# Coordination of Mental Health Services

by

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Presented to the Public Administration Faculty
at the University of Michigan-Flint
in partial fulfillment of the requirements for the
Master of Public Administration Degree.

8-10-90

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The two most important trends in community mental health care are deinstitutionalization and community support. Community based treatment of mentally ill individuals is essential in regard to maintaining individuals in the community after discharge from state facilities, but traditional community mental health services alone cannot have an impact on the ability to reenter the community. The ability of a community support program to maintain individuals in the community depends on its ability to perform certain functions.[1] These include:

> "identification of the population, whether in the hospital or the community, and outreach to offer appropriate services; assistance in applying for entitlements, crisis stabilization services in the least restrictive setting possible, with hospitalization available when other options are insufficient; psychosocial rehabilitation services, including transitional living arrangements, socialization, and vocational rehabilitation, support services of indefinite duration, including sheltered living arrangements; supportive work opportunities, and age-appropriate, culturally appropriate daytime and evening activities, medical and dental care; back-up support to families, friends, and community members in planning, volunteering, and offering housing or work opportunities; protection of client rights, both in hospital and in the community; and casemanagement, to insure continuous availability of appropriate forms of assistance".[2]

There have been innovative and creative outlooks and techniques for treating mental illness. The problem tends to still be the range of treatment modalities and settings continue to be limited. Mental health clinicians are oriented to approaches with which they are the most familiar, predominantly providing direct treatment.

To achieve the goals of community care it is, and will continue to be important to break away from classical treatment modalities, and offer new types of care and build a strong community support system.[3]

In a period of rapid social change, inconsistent government mandates, and reductions in federal and state allocations, planning can provide program coherence and direction for the community mental health system. A trifocal view of planning that includes internal program planning, interagency planning, and long-range planning is essential to the continued development of the community mental health movement.[4] Interagency planning and coordination of services is considered an essential focus of agency service provision and client participation. Human service agencies cannot function autonomously and effectively in the best interest of clients. Therefore, there is a shift administratively and politically in support of coordinated human services models.

In the planning, development, and evaluation of mental health services it is important to understand the context that the needs and priorities of mental health services were determined by professionals and officials.

Prior to the 1940s, there was a diverse and conflicting response by states to the social problems posed by mental illness. This was reflected in a political culture based on local and state boundaries which contain numerous centers of political authority.[5] During the 1930s and 1940s, a few states developed family care systems.

These programs were very small, and in no state did the number of patients reach two percent in private homes. Because the system involved direct payment to third party reimbursers the benefits to the states were not evident. Hospital officials were not enthusiastic about the program because they were responsible for supervising a decentralized system of care which created many problems for them. After World War II the policy of "deinstitutionalization"[6] of patients from state mental hospitals provided the impetus to shift financial responsibility to the federal government.

Individuals and groups who participated in the attack on the legitimacy of mental hospitals argued the hospitals represented the remnants of a distant and unenlightened past. The arguments and judgements varied greatly in support of deinstitutionalization. There were those who described the harmful and dehumanizing effects of prolonged institutional care.[7] Others believed the availability and use of new psychoactive drugs and therapies deviated the need for mental hospital care, and many were concerned with alleged violations of individual rights of the mentally ill.[8] The politicians wanted to shift fiscal responsibility from states to the federal government, and many people did not want any involvement of government in general.

All of the arguments held some validity. But those individuals who led a sustained attack on traditional hospital care did not recognize how their present involvement did not include an appreciation of the historical context that was shaping their perceptions

and behavior. They assumed mental hospitals served no other purpose than the continued perpetuation of their own existence, and therefore argued for an end to traditional mental hospital care. They contributed to the myths of mental hospital care which justified the revision of policy that dates back to the early nineteenth century.[9]

Not all mental hospitals were good institutions, but the myths were quite different from the reality. Hospitals differed in both qualitative and quantitative terms. Many hospitals had serious problems in regard to quality of care, staff-patient ratios, poor staff-patient relationships, and an environment that could be disruptive and inhumane. But these problems were not isolated problems of the mental hospital system, they mirrored the imperfections and limitations of many human institutions in the country.[10]

Mental hospital care represented one of the few institutions that could provide minimal basic care for an individual whose mental and physical condition caused them to be dependent on others for their survival. This basic fact did not effect the attack on the legitimacy of mental hospital care. For patients at this time it was a choice between institutional care and no care at all because there were no other alternatives.[11] Therefore on July 3, 1946, P.L. 79-487, was signed into Law. The Bill authorized the creation of the National Mental Health Institute within the National Institute of Health, and provided 7.5 million dollars for construction of the building for the new Institute. The purpose of NIMH is to

conduct and coordinate research and training in mental health problems through its own activities and through grants to groups and individuals for research and training purposes. NIMH also authorized grants to states for the development of mental health services. Also, under this legislation up to 10 million dollars a year was authorized in grants to the states for mental health services. NIMH was not actualized until 1949.[12]

Following World War II there was a sustained attack on the legitimacy of mental hospitals which gained momentum. The result was manifested in the movement to deinstitutionalize a patient population that exceeded 500,000 by the mid-1950's. The Joint Commission on Mental Illness and Health was created by a unanimous mandate from Congress in 1955, to recommend a national policy for the mentally ill. In 1961, the Commission submitted its final report and recommended that no new mental hospitals be constructed. It further recommended, in this report, that all state mental hospitals with more than 1,000 beds should be gradually converted into centers for the long-term and combined care of chronic diseases, including mental illness. The report reflected the movement away from mental hospital care that had started during the 1950s. In 1955 the patient populations of state and county mental hospitals peaked at 559,000, and then began to decline. In the fifteen years between 1960 and 1975 patient census fell from 536,000 to 193,000. The decline is

much more dramatic than the statistics suggest. In 1940, 434,000 patients were in mental hospitals out of a total population of 133 million. By 1977, only 159,000 patients were in mental hospitals out of a total population of 217 million.[13]

The Congress was satisfied with this statistical progress, and continued to renew the Community Mental Health Centers Act of 1963, P.L. 88-164, during this period.[14] This Act provided for the allotment of federal funds to the states for construction of community based mental health centers. State allotments were based on population, extent of facility need, and financial need.[15] But many recognized the federal government would never have the resources to assume a significant level of support for the CMHC program. Therefore, a declining grant structure was devised to allow the federal government to experiment with a new concept of care while utilizing minimal federal resources.[16] The Act required that each state develop a comprehensive mental health plan, and a list of priorities for action regarding the activities proposed by the state. Assistance assurances were required to be provided by the states that the services of CMHC's would be available to all and a reasonable amount of care would be provided to indigent persons.

The 1965 Community Mental Health Center's Amendments, P.L. 89-105, provided for the allotment of grants to cover a portion of staffing cost for centers. Federal funding for staffing was provided on a declining basis, and limited to 51 months.[17] This amendment

required the delivery of five essential elements: inpatient, outpatient, partial hospitalization, emergency, and consultation and education services. In 1968 Congress mandated that one percent of grant and contract funds appropriated for the Alcohol, Drug Abuse, and Mental Health Administration (ADMHA) be allotted to evaluate the effectiveness and functioning of CMHCs. Later, P.L. 94-63, allotted two percent for the purpose of evaluation and made it mandatory that every CMHC conduct evaluations. These created a great deal of interest in evaluation among research workers in consulting firms and universities.[18] The 1970 amendments, P.L. 91-211, provided for an extension of the maximum percentage of federal funds to CMHCs in designated poverty areas.[19] In response to Congress' continued authorization of funds, the Nixon administration expressed its opposition. President Nixon was opposed to the CMHC concept, as well as to expenditures for research and training in health and mental health in general. The funds that were authorized by Congress were impounded by President Nixon and he refused to spend the funds. The measure was taken to court and the funds were released.[20]

The years under the Nixon Administration and under President Ford continued to be difficult with little administrative support and actual funds. The 1975 Community Mental Health Centers Amendments, P.L. 94-63, was a continuation of the Nixon legacy under the Ford administration. President Ford vetoed the act, but Congress overrode the veto clearly indicating Congressional support

fiscally and conceptually the importance of the CMHC program nationally. The 1974 amendment provided a clear definition of a CMHC, and described the comprehensive mental health services that had to be provided to be eligible for funding.[21] The amendment mandated the addition of services for the care of children and elderly, aftercare for post-hospitalization, and community residential care homes. These services addressed the longstanding neglect of long overlooked sectors of the population, but it also created an additional burden of CMHCs.[22] This legislation also placed pressure on CMHCs to become more dependent on insurers to cover the cost of services.[23]

In 1967, 186 CMHCs had received federal support. By 1970, this number had grown to 450, but from 1970 forward the growth rate slowed drastically. In 1973, only 493 CMHCs were federally funded, but not all of these were operational. In 1975, 603 CMHCs had received some federal funds, and only 507 were operational.[24]

The 1978 Community Mental Health Center Amendment, P.L. 95-622, provided flexibility for service delivery by CMHCs. It allowed new centers to start with six basic required services, and to develop, within a three year period of time, a plan to provide all other mandated services. To avoid unnecessary duplication of services, the amendment also allowed the sharing of certain services between amd among catchment areas.

The final legislation that amended the CMHC program was the Mental Health Systems Act of 1980, P.L. 96-398. This amendment

extended the CMHC program, and provided for a higher role by the states in the administration of the CMHC program, and more money.[25] This legislation introduced the centralization and control of planning to the states in regard to service delivery, and it authorized the expenditure of a good deal more money on services to the chronically mentally ill.[26] In 1981, the Community Mental Health Centers Act was replaced by the Alcohol, Drug Abuse, and Mental Health Services Block Grant (ADMHS), P.L. 97-35. This legislation consolidated several categorical programs into single block grant authority to the States. These included grants for Community Mental Health Centers, grants and contracts for alcohol abuse services, and grants for drug abuse services. States could use their funding grants to CMHCs for services to chronically mentally ill individuals, identification and assessment of mentally ill individuals and the provision of appropriate services; and services for identified populations that are currently underserved. In 1984, P.L. 98-509, was passed and this legislation revised and reauthorized this program until the end of fiscal year 1987.[27]

The State Comprehensive Mental Health Services Plan Act of 1986, P.L. 99-380, amends Title XIX of the Public Health Services Act. It authorizes grants to states for the development and implementation of State comprehensive mental health services plans. The bill appropriates 10 million dollars for each fiscal year 1987 and 1988. It is to be allocated among the states by a formula based on population,

and no state will receive less than 150,000 dollars a year.[28] Each state will submit to the secretary of Health and Human Services a State Comprehensive Mental Health Services Plan. The plan has to include certain criteria related to the provision of services for the chronically mentally ill individuals. "The requirements include:

> (1) The establishment and implementation of an organized community-based system of care for chronically mentally ill individuals: (2) quantitative targets to be achieved, including numbers of chronically mentally ill individuals residing in the areas to be served; (3) a description of services to be provided to enable chronically mentally ill to gain access to mental health services; (4) a description of rehabilitation, employment, housing, medical and dental, and other support services to be provided to chronically mentally ill individuals to enable them to function outside of inpatient institutions to the maximum extent of their capabilities; (5) activities to reduce the rate of hospitalization of chronically mentally ill individuals; (6) the provision of casemanagement services to each chronically mentally ill individual in the state who receives substantial amounts of public funds or services; (7) provision for the implementation of casemanagement requirements which call for phasing in the provision of such services beginning in fiscal year 1989 and completion by the end of fiscal year 1992; and (8) the establishment and implementation of a program of outreach to, and services for chronically mentally ill individuals who are homeless."[29]

Each state is required to consult with representatives of employees of state institutions and public and private facilities who care for the chronically mentally ill in preparing their plan. The secretary is required to provide technical assistance in developing and implementing State plans. This includes the development and publication of model elements for state plans and model data sys-

tems to collect data in regard to the implementation of State plans. The secretary is authorized to withhold the allotment to the State for administrative costs under the Alcohol, Drug Abuse, and Mental Health block grant if the State has not developed and implemented the plan by the Fiscal Years 1988, 1989, and by the end of 1990. The secretary has to develop and make available within one year of the enactment of this legislation a model plan for a community-based system of care for chronically mentally ill individuals who are eligible for services under the Community Services Support Program.[30]

The enactment of this legislation reflects the need for an effective system to plan, develop, and initiate services to the mentally ill. Its focus is on individuals who have a chronic and disabling mental illness and who "fall through the cracks" of the mental health and social service systems. These individuals are unnecessarily hospitalized, are in the criminal justice system for minor infractions, or are homeless. Other populations, such as mentally ill children, and the elderly, also are effected and suffer from a lack of coordination, collaboration, and statewide planning for services for the mentally ill.[31]

At the time this legislation was enacted in 1986, there was an estimated 1.7 to 2.4 million persons in this country who suffer from a persistent, severe form of mental illness. Approximately 900,000 chronically mentally ill persons live in institutional settings. Of these 900,000, 130,000 are in state mental hospitals, and 770,000

are in nursing homes. It is estimated that between 800,000 severely disabled and 1.5 million moderately to severely disabled mentally ill individuals are estimated to be living in the community.[32] These individuals have multiple needs including: clothing, housing, medical and dental care, transportation, education, recreation, and money. They are in need of a personal support system, people who are interested and care for them as individuals. Many of these people suffer from profound, and irreversible, functional disabilities. Many of these individuals are unable to work in regular employment because of the severity of their impairments. They have poor activity of daily living skills, and experience the effects of ignorance and a generalized fear that mentally ill persons have had to face historically.

The majority of chronically mentally ill individuals who live in the community live with their families. The percentage of patients who live with their families or are discharged from institutions to their families is decreasing. A large number of chronically mentally ill individuals do not live with their families in the community but live in a variety of other settings including: residential treatment centers, group homes, sheltered apartments, and independently. Another large number of chronically mentally ill individuals cycle between hospitals, homelessness, and jails because of the inadequacy of state and local systems of services.[33]

The Reagan administration has shifted policies towards giving

states a larger role in the provision of services, not funding, of mental health services. There has been a movement toward increased centralization of funding service areas such as education, welfare, and health, has centralized funding but centralization of program decisions has not necessarily followed. Funding levels have increased on a federal level but substantial decisions regarding mental health issues are made primarily on a state and county level. Unifying sources that are funded on a federal level has not occurred. Many federal funding sources remain categorical, are spread among a number of bureaus, uncoordinated, and impose large administrative burdens on local agencies that must coordinate different funding flows and requirements.[34]

As pronounced on a federal level as in any other level of government is fragmentation, lack of clarity, and a failure to define coherent policies. There is a federal program to respond to almost any need a mentally disabled individual has. But agencies do not coordinate, cooperate, and continue to pursue individual priorities for program development.[35] There is not a formal policy statement labelled 'deinstitutionalization'[36] on a federal level. There is not an identified agency which has the power and authority to coordinate policies and programs to cut across agency and cabinet lines. Coordinating mechanisms within the Executive branch are not able to complete this purpose. Agencies external to HEW, and many HEW Departments do not cooperate in coordinating actions. NIMH and the

Developmental Disabilities Office, within HEW, have direct responsibilities for deinstitutionalization. These offices have no authority over the HEW offices, or over agencies that are responsible to different Cabinet offices.

Bureaucracies have their own priorities and objectives. The lack of clear policy on a federal level complimented and compounded the problems on a state and local level, and the ability to implement Kennedy's new approach. The emphasis on deinstitutionalization was in response to the belief that large numbers of people were in large institutions who did not need to be there. It reflects the belief that large institutions are bad,[37] and that institutions themselves were partly responsible for the manifestation of chronic mental illness. Deinstitutionalization was not a policy to provide a rationale for discharging patients from the hospital into the community, without support, to continue to save money. Deinstitutionalization means a change of care from an institutional setting to a less restrictive or structured setting, from a more dependent to a less dependent living situation. It is defined as the development of responsible and supportive alternative living arrangements and support services. It is difficult to coordinate a comprehensive service program within an individual institutional setting.[38]

The emergence of coordinated mental health services center on deinstitutionalization and community support. Community based treatment is important in the maintenance of residents in the community

after discharge from the state facilities.[39] CMHC services alone do not have a significant impact on reintegrating individuals into the community without a community support system. The basis of a support system is 'a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community.'[40] The NIMH Community Support Program states that an adequate community support system must be able to perform ten functions:

> "identification of the population, whether in the hospital or in the community and outreach to offer appropriate services; assistance in applying for entitlements; crisis stabilization services in the least restrictive setting possible, with hospitalization available when other options are insufficient; psychosocial rehabilitation services, including transitional living arrangements, socialization, and vocational rehabilitation; supportive services of indefinite duration including sheltered living arrangements; supportive work opportunities, and age-appropriate, culturally appropriate daytime and evening activities; medical and mental health care; back-up support to families, friends, and community members; involvement of concerned community members in planning, volunteering, and offering housing or work opportunities; protection of client rights, both in hospital and in the community; and case management, to insure continous availability of appropriate forms of assistance."[41]

These are services that are provided through individual agencies, each has its own administration, eligibility requirements, funding sources, and procedures for providing services. It is not enough to recognize how large institutions can be harmful, expensive, and unnecessary, because the social and political context of government and program planning need to be recognized. However,

it is not only big government that lacks policies and procedures, because social scientists and the mental health profession do not have the expertise to resolve the problems of planning and how the context effects whatever happens or does not happen.[42]

The interpersonal relationships of participants of different organizations are an important link between organizations. These relationships occur on many different levels by personal or official interactions by individuals among organizations. Individuals may act either in a private role or as a boundary role incumbent, personnel transfers or unit mobility, or as an individual holding positions in more than one organization at a time.[43]

> "In an earlier NIMH-supported publication,... note: The principle topic to which interorganizational analysis has been directed relates to the coordination and integration of human services (references ommitted-available in original document). A library of terms have been used to describe the patchwork of fragmented and discontinuous health and welfare services in which consumers are confronted.... In one form or another, this state of affairs has been attributed to the excessive autonomy of service agencies and their attempts to preserve perogatives about problem definition, intervention priority, and client disposition.... From a community organization perspective, the historic response has been to seek a pattern of coordinated services relying upon procedures that would insure the autonomy of the individual organizations in areas of conflict while at the same time permitting their unified effort in areas of agreement.... The experience with voluntary coordination mechanisms in the human services field, however, has been rather dismal.... More recently, greater attention has been paid to the managed forms of coordination in concerted decision making among service agencies as well as to the ways conflict can result from such cooperative actions.

> The relative efficacy of these forms, however, has yet to be carefully documented and their impact to be objectively assessed....
> A decade of recession and inflation, in combination with a climate of social and fiscal conservatism, has eroded the support base for large-scale intervention programs, but issues of service coordination are salient still today. Public policies are now predicated on austerity and consolidation, and current forecasts indicate that few large scale social programs or human service initiatives will be funded.... Instead, relatively modest programs that make limited demands on scarce resources have been advanced to reduce fragmentation and to to coordinate existing health and welfare services. In the mental health field, this strategy underlies a number of initiatives sponsored by the National Institute of Mental Health, including Community Support Programs for chronic mental patients..., Primary Health Care-Community Mental Health Center linkage projects..., and the Most-In-Need Program for child mental health services.... Thus, the development and evaluation of interorganizational service delivery systems in the mental health arena will continue to be a central policy concern in the next decade.[44]
> There has been enough research and informed assessment in the area to demonstrate that there are costs as well as potential benefits to coordination and to autonomy of service providers.... Only if these costs and benefits are closely examined and weighted can effective policies be implemented. Notwithstanding the current emphasis on the integration or consolidation of mental health and related human services at the federal, state, and local levels, greater attention must be focused on coordination-integration of what (tasks, functions), for what or for whom (purposes, beneficiaries, outcomes), and by what or to what extent (structure, processes)? The analytical tools developed in the field of interorganizational relations offer a framework for addressing these important issues."[45]

Relationships between organizations vary between competitive to cooperative along the continuum. On one end of the continuum, competition prevails, and collaboration exists only to the degree that

it supports the interest of the individual organization involved.[46] At the midpoint, along the continuum, cooperation may be contingent because 'organizations are expected to balance their commitments to collective purposes with their own more specialized goals.'[47] On the opposite end of the continuum, cooperation is mandated which 'implies the existence of a centralized control agency, which has the power to structure and restructure the total network.'[48] Therefore, whether interorganizational cooperation is mandated or voluntary it supports the possibility of a degree of coordination among system units even if they may have conflicting goals.[49]

There is no specific mandate requiring organizations that serve the chronically mentally ill to coordinate their activities. Coordination has to occur voluntarily between organizations. This has historically been a difficult task to achieve in the area of human services. There are several major factors that have created a lack of support among organizations that serve the chronically mentally ill which include, confusion, which is a result of separate funding sources for care, no mandate for interorganizational planning, and budget constraints. Other reasons include competition for resources, multiple network memberships which result in conflicting relationships between organizations, goals, role expectations, and differences in organizational activities and client target groups. Also, a dynamic that may attribute to the lack of coordination and discontinuity of care among organizations is the effort made by con-

stituent organizations to maintain autonomy and control their boundaries. Organizations often deny services to 'inappropriate' or 'undesirable'[50] clients or populations.[51]

There are several distinctive features that influence mental health management. Societal ambivalence towards mental health agency goals will often result in a lack of political support, especially during times of funding cutbacks and political reaction. Therefore, mental health administrators devote a great deal of time on advocacy on behalf of their programs needs and to justify continuation of existing programs. They must become adept at developing strategies to buffer external sources that may harm agency operations.

The "raw material"[52] that mental health agencies are trying to change are human beings, and their cooperation is essential in regard to service delivery. Managers must be aware of the needs, interests, rights, and values of their clients. They must keep themselves informed and remain sensitive to client preferences, and develop ongoing processes that assure decision making reflects client preferences.

Mental health agency goals are value statements and there are likely to be disagreements among groups and organizations in the community and within the agency. There rarely is widespread agreement regarding mental health agency goals. Therefore, a central function of mental health administration is to build a level of consensus and mediate between conflicting conceptions of agency

purpose.

Mental health professionals have values, ethics, norms, and conventions that at times run counter to agency expectations. Management is responsible for negotiating and accommodating differences between personnel and agency expectations. Many services provided by mental health agencies are nonroutine, individualized responses to client needs, and front-line workers often need to exercise discretion in delivering services.[53] Therefore, managers often have to precariously balance maintaining equity and reliability in the administration of programs, and still allow workers sufficient autonomy to respond to individual needs. Balancing these needs complicates the managers ability to monitor, control, and evaluate performance and poses special problems for managers.

Mental health agencies must develop mechanisms to evaluate program effectiveness because they lack a market mechanism that can reliably determine the value of services to clients. Administrators have to develop valid and reliable measures of effectiveness that are feasible to implement within the program.[54] Managerial choices are primarily influenced by the market from outside of the organization. All of the organizations resources come from outside and all results occur from outside. The business of the organization is market driven and it is important that management decisions are based on the market climate.[55]

When planning for an extensive entity like a state, to deli-

neate the components of the system is a comprehensive task. The system is a complex interaction of socioeconomic, political, professional, technical, bureaucratic, and other considerations.[56] Inherent in this type of comprehensive planning is a vast array of competing forces that will be affected. Many have a strong vested interest in preserving the status quo. The state mental health department may actively participate in interdepartmental planning for a target population as long as the planning does not threaten the departments budget or authority or imposes unwanted responsibilities. Legislative and executive leadership may understand the value of developing flexible intervention programs but may not grant community units the fiscal freedom to exercise flexibility. These problems may be symptomatic of longstanding positions, but they limit the planners' freedom and impair the development of relationships needed between competing entities within the system by which innovative efforts are being directed.

Due to rapid social change and inconsistent government mandates in regard to managing mental health services, planning can provide program coherence and direction for the community mental health system. The board and administrations role in planning includes internal program planning, interagency program planning, and looking ahead at trends and social indicators.[57]

Two steps in effective planning are the acquisition of an intensive understanding of the internal workings of the system and,

lacking power and authority, the ability to function under the umbrella of positive sanction. These are closely related factors. To create major change in a large system, a large amount of technical and political information and history is required. This information is not found in written reports or interviews. An accurate sense of this information is only achieved by immersing oneself in the workings of all aspects of the system through involvement in the problem-solving process or through the confidence of individuals within the system who view planners as collaborators.[58]

The most significant activities that board members and administrators of community mental health agencies participate in are system development and coordination of services. CMHC's need to operate interdependently, because the appropriate services ensures that clients may receive services of other mental health and human services agencies.[59]

The Organizational process includes the development of a decision-making body, the administration and acquiring of resources, and the reduction of constraints. These aspects are part of planning and of the politics of mental health. An operational framework has to be developed. Fiscal, administrative, and legal aspects are integrated into a working system and the decision-making process is codified or implicitly understood. If responsibility may be shared among several agencies, or if certain alternatives are to be assigned to an agency or a community organization, these

arrangements should be explicit and viable. When a program's goals are specified, the ability to achieve those goals is dependent upon the explicit consideration of the options available and how they are prioritized and adopted.[60]

Interagency planning is the activity that links an agency's internal plans with external agency strategies.[61] All programs should be involved in goal setting, and within a community setting this may include a great deal of negotiation among professionals and community members. Resources are allocated to achieve goals, and this process involves decisions that include who will provide what service to whom, at what occasion on time, and what location.

System development and coordination are concepts that are related but distinct. System is defined as regular and/or patterned sets of interactive activities by diverse agencies with identifiable boundaries. In discussing mental health systems, we refer to the development of activities between mental health service organizations and other human service agencies. Coordination is the means by which systems develop policies and/or procedures of two or more agencies. The mechanism for coordinating programs and operations are linkages, and include staff contacts, written agreements, and formal policy councils.[62]

Development of interagency programs and affecting cooperation between agencies can be costly, threaten an agency's identity and autonomy, and be of marginal value. Five conditions have been

identified that affect the success of interagency coordination including: resource dependency, agency power, awareness of dependency, uniform procedures, and legal mandates for coordination.[63]

When agencies depend on another for services, personnel, clients, or information, a state of resource dependency is created. Without resource dependency, there is insufficient incentive for agencies to interact and coordinate activities. Scarcity of resources and limited agency service capacity creates agency dependency.

For example, specialized children's services depend on mental health centers, local hospitals, or crisis centers for referrals. There may be a mutual or reciprocal dependency and the exchange of services may provide the basis for coordination. Mental health centers and hospitals depend on specialized treatment programs to complete their commitment to provide a full range of treatment under funding regulations.[64]

New laws, regulations, and funding requirements established on any government level may create a change in the balance of dependency. Federal community support programs give increased attention to the priorities of formerly weak service agencies because independent agencies now need their cooperation. By mandating increased authority to existing agencies, establishing new agencies empowered to enforce coordination, and by providing tangible and enforceable penalties for uncooperative agencies, laws and regulations can be used to insure coordination.[65]

The extent to which other local agencies can provide similar or related services may create interagency dependency. Increases in the number of organizations and changes in programs creates an unstable environment for the successful functioning of an agency.[66] Therefore, agencies must establish joint objectives and well-defined relationships to avoid policy shifts and agency alignments.

The level of resources an agency has as a basis for independent and/or cooperative relations is an issue of interdependency and agency power. A local agency that has an external and independent resource base has power. For example, local offices of state and federal programs are not as likely to cooperate. Constituencies of agency's are another power source, especially when an agency is faced with budget reductions.[67]

If agencies are aware of the scarcity of resources and a need for interagency cooperation, coordination will more likely take place.[68] For example, the possibility of interagency referrals need to be acknowledged by agencies so they may see linkages as mutually beneficial.[69] It is much more difficult for agencies to see how their resource allocations and treatment decisions have an overall effect on the service network. Individual agency policy decisions in regard to client service eligibility or payment for care can create service gaps and overlaps in service and reduces the overall efficiency of the service network. Agency consensus in the service delivery network in regard to the role, goals, and juris-

diction of each agency is essential in the coordination of agency services. Disagreement creates a climate of competition for clients and jurisdictions. If competition depletes agency resources and jurisdictions. If competition depletes agency resources and reduces effectiveness, coordination can be viewed as a useful management and linkage tool.[70]

Consistent agency operation approaches support the facilitation of coordination. In mental health this means developing a consistent approach to problem definition, diagnosis, categories of client care, and management of agency operations. Agencies that increasingly share common languages and treatment approaches, support an increased likelihood of a successful outcome to coordinate services between agencies.[71]

Legal mandates that enforce the coordination of services among agencies are conditioned by the factors discussed so far. If an agency does not recognize a clear benefit, there is no basis for communication, and if there is a power base for an agency to resist enfringements on its jurisdictions or resources, legal mandates can be costly and futile.[72]

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authority to existing agencies, establishing new agencies empowered to enforce coordination, laws and regulations can be used to insure coordination.[73]

Agencies can be viewed as balancing the conditions of interorganizational coordination that can be used as principles for linkages.[74] There are three strategies that boards and other agencies may use to build a system of coordinated services. At an agency level, service needs and client-centered links to those services are built into the treatment plan. Second, boards support the development of linkages between mental health agencies, and establish a stable network of mental health services. Third, boards can support the development of linkages to other human service networks.[75]

Human services integration identifies a large number of coordinative activities amongst service agencies. Service integration activities are identified in four areas which include: A broad service delivery approach, where providers view the client as an individual with complex needs, and by way of casemanagement, information, and referral those needs are met; 'program linkages'[76] are created where independent agencies coordinate services, with a result of creating a comprehensive multiagency service delivery system; government units work together to coordinate various programs within the intergovernmental system, and develop policies for all programs; and the creation of 'umbrellas'[77] or new organizations that manage a number of human services to improve policy management,

program linkages, and service delivery.[78]

The elements of a coordinated model of service with other agencies include: general intake and assessment of clients' problems; knowledge of service facilities; responsibility for referring client;[79] responsibility for a formal contract between clients, systems managers, and programs; evaluation of the quality of the service rendered to the client; follow-up to obtain client service and agency effectiveness feedback; the administration of funds for the operation of coordinative system; and research responsibilities in regard to unmet service needs and service system delivery gaps. Also essential in a governing structure is the ability to evaluate the effectiveness of the model, resolve identified barriers to service, institutionalize policy changes, and develop innovative funding sources and administration.[80]

There are four sets of tactics that may be used by mental health boards to facilitate coordination. The first set of tactics involves the assessment of coordination activities in the service system. These activities are generally performed by staff. Activities include: 1). Compiling an inventory of mental health and related resources in the local community.

2). Catalog community resources that are an informal part of the mental health system and rate the contribution they have to community treatment and support.

3). Identify formal community organizations that could provide

social support for psychiatric clients.[81]

4). Research current common patterns of interaction among health agencies and other agencies, and determine types of linkages that exist.

5). Research the current state of resource dependency among mental health and other human service organizations. Include the referral network, shared resources, contracts, and other linkages that exist.

6). Identify present conflicts and animosities between agencies.

7). Develop a process evaluation research project, and evaluate the current system. Identify the major effects of the current system in the development of gaps and/or duplication of services. This will provide a basis for action.[82]

The second set of tactics includes the board in an active or adjudicative role in the development of coordination among service agencies. The board can take an active role in establishing a task force that brings together staff from different agencies into a face-to-face forum to identify interdependencies and develop linkages. Problems that may develop in the execution of linkages, if conditions change, or if key personnel leave, may be remediated with the board's assistance by developing new linkages or a new channel of execution. The board can be a useful avenue in negotiations over coordination, and may provide insights and innovative compromises. The type of linkage should not exceed its purpose.[83]

The third set of tactics are in regard to the development of

linkages and coordination involving the investigation of resources available for joint programs and planning. The board may negotiate with other human service agencies to work out details for financing shared personnel, services, or physical facilities. Staff members from each agency can track federal and state announcements of funds for demonstration projects for local service coordination. Board members can become involved with other human service agencies to identify new funding sources and influence coordination by serving on other boards, task forces, or advisory councils.[84]

The fourth set of tactics involves an education role for the board. Boards can serve as information centers for mental health and human service agencies to provide information in regard to local services, personnel resources, other community linkage programs, and information about coordination support programs. Boards could develop in-service training programs that examine community support systems and different models of interagency coordination.[85]

It is necessary for boards to view these tactics within the context of local community objectives, needs, and resources. Coordination of services and operations is a necessary and responsible response to new treatment needs and a growing scarcity of resources. Boards face the difficult task of devising workable mechanisms for coordination that respond to the complex configuration of local needs and resources.[86]

A theory of community based care has been developing and ex-

perienced mental health professionals understand what the individual needs and services are.[87] Several experiments in coordinating services have been tried and have failed, and cooperation is difficult for many reasons.[88] But, many studies now confirm how the availability of community based services reduces hospitalization admissions. Studies conclude that the hospitalization or recidivism rate is reduced by almost half when community based services are available.[89]

From a longitudinal study of 95 dyadic relationships among chief care and health organizations in Texas a theory was developed regarding the creation, growth, and decline of interorganizational relationships. The model was revised to explain the data acquired and new patterns were recognized that were important to the development of interorganizational relationships over time. These new patterns were identified and included: 1). Perceptions of dependence on other organizations for resources stimulates the development of interorganizational relationships. A very powerful direct determinant of communications, resource transactions, and consensus is resource dependence.

2). Growth of interorganizational relationships is dependent on frequent communications to formalize relationships and to build a consensus in regard to the terms of the relationship among the participating parties.

3). Client referrals and monetary transactions require different

patterns of coordination.

4). A positive outcome of initial resource dependence is consensus among the participating organizations in an interorganizational relationship but has a negative impact on subsequent perceptions of resource dependence.[90]

The longitudinal research in this report examined the mobilization of coordination efforts initiated by fourteen early childhood development (ECD) organizations. Mobilization coordination focuses on activities of an organization in regard to a particular objective for which it needs support, cooperation, or resources from a group of organizations. The primary organization functions as an entrpreneur to gather resources and support and develops ad hoc relationships needed to support the organizations objectives. This type of coordination is important but is overlooked because coordination is related to structured coordination. The ECD agencies were initially funded by a Texas state department and became financially independent of the state within three and one half years. In the interim, the ECD organizations' directions recognized they were going to need the support of other organizations to survive and understood that they needed to integrate into the human service delivery systems on a community level.[91]

Another analysis of the development of children's services identifies and analyzes findings from states that have initiated the development of coordinated approaches for delivery of services

to children and adolescents who may be multihandicapped or are in need of services from two or more state agencies. The survey conducted in 1983, by the Alpha Center, Bethesda, Maryland, for the National Institute of Mental Health (NIMH), identified fifteen states having a formal coordinated structure for children's services, including mental health services, at the state level. Coordination activities in these states were the result of legislative or executive mandates, or strong child advocacy movement in the state. These states intentions are to improve services to multiproblem children, "those who fall through the cracks,"[92] by strong interagency cooperation and coordination.[93]

Three types of administrative structures were identified for delivery of services among the fifteen states. These were: states with consolidated agencies responsible for administering almost all children's services; states with 'quasi'[94] consolidated agencies responsible for administering some part of children's services: and states with a formal coordinating mechanism responsible for oversight and development of policy for children's services.[95]

There were three states identified with consolidated agencies at the state level; Connecticut, Delaware, and Rhode Island. Welfare, juvenile justice, child protection, and child mental health programs and services are under the new department, which has responsibility for the administration of children's services.[96] Consolidated agencies assume responsibility for staff, office equipment,

furnishings, and budget allocations. They also assume traditional management functions in regard to planning, budget development, program development and administration, and development of management information systems and data collection.[97]

It is considered that the consolidated agency approach is the most difficult structure to develop and implement. This is due to the legislative and administrative changes that are necessary. Also at issue are concerns in regard to agency autonomy and position, which may initiate strong opposition from agencies that view themselves as weak and vulnerable. The consolidation model has not been widely adopted although several states have reviewed the model as a consideration.[98]

The underlying strengths of this model include more visibility for children's services; strong legislative support with likely increases in budget for services; increasingly effective coordination of services and programs and effective management control, therefore reducing duplication and waste; reducing 'turf' battles and avoidance and shifting of service responsibility in care; a decrease in departmental stagnation which helps to eliminate tunnel vision and recruit 'new blood'; the development of links with restrictive environments to establish alternatives; the development of a strong children's constituency and advocacy group; and the increased presence of mental health in all children's services.[99]

From a mental health perspective there are some inherent prob-

lems that may influence the mental health structure. These include: if department directors retain a biased viewpoint this may result in a decrease in attention on mental health needs; and mental health services may need to compete with other children's services for part of the departments' budget, as they did when they competed with adult mental health programs for a part of the mental health budget.[100]

'Quasi'[101] consolidated agencies are similar to consolidated agencies in that they tend to be established as divisions within existing umbrella agencies.[102] Many strengths identified under the consolidated agency model are also identified under the quasi consolidated model. They include: more visibility for children's services; strong legislative support with likely increases in budget for services; increased casemanagement capability;[103] increased likelihood of joint ventures between agencies, especially education; the development of links with restrictive environments to establish alternatives; a decrease in departmental stagnation; and the support to accomplish better interagency integration and coordination.[104]

But, unlike consolidated agencies, the mental health department and other agencies that are autonomous are able to retain and maintain more control of services. Therefore, there is not as much interest in coordination with other mental health services. A primary weakness in the quasi consolidation process is there continues to be duplication and overlap of services.[105]

States with formal coordinating mechanisms vary in structure

greatly.[106] The structure can range from a new division in an umbrella agency, to a council of commissioners or department directors that coordinates multiagency activities and services. These bodies do not have the responsibility of administering children's service programs but serve to coordinate policy and planning development among agencies and programs. Individual agencies maintain their autonomy in regard to staff and budget resources.[107]

The formal coordinating function varies greatly from state to state but there are common strengths noted across these structures. Strengths include: the ability to retain departmental identities; the enhancement of coordination among departments;[108] they provided a mechanism to keep children from 'falling through the cracks,'[109] and the presence of a force that could be objective and neutral.[110]

The weaknesses of the formal coordination approach included: the inability to avoid turf issues, even though there is a mechanism to assist in resolving some conflicts because very little staff or money is allocated to support these bodies, there is a difficulty in functioning and implementing needed program changes; and because departments remain autonomous and function as independent, self-contained bodies, there is very little real control over departments under this model.[111]

A common factor shared in regard to the development and implementation of a model was negative publicity, and criticism of the current system of service provision. If public advocacy and atten-

tion is substantial, then negative attention can result in successful legislative and administrative advocacy. Departments do not have control over funding that the legislature and governor has, and at this level change was initiated. This attention bypassed departmental posturing, defensiveness, and self-protectionsm. The governor or legislature provides a level of influence that supports agencies to cooperate and participate. An interesting finding of this report is that almost all states reported some degree of success in implementing interagency coordination.[112]

In the quasi consolidated and consolidated agency models the fear of loss of power and of being ignored was expressed by mental health representatives frequently. Child welfare and juvenile justice systems have control over more resources and staff than child mental health programs.[113] Within the Department of Mental Health children's services experience limited staffing and funding, and therefore enter the arena as a less powerful entity. Therefore, the influence mental health has can grow as services become an integral part of the treatment intervention for all children and families. Child welfare philosophy is not incompatible with mental health ideas but neither can use rigid or narrow definitions. This means that children's mental health services have to be more broadly defined than transactional psychoanalytic therapy and DSM-III diagnoses.[114]

Coordination structures that have a degree of control over

funds have an increased likelihood of being successful in the development and implementation of new programs. When a coordinating structure does not have resources, the commitment and good will of the agencies involved needs to be utilized. If the activities of the coordinating structure produce some concrete and tangible changes, participation by agencies is likely to continue, but if there are not changes participation is likely to decrease. One of the problems inherent in the formal coordinating approach is the development of innovative plans that lack resources for implementation, and therefore result in disillusionment with the process.[115]

Coordination tends to include agencies within the human services system. Education is the single largest agency serving children but in general was not included in the consolidated or quasi consolidated model. But, there was a coordinated relationship between the coordination structure and the Department of Education. Also, specified health services were not usually among consolidated services, but participated in planning and coordination with the new coordinating structure.[116]

A concern developed in regard to the interface between the children's agency and the state mental health authority when children become eligible for programs in the adult mental health system. The mental health department had more difficulty in planning for the needs of a child as he enters the adult system. Therefore, the consolidated children's agency needs to maintain contact with

the adult mental health system.[117]

Service providers have adapted and learned to work with and around imprecise terms in mental health. This impreciseness allows systems to be manipulated to gain ends supposedly for the welfare of patients and clients. In fact, terms are used as obstructions to goals.[118] Fragmentation has overcome coordination with the result of patient care and treatment outcomes suffering. Patients and families are more amenable to shopping for services when they have options. Lapses in service continuity and care has created increased public disillusionment and unhappiness in regard to the aftereffects of deinstitutionalization.[119]

Rochester, New York, has long been in the lead of innovative healthcare system development. In an attempt to rationalize a system of public-funded mental health services in a two-county area Integrated Mental Health, Inc. (IMH) was conceived. In 1978 five area community mental health centers in conjunction with the Rochester Psychiatric Center, the state facility serving this area, applied to the state government for a single service system grant. The grant was awarded in 1980 via the states Office of Mental Health, and the Rochester Area Hospitals Corporation was selected to administer the grant. The project was divided in two phases that included an analysis of current problems in the community and designing a better system for the future. Findings of the analysis included: "The community had spent 72 million dollars for mental health ser-

vices in the year 1981. Many of these dollars were being used ineffectively and care was being compromised as a result. There was no focal point for identifying problems and implementing solutions. Governance, management, and financing responsibilities were fragmented and scattered. Revenues to mental health centers were unpredictable and financing mechanisms encouraged overuse of expensive inpatient care rather than less costly and often more appropriate outpatient options. There was little information adequate for planning and managing patient care or indeed for knowing what happened in the course of patient care.[120]

After identifying the problems, the next objective was to design a system that would substitute fragmentation with comprehensive, coordinated community planning and offer community mental health providers the financial incentives to provide needed services. A five-part program was developed to achieve these objectives which included: "1). Integrated Mental Health, Inc. (IMH). A standing not-for-profit corporation organized to provide a community-wide planning, coordinating focus for mental health services;
2). Contract Revenue System (CRS). A delivery and finance system designed to provide stable, predictable funds for community mental health agencies;
3). Capitation Payment System (CPS). A delivery and financing system to assure the chronically mentally ill substantial services in the community tailored to their needs, with a Lead Agency respon-

sible for their care by contract and with access to data for[121] planning and carrying out the necessary services. (An HMO model, with cash advanced for patient care, works in partnership with the state hospital facility, Rochester Psychiatric Center.);

4). Start-up Capability for CPS. A commitment from the State of New York to allow for initiating necessary facilities, staff, staff training and supplies so as to accommadate the needs of patients new or only peripherally served previously in the community;

5). Management Information System (MIS). A sophisticated set of data systems with a common format for all participating agencies enabling IMH to monitor patient outcomes, support the complex financial and management reporting systems, supply the provider agencies with capability to monitor, evaluate, and plan in automated fashion for service delivery."[122]

The new corporation, IMH, quickly secured contracts for the design of the management information system to be ready for implementation of the program. This was an ambitious system to implement and an extensive network of contracts were designed. Payor contracts to support this system are between the State of New York, the Counties of Monroe and Livingston, the United Way of Greater Rochester, and Integrated Mental Health, Inc.. There are nineteen organizations that are members now. Casemanagement is emphasized to assess, plan, coordinate, refer, and monitor community treatment of the chronically mentally ill.[123] IMH, Inc. manages and coordinates

the many interlocking systems. It accepts delegated authority for planning, funding, monitoring, and evaluating mental health service.[124]

Outcomes of the IMH project included: Documented results of an evaluation study, supported by the National Institute of Mental Health, contrasting functional outcomes in a managed care community based system for chronically mentally ill individuals with patient outcomes served in the mental health system; evaluation of management and system accountability using standardized data generation and reporting; using a system-wide Management Information System increased ability to plan based on system wide, comparable information; use of local management delegation using funding control, capitation, and financial incentives; measurement of the ability of a local service system funded by public money to participate and influence mental health service environment through a consolidated corporate decision making process that creates a total system of care and to learn and share the knowledge ascertained by developing a complete service record of patients moving through a service system.[125]

Almost all states have a mechanism developed to fund local community mental health centers. The State of Michigan has 83 Community Mental Health Center Boards which are attached to local county government systems. Annually, the State Department of Mental Health submits to each Board an instructional packet for the development and submission of a program plan and budget. The Department reviews each Boards annual plan and budget and approves or disapproves in

whole or part. Eligibility for state funds is contingent on an approved plan and budget.

In reviewing a county program's annual plan and budget the Department of Mental Health considers the state's mental health needs, the county's mental health needs, and the state's need for a reasonable degree of statewide standardization and control of services.

> This includes "the county program's need for a reasonable degree of flexibility and freedom to design, staff, and administer services in a manner that the county program deems appropriate to its situation. The county program's need for a reasonable expectation that services meeting an essential mental health need and which are appropriately designed and executed will receive continuing state financial support within the constraint of state funds actually appropriated by the legislature. The demonstrated relevancy, quality, effectiveness, and efficiency of the county program's services. The adequacy of the county program's accounting for the expenditure of state funds"[126]

Prior to the beginning of the states' fiscal year, the Department of Mental Health notifies each Community Mental Center Board of the approval or disapproval of its plans and budget and the allocation of funds. If there are insufficient funds for the allocation of

approved plans and budgets, the Department decides based on the criteria how to divide the funds available to the Boards.[127] The state is mandated to pay 90% of the annual net cost of a county community mental health program.[128] The county is financially liable for 10% of the net cost of services provided by the state and by contract to a Community Mental Health Center Board.[129]

The Michigan Mental Health Code, Act 258, was enacted in 1974. It was enacted to:

> "modernize, add to, revise, consolidate, and codify the statutes related to Mental Health; delineate the powers and duties of the department of mental health; to establish county community mental health programs; to delineate state and county financial responsibility for public mental health services; to create certain funds; to establish procedures for the civil admission and discharge of mentally retarded and developmentally disabled persons to and from facilities; to establish guardianship arrangements for mentally retarded persons; to establish certain rights of persons who receive mental health services; to establish financial liability for the receipt of mental health services; to establish certain miscellaneous provisions relating to mental health; to establish procedures pertaining to mentally ill and mentally retarded persons who are under criminal sentence, to persons who are mentally incompetent to stand trial, and to persons who have been found not guilty by reason of insanity; and to repeal certain acts and parts of acts."[130]

The State Department of Mental Health is responsible for the implementation of Act 258. It is responsible for the development and establishment of arrangements and procedures for the coordination and integration of state and county program services. The Department reviews and evaluates the quality, effectiveness, and

efficiency of programs. The Department provides consultative services to county programs by assignment of Area Managers who act as liaisons between the Department and County Boards. The Department establishes and approves county programs, program plans and budgets. It provides financial liability schedules, provisions, and procedures for individuals who receive mental health services through a county mental health program. It is mandated that individuals cannot be denied a county mental health service because of inability to pay for a service. The Department conducts annual audits of the expenditure of state funds through county programs. It develops the rules and procedures to implement the objectives and provisions and rules of federally funded insurance programs, and third party reimbursers.[131]

Planning requirements for mental health services are developed and completed, in the state of Michigan, as part of the State Health Plan (SHP). The State Health Planning and Development Agency (SHPA) is selected by the Governor. In Michigan, the development of the SHP is the responsibility of the Office of Health and Medical Affairs, which is the SHPA. The SHP, when completed, is presented to the statewide Health Coordinating Council (SHCC) for review. The SHCC is a 53-member council comprised of consumers and providers of health care which is appointed by the Governor. The review process includes holding public hearings to obtain information from the public concerning the plan. When the SHCC approves

the plan, it is submitted to the Governor and legislature for review and approval.[132]

The SHP is to be used as the principal guide in regards to the development of mental health programs and the allocation of resources to mental health services in the state. The SHP is the basis for approval or disapproval of the Proposed Uses of Federal Funds for the state mental health program and budget; and is the basis for the standards and criteria certificates of need.[133]

The goal developed for mental health and developmental disabilities set forth in the present 1983-87 State Health Plan is there are twelve types of mental health services that should be available to all Michigan residents. Priority basis is to be provided to the most severely disabled. Services are to be provided at a capacity level to meet the service level need of each community and provision of services are to be cost-effective in the least restrictive settings appropriate to the need. The twelve types of services that should be available are: inpatient services, partial day services, residential services, outpatient services-including 24-hour intervention, casefinding services, public information and consultation, rehabilitation services, habituation services, respite/family support services, casemanagement services, and protection and advocacy.[134]

Quality of services should be enhanced by the development of a complete set of standards and guidelines which cover all aspects and levels of administrative and clinical functioning. These standards

and guidelines are to be updated within five year periods of time.[135]

The objectives of the mental health plan are to be met by 1987. The provisions include:

> "By 1987 all admissions for acute care psychiatric episodes should be to private facilities. By 1984 the State Department of Mental Health should adopt a policy regarding the treatment of the chronically mentally ill.[136] By 1987 there should be an adequate array of services in each Community Mental Health Service Board (CMHSB) service area which will enable mentally ill and developmentally disabled persons to stay in their community of residence. By 1984 the Department of Mental Health (DMH) and other appropriate agencies such as the Office of Services to the Aging and the Department of Corrections should have adopted a policy which addresses the needs of the following special populations: (1) institutionalized elderly, (2) noninstituionalized elderly, and (3) incarcerated persons. By 1987 at least 75 percent of the Community Mental Health Services Boards should be designated by the Department of Mental Health as the mental health authority for their service area."[136]

The SHP develops recommended actions and strategies to meet the goals and objectives of the SHP. The first recommendation is in regard to state facility reduction. The SHP recommends the Department of Mental Health develop and adopt the use of model contracts agreements between community mental health service boards and private hospitals to provide acute psychiatric inpatient care for public patients in private facilities. The SHP recommends that contracts should include elements in regard to transfer arrangements from private facilities to state operated facilities or other long-term facilities for patients who require care beyond 30 days; billing and financing arrangements; minimum treatment requirements for patients;

coordination of services between private facilities and the community mental health services board; special provisions for emergency admitting procedures;[138] voluntary and involuntary admission procedures; and agreements with private facilities in regard to availability of beds for community mental health service board use. The Department of Mental Health should estimate a minimum number and general location of private community-based psychiatric inpatient beds needed to facilitate the closure of state facility acute psychiatric inpatient beds, and actively facilitate the development of the number of beds needed with community based hospital providers. The SHP also recommends that the Department of Mental Health, in coordination with the Department of Social Services, Department of Public Health and Department of Labor, should develop specialized nursing home services for individuals presently residing in state facilities who would be appropriately served in a less restrictive setting, and as an alternative for appropriate individuals who do not have a previous history of state facility inpatient care. Development of specialized nursing home services should certain issues in regard to the determination of alternatives for individuals requiring such services; staffing levels and the inclusion of psychiatric nursing, social work, and behavior management disciplines; billable Medicaid and Medicare services: a process for recruiting and selecting providers; and the participation of the nursing home industry in developing standards for programs.[139]

The second recommendation of the SHP is in regards to Communi-

ty Service strategies. The SHP recommends the Department of Mental Health and the Developmental Disabilities Council should jointly develop a plan for use by the Department of Mental Health to facilitate the budget process that specifies the types and levels of service and funding levels for individuals who are developmentally disabled.[140] The SHP recommended the development of services needed by developmentally disabled individuals over 26 years of age, and the development of family support services, that would support families who care for developmentally disabled or mentally ill family members in the home. It recommended the Departments of Mental Health, Social Services, Education, Public Health, and Labor to jointly develop a model life services project. The Department of Mental Health and the Department of Education's Rehabilitation Services should develop standards for work activity/adult activity and sheltered workshop positions per 1,000 general population ratios.[141]

The third recommendation by the SHP is in regard to Special Population strategies. It recommends there be an interagency agreement between the Department of Mental Health and Office of Services to the Aging. The agreement is to incorporate recommendations of the Mental Health Aging Advisory Group which includes:[142] "advocacy activities for the elderly, psychotropic medication guidelines, cooperative working agreements between various service providers, specific proposals for enhancing service availability, accessibility, and safety, staff training and consultation, and research."[143]

The Mental Health and Aging Advisory Group will be responsible for the review of new Department of Mental Health and Office of Services to the Aging policy and program development. They will also oversee the evaluation and training, and other activities to decide whether senior citizens needs are being provided for appropriately.[144]

The needs of incarcerated mentally ill and developmentally disabled individuals should be addressed by an interdepartmental committee. The committee is to be appointed by the Governor and include the Department of Mental Health, Department of Corrections, and the Office of Criminal Justice Programs.[145]

The fourth SHP recommendation is in regard to Community Authority strategies. It recommends that the Governor allocate a portion of the savings derived by the redirection of individuals into private acute care services from state facilities to community mental health service boards to develop programs and to become full management boards. Full management community mental health boards should fulfill certain criteria including: at the local level there should be a completion plan for a central registry and client services management functions, voluntary and contractual agreements with courts and other public agencies that are willing to assume clinical responsibility for involuntary patients;[146] a plan to develop a local system of recipient rights that is consistent with the Mental Health Code; to create a single local appropriations unit; a performance plan and budget that is based on client functioning level,

program objectives, and units of service delivered for funds allocated by the Department of Mental Health; Community Mental Health Boards must agree to a minimum of quarterly performance reviews, terms of contract negotiation and appropriate sanctions and rewards based upon contractual performance; a plan to collect and report data needed to monitor performance agreed upon in the contract; and a plan for state employees seeking community mental health employment.[147]

The SHP recommends that the Department of Mental Health appoint a committee to review existing standards for community mental health programs and develop standards that address all administrative and clinical services. It also recommends that the Legislature continue to support the community mental health program as embodied in state law with special focus on state licensed residential facilities that provide care for six individuals or less being a permitted use of residential property, and the Department of Social Services to continue to assure that communities do not support an excessive number of these types of facilities.[148]

Implementation of the community mental health services program in the State of Michigan varies widely. Each Community Mental Health Services Board functions as an independent public agency. Even though each Board receives 90% funding from the state and 10% funding from the county the development and implementation of programs mandated by the Michigan Mental Health Code, the State Health Plan, and

federal funds varies greatly.[149]

The two most important trends in community mental health care are deinstitutionalization and community support. Community-based treatment of mentally ill individuals is essential in regard to maintaining individuals in the community after discharge from state facilities, but traditional community mental health services alone cannot have an impact on helping to reenter the community. The ability of a community support program to maintain individuals in the community depends on its ability to perform certain functions.[150]

There have been innovative and creative outlooks and techniques for treating mental illness. The problem tends to still be the range of treatment modalities and settings continues to be limited. Mental health clinicians are oriented to approaches which they are the most familiar with, which is predominantly oriented to providing direct treatment. To achieve the goals of community care it is, and will continue to be, important to break away from classical treatment modalities, and offer new types of care and build a strong community support system.[151]

Prioritizing program needs is a difficult process. A Center must take into account program costs relative to benefits, and make value judgements about the needs of the community. Decisions about who to serve first, or on whom to spend the most money, are as individual as the community. There are no guidelines for this process because the interests and needs of a community are a function of eco-

nomics, politics, and the functional characteristics of recipients.[152]

Each mental health system must start with a basic statement of purpose. This is important because this statement should embody the values and beliefs of local residents and values of the community mental health movement as it is applied to the mental health needs of the catchment area. The purpose is translated into operating principles to facilitate the design of a mental health model, which facilitates the development of goals that can be measured. The discrepancies between goals and outputs facilitates the process of prioritizing program. Economic and political constraints may cause a system to amend its model, but the purpose of the program allows for a direction and facilitation of priorities ascertained to be needed to be met ultimately.[153] "Gaps in intersystem relationships among health and medical practice, criminal justice, welfare and rehabilitation, education and mental health organizations have long been considered as a major problem and deterrent to effective service delivery. As a result, there is a strong appeal in shifting the focus from the level of the single organization to that of a complex network of agencies and in planning in terms of a community of inter-organizational systems of which individual organizations constitute components or subsystems. Applying the term 'system' to an organization implies 'interdependence' in the sense of maintenance of the integrity of system elements through boundary control processes. Human service organizations find themselves entering into relation-

ships and decisions that are aimed at multilevel outcomes. The transactions and resource exchanges must be approached in terms of their relevance to community needs interorganizational requirements for system survival."[154]

There are no easy answers in dealing with the issues of homelessness, exploitation of individuals, lack of medical care, money, etc., when discussing the needs of the mentally ill. There is little agreement among professionals as to how to approach the problem and this is why there is so much diversity in programs. It is going to be important for mental health professionals to be innovative, creative, realistic, and compassionate in regard to making decisions about how to deal with these issues. The shortcomings of mental hospitals thirty years ago, have now been mirrored in the community mental health system, and again mirrors the imperfections and limitations of most human institutions to respond to the needs of individuals. The major difference thirty years later is that it is not behind the closed doors of a mental hospital. It is now in full public view for everyone to see, sometimes whether we want to or not. We cannot hide from the issues because they are there before us.

This is a time of inconsistent government mandates, and reductions in federal and state funding allocations, and planning can provide program coherence and direction for the community mental health system. A trifocal view of planning that includes internal program planning, interagency planning, and long-range planning is

essential to the continued development of the community mental health movement.[155] Interagency planning and coordination of services is considered an essential focus of agency service provision and client participation. Human service institutions can no longer function autonomously and effectively in the best interest of clients, communities, and society.

## Footnotes

[1]Silverman, Wade A., 1981. Community Mental Health. Praeger Publishers, p. 291.

[2]Ibid.

[3]Ibid.

[4]Fogelson, Franklin B., and Harold W. Denome, Jr., 1969. "Program Change Through Mental Health Planning." Community Mental Health Journal. 5(1): 3-13.

[5]Grob, Gerald N., 1983. Mental Illness and American Society, 1875-1904. Princeton University Press, p. 106.

[6]Ibid., p. 291.

[7]Ibid.

[8]Ibid.

[9] Ibid.

[10]Ibid., p. 318.

[11]Ibid., p. 319.

[12]Ibid., p. 317.

[13]Ibid.

[14]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 63.

[15]U.S. Senate. Committee on Labor and Human Resources. Entitled the "State Comprehensive Mental Health Services Plan Act of 1986" (Sn. Rpt. 99-380). Washington: Printing Office, 1986, p. 3.

[16]Silverman, Wade A., 1981. Community Mental Health. Praeger Publishers, p. 115.

[17]U.S. Senate. Committee on Labor and Human Resources. Entitled the "State Comprehensive Mental Health Services Plan Act of 1986" (Sn. Rpt. 99-380). Washington: Printing Office, 1986, p. 3.

[18]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 63.

[19]U.S. Senate. Committee on Labor and Human Resources. Entitled the "State Comprehensive Mental Health Services Plan Act of 1986" (Sn. Rpt. 99-380). Washington: Printing Office, 1986, p. 4.

[20]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 63.

[21]Ibid., p. 64.

[22]Silverman, Wade A., 1981. Community Mental Health. Praeger Publishers, p. 232.

[23]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 82.

[24]Ibid., p. 63.

[25]U.S. Senate. Committee on Labor and Human Resources. Entitled the "State Comprehensive Mental Health Services Plan Act of 1986" (Sn. Rpt. 99-380). Washington: Printing Office, 1986, p. 4.

[26]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 202.

[27]U. S. Senate. Committee on Labor and Human Resources. Entitled the "State Comprehensive Mental Health Services Plan Act of 1986" (Sn. Rpt. 99-380). Washington: Printing Office, 1986, p. 4.

[28]Ibid., p. 2.

[29]Ibid.

30Ibid.

[31]Ibid., p. 7.

[32]Ibid., p. 3.

[33]Ibid.

[34]Scott, Richard W., and Bruce L. Black, 1986. The Organization of Mental Health Services: Societal and Community Systems. Sage Publications, Inc., p. 44.

[35]Ibid., p. 46.

[36]Ibid., p. 47.

[37]Ibid.

[38]Ibid.

[39]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 91.

[40]Ibid., p. 92.

[41]Ibid., P. 93.

[42]Silverman, Wade A., 1981. Community Mental Health. Praeger Publishers, p. 291.

[43]Ibid., p. 292.

[44]Ibid.

[45]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 93.

[46]Scott, Richard W., and Bruce L. Black, 1986. The Organization of Mental Health Services: Societal and Community Systems. Sage Publications, Inc., p. 47.

[47]Ibid., p. 148.

[48]Ibid., p. 149.

[49]Ibid., p. 165.

[50]Ibid.

[51]Austin, M. J., and William E. Hershey, 1983. Handbook on Mental Health Administration. Jossey-Bass, P. 139.

[52]Ibid.

[53]Ibid., p. 140.

[54]Kipp, Michael F., 1987. "New Directions for Community Mental Health Centers." Journal of Mental Health Administration. 14: 26-31.

[55]Fogelson, Franklin B., and Harold W. Demone, Jr., 1969. "Program Change Through Mental Health Planning." Community Mental Health Journal. 5(1): p. 3-13.

[56]Ibid., p. 6.

[57]Austin, M. J., and William E. Hershey, 1983. Handbook on Mental Health Administration. Jossey-Bass, p. 121.

[58]Ibid., p. 126.

[59]Golann, Stewart E. and Carl Eisdorfer, 1972. Handbook on Community Mental Health. Appleton-Century-Crofts, p. 7.

[60]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 290.

[61]Ibid., p. 291.

[62]Silverman, Wade A., 1981. Community Mental Health. Praeger Publishers, p. 295.

[63]Ibid., p. 296.

[64]Ibid.

[65]Ibid.

[66]Ibid., P. 297.

[67]Ibid.

[68]Ibid., p. 298.

[69]Ibid.

[70]Ibid.

[71]Ibid.

[72]Ibid., p. 296.

[73]Ibid., p. 298.

[74]Ibid., p. 300.

[75]Ibid., p. 302.

[76]Ibid., p. 303.

[77]Ibid.

[78]Ibid.

[79]Ibid., p. 305.

[80]Ibid., p. 306.

[81]Ibid.

[82]Ibid.

[83]Ibid., p. 307.

[84]Ibid.

[85]Levine, Murray, 1980. The History and Politics of Community Mental Health. Oxford University Press, Inc., p. 96.

[86]Ibid., p. 62.

[87]Ibid., p. 96.

[88]VandeVen, Andrew H. and Gordon Walker, 1984. "The Dynamics of Interorganizational Coordination." Administrative Science Quarterly. 29: 598-621.

[89]Ibid.

[90]Isaacs, Mareasa R., 1984. "An Analysis of State Administrative Structure For the Provision of Coordinated Services To Children and Youth." The Office of State and Community Liasion National Institute of Mental Health. p. 1-22.

[91]Ibid.

[92]Ibid., p. 2.

[93]Ibid.

[94]Ibid.

[95]Ibid., p. 4.

[96]Ibid., p. 6.

[97]Ibid.

[98]Ibid., p. 7.

[99]Ibid.

[100]Ibid.

[101]Ibid., p. 8.

[102]Ibid., p. 9.

[103]Ibid.

[104]Ibid.

[105]Ibid., p. 10.

[106]Ibid., p. 16.

[107]Ibid., p. 17.

[108]Ibid.

[109]Ibid.

[110]Ibid., p. 18.

[111]Ibid.

[112]Ibid., p. 19.

[113]Ibid.

[114]Ibid.

[115]Ibid., p. 20.

[116]Marshall, Phyllis E., 1986. "Integrated Mental Health: A Creative Model for Community Mental Health in the 1980s." Journal of Mental Health Administration. p. 23-27.

[117]Ibid., p. 24.

[118]Ibid.

[119]Ibid.

[120]Ibid., p. 25.

[121]Ibid.

[122]Ibid., p. 26.

[123]Ibid.

[124]Ibid.

[125]Ibid., p. 27.

[126]Michigan Department of Mental Health. Michigan's Mental Health Code 1986, Lansing, Mi., p. 22.

[127]Ibid.

[128]Ibid., p. 28.

[129]Ibid., p. 27.

[130]Ibid., p. 1.

[131]Ibid., p. 23.

[132]Michigan Statewide Coordinating Council. Michigan State Health Plan 1983-1987: Summary, p. iii.

[133]Ibid.

[134]Ibid., p. 22.

[135]Ibid.

[136]Ibid.

[137]Ibid., p. 23.

[138]Ibid.

[139]Ibid., p. 24.

[140]Ibid.

[141]Ibid., p. 25.

[142]Ibid.

[143]Ibid., p. 26.

[144]Ibid.

[145]Ibid.

[146]Ibid., p. 27.

[147]Ibid.

[148]Ibid.

[149]Michigan Department of Mental Health. Michigan's Mental Health Code 1986, Lansing, Mi., p. 22.

[150]Silverman, Wade A., 1981. Community Mental Health. Praeger Publishers, p. 291.

[151]Ibid.

[152]Ibid., p. 426.

[153]Ibid., p. 438.

[154]Scott, Richard W., and Bruce L. Black, 1986. The Organization of Mental Health Services: Societal and Community Systems. Sage Publications, Inc., p. 44.

[155]Fogelson, Franklin B., and Harold W. Denome, Jr., 1969. "Program Change Through Mental Health Planning." Community Mental Health Journal. 5(1): 3_13.

## Bibliography


Silverman, Wade A., 1981. Community Mental Health. New York, New York: Praeger Publishers, 1981.

Fogelson, Franklin B., and Harold W. Denome, Jr., 1969. "Program Change Through Mental Health Planning." Community Mental Health Journal. 5(1): 3-13.

Grob, Gerald N., 1983. Mental Illness and American Society, 1875-1904. Princeton, New Jersey: Princeton University Press, 1983.

Levine, Murray, 1980. The History and Politics of Community Mental Health. New York: Oxford University Press, Inc., 1980.

U.S. Senate. Committee on Labor and Human Resources. Entitled the "State Comprehensive Mental Health Services Plan Act of 1986" (Sn. Rpt. 99-380). Washington: Printing Office, 1986. (8-6, 1986).

Scott, Richard W., and Bruce L. Black, 1986. The Organization of Mental Health Services: Societal and Community Systems. Beverly Hills, California: Sage Publications, Inc., 1986.

Austin, M. J., and William E. Hershey, 1983. Handbook on Mental Health Administration. San Fransisco, California: Jossey-Bass, 1983.

Kipp, Michael F., 1987. "New Directions for Community Mental Health Centers." Journal of Mental Health Administration, 14: 26-31.

Golann, Stewart E. and Carl Eisdorfer, 1972. Handbook on Community Mental Health. New York, New York: Appleton-Century-Crofts, 1972.

VandeVen, Andrew H. and Gordon Walker, 1984. "The Dynamics of Inter-organizational Coordination." Administrative Science Quarterly, 29: 598-621.

Isaacs, Mareasa R., 1984. "An Analysis of State Administrative Structure For the Provision of Coordinated Services to Children and Youth." The Office of State and Community Liaison, National Institute of Mental Health, Bethesda, Maryland: 1984.

Marshall, Phyllis E., 1986. "Integrated Mental Health: A Creative Model for Community Mental Health in the 1980s." Journal of Mental Health Administration, p. 23-27.

Michigan Department of Mental Health. Michigan's Mental Health Code 1986. Lansing, Michigan. No Date.

Michigan Statewide Coordinating Council. Michigan State Health Plan 1983-1987: Summary. No place. No date.