programs is specially designed to direct resources to serving the chronically mentally ill.

The funds allocation process is as follows:

1. All funds available for community mental health services from the State Department of Mental Health and the federal block grants are combined.

2. From this aggregate fund is set aside an amount sufficient to pay for certain services for the chronically mentally ill: the group home program, two currently existing inpatient programs providing alternatives to the State Hospital, 24-hour emergency services in each of the State's eight catchment areas, and a pilot non-hospital acute services program.

3. Next, a second amount of money is set aside to meet state-to-local matching fund obligations. Currently, $2.33 of state money is allocated for every $1.00 of local funds spent.

4. The remaining money from the aggregate fund is allocated to centers on the basis of catchment area population levels with adjustments made according to characteristics chosen by the State that are believed to indicate the incidence of mental illness.

After the mental health funds are divided in this manner, separate contracts are awarded by the Department of Mental Health, Retardation, and Hospitals to groups providing the above services. The one exception is that a little less than half of the State's contribution in matching funds is left to communities to spend according to their priorities as long as they are consistent with the State plan.

Tennessee:

Funds are distributed to community programs principally on a per capita basis. However, once a certain base-level of funding is

achieved a formula is used which provides CMHCs with additional funds by transferring them from state hospital budgets as patients leave the hospitals and return to the community centers to which they are assigned.

Virginia:

Funds are allocated to community services boards on the basis of two sets of formulas: one is used to distribute state funds, and the other is used to determine minimum required local matching funds. Because of limited funds, however, these formulas have been only partially implemented. Whether or not these formulas are used, the general goal of the Department of Mental Health and Mental Retardation has been to maintain the current level of services, ensure that certain core services are provided, and increase funds 10% each year.

- The formula for determining allocation of state funds is based on the following factors:
  - population (weighted 90%)
  - relative need (weighted 10%)
- The factors making up the formula to calculate minimum required local matching levels are:
  - relative tax effort;
  - relative ability to pay;
  - statutory minimum of 10% match.

Washington:

Funds are allocated to counties on the basis of the following formula:

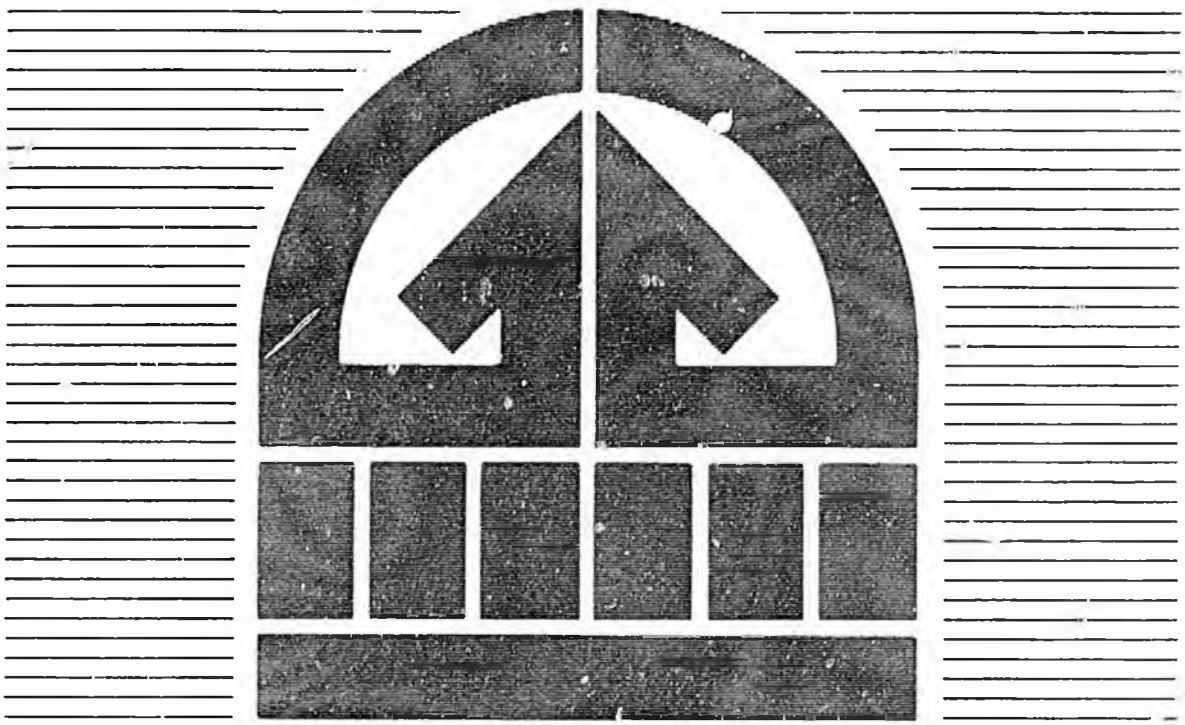
- each county receives $50,000 for staffing requirements, if the money is available;
- 10% of the funds are reserved for special projects;
- the remaining funds are distributed on a per capita basis.

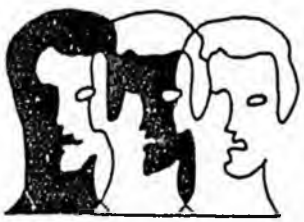
West Virginia:

To determine the funding level for any community mental health program the Division of Behavioral Health Services makes the following calculations:

- amount of funds necessary to maintain current services (equals previous year's level of funding);
- amount of money needed to offset inflation (set at 80% of the current inflation rate for the year and based on gross revenue as shown in contractee's certified audit of the previous fiscal year);
- money needed to offset loss of federal funds (80% of the actual loss);
- funds necessary for expansion of existing programs (80% of the amount requested for an approved new program).

STATE LEGISLATIVE REPORT





MENTAL HEALTH

PROJECT

Human Resources Series

THE HOMELESS MENTALLY ILL:

NO LONGER OUT OF SIGHT AND OUT OF MIND

by

Andrea Paterson and Rebecca Craig

Vol. 10, No. 13 December, 1985

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THE HOMELESS MENTALLY ILL: NO LONGER OUT OF SIGHT AND OUT OF MIND

INTRODUCTION

They're a familiar sight on many downtown street corners: challenging the voices only they hear, demanding answers from passersby. Since the early 1960s, the increasing presence of the mentally ill among our nation's homeless has substantially changed the face of this troubled population. Bewildered by the noise and confusion of the city, they huddle over grates, trying to protect their bodies against the frigid cold. They wait in lines for a hot meal or a place to spend the night. They rattle up and down back alleys, riffling through dumpsters, sleeping in cardboard lean-tos. In the shelters, the homeless mentally ill are preyed upon by the stronger members of the homeless population. They are a group neglected and forgotten by society. Nationwide, according to the National Coaltion for the Homeless, roughly 300,000 chronically mentally ill are homeless. (1, p 1). The reasons behind their presence on the streets are complex, their future uncertain.

OVERVIEW: THE VISION AND THE REALITY OF DEINSTITUTIONALIZATION

Today's Problems: Looking Back After Twenty Years. Although the numbers vary, between 25-50 percent of the nation's homeless are mentally ill (2, p. 88). Between 20-40 percent of the nation's homeless men and between 50-85 percent of the homeless women are chronically mentally ill (1, p. 7). One study indicates that roughly 15 percent of the nation's total chronically mentally ill population is homeless (1, p. 5). The study further reports that, once homeless, only 15-30 percent will receive any kind of mental health assistance (1, p. 6). In human terms, the meaning of these percentages is evident on the streets of America's cities; in public policy terms, the percentages demand reconsideration of a sound idea--the deinstitutionalization of the mentally ill--gone astray.

Deinstitutionalization not only changed the mental health service delivery system, but dramatically altered the lives of the chronically mentally ill. The dream of deinstitutionalization, however, rarely equaled the reality. While today's chronically mentally ill are no longer relegated to the back wards of the state hospitals, they are often isolated in the communites; they hardly live lives of easy access to locally coordinated mental health services. In short, the policies and practices of federal and state deinstitutionalization efforts, as well as federal, state, and local housing policies, have helped produce a tangle of interlocking problems that often work together to encourage recidivism and homelessness.

- Criminalization. Because the homeless mentally ill can be extremely disruptive and a public "eye sore," many communities have begun to insist that something be done to get them off the streets. Yet the lack of community-based housing and support services has left to local jails the jobs of caring for and treating these individuals. Estimates range as high as 34 percent of the county jail residents sharing a common history of homelessness (2, p. 68).

- The Revolving Door/Recidivism. The paucity of community-based services has created a sub-group of mentally ill individuals who shuttle back and forth between the hospital and the community. Unable to access the services that could help them lead more stable lives,

the homeless mentally ill are particularly inclined to be caught in this "revolving door." A recent study of admissions to a San Francisco general hospital's emergency psychiatric unit indicated that 30 percent of the patients admitted were homeless (2, p. 94).

- o A New Category of Young Chronic Patients. Deinstitutionalization's checkered twenty-year history has helped spawn a generation of young chronic patients who have, at most, been briefly hospitalized or have received only marginal care and assistance in coping with their illness. The high incidence of homelessness among this group has significantly lowered the average age of the mentally ill homeless individual.

- o Inadequate Living Arrangements and Support Services. Within the communities, the range of residential programs necessary to keep the mentally ill off the streets simply does not exist. While board and care facilities and single-room-occupancy hotels (SROs) often mean the difference between an immediate home and homelessness, these facilities lack the support programs and the supervision necessary to avert the future homelessness of a mentally ill person in crisis.

Deinstitutionalization: The Promise. Prior to the deinstitutionalization movement of the 1960s and the 1970s, the mentally ill had been largely warehoused in state hospitals. Deinstitutionalization seemed to promise a brighter future. New psychoactive drugs protected those in crisis against one-way tickets to the state hospital. Community-based treatment promised greater civil liberties and individualized care for the mentally ill and greater financial freedom for the states, long since burdened with supporting their overflowing state hospitals.

Significant federal legislation and changes in state commitment laws accelerated deinstitutionalization efforts. Aid to the Disabled (AID) provided first time, categorical federal support to the mentally ill in the community in 1963. In 1965 and 1974 respectively, the regulations governing Medicare/Medicaid and Supplemental Security Income transferred a large portion of the state costs for the care of the mentally ill to the federal government. The federal Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 provided grants for the initial costs of staffing the newly constructed centers. State commitment laws were revised to protect the civil rights of the psychiatric client, rendering involuntary commitment a more difficult and complex process.

Primary Causes for Homelessness: The Lack of Commitment to Deinstitutionalization. While deinstitutionalization promised a bright future, few disputed that the movement would have to be supported both by dollars and by an ongoing public policy commitment. Many mental health professionals, consumers and advocates claim that this necessary, long-term support never materialized. The areas are many in which the policies to implement deinstitutionalization were a far cry from the dream.

First of all, states lacked financial commitment to the deinstitutionalization of the mentally ill. Dollars that could have followed the mentally ill out of the state hospitals and into the community generally did not follow. Even after many of their residents were gone, the state hospitals continued to place considerable demands on the financial resources of the

state mental health systems. New state funds specifically targeting community-based treatment programs were slow to come. In many states, state hospital funds were cut without an accompanying increase in funding for community programs.

Secondly, the open, loosely structured settings of the community treatment system were frequently not appropriate to the treatment needs of the chronically mentally ill, who often deal poorly with stress, have trouble negotiating service bureaucracies, and are frequently isolated from and suspicious of systems that have consistently failed to address their problems. Left to fend for themselves in the community, the deinstitutionalized mentally ill were often unable to piece together a treatment program, even when the necessary services existed. Moreoever, community service providers who often misinterpreted this inability as a lack of motivation or an ambivalence toward services, began to pass over the severely and chronically mentally ill in favor of populations seemingly more willing and receptive to treatment.

Finally, the states did not act to ensure an appropriate range of residential treatment alternatives. Of the nearly half-million patients released during deinstitutionalization, many simply ended up back with their families. In some communitites, as many as one-third ended up in minimum-service facilities such as board-and-care homes (2, p. 63); others were forced to make do in single-room-occupancy (SRO) hotels and nursing homes, which offered, at best, custodial care, when more extensive support services were needed.

Additional Causes of Homelessness: 20 Years of Social Services and Housing Strife. Many additional factors have contributed to homelessness among the mentally ill. The general erosion of mental health and social services on both state and federal levels has increased competition for existing services, already inaccessible to many homeless mentally ill. Federal dollars going to state block grants for community mental health services have been reduced. Changes in federal and state aid policies that have traditionally affected the underprivileged ill have also encouraged homelessness among the mentally ill.

- The eligibility requirements for Social Security Disability Insurance are time-consuming and complicated. Applications for Supplemental Security Income, for example, can require eight to 24 months for a determination, with 80 percent of the applicants initially turned down (3, p. 6).

- In 1981, administrators of the Social Security Disability Insurance program were ordered to begin regularly reviewing the eligibility of beneficiaries. As a result, benefits were terminated for a large number of mentally ill individuals who were dependent on the income to meet basic needs.

Moreover, the inadequate housing market available to the mentally ill has been further depleted. Rent increases, the destruction of housing, the increased demand for public housing, the elimination of many public housing programs and the preference extended to other disabled populations over the mentally ill have all contributed to the problem.

- In the past 10 years, median rent has increased at a rate significantly greater than the average income.

- Over a million single-room-occupancy (SRO) hotels, nearly half the total stock, were destroyed between 1970 and 1982. An estimated 33 percent of the hotel rooms were rented to the chronically mentally ill (1, p. 4).

- Federal Section 8 housing subsidies and public housing program funds have gone from $26.7 billion in 1980 to $8.6 billion in 1983. In 1983, no funds were allocated for construction of new public housing, as compared to $3.7 billion in 1980 (3, p. 4).

- Board and care facilities find it makes better financial sense to serve other disabled populations over the mentally ill. For a developmentally disabled client, a board/care facility would receive $525-$840, whereas a flat rate of $476 would be offered for a mentally ill person (2, p. 64).

GENERAL LEGISLATIVE GUIDELINES

The mentally ill homeless are a fundamentally different group from the homeless who are not troubled by a mental illness. They also differ from the chronically mentally ill who have homes and who are involved in treatment programs in that they tend to be more isolated from friends and family and to reject the structure of most mental health programs.

The American Psychiatric Association (APA), in its task force report on the mentally ill homeless, maintains that this uniquely troubled population requires a carefully integrated and comprehensive system of both general and specialized services. (The Community Support Program provides one model for meeting the complex needs of this population: see California case study for further information on the CSP.)

In brief, a comprehensive system of care for the homeless mentally ill would include the following components:

- A framework for meeting the basic needs of food, shelter and clothing;

- A range of housing opportunities from minimal supervision and structure to a high level of supervision and structure;

- A system of adequate mental health services combined with psychosocial rehabilitation services such as job training;

- Access to general medical treatment;

- Crisis stabilization and intervention;

- A system of ongoing case management;

- Access to general social services.

The APA maintains that states can also focus their attention in several additional areas, if they wish to stem the growing tide of homelessness among the mentally ill:

- Make adequate community-based care a right of the mentally ill;
- Fund additional research into the causes of mental illness and homelessness;
- Ensure a coordinated effort among service providers that spares the homeless mentally ill the task of negotiating different service bureaucracies;
- Provide an adequate number of community-based mental health professionals and para-professionals for the care of the chronically mentally ill;
- Spend additional money for the development of long-term solutions to the problems of homelessness among the mentally ill.

In addition, the APA recommends that states reserve some part of the former state hospital system for the ongoing institutional care of that small percentage of the chronically mentally ill who, unable to care for themselves even with adequate residential options and community support services, often end up on the streets.

THE STATES' RESPONSE IN RECENT YEARS

A few states have attempted to address comprehensively the needs of the homeless mentally ill. In general, however, state legislation addresses a discrete problem that feeds into the larger problem of homelessness, such as the lack of affordable housing and support services for the chronically mentally ill living in the communities.

Comprehensive Service Efforts. At least two states--California and New York--have attempted to address the needs of the homeless mentally ill in a comprehensive fashion. California's efforts to help the mentally ill homeless are detailed in the case study accompanying this State Legislative Report (see page 9). New York has attempted to combat homelessness among the mentally ill by passing various interlocking pieces of legislation over the last decade.

New York began by providing local governments with 100 percent state reimbursement of the net operating costs for services to persons who had been patients in a state psychiatric facility for five years or more, and who were consequently released (1974 N.Y. Laws, chap. 620), and for public assistance and care, such as AFDC and home relief, provided to discharged state hospital residents (1974 N.Y. Laws, chap. 621). The state subsequently provided full reimbursement for medical assistance provided to individuals eligible for such assistance because of a mental disorder (1983 N.Y. Laws, chap. 816).

In 1984, the legislature authorized the commissioner of mental health to establish a continuum of community residential services for the mentally ill through state aid to local governments and voluntary agencies for up to 100 percent of the operating costs and up to 50 percent of the capital costs of

such residences (1984 N.Y. Laws, chap. 298). In 1985, the legislature authorized a third state-approved residential program for the mentally ill, also eligible for 100 percent reimbursement: a "residential care center for adults," targeted at those homeless mentally ill who cannot handle the stress of more structured programs but who need more than a place to stay (1985 New York Laws, chap. 351). In 1983 New York also created the Homeless Housing and Assistance Program, establishing separate funds for housing assistance to the homeless and for shelter facilities for homeless individuals (1983 N.Y. Laws, chap. 61).

The Lack of Affordable Housing and Support Services. While not exhaustive, the following state examples illustrate approaches to the problems of housing and support services for the homeless mentally ill.

New Jersey enacted the Prevention of Homelessness Act (1984 N.J. Laws, chap. 180) to provide temporary rental or other housing assistance to persons who are homeless or in imminent danger of homelessness, to authorize special subsidies and loans to assist in the establishment of low income housing, and to provide medical support services for homeless individuals.

Illinois and Maryland, respectively, established special shelter programs for homeless youth (S.B. 1018) and homeless women (1980 Md. Laws, chap. 851, 1985 Md. Laws, chap. 151). Maryland also established (1984 Md. Laws, chap. 777) a "shelter, nutrition, and service program for homeless individuals" to provide crisis and transition shelter, proper nutrition and basic services to homeless individuals.

Ohio considered two bills during 1985 that would help ease the housing crunch for the homeless mentally ill by providing grants to private, nonprofit organizations for emergency shelters and transitional housing. In addition, Ohio Governor Richard Celeste has convened a state-level "cabinet-cluster" involving agencies with overlapping responsibility for the homeless mentally ill. Actions of cabinet-cluster agencies thus far include reactivating "seed money" loan funds to provide interest free loans for low or moderate income housing developments.

General efforts to provide adequate community-based housing for the mentally ill also help the homeless mentally ill.

- Arizona (1984 Ariz. Sess. Laws, chap. 389) now requires only a 25 percent local match for residential treatment programs for the mentally ill and has mandated the development of a statewide plan for a community residential treatment system.

- Hawaii provided guidelines for a statewide system of residential treatment programs that will provide a range of alternatives to institutional care (1980 Hawaii Laws, act 211; 1985 Hawaii Laws, act 219).

- Indiana (1984 Ind. Laws, p.l. 40) established the state community residential care program and mandated appropriate placement of the mentally ill in community residential facilities.

- Louisiana (1981 Louisiana Laws, act 770) developed a Community Residential Program Development Fund to provide loans to cover initial expenditures related to starting community residential programs.

- Texas requested interagency cooperation in developing incentives for both public and private community residences, established the goal of 60 community beds per 100,000 population and mandated the development of a plan for reimbursement of rehabilitative residential programs in lieu of more costly programs (1985 session, S.C.R. 62 and S.C.R. 63).

- Nearly half the states have enacted pre-emptive zoning laws that facilitate placement of community group homes by limiting local zoning authority in siting matters.

Legislation Aimed at Creating A Safety Net for the Mentally Ill. Again, while not exhaustive, the following states provide useful examples of the safety nets that can help the homeless mentally ill.

Illinois (1985 Ill. Laws, pub. act 894-918) acted to keep the temporarily rehospitalized or soon-to-be-discharged individual off the street by providing for the continuation or the immediate restoration of benefits and by requiring interagency agreements to expedite applications for public aid prior to a patient's release.

Other states have created a safety net by coordinating their general mental health services.

- Florida's Community Mental Health Services Act involves a comprehensive and coordinated effort to establish a state-wide network of service districts for the treatment of mental illness and substance abuse, overseen by a network of local planning councils (Fla. Stat. § 394.65-394.81 (Supp. 1984)).

- Oregon now requires agreements between community mental health programs and the state hospitals to ensure a continuum of services for patients admitted to and discharged from the state hospital (1981 Or. Laws, chap. 750).

- Washington has now defined the roles and coordination responsibilities of state, county and individual mental health service providers in the provision of services to most-in-need populations among the mentally ill (1982 Wash. Laws, chap. 204).

- Nevada and Texas, respectively, established a state commission on mental health and mental retardation and a state-wide coordinating council to oversee coordination of mental health services in the state (1985 Nev. Stats., chap. 672; 1983 Tex. Gen. Laws, chap. 708).

Federal Legislation. One federal effort to ease the plight of the homeless involved the creation of the the Emergency Food and Shelter Program, to be administered by the Federal Emergency Management Agency, in March 1983. Although originally stated as a one time assistance program to help recently unemployed workers, Congress has twice appropriated additional

program funds for the National Board Program. Initially, funds were also made available to the states. Cumulatively, the FEMA program has provided $210 million in food and shelter aid for the homeless.

FUTURE IMPLICATIONS AND DIRECTIONS

At best, community-based treatment programs have helped the chronically mentally ill meet basic food, shelter and treatment needs. At worst, these programs have been so poorly organized and inadequately funded that they have encouraged the mentally ill to take to the streets. Moreover, many individuals feel that temporary programs set up to meet the immediate needs of the homeless mentally ill often block the process of effective long-range planning.

The recent rash of television and newspaper reports have helped bring into public focus the brutality and the hopelessness of life on the streets for the chronically mentally ill. Yet these same reports have sometimes obscured the larger issues of homelessness. The mentally ill are on the streets because the communities simply do not have the community support systems that would help them help themselves. Addressing one homeless individual's immediate need for a meal or a place to sleep does not keep another mentally ill individual from taking to the streets and perpetuating the cycle.

Without facing squarely the task of providing adequate services for the mentally ill living in the community, states can expect continued problems with homelessness. On economic grounds alone, proposals to reinstitutionalize the mentally ill are untenable. But if the policies of the last twenty years are not significantly improved, states can expect to pay dearly for the mentally ill that end up in the jails, the emergency rooms, and the limited beds in the remaining state mental hospitals.

In order to deal with the population's immediate and often desperate needs for food and shelter and to prevent further homelessness, mental health planners, policy makers and providers should focus long-range planning activities in the following areas:

- o Improving community mental health and rehabilitation systems so that the basic and the specialized needs of the mentally ill are comprehensively addressed before they can become homeless;

- o Improving the emergency and transitional shelter network to provide the homeless mentally ill with appropriate emergency mental health services, as well as linkages to the formal mental health, housing and social service systems.

CASE STUDY: CALIFORNIA

INTRODUCTION

In October 1983, California Assembly Speaker Willie Brown created the Assembly Select Committee on Mental Health, chaired by Assemblyman Bruce Bronzan. The Committee was slated to review California's mental health system and make recommendations to the legislature on how to improve it.

During 1984, the committee generally researched and gathered information on the state's mental health issues, conducted public hearings, visited treatment programs and facilities and communicated with key members of the mental health community. In December, the committee released a report presenting its preliminary findings and suggestions for change.

In March 1985, the committee introduced the California Mental Health Services Reform Act (AB 2541), which addresses many of the problems outlined in the committee' report, including the homeless mentally ill. Primarily authored by Assemblyman Bronzan and Assemblywoman Sunny Mojonnier, this pending legislation proposes to establish at least six "social support agencies" for the homeless mentally ill and to provide coordinated support services specifically addressing the population's needs. The legislation would also provide funds to develop alternatives to the local county jail for those homeless mentally ill who have committed minor crimes, and to develop Vietnam veteran outreach programs for homeless veterans who are suffering from post-traumatic stress disorders.

Members of the Senate also participated in this mental health effort. Senator Jan McCorquodale authored Senate Bill 822, which would have apropriated money for pilot projects to provide case management services to homeless mentally ill persons. S.B 822 was vetoed by the governor. Senator LeRoy Greene authored Senate Bi 942, which would have provided emergency funds for deferred payment loans for housing for the mentally ill. S.B. failed in the Senate Appropriations Committee.

In 1984, California enacted legislation (1984 Cal. Stat., chap. 1691) establishing separate funds for emergency shelter programs and for the preservation and creation of low-income housing. It required inclusion in state and local housing plans of housing policies and goals affecting the homeless, and made illegal zoning regulations that effectively discriminate against shetlers.

To address specifically California's issues and concerns regarding the homeless mentally ill, the NCSL Mental Health Project agreed to provide the state with a technical assistance program in August 1985. Members of the Assembly Select Committee on Mental Health and other involved legislators and staff provided information on the problems of the homeless mentally ill in California.

THE HISTORY OF THE MENTALLY ILL HOMELESS IN CALIFORNIA

Lack of commitment to the deinstitutionalization of the severely mentally ill. Fifteen years ago, following passage of the Laterman-Petris-Short Act, California largely abolished its practice of indefinitely committing the mentally ill to state hospitals. Between 1967 and 1984, the number of

mentally ill people in California state hospitals dropped from 37,500 to 5,000 (3, p. 2). Thousands of patients who would have been sent to a state hospital remained in their communities. Yet the community mental health centers could not meet the treatment needs of those who were left behind.

Inappropriate/inadequate structure and services. Since California's early days of deinstitutionalization, the community mental health system has not been able to meet adequately the treatment and support needs of the state's chronically mentally ill. Brief appointment-based psychotherapeutic services, combined with outpatient medication monitoring, comprised the standard community treatment program. The essentials of effective treatment--continuity of care, flexibility of resources, and the ongoing participation of the client--were scarce. Additional problems within the system exacerbated those posed by the lack of an appropriate framework for basic services.

- The mentally ill are the lowest priority population for shelters and other public social services.
- The state's complex service system lacks the transportation, information and advocacy programs that would make it more accessible.
- There is no systematic approach to the provision of psychiatric, medical, welfare or housing services.
- A mentally ill person without resources may wait 10 to 14 days to receive general assistance, and up to eight to 24 months for federal assistance.

Erosion of mental health and social services. During the 1970s, California decreased tax revenues and funding for many programs, while inflation drove up program costs. State funding for county mental health programs has dropped from an average of $16 per resident in 1978 to $13 today. a decrease of $150 million (4, p. 1). If California were still supporting the 37,500 people originally housed in the state hospital, it would cost the state $2.5 billion per year. Instead, the state now gives $500 million per year for services to the mentally ill (3, p. 2). Subsequently, California's mentally ill have had to face the elimination or reduction of many support services.

Moreover, national policy changes in the administration of SSDI programs and a cooling economy set the stage for a decade of reductions in the level of funding for social programs. Federal block grants to states for community mental health services were reduced. In 1980, Social Security officials were ordered to review the eligibility of each beneficiary at least once every three years. From 1981 to 1983, the benefits of 54,000 disabled Californians were terminated. Half were reinstated upon appeal (3, p. 3). At present, a single person living on his/her own can receive a maximum of $206 per month of state general assistance and $ 6 per month from SSI to cover his expenses (3, p. 5).

Lack of affordable housing. Housing has become almost a luxury for many of California's chronically mentally ill. Over the past 10 years, California rents have more than doubled. From 1970 to 1980, the median rent paid in California rose from $113 to $253 per month (3, p. 3). The number of low-income households seeking rental units vastly outnumber the available

units; subsidized housing projects have burgeoning waiting lists. Single-room-occupancy hotels have been destroyed as part of downtown renovation efforts. In Sacramento alone, the number of SRO hotels has been depleted by two-thirds (3, p. 3). Federal support for low income housing has also been significantly reduced.

A POSSIBLE SCENARIO FOR CALIFORNIA: COMMUNITY SUPPORT PROGRAMS FOR THE HOMELESS MENTALLY ILL

Anne Lezak, Coordinator, Program for the Homeless Mentally Ill, National Institute of Mental Health, presented this model for addressing the problems of the homeless mentally ill in California (5). The suggestions presented are not necessarily those of the NCSL Mental Health Project.

A Modified Community Support Program. In 1977, the National Institute of Mental Health, recognizing that the patchwork of community-based mental health services was offering the chronically mentally ill limited opportunities for growth, spearheaded the development of the Community Support Program (CSP). The CSP is a modestly funded federal demonstration project that recognizes both the mental health and social welfare needs of the mentally ill. The program provides grants to state mental health agencies. State officials and community support staff assist local communities in developing "community support systems" (CSS): networks of integrated mental health and social rehabilitation/support services for the chronically mentally ill living in the communities.

The ideal community support system has 10 essential components that could be used to establish a local CSS for the homeless mentally ill. In addition, the state could act to create a climate favorable for CSS development while still allowing for local responsiveness to the needs of the homeless mentally ill in a given area.

The ideal community support system provides the following 10 services: 1) outreach; 2) assistance in meeting the basic needs of food, clothing and shelter; 3) adequate mental health care; 4) 24-hour crisis assistance; 5) comprehensive psycho-social services; 6) a range of rehabilitative and supportive housing options; 7) back-up support, assistance, consultation and education for community support systems workers and volunteers, as well as the community at large; 8) recognition and involvement of natural support systems; 9) establishment of grievance procedures and mechanisms to protect client rights; and 10) facilitation of use by clients of formal and informal helping systems.

By adopting this model at the local level and by supplementing essential services, California could develop a program within its existing mental health system that could more effectively address the underlying problems of homelessness among the mentally ill.

Outreach. Outreach efforts suited to the target population would be necessary to locate and identify mentally ill homeless clients and to link them to potential services. Outreach staff could go into alleys, shelters and soup kitchens, build a relationship with the potential client by approaching him or her in a non-threatening way--offering coffee or sandwiches--over a period of months, and offer to help the client link up to other available resources. New York City's Project Help offers outreach and basic assistance to the homeless mentally ill. Project Help finds clients

by cruising the city in a mobile outreach unit and by taking referrals from a hotline and provides its clients with crisis medical and psychiatric services.

Assistance in meeting basic needs. Many argue that basic needs for food, shelter and clothing must be met before any other treatment needs of the homeless mentally ill are considered. Few homeless mentally ill will ask for assistance in meeting basic needs. To overcome this reticence, a trusted friend, or a non-threatening environment, such as a downtown "drop-in center," where few questions are asked in return for a meal, a good night's sleep or a hot shower, will generally produce the best results. The outreach worker who has gained the homeless individual's trust is an ideal person to offer assistance in meeting basic needs.

Adequate mental health care. Many homeless mentally ill shun the formal mental health system. Mental health service providers dealing with the homeless mentally ill may do best to provide initial mental health services in shelters or soup kitchens. They can also be provided in conjunction with mobile outreach programs, or in non-threatening settings such as "community living rooms," which offer a comfortable place to relax as well as a link to the maze of formal services. Los Angeles' Downtown Women's Center, serving homeless women, provides them with meals, a place to go during the day, and psychiatric and medication services.

Twenty-four hour crisis assistance. As the homeless mentally ill may require crisis assistance in places like shelters or soup kitchens, which generally lack mental health professionals, such professionals can help the para-professionals and volunteers working in these places by providing crisis intervention training. Mental health professionals can also work with criminal justice professionals to develop appropriate alternatives for the person in crisis and to develop mechanisms for brief psychiatric hospitalization.

Comprehensive psycho-social services. In conjunction with having their basic needs met, the homeless mentally ill can also benefit from basic vocational rehabilitation services, case management, residential services and socialization programs. Once these initial services have been provided, the client may be drawn into a more long-term psycho-social rehabilitation program that provides training in the living, vocational and social skills that are essential to the success of future residential placements.

A range of rehabilitative and supportive housing options. The chronically mentally ill require a range of living arrangements with varying degrees of supervision and structure. In addition to providing an adequate range of living arrangements for the chronically mentally ill, a community support system specifically targeting the homeless mentally ill would need to provide for emergency shelters, as an immediate alternative to life on the streets and, perhaps more important, for transitional housing as an opportunity to plan for more long-range treatment and rehabilitation efforts. The Buckelew Housing Program in San Rafael, California, provides an array of housing opportunities--from the highly structured and supervised program, to the largely independent apartment--to help bridge the gap between the hospital and the community.

Back-up support, assistance, consultation and education. Because the homeless mentally ill suffer the dual stigma of mental illness and homelessness, they become targets for discrimination and ostracism. Those involved in a community support system or in other advocacy groups could act as advocates and assistants for all who come in contact with the homeless mentally ill--landlords, employers, social support workers, families--to help them understand this complex population. The Los Angeles Skid Row Development Corporation combines outreach to and involvement in the local business community with the Corporation's efforts to meet the housing and employment needs of the homeless individuals in the Skid Row area.

Recognition and involvement of natural support systems. While churches, local businesses, neighborhood organizations and voluntary agencies are already working to combat homelessness, a community support system for the homeless mentally ill should involve natural support programs for the mentally ill. The COMPEER program, for example, in Rochester, New York, matches mentally ill individuals with community volunteers who assist in many of the functions of case management.

Establishment of grievance procedures and mechanisms to protect client rights. General biases against the mentally ill and the homeless mentally ill person's propensity for unusual behavior combine to make this troubled population much more susceptible to criminalization, hospitalization and both overt and covert discrimination. Support systems staff and other community advocates could work to establish grievance procedures under which the rights of the homeless mentally ill could be ensured: the right to shelter, the right to entitlements, the right to treatment, etc.

Facilitation of the use by clients of formal and informal helping systems. Very often, the homeless mentally ill need help in identifying and accessing housing and support services. Ideally, one person should be appointed to help the homeless mentally ill person through the maze of helping systems. Los Angeles' Mental Health Skid Row Project patches together mental health services for use in shelters. The Project uses a team approach with other agencies, enabling them to offer food, shelter, clothing and medical and psychiatric care in a coordinated fashion.

OVERCOMING THE ROADBLOCKS TO A COMMUNITY SUPPORT SYSTEM FOR THE HOMELESS MENTALLY ILL

While the implementation of the community support system for both the chronically mentally ill and the homeless mentally ill may promise a brighter future for these often-neglected populations, California may want to consider changes in several key areas to help ensure success of the CSS approach, according to Lezak.

The need for leadership. Many service providers will have to contribute to the effort of getting the homeless mentally ill off the streets. Mental health professionals will need to demonstrate leadership that will serve to inspire other human service workers. On a program level, mental health professionals can identify, document and evaluate the success of innovative program models that deal with the homeless mentally ill and share the results of such program successes with others working with the homeless mentally ill. On a research level, professionals can continue to explore the causes of homelessness so that service providers can anticipate emerging service needs.

The need for improved financing. The community support program approach requires a broad financial base combining traditional mental health and disability insurance with innovative financing mechanisms. The traditional Social Security disability programs, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), can be critical to the disabled person trying to find and maintain adequate housing. To ensure that these disability programs support the CSP, California could work with necessary federal and state officials to achieve the following goals: 1) developing special outreach programs for getting the homeless enrolled in such benefit programs; 2) adopting standards for quick determinations, including presumptive disability assessment to obtain income maintenance for obviously disabled homeless individuals as soon as possible; and 3) developing procedures for maintaining housing payments for SSI/SSDI recipients who are briefly hospitalized, as a way to prevent homelessness.

Medicare and Medicaid also play key financing roles. Mental health care under Medicare is largely limited to inpatient care and partial reimbursement for non-hospital services. Under Medicaid, neither standard nor state optional benefits typically cover the case management, adult day treatment and psycho-social rehabilitative services required by a chronically mentally ill person. However, under the "Home and Community-Based 2176 Waiver's Program," a state can obtain a waiver for Medicaid benefit restrictions if it can demonstrate "budget neutrality"--i.e. it can provide a mix of alternative services for no more total dollars than those spent on traditional services. Such a waiver could provide flexibility to reimburse services provided through a community support program for the homeless mentally ill. California is presently planning to submit its third proposal for such a waiver.

Another key element in the financing of a CSS involves the transfer to community-based programs of the funds spent on the state hospitals. A state must provide adequate community-based mental health and psycho-social rehabilitation services if it hopes to prevent homelessness among the mentally ill.

The need for better coordination among service providers. At present, responsibility for the services that might begin to address the problems of the homeless mentally ill is scattered among various health, housing, and human service agencies, creating service discontinuities and funding gaps. Mental health professionals must begin aligning themselves with other professionals to ensure a united voice in obtaining more affordable housing and adequate support services within the reach of the state's disabled populations.

CONCLUSION

California, along with many other states, is at a critical crossroads with respect to the homeless mentally ill. California must decide if it wants to continue focusing its efforts on emergency measures like shelters and soup kitchens, or if it wants to begin the task of reworking its mental health system to prevent homelessness among the mentally ill. Assemblyman Bronzan's proposal to establish social support agencies for the homeless mentally ill could begin to address this central problem. Yet the state will have to remember that, in the words of Assemblyman Bronzan, "it has taken two decades of neglect for the problems of the mentally ill to become as severe as they are." One or two bills will not correct the damange.

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4) Newsletter from California State Assemblyman Bruce Bronzan. "Dramatic Reforms Will Relieve Chaos in California Mental Health System." Sacramento, California. March 18, 1985.

5) Anne Lezak's suggestions largely encapsulate those outlined in "Developing Community Support Systems for the Homeless Who Are Seriously Mentally Ill," authored by Irene Shifren Levine, Anne Lezak and Howard H. Goldman, all of the National Institute of Mental Health.

TECHNICAL ASSISTANCE PROGRAM TAPES AND BACKGROUND MATERIALS

Available through the NCSL Mental Health Project are edited tapes of the actual technical assistance program presented for California in August 1985, as well as the background materials distributed at the program.

The technical assistance program tapes are introduced by Louisa Stark, President, National Coalition for the Homeless, who presents an overview of the problem of homelessness among the mentally ill. Ms. Stark is followed by Anne Lezak, National Institute of Mental Health, who discusses the feasibility of adapting the model of the community support program to fit the needs of the homeless mentally ill. A panel discussion follows Ms. Lezak. The members of the panel are California state Assemblyman Bruce Bronzan, Ohio state Representative JoAnn Davidson, Texas state Senator Ray Farabee, and Seattle Mayor Charles Royer.

Background materials relating to homelessness among the mentally ill include a summary of select state legislation, a discussion of model programs, a bibliography, and a checklist that interested legislators and staff may return for copies of legislation and bibliographic materials.

If you wish to receive loan copies of these tapes, or the background information distributed at the technical assistance program, please fill out and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, CO 80265.

Name: _____

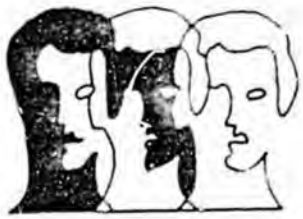
Title: _____

Address: _____

_____

_____

Requesting loan copies of tapes ____ background materials ____



MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In February 1985, the National Institute of Mental Health (NIMH), U. S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues.

The goal of the NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information surrounding mental health issues.

Through this fourteen month program, the Mental Health Project can respond to specific issue and format needs of legislators. By involving the Panel of Experts, a group composed of legislators and persons with mental health experience, expert consultants, and state policy makers, programs will be developed to provide a variety of services to states, including testimony, special workshops and seminars, and staff assistance.

Based upon input from the state legislatures, ten states were chosen to receive technical assistance with state-specific mental health issues. Along with the programs, background materials, audio tapes, and a State Legislative Report will be developed for each issue area and are available free of charge to requesting parties. The scheduled technical assistance programs include:

South Carolina	Involuntary Civil Commitment	May 10, 1985
California	Mentally Ill Homeless	August 7, 1985
Missouri	Mental Health Services Coordination	September 24, 1985
Kentucky	Mental Health Services for Adolescents	October 3-4, 1985
Pennsylvania	Revolving Door Syndrome of Mental Health Services	October 23, 1985
Virginia	Housing for the Mentally Ill	November 18, 1985
Oklahoma	Community Care for the Chronically Mentally Ill	December 4-5, 1985
New Hampshire	Mandated Mental Health Insurance/ Mental Health Services for the Elderly	January 9, 1986
Michigan	Mentally Ill Offender	January 28, 1986
Oregon	Mental Health Services Funding	March 4, 1986

The Mental Health Project Manager is Rebecca T. Craig, who may be contacted at NCSL's Denver office (303) 623-7800. The federal project officer is Lee Dixon, Office of Policy Development, Planning, and Evaluation, National Institute of Mental Health, at (301) 443-3175.

National Conference
of State Legislatures
1050 17th Street, Suite 2100
Denver, Colorado 80265

Nancy Bennett
House HESS Committee
State Capitol
Pouch V
Juneau, AK 99811

EXCERPTS FROM THE FAIRBANKS FACILITY REQUEST FOR PROPOSAL

December 1985

Provided by the Alaska Alliance for the Mentally Ill

effective, services must form a continuum in the true sense of the word. To reach that goal, not only must components be added to the system, but also existing and proposed components should be closely linked to ensure ease of access for clients. Furthermore, personnel must be acquired to act as "case managers" who will facilitate individualized program planning for every client.

In defining the service needs for the chronically mentally ill, the Subcommittee adopted several guiding principles. These principles include emphasis on: 1) community-based rather than centralized/institutional care; 2) maintenance of the highest achievable level of independent living for each client; 3) programming which assures the maximum adaptive level of functioning for each client; 4) procedures which allow an individual to move through the service continuum as his/her needs change; 5) opportunities to engage in meaningful daily activities; 6) easy access to services; and 7) tailoring of services to account for varying regional and cultural needs. The philosophy of normalization underlies all planning done to date.

Other guiding principles include: involvement of the client and family in treatment planning; strong emphasis on case management; the need for attention to aftercare and service follow-up and regular involvement educating the family and in some cases other members of the client's community about the client's illness and appropriate means to aid in their treatment.

The Subcommittee has identified a range of services necessary to meet the needs of chronically mentally ill adults in the northern region. At this time, available funds are insufficient to address all the needs. Therefore, the State, with direction from the Resource Committee for SB 520, has selected the following components for development in FY 1986 and FY 1987:

A. Supervised Apartments (Client Capacity -- 16).

B. Group Home with Crisis Beds (Client Capacity -- five beds in the group home section, with two additional beds reserved for short-term crisis situations).

C. Multi-purpose Center (Client Capacity -- 30 per day or 50 per week).

D. Vocational Education Workshop (Client Capacity -- 15 per day on site).

Each of these components is elaborated under Part III, Section 3-3 below.

2-2. DEFINITION OF CLIENT POPULATION

Respondents must confine their services to the chronically mentally ill. A "chronically mentally ill person" is someone who is eighteen years of age or older and who satisfies two or more of the following criteria:

A. Is diagnosed as having a schizophrenic, major affective, or paranoid disorder (DSM-III diagnosis of 295.1, 295.2, 295.3, 295.4, 295.6, 295.7, 295.9, 296.2, 296.3, 296.4, 296.5, 296.6, 297.1, or 297.3) or another severe mental disorder, with a documented history of persistent psychotic symptoms other than those caused by substance abuse.

B. Has impaired role functioning in at least one of the following:

1. Social role -- an inability to function independently in the role of worker, student, or homemaker.

2. Daily living skills -- an inability to engage independently in personal care (e.g., grooming, personal hygiene, etc.) or community living activities (e.g., handling personal finances, using community resources, performing household chores, etc.).

3. Social acceptability -- an inability to exhibit appropriate social behavior, which results in demand for intervention by the mental health and/or judicial system.

C. Is a danger to self or others.

Clients will include persons who show sporadic improvement as well as those who experience occasional outbreaks of severe pathology. Many clients will vary from day to day and month to month in their service requirements. Therefore, programs should be designed flexibly to ensure tailoring of services to changing individual needs.

2-3. CLIENT APPROPRIATE SERVICES

Due to the range of different cultural, ethnic, age, gender and other distinctions in the population to be served, services proposed should be sensitive and appropriate to the maximum extent possible to the individual client needs. These include but are not limited to: treatment, setting, staff, activities and food.

2-4. WORK TO BE PERFORMED

Work to be performed consists of tactical program planning, start-up, and implementation of the four service components of supervised apartments, group home, multi-purpose center, and vocational education workshop. A great deal of the effort in the first six months (January 1, 1986 - June 30, 1986) is expected to be of an organizational nature, including precise program design, hiring of staff, and formalizing policies and procedures. However, grantee(s) are expected to provide direct services in each component. Respondents whose proposals demonstrate ability to bring direct services on line quickly will have an advantage during proposal evaluation

Articles of Incorporation

Bylaws

Board of Directors Roster

Organization Charts (for the existing organization, each proposed component, and the "new" organization following the award of a grant.

Accountants Report/Audit Report from most recent fiscal year or other audit period
Position Descriptions and Resumes of Key Personnel

Agency Budget (overall) (if different from the proposed budget)

Personnel Policies

Business Licenses

Proof of public Non-Profit Status.

Documentation of Community Support and Interagency Coordination .(This section shall contain signed memoranda of agreement with key organizations to assure non-duplication of services and continuity of care for clients. Letters of support are also helpful but less essential.)

Names and Addresses of References (if the respondent is an individual or has never before provided services within the State of Alaska)

3-3. GUIDELINES FOR THE TECHNICAL PORTION OF PROPOSALS

The following material describes the State's perspective on each component of services addressed under this RFP. Services and hours proposed and numbers of clients to be served are minimums. Respondents are encouraged to expand services and hours of operation based on their resources.

A. Supervised Apartments Component

Supervised apartments will provide residential services for chronically mentally ill adults who need minimal support. Residents will share an apartment with up to three other chronically mentally ill adults in a family-like setting. The living arrangements shall encourage social interaction and provide minimal supervision geared toward helping residents function in as normal a capacity as possible within the community. The program shall emphasize living

skills, such as budgeting, shopping, paying bills, and working at appropriate levels of functioning.

By July 1, 1986, the State intends to build or purchase a six-unit block of apartments, with four units for clients, one unit for the live-in resident managers, and one unit for a family hostel (a place for out-of-town family members to stay while visiting with and/or participating in the treatment of any client receiving state supported mental health services. All the apartments will have double-occupancy bedrooms. The apartments must be able to house a minimum of sixteen chronically mentally ill clients. For this RFP however, the respondent must find and lease space and be responsible for all programming. The respondent must budget for lease payments and related fixed costs. The respondent is expected to serve a minimum of sixteen clients and must locate space which will support the services outlined under this RFP.

The respondent shall incorporate the following ideas into the program plan:

1. The apartments should encourage social interactions among residents.

2. Residents of any one apartment should plan meals and eat together regularly.

3. A live-in manager should serve as the case manager for residents unless residents have designated case managers within the multi-purpose center or elsewhere in the mental health system. In the latter case, the live-in manager should work closely with the case manager. The apartment manager should maintain daily contact with each resident; assist residents in "normalizing activities" (e.g., paying bills, shopping, pursuing jobs or training, etc.); counsel residents with routine problems and projects; and, schedule occupancy of the family hostel. The manager should also coordinate closely with other mental health services and programs.

4. The manager should be a paraprofessional- or professional-level mental health worker.

5. A manager or a designated alternate should be available 24 hours per day.

6. Residents/clients should be assisted as needed to obtain the range of services necessary from a variety of agencies to enable them to maintain viable functioning in

the community. The respondent must show proof that clients are eligible for services provided by all other components of the services continuum for chronically mentally ill adults (see Part III, Section 3-5 below).

B. Multi-Purpose Center

The multi-purpose center shall provide on-going assessment and treatment for chronically mentally ill adults in order to allow them to maintain themselves in the community. This center, envisioned as the hub for services for chronically mentally clients, will eventually be built and owned by the State and operated by the grantee. It will be located adjacent to the Adult Group Home, which will also eventually be built and owned by the State. In this grant award, however, the respondent must locate appropriate space and budget for lease payments and related fixed costs.

Services shall include day treatment, group therapy, case management, individual counseling, psychological and psychiatric evaluations, and day respite. Average client load should be a minimum of thirty clients per day or fifty clients per week. In other words, although approximately fifty individuals clients will receive service each week, only about thirty clients will be served on any given day. While some clients may attend daily, others may come to the center only once or twice a week.

Respondents shall include provisions for ordering, storage, and dispensing of psychotropic medications, as well as protocols for drug monitoring.

Activities shall be planned for each individual client in accordance with his intelligence, functional, skill, and interest levels. The program must be flexible enough to accommodate differences between clients, as well as differences within clients over the course of time.

The respondent should plan to provide all but the most specialized services with in-house staff. The core team of in-house professionals should be supplemented through consultation or contractual services on a case-by-case basis. Because of the diverse treatment and therapy needs anticipated in the target population, the respondent should consider a multi-disciplinary team approach as generally the most effective treatment mode.

Grantees are encouraged to cultivate team management relationships with a variety of private practice professionals.

While the Department is currently planning the center to be a forty-hour-per-week operation, respondents are encouraged

to extend hours as much as possible. It is widely recognized that there is a need for this facility to provide 24-hour services. Around-the-clock operation is the goal, when and if additional funds become available.

The respondent shall incorporate the following ideas into the program plan:

1. The multi-purpose center should be the location of the case management team for the entire service delivery system for chronically mentally ill adults in Fairbanks.

2. The multi-purpose center should be the hub of services for chronically mentally ill adults.

3. Programming should encourage social interaction but also provide for various degrees of privacy.

4. All programming should be client centered, with individualized treatment plans.

5. One of the main functions of the multipurpose center should be to evaluate psychological functioning of the clients. Assessments should be done both formally and informally.

6. Possible staff for the multi-purpose center include: 1) a clinician/director; 2) an administrator; 3) case managers; 4) a psychiatric nurse; 5) social workers; 6) other professional staff as needed; and 7) support staff as needed.

7. Day treatment activities should include group therapy, recreation, skill building, group meetings, and occupational therapy. Provision should also be made for crisis intervention.

8. A typical therapeutic regimen for a client might include one hour per week with a case manager, one hour per month with a psychiatrist, and one hour per day with a case manager or psychiatrist during a crisis.

9. Although clients may spend some of their free time at the center, the facility is not to be merely a drop-in center. Therapy and group activities shall be scheduled.

C. Group Home with Crisis Beds

Like the multi-purpose center, the group home will eventually be built and owned by the State. In this grant award, however, the respondent must locate appropriate space and must budget for lease payments and related fixed costs. Respondents should be mindful of the State's intention to co-locate the group home and multipurpose center when these facilities are constructed. Proposals in response to this RFP should aim toward this eventuality to the extent possible.

The adult group home shall provide intensively supervised voluntary residential services for five chronically mentally ill adults. Residents should be encouraged to participate under supervision in household activities such as cooking, cleaning, self-care, and other activities of daily living. The group home should emulate a family-like lifestyle in accordance with the philosophy of normalization. Both sexes should live in the home and should be encouraged to participate in activities that promote self esteem.

As a place of residence, the group home must be designed to incorporate normal features of community living. For example, provision could be made for residents to have pets and/or a garden. Residents should also be encouraged to participate in appropriate recreational activities.

In addition to normal residential pursuits, residents should be involved in structured therapy and vocational programs, as appropriate, which are to be provided through other components of this RFP and which are otherwise provided in the community. The proximity to the multi-purpose center will help to ensure use of therapy by group home residents. The respondent should design other measures to ensure client involvement in community services and social and vocational opportunities.

Within the group home but structurally separate from the main residential areas, two crisis beds shall be available on a 24-hour basis for persons who have short-term problems which require immediate, intensive care but which can be managed outside of a hospital setting. Although group home residents may use the crisis beds periodically, these beds should be available primarily for the larger community. Group home staff should cover the crisis component but should have a plan to call for additional help as needed. Memoranda of agreement with other community services, including Fairbanks Memorial Hospital, are essential for this component. Proposals must include admission and discharge criteria and protocols for these crisis beds.

Group home staff might include a program coordinator on all shifts and a program aide during the evening and night shifts. Since some residents will be participating in activities at the multi-purpose center or other locations

during the day, one program staff member at the group home will probably be sufficient during the day time. Additional staff may be needed for extra coverage during times of the day when intensive activity occurs. The respondent should develop and justify an appropriate staffing pattern. The respondent shall incorporate the following ideas into the program plan:

1. Residents must not be discharged until such time as they no longer need the help of this facility. Programming should be flexible enough, with individual case planning, to accommodate the varying needs of individual clients within the larger parameters of group home capabilities.

2. Because of the nature of the clients' disabilities, staffing and programming should be planned to provide almost constant supervision.

3. Adequate staffing is very important to client outcome and stability. It will probably be necessary to have at least two staff on duty at all times when clients are present.

4. Protocols should be developed to ensure back-up for group home staff when crises occur or the client mix requires higher staff-to-client ratios.

5. Clients, with appropriate supervision from staff, should plan, shop for, and prepare their own meals. Residents should eat together family style.

6. Programming should attempt to integrate clients into the mainstream of community life as much as possible.

D. Vocational Education Workshop

Vocational services shall be provided in space leased or owned by the grantee; the respondent must include costs for any lease(s) in the proposed budget, along with maintenance, utilities, insurance, and other such costs.

This component shall serve a minimum of fifteen clients at a time. The grantee must develop placements in community businesses and other work sites to accommodate clients for whom such placements are appropriate. Proposals must include plans for developing and supervising these placements.

Vocational educational workshop services, as envisioned under this RFP, should help chronically mentally ill adults maintain, transition, or retransition into the labor market. The overall goal for this component is to provide meaningful employment appropriate to the individual's level of functioning, in a sheltered workshop environment and through on-the-job assistance and support. Coordination with existing services as well as integration with community businesses is encouraged. The program shall complement existing community programs and should provide new options and opportunities for clients on a "no failure" basis.

The vocational program shall feature individual assessment of client needs and capabilities and development of tailor-made training programs. The program shall attempt to create or enable as normal a work environment for the client as possible. The respondent should recognize that clients will have widely differing capabilities and needs and should plan accordingly.

Education and training opportunities shall be provided to every client at his or her own pace and within his or her own level. The educational/training experience should be meaningful. It should be a learning experience which will provide income as well as give a feeling of personal achievement.

For a client who would benefit from academic education instead of or as an adjunct to vocational training, the program shall assist the client to participate in existing community-based programs and college courses.

The vocational training environment and services shall be specific for people with chronic mental illness. However, the respondent should explore opportunities to share some services, purchasing, or facilities with existing agencies or businesses in ways which will promote cost savings.

The respondent shall incorporate the following ideas into the program plan:

1. Chronically mentally ill adults with all levels of disability should be incorporated into vocational training if they are in need of such service. Program planning should allow for a great diversity of abilities and interests.

2. Work is a normal activity for adult Americans. Therefore, this program should provide vocational and training opportunities that will constitute real work and preparation for real work, not "make work."

3. The program should be decentralized into existing businesses and other normal work sites as much as possible and on an individual basis.

4. The staff of the vocational program should have both psychology skills and workshop/vocational training experience. Anyone providing academic instruction should be trained in adult education as well as his or her subject matter.

E. Case Management Services

Respondents shall make provision for case management services, whether they propose to provide one component under this RFP or all four. Because many of the clients will be involved with services beyond those offered by the grantee the respondent shall develop relationships with other providers which will enable non-duplicative, comprehensive services and continuity of care and follow-up for each client.

For clients from communities outside of the immediate Fairbanks area, provisions should be developed for case managers to provide follow-up to clients and their support systems when the clients return to their home communities.

F. Management/Administration

All four components under this RFP require administrative/management support services. However, because of the State's intention that programs be client centered and because of the desire to provide the most direct services possible with limited funds, the Department encourages respondents to keep the number of administrative and support staff as low as possible while maintaining quality. Respondents should make every attempt to promote cost savings in the administrative area. Respondents proposing to provide more than one component should document cost savings in administrative areas that would accrue as a result of providing more than one component.

C. Program Evaluation

All proposals shall include a description of the client populations or sub-populations to be served under the proposed component(s) and an analysis of expected benefits for these populations. In addition, all proposals must detail a plan for program evaluation.

3-4. SUPPORTING FACILITIES, EQUIPMENT, AND SUBCONTRACTORS

Each proposal shall describe where services will be offered and how such a facility will be obtained. Proposals must address any anticipated problems in obtaining a facility and discuss alternative solutions to these problems. Any planned subcontracts must be defined as a part of the proposal.

3-5. EVIDENCE OF COORDINATION

All proposals shall demonstrate development, expansion, or direct linkage to existing mental health and counseling programs and providers and to existing social rehabilitation programs such as day treatment programs, soci . clubs, or other models for social rehabilitation that are demonstrated to be effective for chronically mentally ill persons. Proposals shall demonstrate efficient utilization of existing treatment and rehabilitation resources. If new programs are proposed or existing programs expanded, evidence must be provided that there are direct linkages among existing components of the system and that need exists to expand services.

It is of utmost concern to the State that services provided in accordance with this RFP complement rather than duplicate existing programs and services. The four components to be provided under this RFP must fill gaps in community services and promote comprehensiveness and continuity of care for clients.

In the case that a respondent is a consortium of agencies and organizations, written memoranda of agreement between the consortium members must accompany the proposal. Written memoranda of agreement with unaffiliated agencies and organizations with whom close working relationships and transfer arrangements are essential to continuity of care should also be included to the extent possible. The respondent shall include a plan for developing formal relationships and memoranda of agreement which are essential but which have not been practical to date. These memoranda must document agreements regarding criteria of admission and eligibility for services. The criteria shall be designed to ensure that clients of each component of the continuum of services for the chronically mentally ill are eligible for services provided by all other components, whether or not particular components are operating in response to the RFP. Finally, the respondent may wish to attach letters of support from more "peripheral" service providers, agencies, organizations, and consumers.

During proposal evaluation, a heavy weighting will be given to interagency coordination and avoidance of unnecessary duplication.

Alaska State Legislature

House of Representatives

House Judiciary Committee

Pouch V
State Capitol
Juneau, Alaska 99811
(907) 465-4990

MEMO: Jan. 24, 1986

TO: Rep. Max Gruenberg
Rep. Niilo Koponen
Co-chairmen, House HESS Committee

FROM: Rep. M. Mike Miller
Sponsor

RE: SS HB 412
Chronically Mentally Ill

The bill before you has been introduced to bring forth discussion of the needs of the chronically mentally ill. This group is one which has received short shrift, not just here in Alaska but all across the country. Enclosed you will find an article from a recent issue of NEWSWEEK which is to the point in addressing a national tragedy.

Also enclosed in your packet is an executive summary of a needs assessment recently completed by the Juneau Alliance for the Mentally Ill, which indicates the severity of the problem locally. Unfortunately, Juneau is behind the rest of the state in addressing the needs of the chronically mentally ill, and Alaska has been said to be ten years behind the rest of the nation.

This indicates that the needs of the chronically mentally ill have not been addressed adequately by the Alaska Legislature, and that the issue -- and the people that should be better served -- literally cry out for attention.

This bill, combined with the recently released audit of mental health programs of the state (which was requested by me at the same time I started work on this bill), is intended to be the start of discussion of an issue which I hope whose time has come.

The mental health lands issue and recent problems at Alaska Psychiatric Institute also are ones which must be weighed along with this or any alternative legislation and funding which may be considered this session.

I look forward to working with you in helping to develop a good bill leading to better treatment of the chronically mentally ill.