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REGIONAL PLANNING OF MENTAL HEALTH SERVICES: AN ILLINOIS CASE EXAMPLE

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ABSTRACT

Now that Reagan has ended a twenty-year pattern of federal involvement in setting mental health policy priorities, states must develop models for implementing and maintaining services to the mentally ill. The Illinois model of regional offices which plan and monitor programs is described. A case example showing how one such office developed services in a minority community is given. Examples of the work of other offices illustrate the flexibility of this model in meeting special community needs.

With the Reagan administration's shift of the federal mental health funding to a block grant to each state, we need to look more closely at models for state roles in the mental health delivery system. Illinois provides a timely example because of its history of funding mental health services in the community and because of its relative lack of reliance on federal dollars. By 1980 half of the mental health catchment areas in the United States received federal funds (Neigher, et al., 1982). Only a third of the catchment areas in Illinois received federal funding, but all had some state-funded mental health services.

This paper will briefly review the structure of services in Illinois from the 1960s to 1983. Illinois used a model of regional state offices to promote continuity of care between state-operated hospitals and voluntary community services and to facilitate monitoring and accountability of state funds. The work of one such regional office in developing the delivery system in a minority community will be considered as a case study. To highlight how regional offices can tailor their work to the specific needs of the community, examples will be given of the work of two other offices. The changes instituted in early 1983 will be described and their potential limitations discussed.

Finally, the applicability of the Illinois regional model for the current national situation will be discussed. Under Reagan's new federalism, the states have assumed responsibility for federal mental health, health and social service block grants, all at reduced funding. States should be considering models that can take into account the differing needs of various regions and communities and confront competition among various service providers for decreasing resources.

Federal vs. State Roles

Recent analyses of mental health policy (e.g. Mechanic, 1980; Levine, 1981) have focused on the role of the federal government while largely ignoring the role of state government and

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state agencies. During the 1960's and 1970's states were characterized as the owners and operators of over-crowded, under-staffed hospitals. States were sued for abrogating clients' rights, (e.g. Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), O'Connor v. Donaldson, 422 U.S. 563 (1975)) and for lack of adequate treatment facilities (e.g. Wyatt v. Stickney, 344 F.Supp. 373 (M.D. Ala. 1972)). By contrast the federal government was seen as fostering de-institutionalization, promoting prevention and early intervention, and funding community mental health centers as the major alternative to hospitals.

These examples should not lead one to the conclusion that the federal government encouraged reform in mental health policy while the states did not. Dorothea Dix and other reformers went to state legislatures for help and received it. In response to their pleas the first state hospital in Illinois was opened in Jacksonville in 1851. In contrast, President Pierce vetoed legislation in 1854 which sought federal land grants for the construction of asylums for the mentally ill, because he believed care of the needy was the responsibility of the states, not the national government.

As hospitals became over-crowded at the turn of the century, suggestions for reform came from within. Adolf Meyer, who came to the United States in 1903 to head the asylum in Kankakee, Illinois, was one of the leading mental health reformers of the Progressive Era. His innovations included the psychopathic hospital and its outpatient clinic, outreach, aftercare, and the promotion of "civic medicine" (Rothman, 1980).

States have affirmed their response to citizens in need by enacting statutes that establish agencies under the executive branch of government to serve the needy. The statutory base for such services has been established, amended, and expanded throughout the twentieth century. In Illinois a large public welfare department was created in 1920 which had responsibility for mental health, corrections, vocational services, public assistance, and child welfare. In the 1920s and 1930s most state legislatures were concerned with the existing hospitals, but a few states also began to develop outpatient programs (Rothman, 1980). Today all states have statutes that specify their responsibility for mental health functions.

Illinois' Role

While the federal government was developing its response to the report of the Joint Commission on Mental Illness and Health (1961), Illinois was devising its own innovative plans for responding to the needs of the mentally ill. In 1960 voters approved a bond issue to provide $150 million for capital improvements for state hospitals. Under the leadership of Dr. Francis J. Gerty these funds were used for the construction of "zone centers" -- modern hospital and outpatient facilities located in each of eight regions of the state to make mental health services accessible to all citizens (Reidy, 1964). In 1961 a new state Department was established with responsibility for mental health, developmental disabilities, and alcoholism services. Legislation passed in 1963 authorized the state agency to make grants-in-aid to community groups to provide services. Subsequent legislation enabled counties and townships to raise money for mental health services by adding additional taxes. However, many areas, most notably Chicago, did not utilize this legislation.

By the time the first federal community mental health legislation (PL 88-164) was announced in 1963, Illinois was well on the way to modernizing its mental health system. The major push for deinstitutionalization in many states including Illinois came in the late 1960's when changes in Medicaid regulations enabled the states to save money by discharging patients to nursing homes (Levine, 1981). By the early 70's, fostered by a grant-in-aid system, community mental health programs were available in all of Illinois' eighty-two catchment areas. About a third of these centers ever received federal monies appropriated for

comprehensive mental health centers. In most areas local funding covered outpatient and early intervention services and state funds covered after-care for patients discharged from the hospitals. These programs were operated by voluntary agencies or units of local government, e.g. city or county health departments.

The Role of the Regional Offices

Regional offices of the Department of Mental Health were developed concommitantly with the zone centers and the community programs. Each region was to have a zone center. The larger regions were further divided into sub-regions to facilitate planning and increase accessibility. For example, the region serving the greater Chicago area was originally divided into fifteen sub-regions, each of which was a group of catchment areas that generated about 1,000 admissions per year to the state hospitals. The region and sub-region offices were responsible for the development of community programs, continuity of care between hospital and community, and the monitoring of expenditure of grant-in-aid monies.

Case Example: An Urban Minority Sub-Region

Not all areas had been able to develop adequate community programs. One area on the south side of Chicago in which a zone center had not been developed had special difficulties. In the late 60's and early 70's while most areas developed and consolidated their community mental health programs, this area was experiencing extreme population changes. The movement of blacks and the resulting white flight led to a near-total racial change making it difficult to find community groups to provide mental health services. The sectarian agencies that had served the white religious and ethnic communities had moved out. The total amount of state mental health funds going into this community of 700,000 was the same as the budget of an area in another part of the city with 1/10 the population which was receiving federal CMHC funds.

In 1975 a leadership change in the sub-region office serving this area led to a variety of new efforts to develop services. In order to carry out the mission of developing programs in this under-served area, the new director hired four new staff for a total of 12. All had experience in mental health services or administration, and the majority had graduate training in social work, nursing, psychology, or sociology. This author's role was program evaluation, including conducting needs assessments, identifying gaps and duplications in services, and evaluating specific programs (Korr and Beech, 1983). In keeping with the demography of the community, the majority of the staff and the director were black. The new director of the sub-region retained the goals of community development, continuity of care, and accountability and monitoring.

One of the first tasks was to collect and analyze data about the six catchment areas, the sub-region and the existing community services. The major findings were: increasing public assistance caseloads (in some areas, 100% increases in a year), large numbers of young black men between 18 and 35 going in and out of the state hospital, outpatient caseloads composed primarily of older women.

The sub-region office began to work toward change. In the area of community development staff worked closely with community groups to explain mental health needs and to train the boards of the few existing voluntary mental health agencies. The board of a small day treatment center worked with sub-region staff and obtained a planning grant for a federally-funded CMHC for their catchment area. Cooperation with a group of black businessmen and professionals led to their incorporating as a not-for-profit agency and receiving a grant for the first transitional living facility and another day treatment center.

In one catchment area of the sub-region a staff member started a network of providers including mental health programs, the area hospital, a family service agency, the public assistance and social security offices, and area churches. These groups worked together to meet the needs of mental health clients and their families.

Staff also focused on continuity of care. An intake-aftercare coordinator reviewed state hospital admissions and facilitated discharge planning. Sub-region staff coordinated weekly discharge planning meetings in which community agency representatives came to the hospital more than twenty miles away. Staff previously limited to planning for patients being discharged to nursing homes were able to develop other alternatives including family homes and boarding homes. A contract with the police department led to screening of clients in the emergency room of a community hospital and more deflection from hospitalization. State funds for purchase of care helped support this program.

Because newer agencies have more difficulty in meeting accountability standards than established agencies, sub-region staff provided ongoing training in management by objectives, accounting techniques, filling out fiscal and programmatic monitoring forms, and program evaluation.

In order to continue to develop innovative programs, other funding sources were exploited. Federal monies given to the states under section 314d of the 1966 Partnership for Health Act went to a community agency to open an emergency living facility as an alternate to hospitalization. Title XX funds from the state's donated funds initiative went to a clinic in an isolated public housing project to provide outpatient services to high risk young women.

The late 1970's and early 1980's were a period of consolidation and stabilization. The state grant-in-aid funds for community mental health programs in this area had grown from $1.7 million in FY75 to $3.1 million in FY82. In 1980-81, $1.7 million of federal funds was awarded to establish a comprehensive CMHC in one catchment area. Its funds now come through the mental health block grant to the state. The boards of two small voluntary community agencies merged to insure fiscal stability and programmatic strength. The Title XX program closed because it could not raise its matching funds. The community hospital felt it wasn't adequately reimbursed for its services and began to cut back its programs.

In 1982 as part of a regional reorganization two sub-region offices were combined. That office was responsible for a geographic area of over 1 million people and planned and monitored services to the developmentally disabled in addition to the alcoholic and the mentally ill. In May of 1983 a fiscal crisis in Illinois led to another re-organization. Two-thirds of the staff in the regional and sub-regional offices were laid off. The city of Chicago, served by twelve sub-regional offices in 1975, now has one office with a staff of eighteen to monitor over 400 programs. The goals and priorities for this staff have yet to be clarified. However, the scope of their work will certainly be narrower.

Use of the Model in Other Communities

Other sub-regions and regions had different priorities, depending on the needs of the particular communities served. While all offices were responsible for the same major functions -- program development, continuity of care, and monitoring -- each could develop plans tailored to the needs of the service area.

For example, one sub-region identified high readmission rates as a major problem in a racially and economically heterogeneous urban catchment area "where nomadic, socially deprived individuals congregate" including a large number of former mental patients (Witheridge, Dincin, and Appleby, 1982, p.9).

The sub-region staff worked to obtain a Hospital Improvement Program grant from NIMH. The grant allowed the sub-region and voluntary agency staff to identify and study the chronic recidivists in this community. The study led to the development of a successful assertive outreach program (Witheridge, et al., p. 11).

One sub-region had to work with a white ethnic urban community which was one of the last catchment areas in the state to develop an outpatient mental health program. In the Illinois model the State mental health department has deliberately chosen not to operate outpatient programs in the community, but rather to give grants to voluntary agencies or local governments to provide services. One approach the State used to develop community services was the "spin-off." When a new service was needed, State staff operated the program in the community until a grantee could be found, then the grantee assumed control of the program. In this case the sub-region staff worked closely with citizens' groups in the community to find a group to take over the state-operated outpatient program (Smith and Beech, 1983). The sub-region staff worked unsuccessfully with mental health advocates in the community to form an independent, not-for-profit mental health agency. Eventually the staff, with input from community advocates, decided that the most qualified agency was a sectarian social service agency. They were given a grant, State staff operating the program either went to work for the new agency or returned to other state jobs, and the program was successfully spun-off.

Some region offices have the additional role of working with local planning authorities. These authorities are established in the counties and townships which passed referenda to raise taxes for mental health services. They set priorities and distribute the local funds. These communities, because of their stronger local funding base, are more able to plan for their own needs than are the urban communities described above.

State legislation in 1980 (PA81-919) provided funds for demonstration projects to develop a continuum of community-based supportive services for the chronic mentally ill. This state initiative paralleled the federally-sponsored Community Support Program (Turner and TenHoor, 1978) implemented in other states. Again, region and sub-region staff worked with community agencies to plan and develop the demonstration project. The fact that the projects begun are all different is an indication of the state's concern for individualized planning for its varied communities.

Current Issues; Future Trends

A sharp decrease in state revenue income has led to a fiscal crisis in Illinois. The legislature granted the Governor power to make 2% cuts in state agency operating budgets for fiscal 1983 and more cuts are expected. Community mental health programs have been cut up to 4%. The Governor has also stated that if the state's flat-rate income tax is not increased for FY84 the General Assistance benefit of $144 per month will be eliminated. Such a cut, combined with the recent increase in denials of SSI applications, will make it increasingly difficult for the mentally ill to find adequate places to live in the community. As the federal and state priority continues to be development of community support services for the chronic mentally ill, Illinois may have lost the staff most qualified to develop these services and see that they become effective parts of the mental health system.

The most pressing issue is providing adequate services in the face of decreasing revenues. All states face similar problems. The block grant led to a net loss in federal monies. State and local funds for outpatient and early intervention programs have decreased (e.g. Schelkun and Cooper, 1982). Increasing unemployment has created an at-risk population which is no longer eligible for third party reimbursement for services. Minority communities, hard-hit by unemployment, frequently have fewer services.

The model described here of region offices responsible for the development of community programs, continuity of care, and accountability is both effective and flexible. It can serve as a means of developing the continuity of care systems that match the needs of clients, families and communities as Bachrach (1981) recommends. In an era when funding is decreasing and private community mental health agencies may be competing with one another and with state hospitals for scarce resources, some group of people must be responsible for the development and monitoring of the the delivery system as a whole. The region office can serve that function.

Now, when the federal government has withdrawn from a leadership role in mental health services and adequate community support services for the mentally ill still need to be developed, the states must fill in the gap. Using the model described here, State staff can work to maximize the use of limited resources to provide services in all communities.

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