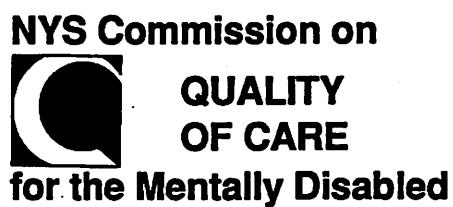


Outpatient Mental Health Services



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Executive Summary

In 1988, in response to a request from the State Legislature, the Commission conducted a study of admission and discharge practices of psychiatric hospitals. The legislative request came against a backdrop of significant overcrowding in virtually all segments of the inpatient psychiatric care network, and a continued high level of demand for psychiatric hospital services, manifested in part by the severe stress placed upon psychiatric emergency rooms in urban areas of the state.

The Commission's report to the Legislature* noted that "the high demand for inpatient psychiatric care, despite the large supply of beds, is partly due to the 'blocking' of a significant proportion of both short-term and long-term psychiatric bed capacity by patients who are no longer in clinical need of inpatient psychiatric care, but who remain because of an absence of suitable alternative care, either within the mental health system or from other human service systems." The Commission concluded that the problems being experienced by the inpatient system despite the largest supply of inpatient psychiatric beds in the country, "are symptoms of a system that has not invested sufficiently in developing the quantity and type of community-based support service that could appropriately respond to the needs of people who are mentally ill and their families."

In Chapter 50 of the Laws of 1988, the Legislature requested the Commission to undertake a study of outpatient mental health services to assess the programmatic and cost-

effectiveness of such services and the role they play in the mental health system.

This study involved an analysis of the cost data obtained from the Office of Mental Health, Department of Social Services and Department of Health; conducting formal and informal site visits to 65 outpatient programs in different areas of the state; tracking the services actually received by a sample of 144 enrolled outpatients over a two-year period and assessing the services provided to another sample of 138 recently discharged outpatients; conducting informal forums with provider organizations, governmental officials, program staff and recipients of services; and conducting surveys of opinions of recipients, families and staff regarding the responsiveness of outpatient mental health services.

One of the most striking findings to emerge from the study of the New York State outpatient mental health service network is its size. There are 950 certified outpatient mental health programs, which deliver services at approximately 1250 sites, and an additional group of approximately 500 contracts are awarded annually to fund a variety of uncertified outpatient mental health services. Together, this segment of the mental health system spent \$745 million in 1986, the most recent year for which fiscal data is available.

Despite its size and significant cost, this part of the mental health service system is surprisingly lacking in many of the normally expected accountability mechanisms, and those that do exist do not work very well.

* *Admission and Discharge Practices of Psychiatric Hospitals: A Report to the New York State Legislature Pursuant to Chapter 50 of the Laws of 1987*, April 1988.

- There are no clearly articulated requirements for essential outpatient mental health services that ought to be available in every locality. The planning process at the state level has not effectively guided the local development of a core array of essential services for each locality. Ninety-five (95) percent of all existing services are clinical in nature, with varying mixtures of clinics, day treatment and continuing treatment programs in each region.
- While eligibility for federal Medicaid/Medicare reimbursement has reportedly influenced New York's reliance on clinically-oriented outpatient programs, actual federal funding plays a relatively modest role in the financing of outpatient services (13 percent). The state (54 percent) and its local governments (18 percent) pay most of the costs.
- State and local governments, hospitals and freestanding voluntary agencies all provide many of the same types of outpatient mental health services, sometimes to the same people. As a result, some providers compete to provide clinical services to the same outpatients in their locality, while at the same time there are substantial unmet needs for services for people with multiple disabilities or for people who require rehabilitative, vocational and support services, which account for only 5 percent of the programs;
- There are virtually no performance standards for any of the various types of outpatient mental health services, no clearly defined priority population to be served, and no measures of the effectiveness of the services provided;
- There are staggering variations in the actual per unit cost of providing services, with a range of 545 percent in continuing treatment programs, 1269 percent in clinics, and over 2000 percent in day treatment programs. While these variations are influenced by the auspice of the provider agency (State-operated, hospital-based, or freestanding), there are significant variations within each auspice as well;
- The absence of cost-based rates, particularly for state-operated outpatient programs, has resulted in the state foregoing justifiable billings to the Medicaid program amounting to millions of dollars each year. These costs have been fully borne by state tax dollars instead of being shared with the federal government.
- The availability of close to one-quarter of a billion dollars in deficit funding from the state and local governments to 70 percent of the programs in 1986 has had the perverse effect of removing any incentive for efficient operations or for aggressively seeking third party reimbursement where available. Here again, state and local governments bear costs that could be paid by the federal government and private insurers.

In short, despite a sizable investment of approximately three-quarters of a billion dollars annually in outpatient mental health services, there is presently little assurance that these services are being held accountable for responding to the critical needs of consumers and families or the community.

The survey we conducted of consumers and their families powerfully communicated the many unmet needs of the people served by the existing system and strongly argued for a change in emphasis in the services provided. Their opinions were substantiated by the clinical records we reviewed of the sample outpatients which clearly demonstrated the vast gulf between their needs as identified by their clinicians and the services that they received over a two-year period.

In the course of this study we found some outpatient programs that explicitly excluded people with multiple problems like alcohol and substance abuse (an increasing segment of the patient population), and many more outpatient programs which have established operating practices that had the effect of excluding persons with serious and persistent mental illness. The absence of walk-in services, the limited hours of operation, the lack of crisis response, and the virtual absence of services after normal business hours, combine to promote expensive reliance upon hospitals and their emergency rooms to provide many services that could and should be provided by outpatient mental health providers. A significant segment of the people seen in psychiatric emergency rooms are experiencing no psychiatric acute emergency but simply require immediate and easy access to services, particularly after normal business hours. It is ironic that while some psychiatric hospitals report a virtual state of siege, this vast network of outpatient mental health services appears to be substantially underutilized, with most programs seeing a small number of clients each day and generating too few units of service to pay their bills.

To a large extent, these conditions exist because the State has historically taken a "hands off" approach to this part of the service system. Neither the certificate of need process, nor the planning process, nor the ongoing certification process effectively direct the types of services provided, the types of people served or the efficiency of the program. Providers themselves largely control the types of services that will be offered without regard to the types of people served. There are no regulatory or fiscal disincentives to the discharge of seriously and persistently mentally ill outpatients who are service-resistant. Funding, which is primarily provided through flat-rate fees for ser-

vices without regard to the type of outpatients served, provides little reason for state agencies to scrutinize actual costs or program effectiveness. Although the role that State and local governments play in financing the operating deficits of many outpatient programs provides substantial justification for scrutinizing their cost-efficiency, their service priorities and their effectiveness, such scrutiny has been largely missing.

The Commission recognizes that there is clearly a need for access to clinical services for mentally ill people who live in the community. There is an unquestioned role for providers to play in determining priorities for who is served in the communities where programs operate, at least in part because non-governmental funds pay for a portion of the operating costs, albeit a small one. However, the Commission believes that there needs to be a greater recognition that the existing outpatient service network responds to a narrow spectrum of clinical needs to only a portion of the mentally ill population. At the same time, a growing part of the mentally ill population that has multiple disabilities, including alcohol and substance abuse, is poorly served. In particular, the non-clinical but essential needs of these outpatients in the community for psychosocial rehabilitation, vocational opportunities and support services are largely unaddressed.

These weaknesses in the outpatient services network have forced many people with serious and persistent mental illness to rely primarily on psychiatric hospitals and psychiatric emergency rooms for clinical services, and have provided them with few opportunities to develop the vocational, educational or community living skills that are essential to enjoying more successful lives in the community. These weaknesses are expensive both in terms of the opportunities lost for these persons to achieve

meaningful lives in the community and in the costs incurred by state and local governments for more expensive hospital and emergency room services.

Refocusing this massive system more sharply to better serve people who are seriously and persistently mentally ill, and especially those who have concomitant drug and alcohol abuse problems, and to provide a wider array of services to respond to the full spectrum of their needs will not be easy. Nor will it be possible to accomplish the task by tinkering with the system at the margins, or relying largely on new funds to accomplish needed change. The Commission believes there is a need to re-examine the existing commitments of resources, and to begin the process of redirection by examining expensive, inefficient and duplicative programs.

A reasonable starting point is a re-examination of the most expensive component of the existing system — state-operated outpatient programs which annually cost approximately \$200 million. The state's role in this sector of the system needs to be reassessed, particularly considering the need for the state to play this role in various localities; the relative cost-effectiveness of the services provided; and the availability of specific types of outpatient services to people who have difficulty finding necessary services from other sectors of the service system.

It is equally important to examine the portion of the system that receives deficit funding from state and local governments to augment the flat rate income they receive, particularly to ensure the responsiveness of these programs to the needs of people who are severely and persistently mentally ill and multiply disabled for clinical, psychosocial rehabilitation, vocational opportunities and support services.

We believe that the voices of the recipients of services and their families

should play a substantial role in determining the types of services that are funded and the conditions under which they are made available. From the surveys of and forums with these groups, it is evident that there is a significant need for programs and services that help build self-esteem and respect human dignity by providing opportunities, in normalized community settings, to develop personal, social and work relationships with other people, including people who are not mentally ill.

It is time for the Office of Mental Health to take a firm grasp of the reins, to use the planning process to guide the development of a core array of essential outpatient services in every locality, and to target available state funding to ensure that the people most gravely in need have reliable access to the range of outpatient services necessary to live successfully in the community.

The Commission has several specific recommendations to achieve these objectives and to inject a greater sense of accountability for performance and cost-effectiveness into this sector of the mental health system.

This report reflects the unanimous opinion of the members of the Commission.

Clarence J. Sundram
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The Commission wishes to acknowledge the many recipients of mental health services, family members of individuals with mental health problems, and administrators and staff of outpatient mental health programs who so willingly offered their perceptions, concerns, and recommendations in the conduct of this review.

Special thanks are extended to consumers, administrators, and staff who so cordially accommodated Commission interview teams visiting their programs and those individuals who reviewed and offered written comments on the draft report and its recommendations. The Commission would also like to thank local chapter members of the Alliance for the Mentally Ill and the Federation of Organizations for the New York State Mentally Disabled, Inc. for distributing and responding to the family member opinion survey regarding mental health outpatient services. The Commission would also like to acknowledge the assistance of staff of the Office of Mental Health who graciously accommodated numerous requests for information and data.

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Chapter I

Introduction

Statement of the Problem

In Chapter 50 of the Laws of 1988, the State Legislature requested that the Commission conduct a study of mental health outpatient services. This request reflected concern that, although New York spends more than virtually any other state per capita on these services, its service system does not seem to be responding adequately to the needs of New York's most seriously mentally ill citizens.

State legislators, reflecting the complaints of their constituents, have expressed concerns that many mentally ill persons who reside in their communities do not receive needed services. Many recipients of services have also criticized outpatient services as outmoded and inflexible in meeting their needs for educational and vocational services to help them lead more independent lives.* Families of persons with mental illness have echoed these

concerns, and also complained that the outpatient service system is not responsive to their needs for assistance as the primary community support structure for the majority of persons with serious mental illness.

A recent Commission study** of the State's inpatient psychiatric facilities also concluded that there are inadequate outpatient programs in many parts of the State which assist individuals in acquiring needed daily living and vocational skills, and which offer crisis intervention services. The study found that the absence of such services contributes significantly to the recurrent hospitalizations of some patients and the serious overcrowding of inpatient psychiatric units and emergency rooms, particularly in urban areas of the State. The study also highlighted the inadequacy of mental health outpatient programs in addressing concomitant drug and alcohol abuse problems, which afflict between 40-60

* *A Review of 32 Office of Mental Health Supervised Community Residences*, Commission on Quality of Care, 1988.

** *Admission and Discharge Practices of Psychiatric Hospitals*, Commission on Quality of Care, 1988.

percent of the patients discharged from inpatient psychiatric facilities.

Implicit in these observations is a fundamental question of whether the tax dollars devoted to mental health outpatient services are being targeted and spent appropriately and are consistent with priorities. Although New York has a relatively large number of outpatient mental health providers and programs, there is increasing concern that the myriad provider agencies are poorly directed and coordinated at the State and local level, and that there exist both the unnecessary duplication of services and critical gaps in services in many communities.

More recently, the Office of Mental Health has expressed its concern that these services are unresponsive to the needs of the State's most seriously mentally ill citizens, many of whom, because of their complex and multiple problems, are excluded from outpatient programs. According to OMH, the failure to serve these individuals, who include people with concomitant drug and alcohol abuse problems and people who are resistant to traditional service delivery models, results in unnecessary and frequent inpatient psychiatric hospitalizations for the seriously mentally ill in New York, which are extremely costly, and yet not particularly beneficial to the individuals' long-term rehabilitation.*

Objectives of the Study

Given this backdrop of diverse and fundamental concerns, the Commission designed its review to answer five basic questions:

- How much does New York spend on publicly funded mental health outpatient services?
- What types of publicly funded mental health outpatient services are available in New York statewide and in various regions of the State, and how much do these specific types of services cost?
- Who operates mental health outpatient programs in New York State, and how have the service priorities of these providers been identified and coordinated?
- How responsive and accessible are available mental health outpatient services to the needs of persons with serious and persistent mental illness?
- How effectively has the State assured public accountability for the planning and development and the programmatic and cost effectiveness of publicly funded mental health outpatient services?

* *Statewide Comprehensive Plan for Mental Health Services 1989-1991, NYS Office of Mental Health, 1988.*

Methods

In addressing these study objectives, the Commission used a variety of strategies to collect relevant information and data:

- (1) Informal forums were held with various provider organizations, governmental officials, and homeless shelter providers;
- (2) Formal unannounced and announced site visits were made to 65 different mental health outpatient programs operated by voluntary agencies, general hospitals, and State psychiatric centers across the State;
- (3) Cost data on mental health outpatient programs were obtained from the Office of Mental Health, Department of Social Services, and the Department of Health, and analyzed;
- (4) A sample of 144 enrolled outpatients in 24 different mental health outpatient programs in six different regions of the State was studied to determine the responsiveness of the mental health system to their needs over a two-year period. This review included record reviews, interviews with all providers who had served these people in the past two years, interviews with the individuals' primary therapists, and, wherever possible, interviews with the persons receiving the services;
- (5) A sample of 138 recently discharged outpatients in 23 mental health outpatient programs in six different regions of the State was studied to determine the benefits they received from service provision and the reasons and appropriateness of their discharges;
- (6) With the cooperation of the New York State Alliance for the Mentally Ill and the Federation of Organizations for the New York State Mental-ily Disabled, Inc., a survey of family member opinions of the mental health outpatient system was conducted;
- (7) Formal consumer and staff opinion surveys of the responsiveness of mental health outpatient services to the needs of persons with mental illness were conducted; and,
- (8) Informal open discussions were held with staff and recipients of services in 24 different mental health outpatient programs.

It should be noted that, in the above information and data collection efforts, the Commission focused on the responsiveness of the publicly funded mental health system to persons with serious and persistent mental illness. While acknowledging that many persons, in times of specific difficulties or transitions (e.g., divorce, death, loss of job, etc.), have short-term interactions with mental health services, the Commission recognized that the most grave concerns surrounding publicly funded mental health outpatient services focused on the role and accountability of this service system to individuals with more serious and enduring mental illness. Thus, the Commission's sample of 144 enrolled mental health outpatients and 138 discharged mental health outpatients were chronically mentally ill in-

dividuals, as defined in the State's eligibility criteria for Community Support Services. These criteria specify that individuals must have a primary DSM III-R psychiatric diagnosis, a history of psychiatric hospitalizations or long-term residence in an alternative supervised community setting, and at least three significant functional deficits in areas such as self-care, daily living skills, or economic self-sufficiency.

Additionally, the Commission's review focused on publicly funded mental health outpatient services for adults. While reported cost and program data provided by the Office of Mental Health reflect data from both adult and children's programs, readers should be mindful that site visit data, outpatient

sample data, and consumer and family satisfaction survey data were obtained from adult programs only.

In planning the review, the Commission also heard many concerns about the appropriateness of mental health outpatient services for children. Due to the scope of the review of adult mental health outpatient services, as well as the unique issues related to children's services, the Commission decided to restrict its direct data collection to adult services. While some of the service provision issues raised in this report may also apply to children's services, it is important to emphasize that, in New York, children's mental health services are largely segregated from adult services.

Chapter II

Overview of New York's Mental Health Outpatient Service System

Perhaps the most striking feature of New York's publicly funded mental health outpatient service system is its size. Comprised of 950 certified programs, and with total expenditures in 1986* of \$745 million, New York's mental health outpatient service system is the largest in the nation.

Clinical Orientation of the Service System

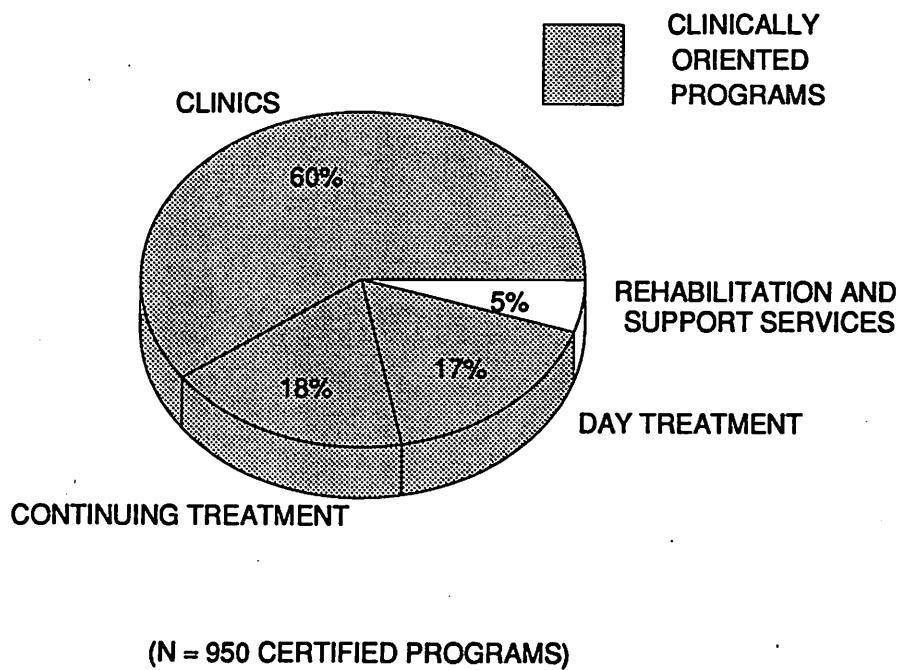
This service system includes a variety of different types of outpatient programs and services, although the vast majority share a clinical orientation. Of the total 950 certified mental health outpatient programs, 60 percent are mental health clinics, and an additional 35 percent are clinically oriented

day treatment and continuing treatment programs (Figure 1). Due to their clinical/medical orientation, these programs are reimbursable by the federal Medicaid/Medicare programs and some private health insurance plans.

Core services of these programs focus on the person's psychiatric condition and include individual therapy, group therapy, and medication management. People generally attend clinic programs one to three times a month for 15-30 minute appointments, whereas people enrolled in day and continuing treatment programs usually attend for full five-hour days, two to five days a week. Existing New York Medicaid fees for these services vary from \$18.55 per individual attending a group therapy clinic session to \$53.00 per individual for a 30-minute individual therapy

* All expenditure data in this report reflect 1986 costs. This is the most recent year for which the Office of Mental Health could provide expenditure data.

**FIGURE 1: CERTIFIED OUTPATIENT PROGRAMS
BY TYPE AND BY CLINICAL ORIENTATION
(1989)**



clinic session to \$45.00 per full-day attendance at a day treatment program and \$42.30 per full-day attendance at a continuing treatment program.*

Only 5 percent (45 programs) of New York's certified mental health outpatient programs have a social rehabilitation or vocational rehabilitation focus. These programs, which include traditional day training programs, psychosocial club programs, and supportive work programs,** provide few

clinical mental health services and focus instead on vocational, educational, socialization, and daily living skills. Individuals usually attend these programs for full or half days (three to five hours), two to five days weekly, and the programs receive their financial support almost exclusively from State and local funding. These people obtain needed clinical mental health outpatient services by using a mental health clinic or, less commonly, by attending a clinically

* A slightly higher per-day fee of \$45.00 is allowed for continuing treatment programs in the five boroughs of New York City. In addition, those clinics in the New York City area which receive deficit funding recently were approved to receive \$60.00 per clinic visit.

** Psychosocial club programs and supportive work programs are recent additions to New York's mental health outpatient services system. Both types of programs differ from more traditional outpatient programs in their emphasis on practical rehabilitation training and their reliance on consumer direction and involvement. OMH has allowed providers of these programs to operate as uncertified programs or to seek certification under the program category of more traditional day training programs.

oriented day program one or more days a week.

In addition to these certified outpatient programs, the Office of Mental Health provides 585 funding contracts to support uncertified outpatient services. Some of these grants (12 percent) support clinical services, like clinic emergency services, crisis services, and mobile crisis teams. Other grants support non-clinical programs or services, including case management (24 percent of the grants), uncertified psychosocial club and supported work programs (18 percent of the grants), outreach (4 percent of the grants), and transportation (6 percent of the grants). In many instances, these contracts support supplemental uncertified services in existing certified programs; in other cases they support freestanding uncertified mental health programs.

The clinical orientation of New York's mental health outpatient system is also reflected in its expenditures by program type. In 1986, 55 percent of the total expenditures for publicly funded mental health outpatient programs were spent on mental health clinics, and

26 percent were spent on clinical day treatment or continuing treatment programs, while 19 percent were devoted to non-clinical socialization/rehabilitation and support services programs (Figure 2).

Notably, the clinical orientation of New York's publicly funded mental health outpatient system has not evolved based on reliable needs assessment data, nor does it reflect less formally gathered information on the needs of the most seriously mentally ill persons residing in the State's communities. Although the literature, as well as most informed experts agree that these individuals do often require ongoing clinical services, there has been a growing recognition that successful transitions to community living for most persons with serious mental illness are equally contingent on an array of non-clinical rehabilitative and support services, which assist them in gaining basic independent living and vocational skills essential to their enjoying more productive lives.*

In explaining New York's heavy reliance upon clinically oriented out-

* Bachrach, L.L., "Program Planning for Young Adult Chronic Patients." B. Pepper and H. Ryglewicz (Eds.), *New Directions for Mental Health Services: The Young Adult Chronic Patient*, No. 14, San Francisco: Jossey-Bass, June 1982;

Goldfinger, S.M., Hopkin, J.T., and Surber, R.W., "Treatment Resisters or System Resisters?: Toward a Better Service System for Acute Care Recidivists." . Pepper, H. Ryglewicz (Eds.), *New Directions for Mental Health Services: Advances in Treating the Young Adult Chronic Patient*, No. 21, San Francisco: Jossey- Bass, March 1984; and,

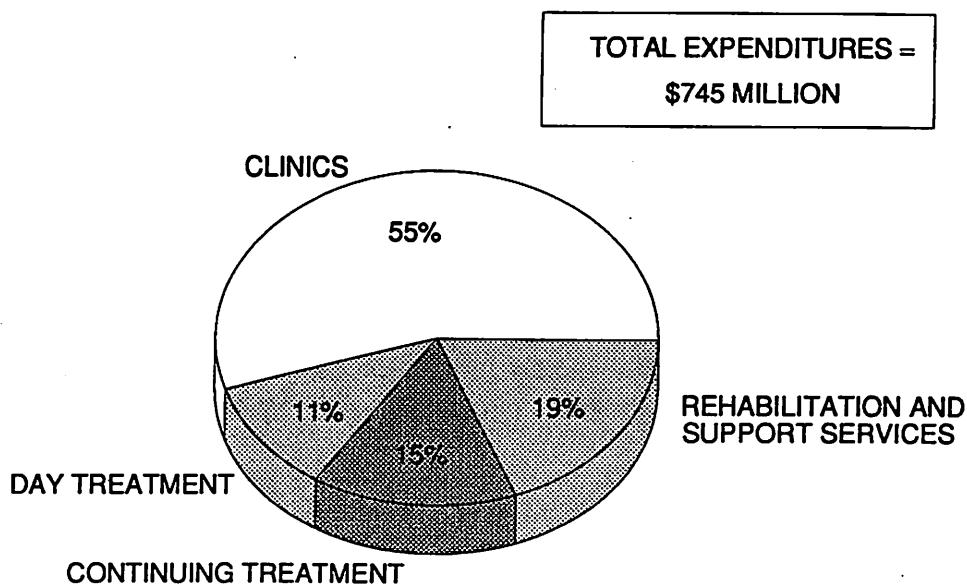
Kent County, Rhode Island Case Study: Generation of Comprehensive Community-Based Mental Health Service System, National Technical Assistance Center for Mental Health Planning, 1988.

patient programs, Office of Mental Health officials acknowledge that outpatient service development priorities have historically been tied to accessing federal Medicaid and Medicare reimbursement streams. These program models were largely developed during the early phases of implementing the policy of deinstitutionalization, when the full range of people's needs in the community were not as fully understood or recognized as they are today. State officials also point out that all but one of New York's certifiable outpatient program models (day training) have a clinical orientation, which has also discouraged non-clinical rehabilitative program development. Indeed, only in the past three years has the Office of Mental Health, with State legislative support, set aside relatively small

amounts of dedicated funding for rehabilitation programs, including supported work and sheltered employment programs.

With the recent change in administration at the Office of Mental Health, there is greater recognition that the focus on mental health outpatient services must change, and that there must be a greater emphasis on tangible rehabilitative and support services. Unfortunately, however, current efforts to orchestrate these needed changes have focused primarily on the more targeted allocation of new funds for mental health outpatient services, and they have been able to make only a marginal impact on the overall clinical emphasis of available outpatient services. Without more drastic efforts, which also focus on the redirection of existing publicly

**FIGURE 2: TOTAL EXPENDITURES FOR
OUTPATIENT SERVICES BY PROGRAM TYPE
(1986)**



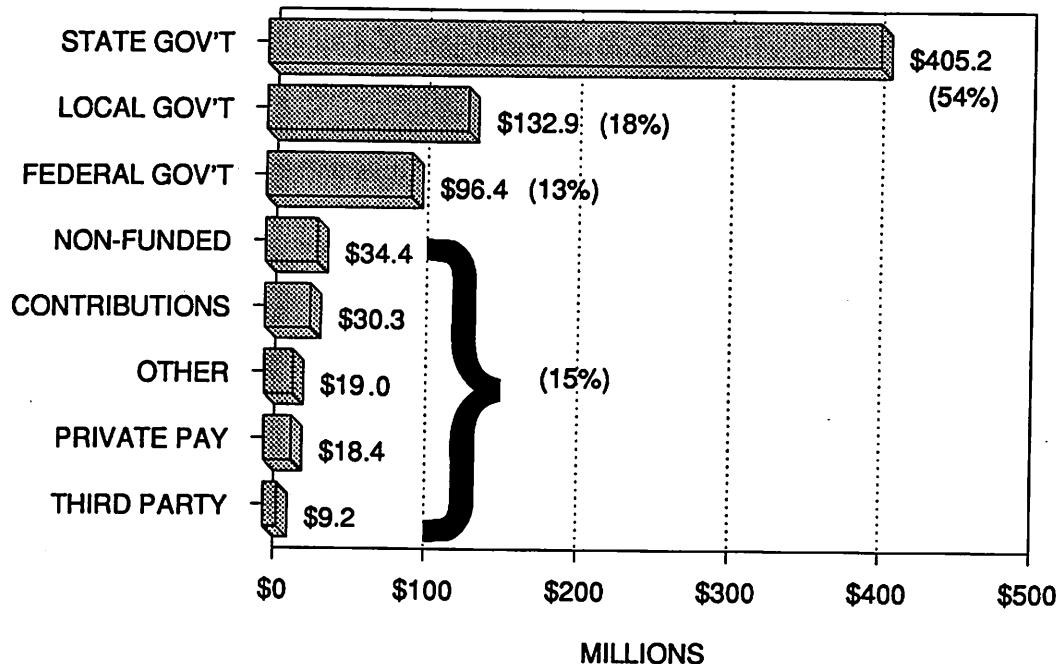
funded programs, it appears that New York's clinical orientation to mental health outpatient services will prevail in the foreseeable future.

Heavy Reliance on State Funding

A second outstanding, and somewhat surprising, feature of New York's publicly funded mental health outpatient service system is its heavy dependence on State funding (Figure 3).

Although 95 percent of the certified programs are clinically oriented, and are reimbursable by Medicaid/Medicare and some private insurance plans, only 13 percent of the costs of New York's publicly funded mental health outpatient system in 1986 were funded by federal Medicaid or Medicare payments,* and only 1 percent were funded by private health insurance payments. The majority of the costs of this service system, 54 percent, were funded by State tax dollars. Eighteen (18) percent were funded by local government

FIGURE 3: TOTAL EXPENDITURES FOR OUTPATIENT SERVICES BY FUNDING SOURCE (1986)



* Data indicated that approximately 28 percent of publicly funded outpatient services costs are billed to Medicaid/Medicare. State and local governments share approximately 50 percent of the costs of these billed services.

revenues, and the remaining 14 percent were funded by voluntary contributions (4 percent), direct client payments (2 percent), and provider and other payments for "non-funded" costs (8 percent).

In dollars, these percentages translate to \$405 million in State funds, \$133 million in local government funds, \$96 million in federal funds, and \$111 million in other funds supporting mental health outpatient service expenditures in 1986.

The relatively low federal Medicaid reimbursement for publicly funded outpatient services is attributable to several factors: their heavy reliance on deficit funding, which provides few incentives for providers to maximize federal Medicaid or Medicare payments or private insurance payments, poor record-keeping practices of many providers, which hinder Medicaid, Medicare and private insurance billing, and fee schedules that are not cost-based, resulting in substantial underbilling of State-operated outpatient program costs. It should also be noted that a significant segment of the individuals served at these programs, estimated at between 30-50 percent, are not Medicaid eligible.

The flat-rate fee schedules for Medicaid reimbursement for mental health outpatient services, which are not cost-based, have had a particularly significant impact on Medicaid revenues for State-operated outpatient programs.

These rates apply equally to both less costly non-State-operated freestanding programs, and to the significantly more costly State-operated programs.* The Commission found that, on average, actual service costs at State-operated outpatient programs were substantially under-reimbursed by this uniform flat-fee schedule. If, in accordance with existing Medicaid regulations, this fee schedule were adjusted for the higher costs of State-operated programs, the Commission estimates that an additional \$57 million in Medicaid revenues (\$24 million in federal share) could be obtained. It should be noted that these costs are currently borne almost entirely by State tax dollars.

Recently, upon the Commission's identification of this legitimate avenue for increased Medicaid revenues in State-operated outpatient programs, steps have been taken to partially adjust the Medicaid fees for these programs. This adjustment will result in an estimated annual gain of \$13 million in federal revenues to these programs.

Dependence on Net-Deficit Financing

To more fully understand the service system's disincentives in encouraging providers to seek federal and other third party insurance payments, it is worthwhile to digress briefly to describe how mental health outpatient services

* Hospital-based programs can appeal to the State Health Department for special rates based on actual costs. Most typically, however, hospital-based mental health outpatient programs are reimbursed at their general outpatient department rate.

are funded in New York. Non-State-operated mental health programs/services are primarily funded through a fee-for-service and/or a net-deficit financing approach. Fee-for-service is a funding mechanism whereby a program bills Medicaid or the Community Support Services Program, in accordance with a State-established fee schedule (Part 14 NYCRR 579) for services provided consistent with Office of Mental Health standards. This fee schedule is not cost-based and, as noted above, it has historically applied equally to freestanding and State-operated programs.

If program costs exceed the revenues achieved through this fee schedule, client fees from insurance or direct payment, and other revenues, providers may also be entitled to net-deficit funding from the State and local government. By State law, "net operating costs" may be funded 50 percent by the State. Local governments pick up the remaining 50 percent share, although this local share may be offset by any available voluntary contributions.*

While all non-State providers of mental health outpatient programs do not receive net-deficit funding, the

Commission's review found that 70 percent of the agencies or hospitals providing these services do receive deficit funding for one or more of the mental health outpatient programs they operate. Additionally, for these agencies and hospitals, deficit funding covers approximately half of their total operating costs for mental health outpatient services. Thus, many non-State mental health outpatient providers have come to depend substantially on deficit financing. With this ready source of State and local subsidies, extra efforts to maximize federal and private health insurance revenues take on a less than critical priority. The availability of deficit financing may also weaken the incentive for efficient operation and utilization of services since low revenues, reflective of low utilization, will be offset by the deficit financing by State and local governments.

For State-operated mental health outpatient programs, there are even fewer direct incentives to maximize federal Medicaid or Medicare reimbursement or health insurance payments. Unlike non-State programs, these programs are fully financed initially with State funds. Any private-pay fees or Medicaid/

* Five "Unified Services" counties receive State deficit funding at a rate ranging from 69 to 97 percent of their net operating costs. These counties — Rensselaer, Rockland, Warren, Washington and Westchester — opted to participate in a 1973 program which offered a premium to the counties to encourage a coordinated local planning process and to discourage use of State psychiatric institutions.

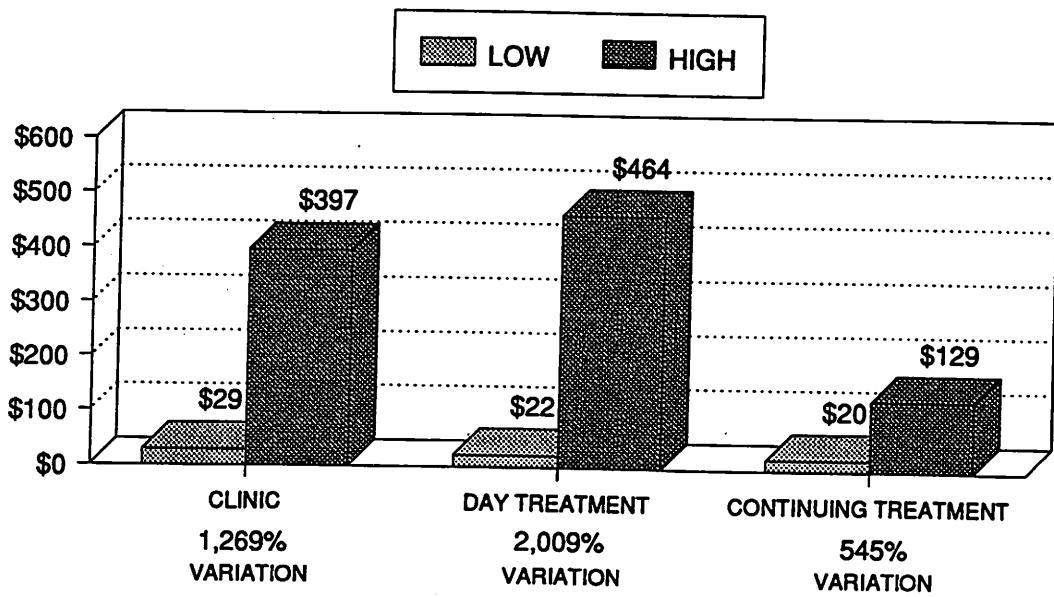
Medicare revenues collected to offset program costs are directly deposited into the State's General Fund. Thus, there is no direct incentive for these programs to focus on maximizing federal or other third party insurance payments.

Cost Variations

In the absence of adequate State incentives to encourage providers to maxi-

mize revenues or to contain costs, the Commission's analysis of available outpatient provider expenditure reports* revealed wide variations in unit-of-service costs across similar types of programs (Figure 4). These 1986 reports indicated a 1,269 percent variation in the unit costs reported for mental health clinic visits, ranging from \$29-\$397 a visit across the reporting clinic programs. Comparable variations were noted in the unit costs of day treatment

**FIGURE 4: RANGE OF UNIT COSTS OF OUTPATIENT SERVICES BY PROGRAM TYPE*
(1986)**



* Includes all hospital-based and State-operated outpatient providers, but only deficit funded freestanding providers or those deficit funded portions of freestanding agencies in NYC which are under contract with OMH. Because non-deficit funded freestanding providers operate without State subsidies, their unit costs may be lower than those displayed above.

* Office of Mental Health officials provided the Commission with unit cost data for all State-operated outpatient programs and for freestanding programs receiving deficit funding. Unit cost data for hospital-based outpatient programs were obtained from the Department of Health. Unit cost data for non-deficit-funded freestanding programs were not available because this information is not reported to the Office of Mental Health.

programs, where unit costs for a day's attendance ranged from \$22-\$464 per visit (a 2,009 percent variation). For continuing treatment programs, unit-of-service cost variations were of a smaller magnitude, but even they ranged from \$20-\$129 per visit (a 545 percent variation).

Additionally, the Commission also found that these unit-of-service cost variations were not determined by just a few "outlier" programs, with extremely high or extremely low unit costs. For example, among the 162 freestanding clinic programs submitting program expenditure reports, 31 percent had per visit unit-of-service costs of less than \$50; 43 percent had per visit unit-of-service costs of \$50-\$75; and 26 percent had per visit unit-of-service costs over \$75 (Figure 5). Similarly, among the 32 free-

standing day treatment programs submitting cost reports, we found that 59 percent cost less than \$50 per visit, while 16 percent cost between \$50-\$75 per visit and 25 percent cost more than \$75 per visit (Figure 6). The actual range in per visit costs for the 162 freestanding clinics was \$29-\$191 per visit, and the range in unit costs for the 32 freestanding day treatment programs was \$61-\$116 per visit.

Closer analysis of these unexpectedly wide variations in unit-of-service costs among similar programs revealed that geographical location had no consistent relationship with higher or lower unit-of-service costs, and that program auspice (freestanding, hospital-based, State-operated) only accounted for a portion of the variance noted. More clearly, the Commission's analysis did

FIGURE 5: UNITS-OF-SERVICE COST VARIATIONS OF FREESTANDING CLINIC PROGRAMS

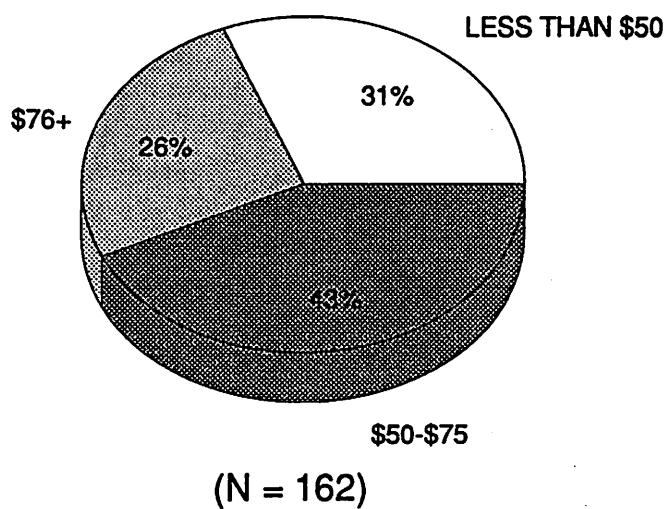
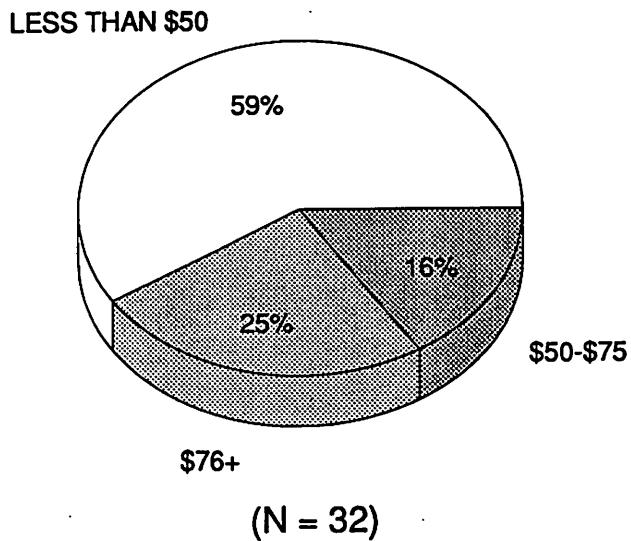


FIGURE 6: UNITS-OF-SERVICE COST VARIATIONS OF FREESTANDING DAY TREATMENT PROGRAMS



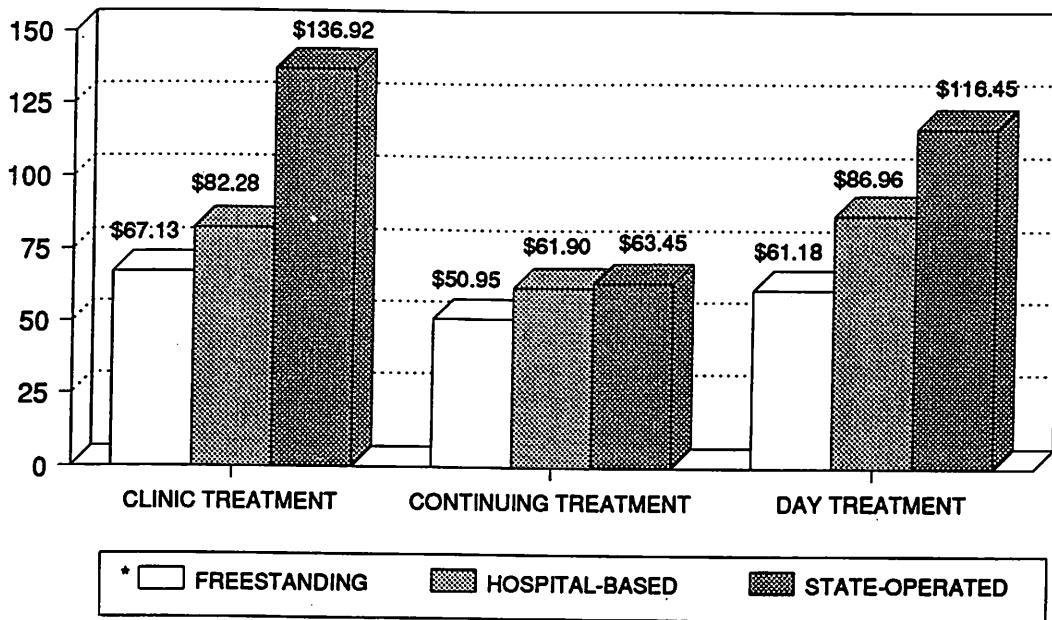
not show, as might be expected, that outpatient programs in the New York City metropolitan area generally had higher unit-of-service costs than upstate programs.

Additionally, while voluntary agency freestanding programs were, on average, the least costly, followed by hospital-based programs, and then State-operated programs, wide variations in costs among reporting programs within the same auspice setting indicated that program operating practices other than auspice played a more significant role in determining unit-of-service costs (Figure 7).

For example, although the average per visit cost for freestanding clinics was \$67,* compared to \$82 in hospital-based clinics, and \$137 in State-operated clinics (a 105 percent variation), actual per visit clinic costs within each auspice setting varied more than 290 percent. Specifically, for freestanding clinics, the costs per clinic visit ranged from \$29-\$191 (a 559 percent variation); for hospital-based clinic providers, per visit costs ranged from \$32-\$397 (a 1,141 percent variation); and for State-operated clinic providers, per visit costs ranged from \$60-\$236 (a 293 percent variation).

* Average costs for freestanding clinics reflect costs reported *only* by those freestanding clinics which requested State net-deficit financing and, therefore, were required to report expenditure data to the Office of Mental Health.

**FIGURE 7: AVERAGE UNIT COSTS OF
OUTPATIENT PROGRAMS BY AUSPICE
(1986)**



* Includes only deficit-funded freestanding providers or those deficit-funded portions of freestanding agencies in NYC which are under contract with OMH. Because non-deficit-funded agencies or portions of agencies operate without State subsidies, their average unit costs may be significantly lower than the averages displayed above.

Commission observations of the actual operating practices of many outpatient programs visited also revealed certain common operating practices which could inflate unit-of-service costs. Many day treatment and continuing treatment programs, for example, were apparently underutilized, and had the capacity to serve five or more additional people daily, and, at some clinic programs, enriched therapist staffing allowed therapists to see less than four people a day. Additionally, at many clinic programs, the lack of regular evening hours curtailed service utilization, while at others, the failure to adjust appointment scheduling practices to compensate for on-going 25-30 percent "no show" rates also limited actual service delivery.

The impact of program operating practices on unit costs can be even more

clearly illustrated by a comparison of two day treatment programs visited by Commission staff. In 1987, one of these programs reportedly served 110 people, while the other reportedly served 147 people. Both programs provided about the same number of units of service per person annually (about 22 visits per year), indicating that the larger program provided about 29 percent more units of service annually than the smaller program. Yet, the larger program cost 455 percent more to operate than the smaller program (\$479,162 versus \$86,373). Closer analysis of reported cost data indicated that the more costly program had approximately seven full-time equivalent direct care/clinical staff, whereas the less costly program had only three full-time equivalent direct care/clinical staff. In total, the more costly program was spending

about 6.0 times more on personal services and about 3.4 times more on other-than-personal services than the less costly program.

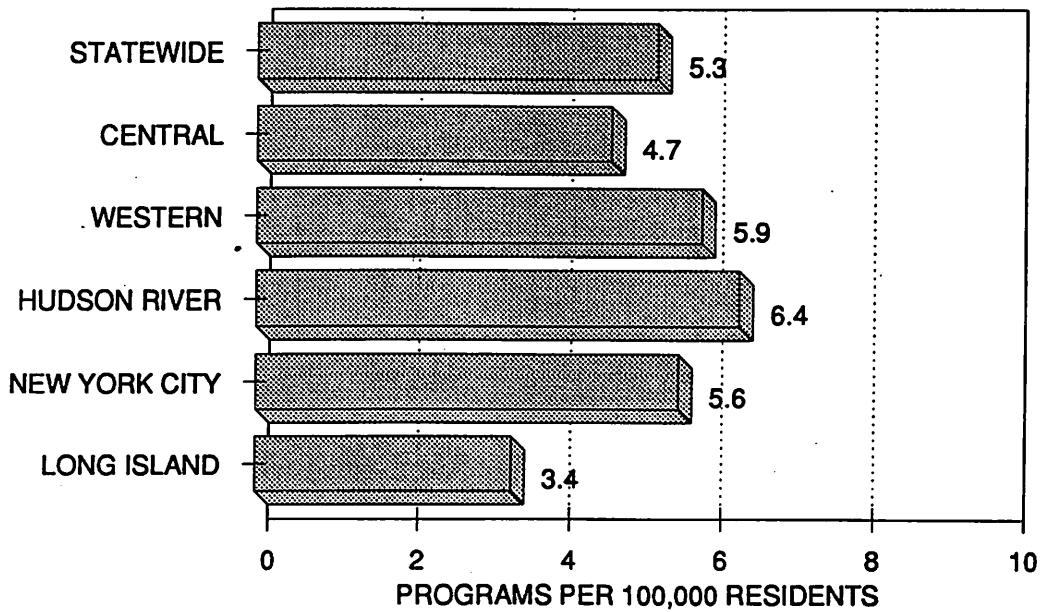
Regional Variability

New York's mental health outpatient service system is also characterized by marked regional variability. Statewide, New York has 5.3 certified outpatient programs for every 100,000 residents, but regional availability of certified mental health outpatient programs* ranges from approximately

6.4 programs per 100,000 residents in the Hudson River Region, to approximately 3.4 programs per 100,000 residents in the Long Island Region (an 88 percent variation) (Figure 8).

There are also marked regional variations in terms of the "mix" of available types of mental health outpatient programs (Figure 9). Whereas in all regions of the State, the majority of certified mental health outpatient programs are mental health clinics, in individual regions of the State, clinics represent anywhere from 54 percent (Western Region) to 71 percent (Long Is-

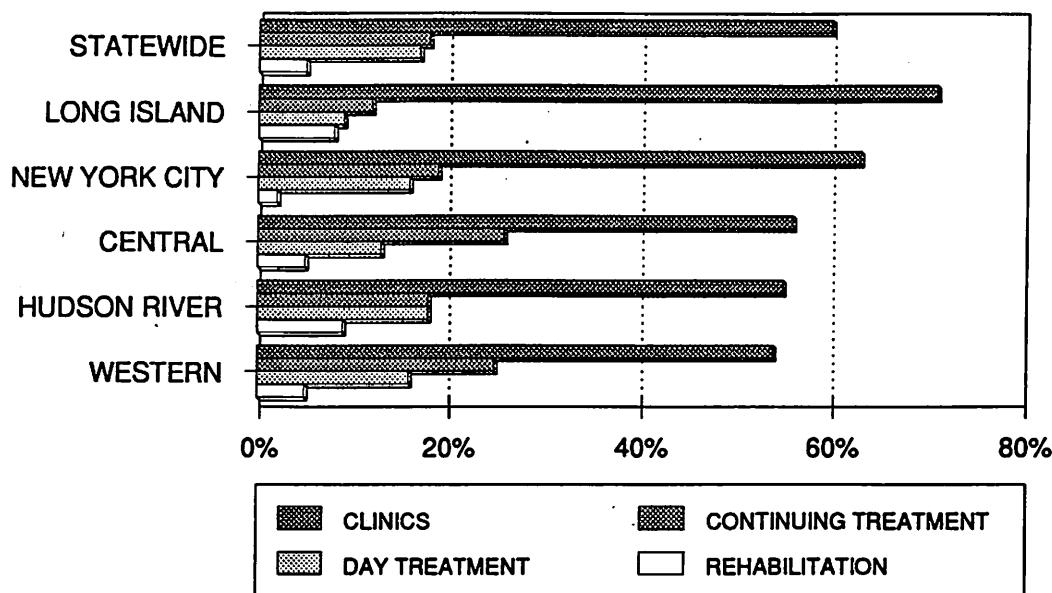
**FIGURE 8: AVAILABILITY OF CERTIFIED
OUTPATIENT PROGRAMS BY REGION***
(1989)



* BASED ON 1985 ESTIMATED CENSUS DATA, NYS DEPT. OF COMMERCE

- * The discussion of the regional availability of mental health outpatient services is based on the Office of Mental Health's five geographical regional administrative catchment areas: the Long Island, New York City, Hudson River, Central, and Western Regions.

FIGURE 9: CERTIFIED OUTPATIENT PROGRAMS BY TYPE WITHIN REGION (1989)



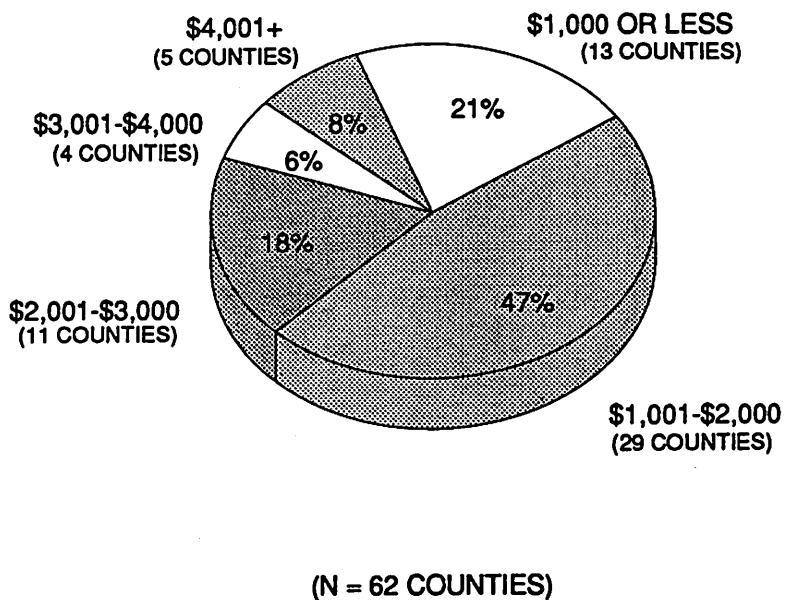
land Region) of the total available programs. As another example, continuing treatment programs represent only 12 percent of the available certified outpatient programs in the Long Island Region, but in both the Western and Central Regions, they represent approximately 25 percent of the available certified outpatient programs.

Regional variations in dollars spent per capita on mental health outpatient services are even more dramatic. Statewide, New York spent \$3,074 for every 100 residents on publicly funded mental health outpatient services in 1986. Across the five Office of Mental Health regional catchment areas, however, the per capita spending level actually ranges from a low of \$1,564 dollars per 100 residents in the Central Region to a high of \$4,114 per 100 residents in the New York City Region (a

163 percent variation). Among the State's 62 counties, the per capita expenditure level varied more than 2,600 percent. On the low end of the scale, total expenditures for mental health outpatient services in Hamilton County were \$337 per 100 residents; on the high end of the scale, total expenditures in New York County (Manhattan) were \$9,379 per 100 residents.

From another perspective, total expenditures for mental health outpatient services for 21 percent of the State's 62 counties were less than \$1,000 per 100 residents in 1986; for 47 percent of the counties, they were between \$1,000 and \$2,000 per 100 residents; and, for 32 percent of the counties, they were more than \$2,000 per 100 residents (Figure 10). This latter subgroup of counties included five counties: Montgomery, New York, Rockland, Ulster, and Westchester

**FIGURE 10: PERCENT OF NYS COUNTIES BY
TOTAL OUTPATIENT EXPENDITURES
PER 100 RESIDENTS
(1986)**



Counties, whose total expenditures for mental health outpatient services exceeded \$4,000 per 100 residents.

Thus, although New York maintains a very large and relatively costly mental health outpatient service system, actual availability of programs and services, as well as actual expenditures, vary tremendously in different communities of the State. In discussing these issues with officials of the Office of Mental Health and providers, there was general agreement that the development of mental health outpatient services has not proceeded in accordance with any statewide master plan to ensure comparable regional availability of services, based on any objective measure of outpatient service need. Instead, most

agree that programs/services have developed primarily at the initiative of local governments and providers, with little attention to the existing regional availability of services or any relative assessment of unmet outpatient services needs.

Variations in Local Government Investments

The absence of a statewide plan for the development of mental health outpatient services has been especially significant given that State appropriations for these services have increased by 51 percent over the past five years (1984-1988), and that some counties have been considerably more willing than others

to participate financially in this development effort.

While local government expenditures statewide for mental health outpatient services in 1986 averaged \$699 for every 100 residents, this local contribution actually ranged from a low of \$321 per 100 residents in the Central Region to a high of \$998 per 100 residents in the New York City Region (a 211 percent variation). Overall, 13 percent of the counties spent less than \$200 per 100 residents; 50 percent spent between \$200-\$400 per 100 residents; and 37 percent spent over \$400 per 100 residents, including three counties (Bronx, New York, and Rockland), which spent over \$1,000 per 100 residents (Figure 11).

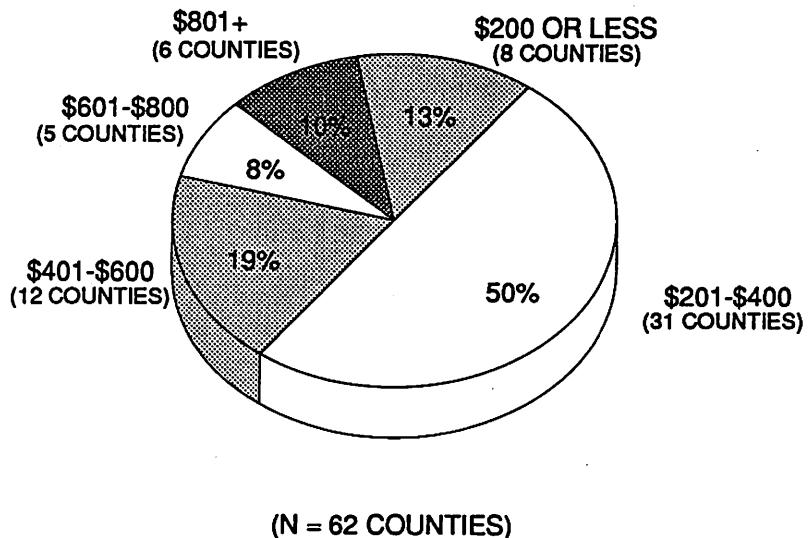
Like many other aspects of New York's mental health outpatient service

system, this variable fiscal participation by local governments has evolved without significant State government oversight or intervention.

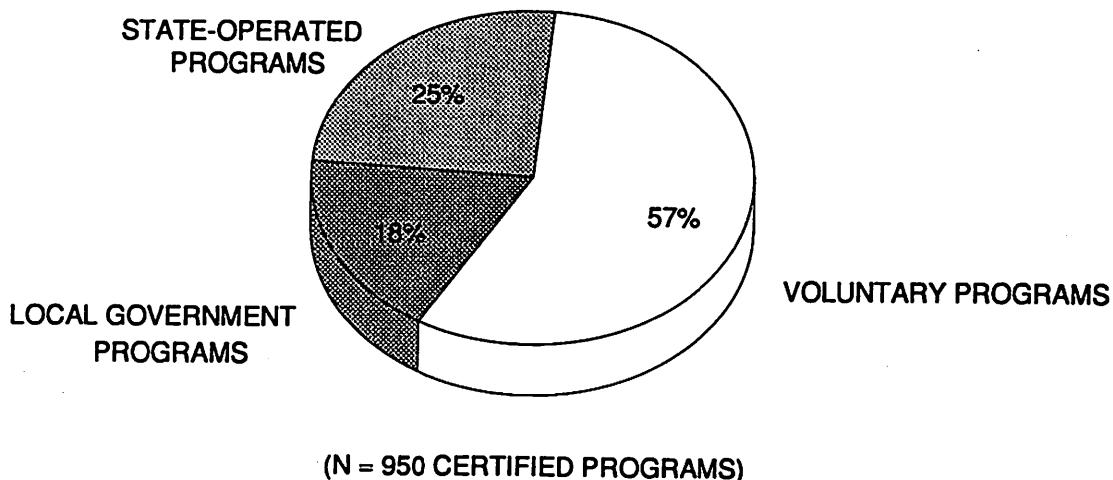
Many Providers, Little Service Coordination

A final, but critical, characteristic of New York's publicly funded mental health outpatient service system is its operation by approximately 500 different voluntary agency, hospital, State psychiatric center, and local government providers. In total, 57 percent of the State's 950 certified mental health outpatient programs are sponsored by approximately 344 different voluntary agencies or hospitals; 25 percent are

FIGURE 11: PERCENT OF NYS COUNTIES BY LOCAL CONTRIBUTIONS PER 100 RESIDENTS TO TOTAL OUTPATIENT EXPENDITURES (1986)



**FIGURE 12: PERCENT OF CERTIFIED
OUTPATIENT PROGRAMS BY AUSPICE
(1989)**



operated by 29 State adult and children's psychiatric centers; and 18 percent are operated by 120 local governments or municipal hospitals (Figure 12). The large and diverse provider network for mental health outpatient services is further complicated by the fact that nearly 42 percent of the providers operate only one program, and that most of the existing programs are relatively small, serving fewer than 25 people daily.

New York's large and diverse panoply of mental health outpatient providers, as well as its reliance on small programs, which may allow more personalized treatment settings, could be viewed as important assets in the provision of community-based care. In

practice, however, the absence of State and local government leadership in establishing targeted service priorities and in promoting efficient service utilization in this vast and expensive group of programs has resulted in far more liabilities.

With few exceptions, State and non-State providers, alike, complained that local coordination of mental health outpatient service provision is poor. As a result, programs often compete for service referrals of "desirable" individuals, while other people, often with more complex needs and multiple disabilities, are deemed inappropriate for all available programs. These criticisms are particularly voiced by freestanding mental health outpatient providers who feel

they are unfairly disadvantaged by hospital-based and State psychiatric center providers who can easily "cream" referrals for their own outpatient programs from their inpatient services.

These provider concerns were also largely validated by Commission staff during their on-site observations of mental health outpatient programs in 13 different counties in the State. In a few counties visited by the Commission, there appeared to be ongoing communication and coordination among at least some of the outpatient providers. Far more commonly, however, individual providers operated as autonomous entities, setting service priorities and operating hours and

developing program services with little or no coordination with other providers in their communities. For example, in one county, the Commission noted that a provider had just opened (with State and local approval) a continuing treatment program, although the county already had two continuing treatment programs, one of which had operated, long-term, at significantly below its optimal enrollment. In many communities, the lack of clinic services, on-call evening crisis services, and recreational activities during the evening hours were cited as longstanding problems, yet most providers continued to offer few, if any, evening services.

Chapter III

Responsiveness of Outpatient Programs to the Seriously and Persistently Mentally Ill

A central focus of the Commission's review was an evaluation of the responsiveness of New York's publicly funded mental health outpatient system to the seriously and persistently mentally ill. These individuals include persons with longstanding psychiatric conditions, histories of multiple psychiatric hospitalizations, and serious deficits in self-care, daily living, and economic self-sufficiency skills essential for community living. It is believed that, in the absence of an adequate array of community-based mental health services, these individuals are most at risk of repeated visits to psychiatric emergency rooms and repeated and expensive in-patient hospitalizations.

As reflected in this chapter, the Commission's assessment revealed severe shortcomings in the service system's overall responsiveness to this population. By all indicators evaluated, the service system does not provide sufficient service priority and attention to

the most basic needs of these individuals, and especially to their non-clinical rehabilitative and support services needs.

Service Priorities

The Commission found no explicit State policy which required publicly funded mental health outpatient providers to place service priority on individuals who are seriously and persistently mentally ill. Although the State has identified eligibility criteria indicative of serious mental illness for accessing the Community Support System funding stream, the much more substantial deficit funding available to mental health outpatient programs, which is unencumbered by eligibility criteria, has allowed many outpatient programs considerable latitude in choosing which individuals they will serve.* Additionally, until recently, the Office of Mental Health paid minimal attention to the ac-

* In 1986, Community Support System funding to mental health outpatient services totaled \$66 million, compared to total net-deficit funding of \$91 million.

tual service priorities established by individual providers, or to the responsiveness of these priorities to the seriously and persistently mentally ill.

In practice, this absence of State mandates and oversight has encouraged most providers to open their doors to a diverse population, only a portion of whom are seriously and persistently mentally ill. Specifically, although psychosocial clubs and most continuing treatment programs visited by the Commission focused their service delivery on individuals who were seriously and persistently mentally ill, most day treatment programs and mental health clinics visited (which comprise 77 percent of the State's certified programs) did not primarily serve persons meeting the Office of Mental Health's criteria for the seriously and persistently mentally ill. Although almost all of these programs did serve some individuals who were seriously and persistently mentally ill, staff at three programs had difficulty identifying even six individuals on their caseloads who met these criteria, and staff at most programs stated that they sought to "balance" their caseloads between individuals who were seriously and persistently mentally ill and those who had more transient emotional problems.

In making this choice, it was apparent that most providers actively sought to serve the full range of local citizens with mental health needs, reflective of local needs and the local role in financing services, both through tax levy funds and voluntary contributions. It was also clear, however, that the historically weak State role in influencing service priorities has not assured the

State's interest in guaranteeing appropriate access and services for individuals who are seriously and persistently mentally ill in heavily State-subsidized programs.

Most critically, this absence of State guidance has allowed many providers, despite the provision of substantial State subsidies, to establish restrictive practices which implicitly or explicitly deny service access or service availability to seriously and persistently mentally ill individuals, and particularly to individuals who have multiple problems and who are less service compliant.

Restrictive Operating Practices

In "tailoring" their caseloads, many providers adopted operating practices which explicitly or implicitly discouraged service provision to individuals with the most serious problems or the most troubled lives. For example, several providers had admission criteria which discouraged service provision to persons with concomitant alcohol and drug abuse problems, and many others had participation requirements, such as regular attendance, active group participation, and compliance with the program's non-smoking rules, which implicitly discouraged the enrollment of seriously and persistently mentally ill people.

Meetings with homeless shelter providers in the Capital District and Westchester County also surfaced criticisms that outpatient mental health providers were reluctant to serve the

homeless mentally ill. These shelter providers noted that, although they are used as discharge sites by many in-patient psychiatric facilities, outpatient mental health programs frequently deny their residents timely appointments or crisis services. In some instances, shelter providers reported that service access was unavailable; more often, they reported that excessive outpatient provider delays in arranging scheduled appointments and the limitations in support and evaluation services typically offered by outpatient programs effectively discouraged homeless individuals from participating successfully in outpatient programs.

The Commission also found that, with the exception of psychosocial clubs, few outpatient programs had operating practices tailored to encourage less organized or service-resistant seriously and persistently mentally ill persons to access their services. For example, most programs do not routinely provide "walk-in" services. Some programs offer no crisis or on-call services, and the vast majority offer no such services in the evenings or on weekends.

Most providers also offered very limited outreach to people who failed to keep appointments or to maintain scheduled attendance at day programs. Across virtually all programs, these efforts were limited to periodic phone calls and letters. Home visits, contacts with involved family members, or substantive outreach efforts to these people to discern why they failed to attend were rarely offered. Additionally, at two clinic programs visited, therapists were not paid when individuals missed

appointments, which provided a powerful financial incentive for clinicians to discharge service-resistant individuals.

Most critically, the Commission found that many seriously and persistently mentally ill outpatients are discharged from outpatient programs because they have not adjusted well to the programs or their operating practices. In total, 53 of the 138 discharged outpatients studied by the Commission had been discharged for service resistance. Actual documented reasons for discharge included missing appointments, non-compliance with program rules, and/or consumer dissatisfaction with program offerings. Notably, 93 percent of these individuals were characterized in their clinical records as having made little or no progress toward their treatment objectives at the time of their discharge, and only 32 percent had been involved in their discharge planning.

Relevance of Service Provision

Other Commission findings suggested that even among those seriously and persistently mentally ill individuals who are served by publicly funded mental health outpatient programs, many do not receive the critical services they need. In its review, the Commission traced outpatient service provision to 144 outpatients who met the State's criteria for the seriously and persistently mentally ill over a two-year period. Although most of these outpatients did have relatively frequent and consistent contact with outpatient

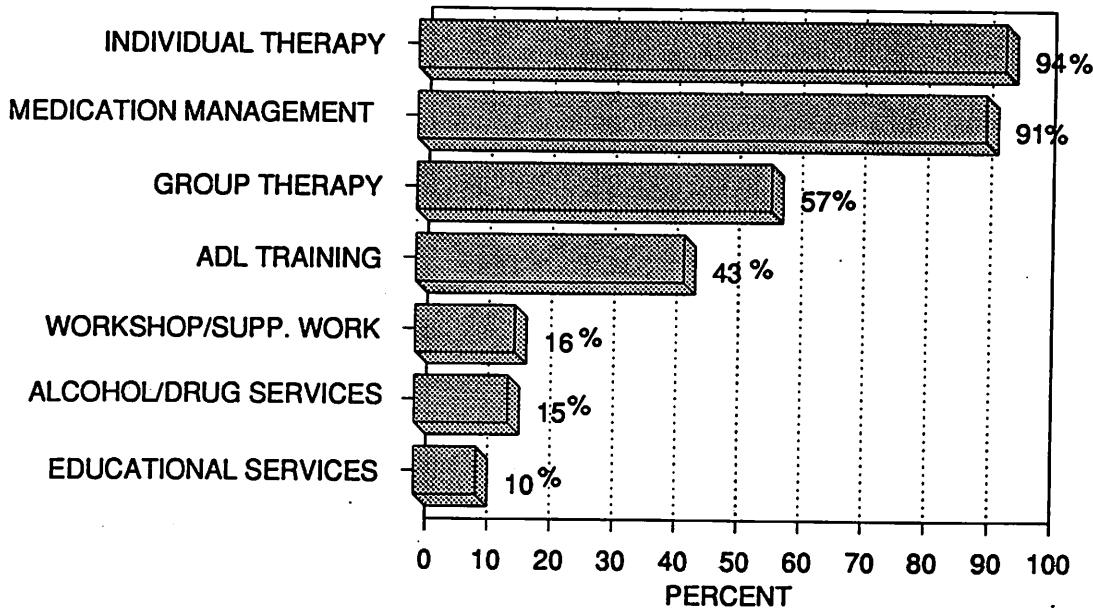
programs, for many, their most basic rehabilitative and support needs went unaddressed over the full two-year review period.

Almost half of these outpatients (47 percent) averaged six or more outpatient service contacts a month over the full two-year period reviewed. Thirty-six (36) percent had averaged 10 or more service contacts a month, including 13 outpatients who averaged more than 20 service contacts a month. The vast majority of the outpatients studied (80 percent) had also maintained enrollment in at least one outpatient program for at least 12 consecutive months over the past two years. Nearly half of the enrolled outpatients studied (47 percent)

were currently enrolled in two or more mental health outpatient programs, and 67 percent had been enrolled in more than one program over the two-year period. Fifteen (15) percent had been enrolled in three programs, and 10 percent had been enrolled in four or five programs.

Further analysis revealed, however, that almost all service provision to these outpatients had focused on their clinical needs (Figure 13). Specifically, the majority of outpatients studied had received individual therapy (94 percent), medication management (91 percent), and group therapy (57 percent) services continuously or periodically over the two-year period. Often in con-

**FIGURE 13: SERVICE PROVISION TO SERIOUSLY MENTALLY ILL OUTPATIENTS*
(N = 144)**



* SERVICES PROVIDED OVER A FULL TWO-YEAR PERIOD

junction with these services, clinical records revealed that the outpatients received advice or assistance in using leisure time (58 percent), in solving family problems (50 percent), and in addressing current problems in daily living (60 percent).

Clinical records of most of the outpatients studied also indicated, however, that in addition to their needs for clinical services, most also had significant rehabilitative needs. For example, 79 percent of the outpatients studied had identified needs in economic self-sufficiency, including inadequate literacy skills, under- or unemployment, and problems in money management; and 42 percent of the outpatients had specific problems in obtaining skills and assistance to get a job. Among this latter subgroup of 61 outpatients, only 9 had the opportunity to attend a sheltered workshop or supported work program at any point in the past two years.

The outpatients' clinical records further revealed that 56 percent had problems in accomplishing specific tasks of daily living, and that 38 percent had problems in attending to their self-care needs. Yet of the 91 outpatients with these specific daily living or self-care training needs, only 40 had participated in a formal daily living skills training program at any point in the past two years.

Additionally, nearly one-third of the outpatients studied (31 percent) had not received a high school or a high school equivalency diploma. Of these 44 outpatients, however, only 4 had received any educational services to enhance their academic skills and qualifications

for employment at any point in the two-year review period. Furthermore, although clinical records of 49 of the outpatients revealed concomitant problems with alcohol or drug abuse, only 14 of these outpatients had received any drug or alcohol abuse services in the past two years.

The seriously and persistently mentally ill outpatients studied were also unlikely to receive ongoing case management services over the two-year period to help them access the services they needed. Sixty (60) percent of the outpatients studied had not received case management services at any point during the two-year period reviewed, and only 15 percent of the outpatients had received case management services for at least 12 consecutive months.

Progress Toward Treatment Objectives

To gain another perspective of the service system's responsiveness to the needs of persons who are seriously and persistently mentally ill, the Commission examined the progress made by these outpatients toward their stated treatment objectives. In this evaluation, the Commission was able to rely on a relatively large sample of 144 seriously and persistently mentally ill persons, who were currently enrolled in outpatient mental health programs, and 138 seriously and persistently mentally ill persons, who had been recently discharged from these programs. Across both sample populations studied, there was substantial evidence that programs were falling short in helping many of

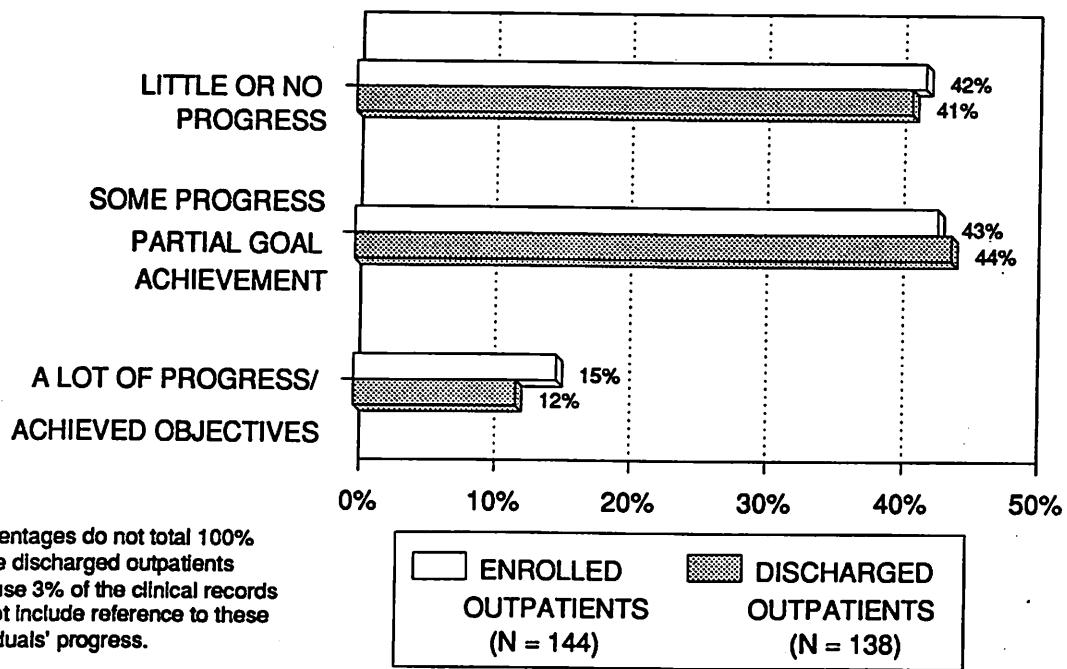
these outpatients to achieve their stated treatment objectives (Figure 14).

According to clinical records, almost half of the currently enrolled outpatients (42 percent) had made *little or no* progress or improvement toward their treatment plan objectives since they had enrolled in their current program. Even more striking, 41 percent of the records of the recently discharged outpatients indicated that they made *little or no* progress toward their treatment objectives at the time of their discharge. Only 15 percent of the enrolled outpatients were characterized as having made *a lot* of progress or improvement since their enrollment, and only 12 percent of the discharged outpatients were characterized as having *successfully*

achieved their treatment objectives at the time of their discharge.

Notably, when outpatient therapists were interviewed, almost all stated that individuals failed to make progress or improvement because of the severity of their illness or their service resistance. In only three cases did therapists indicate that limited progress was attributable to the program's failure to meet people's needs. Somewhat paradoxically, however, most primary therapists of the outpatients studied did acknowledge that these people had unmet needs or serious problems which were not addressed by their program. For example, primary therapists noted that 38 percent of the enrolled outpatients needed job skills; that 22 per-

FIGURE 14: PROGRESS TOWARD TREATMENT OBJECTIVES FOR SERIOUSLY MENTALLY ILL OUTPATIENTS*



cent had problems maintaining personal hygiene; that 29 percent had problems with money management; and that 32 percent had problems with drug or alcohol abuse.

Presumably, these therapists did not view these largely non-clinical service needs as falling within the legitimate domain of their programs. Less explicably, they also did not seem to perceive how failure to address these basic needs or problems may bar an individual's progress or interest in their program.

These paradoxical therapist viewpoints may also reflect the failure of most programs visited by the Commission to have a formal program evaluation or needs assessment process. When interviewed by Commission staff, many providers reported that they periodically informally assess their services, but very few identified any formal process which sought to evaluate the success of their services objectively or which solicited consumer and involved family member input and suggestions.

Rehospitalizations

The Commission's review also confirmed a high rate of inpatient psychiatric treatment among the 144 seriously and persistently mentally ill enrolled outpatients. Over half of the en-

rolled outpatients (51 percent) had been hospitalized at least once in the two-year period, and over one-fourth (26 percent) had been hospitalized two or more times. Among the hospitalized outpatients, the median number of days spent on inpatient status during the two-year period was 50 days, with 63 percent of the hospitalized outpatients spending more than 30 days in the hospital over the two-year period.* Assuming an average inpatient hospital rate of \$300 per day, over the two-year period these hospital stays cost approximately \$2.3 million. The data also showed a higher rate of inpatient hospitalization among the enrolled outpatients who were characterized as having made little or no progress toward their treatment objectives versus those who were characterized as having made some or a lot of progress (57 versus 46 percent rehospitalized).

Consumer/Family Satisfaction

The Commission also directly solicited consumers' and involved family members' opinions of the responsiveness of mental health outpatient services. Both surveys were voluntary and guaranteed respondent anonymity.

* Median length of stay and cost findings are based on length-of-stay data for 68 of the 73 hospitalized outpatients. Length-of-stay data were unknown for the remaining five hospitalized outpatients.

Consumer surveys were distributed at the 23 outpatient programs formally visited by the Commission,* while local chapters of the Alliance for the Mentally Ill and the Federation of Organizations for the New York State Mentally Disabled, Inc. graciously assisted the Commission in distributing family surveys to their members. In total, the Commission received responses from 294 outpatient consumers and 180 family members of persons who are mentally ill.

Overall, 91 percent of the consumer respondents rated their outpatient services as somewhat or very helpful, but slightly more than half (58 percent) also stated that existing services did not satisfactorily address one or more of their service needs (Figure 15). Thirty-nine (39) percent of these consumers indicated that they needed something to do in their spare time; 37 percent indicated that they needed more help with emotional problems; 34 percent indicated they needed job training; 31 percent indicated they needed help with family problems; and 30 percent indicated they needed educational services. Other specific unmet service needs cited by at least one-fifth of the consumers included help with money management (30 percent), help in making good treatment decisions (26 percent), help with physical health problems (22 percent), help in finding a place to live (20 per-

cent), help in using community resources (20 percent), and help in obtaining financial entitlement (20 percent).

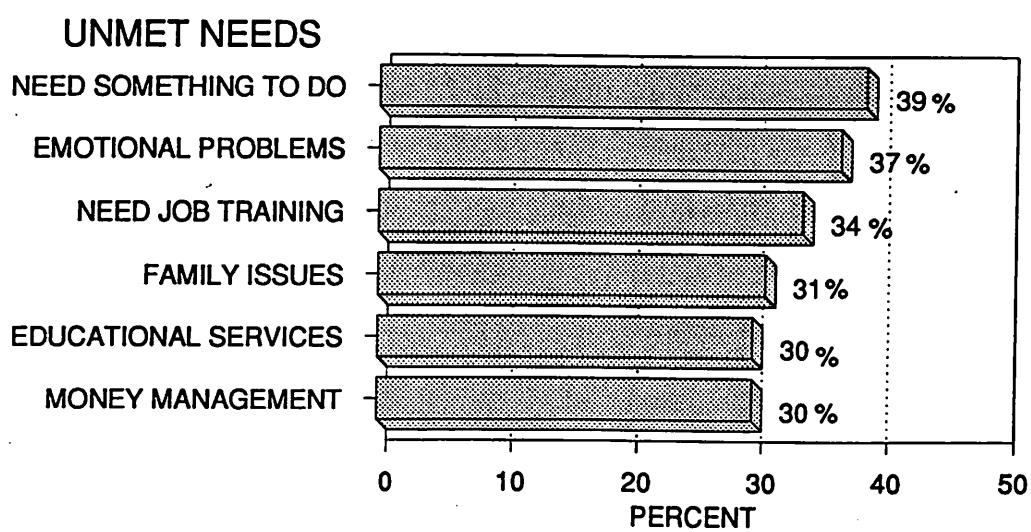
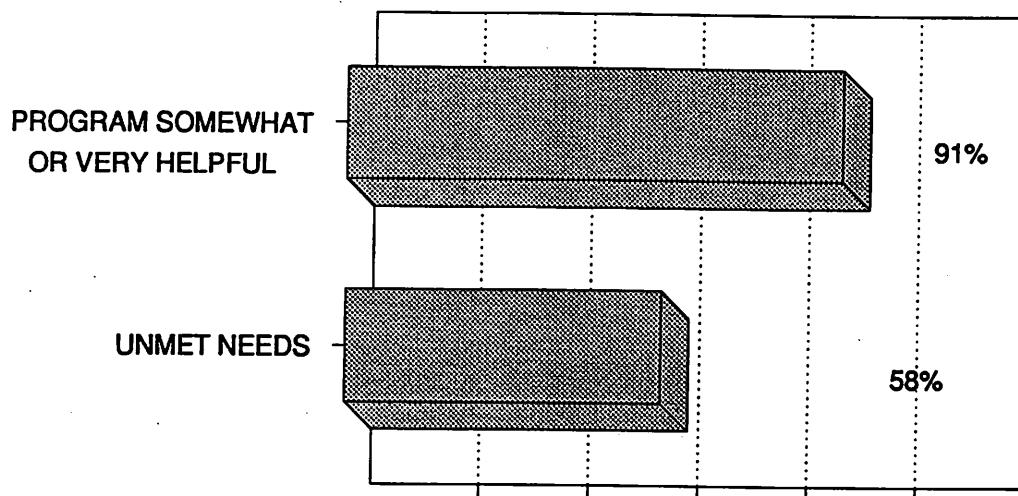
Most of the consumers responding to the survey (51 percent) also recommended that outpatient program offerings be changed to address their unmet needs. While only 15 percent of these consumers recommended an overall restructuring of the activities and services offered, many recommended specific changes, including more vocational training and job opportunities, more educational services, computer training programs, more trips and outdoor activities, and increased transportation services. Many consumers also recommended changes in specific operational practices of outpatient programs, including more time with therapists, more convenient program hours, more meaningful and challenging activities, and better facilities.

Family member comments on mental health outpatient services echoed consumer concerns although, overall, family members were much more critical (Figure 16). Only 20 percent of the family member respondents gave available mental health outpatient services *satisfactory* or *very satisfactory* ratings. Over one-third of the family member respondents (35 percent) rated available services *unsatisfactory*, and 45 percent rated them *in need of improvement*.

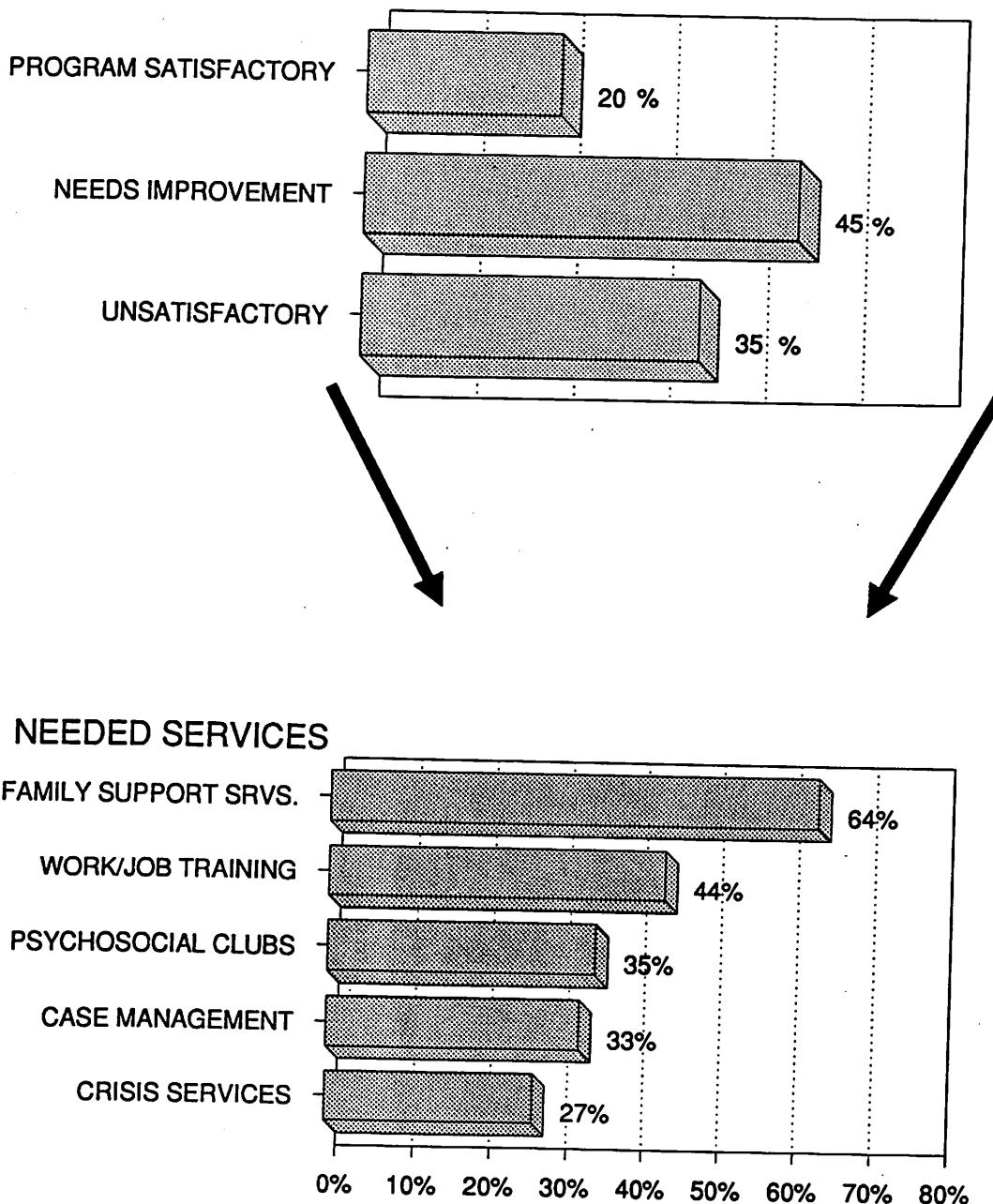
Additionally, 89 percent of the family members responding to the

* Consumer surveys were not distributed at 1 of the 24 programs formally visited by Commission staff because the vast majority of the individuals served were Spanish speaking, and the Commission had inadvertently neglected to ensure surveys written in Spanish.

**FIGURE 15: CONSUMER SATISFACTION
(N = 294)**



**FIGURE 16: FAMILY SATISFACTION
(N = 180)**



Commission's survey made at least one recommendation for changes in out-patient service offerings and, like the consumers' recommendations, their recommendations clustered on increasing the availability of non-clinical rehabilitative and support services. Nearly half of the family respondents (44 percent) advocated for more "real work" and supportive employment opportunities; 35 percent advocated for

more psychosocial club programs; 33 percent advocated for more case management services; and 27 percent advocated for mobile crisis intervention services. Additionally, nearly two-thirds of the family member respondents recommended increased attention to family support services, especially funding for family support groups and education and training services for family members.

Chapter IV

State Accountability for Mental Health Outpatient Services

In addition to concerns surrounding the responsiveness of the publicly funded mental health outpatient system to individuals with serious and persistent mental illness, other issues associated with the State's overall direction and accountability for the service system also surfaced prominently in the Commission's findings. This chapter examines the State's historical role in governing this large and costly array of services, and particularly focuses on the State's effectiveness in assuring accountability for needed service development, optimal program performance, and the cost-effective delivery of services.

As detailed in the following discussion, the Commission found accountability in all of these areas to be seriously lacking. Although State tax dollars have historically provided the primary funding source for the mental health outpatient system, the Office of Mental Health has largely left its governance to local governments and the providers. Simultaneously, while local governments have assumed variable postures in exerting leadership over the development and operation of mental health outpatient services in their com-

munities, many have played a largely unintrusive role in the direction of these local services. Most critically, the Commission found that the State's historical role in exerting little direction or accountability over mental health outpatient providers has left the Office of Mental Health with few ready procedures and mechanisms to institute a greater level of public accountability over this large segment of the mental health service system.

Inadequate Information Systems

Characteristic of the State's historical "hands-off" governance of mental health outpatient services, the Office of Mental Health has maintained little reliable data on outpatient service delivery. At the onset of its study efforts, the Commission discovered that there were no reliable data on the system's service capacity, its service utilization, unit-of-service or program costs, or even how many different individuals accessed the service system annually.

Although all outpatient programs have for some years been required to report outpatient enrollments and units of service delivered, the Office of Mental Health acknowledges that these data are unreliable. On the one hand, State guidelines on how to report units of service are not clear and, therefore, providers have not reported their actual service delivery using consistent measures. Enrollment data, on the other hand, include many duplicative counts of the same individuals who may be enrolled in two or more programs or who may have enrolled, quit, and re-enrolled in the same program two or more times in a calendar year. Enrollment data are also compromised by the tendency of some programs to report outpatients who are enrolled on their caseloads, but who have not actually received services during the year.

Additionally, since the Office of Mental Health has no reliable measure of the service capacity, even with their limitations, available service delivery data are of little use in identifying the service system's development needs or in evaluating the efficient utilization of specific programs, types of programs, or the service system as a whole.

Perhaps most critically, the State Office of Mental Health has not required all mental health outpatient programs to report cost data. While cost data have been maintained for several years for all State-operated programs, only non-State providers who request net-deficit funding or who are receiving a funding grant for an uncertified mental health service are required to submit expenditure reports, and then only for their programs which are funded by deficit

funding or State grants. Approximately 30 percent of the non-State outpatient providers have not been required to submit expenditure data. As a result, the Office of Mental Health does not have a reliable universe of cost data upon which to evaluate outpatient program expenditures or unit-of-service costs. Indeed, because most available expenditure data come from programs operating at a deficit, these data are most likely *not* representative of the expenditure patterns of the system's more cost-effective outpatient programs.

Additionally, because providers are only required to submit cost data on programs for which they receive deficit financing or grants, available cost reports can misrepresent the actual financial well-being of a provider. For example, one provider agency studied by the Commission submitted a cost report for only 1 of its 10 clinics, reporting a net deficit of \$323,000. While the cost report documented the deficit of this clinic, what it failed to show was that the provider's other nine clinics actually had a surplus of \$920,000 for the same year.

The Office of Mental Health is aware that these deficiencies in its information systems on mental health outpatient services have hindered the State's ability to plan, regulate, and evaluate the performance of mental health outpatient programs. In the spring of 1988, the Office of Mental Health commenced a study to examine mental health outpatient service utilization. Targeted for completion in the fall of 1989, a major objective of this study is to provide the Office of Mental Health with a reliable database relating who is served by

publicly funded mental health outpatient programs and what types and how many services enrolled outpatients receive. Data on enrolled outpatients' demographic, clinical, and functional characteristics will also be collected, allowing the Office of Mental Health, for the first time, to profile the actual outpatient population served.

The Office of Mental Health has also proposed a new Consolidated Fiscal Report, which would apply to all mental health providers and require consolidated cost reporting on all inpatient, outpatient, and community residential mental health programs they operate. In preparing Consolidated Fiscal Reports, providers will be required to obtain certified statements from independent public accountants to assure that costs are accurately reported. The Office of Mental Health also plans to issue a manual identifying clear standards for reporting units of services, cost allocation methodologies, disclosure of related-party transactions, non-fundable costs, and other pertinent information. The Office of Mental Health intends to use data from providers' Consolidated Fiscal Reports to identify efficient versus inefficient providers and, eventually, to establish rates more in line with the costs of efficient service delivery, including screens for various types of expenditures.

Both of these data reporting initiatives have the capability of greatly enhancing the State's ability to make informed planning, service delivery, and fiscal decisions related to mental health outpatient services. Like all databases, however, the ultimate reliability of the information received

will be contingent on provider cooperation and diligent State direction and monitoring of the reports received. This will be particularly true for the voluminous and detailed Consolidated Fiscal Reports, which will require careful scrutiny by Office of Mental Health officials. At present, the Office of Mental Health has only one staff person assigned to this project. When the Consolidated Fiscal Report process is fully implemented, this staff person would be responsible for the review of nearly 500 provider reports. Unless an adequate staffing allocation is provided to review these reports, and explicit guidelines are established to govern the comprehensiveness and accountability of these reviews, the potential benefits of the new system may remain unrealized.

Planning Without a Destination

On paper, New York's planning process for mental health outpatient services appears carefully crafted and fully accountable to public, consumer and advocate involvement. At the local level, outpatient service needs are voiced at public forums, discussed at Community Services Board meetings, and finally validated by local governments, which must approve all local service development. The State Office of Mental Health, both through its direct Regional Office oversight of the local planning process and through its official review of proposals for new or expanded programs in the certificate-of-need process, also has a very formal and

prescribed role in guiding the development of mental health outpatient services. Additionally, the State Office of Mental Health, based on local plans and its own regional public planning meetings, develops a statewide plan for all mental health services, including outpatient programs.

As one examines local and State planning activities for mental health outpatient services more carefully, however, it becomes apparent that many of these activities have taken place without basic information critical for sound decision-making. As described above, New York has not maintained reliable data on existing mental health outpatient service delivery. Thus, planning decisions have often been made at both the State and local level without an accurate assessment of what already exists. Local planning forums have also not been guided by any clear sense of the desirable array of publicly funded mental health outpatient services for their communities, as the Office of Mental Health has only recently begun to identify core service requirements. Finally, and perhaps most critically, there are no reliable methodologies used by local governments or the State to measure the actual need for specific types of mental health outpatient services based on the locality's population.

In the absence of this basic information, local and State planning for outpatient services have been typically swayed by the loudest and most persuasive voices. Not surprisingly, in many communities, these voices have come from existing providers of mental health outpatient programs. While these providers certainly have expertise to

lend to the planning process, without objective data on what services are needed, it has been virtually impossible for local citizens or government officials to evaluate their proposals meaningfully. It also is notable that, with the absence of reliable objective indicators of need, the voices of families and consumers have not been heard in the development of programs and services. While there has been some progress in developing psychosocial clubs and supported work programs, this has been a slow process as it has relied largely upon new investment, rather than examining the value of investments in existing programs, many of which appear underutilized.

Thus, although New York invests considerable efforts at both the local and State levels in planning outpatient services, accountability for actual planning and development decisions has been largely unchecked. In point of fact, Office of Mental Health officials acknowledge that they rarely deny a new or expanded mental health outpatient service proposal in the certificate-of-need process.

Oversight of Program Performance

The Office of Mental Health has also provided only limited on-site checks of the performance of mental health outpatient programs. As noted earlier in the report, New York funds 950 certified mental health outpatient programs and awards contracts to fund 585 uncertified mental health services. For uncertified services, the Office of Mental Health is

not required by statute to make any on-site visits and, in practice, these services are rarely subject to on-site reviews by Office of Mental Health staff.

Certified mental health outpatient programs, in contrast, are required by statute (31.07 MHL) to be visited by Office of Mental Health staff twice annually, including one unannounced visit. These programs are also subject to biannual formal certification reviews. In practice, however, the Commission found that actual on-site monitoring of certified programs often did not meet these statutory requirements and, more importantly, that there are no substantive performance standards or uniform review protocols to guide these State oversight activities.

Specifically, despite recent Office of Mental Health efforts to catch up on its substantial backlog of outpatient programs operating with lapsed certifications, as of March 1, 1989, approximately 20 percent of these programs, most of which are located in New York City, still operated with out-of-date certificates. Additionally, few outpatient programs are actually visited twice annually, and these programs are almost never visited unannounced.

Additionally, the Commission's review of Office of Mental Health certification reports of 24 outpatient programs it had visited revealed that these reports rarely commented on substantive issues of service provision. Reports tended to focus on the availability (not substance) of administrative policies, minor record-keeping issues and, in some cases, fire/safety and environmental issues. The reports rarely commented on real is-

sues of program accountability, including the appropriateness of services, efficient program and staff utilization, or the adequacy of admission screening and treatment or discharge planning.

For example, a recent certification report for a day treatment program visited by Commission staff, which had only six enrolled outpatients and seven paid staff, made no reference to the program's obvious inefficient operation. In another case, a continuing treatment program offered clearly inappropriate and inadequate activities, but the certification report made no comment on these issues. At this program, the daily schedule was framed by 45-minute activity periods, labeled "sing-along, table games, music group, art group, etc." During Commission observations, people engaged in such age-inappropriate activities as rolling balls between one another and playing childlike word games on the chalkboard. There were no opportunities at the program for individuals to develop more appropriate daily living skills, although many people had apparent needs in these areas.

In still other cases, Commission staff noted evident problems in treatment and discharge planning which were not addressed in recent certification reports. At several programs, for example, we noted individuals whose treatment objectives had simply been repeated for years. At others, there were apparent questions about the appropriateness of discharge decisions, whereby many seriously and persistently mentally ill persons were discharged, despite a record note that they had made no significant progress and no documentation

that substantial efforts had been extended to address their resistance to treatment or the problems which may have blocked their progress. At one program, individuals had been summarily discharged with a record note stating that their therapist had retired.

Office of Mental Health officials acknowledge that existing practices provide very limited substantive or regular oversight of mental health outpatient programs. They report that a fundamental problem is the lack of measurable performance standards in existing regulatory guidelines for certified outpatient programs. Without these standards, State officials confirm that monitoring, as well as certification reviews, have tended to focus on administrative process issues, rather than on more critical issues of program performance. Office of Mental Health officials also noted, however, that their available surveyor staffing allocations are wholly inadequate to conduct even the minimal monitoring and certifications reviews now required by Mental Hygiene Law, much less more substantive reviews of a large number of programs.

The Office of Mental Health has recently formed a work group to address these certification and program accountability issues for its outpatient, as well as community residential programs. This work group will reportedly be evaluating needed changes in certification standards, the appropriateness of using performance contracts to ensure greater program accountability, as well as the full range of staffing, staff training, and protocol issues surround-

ing Central Office and Regional Office program monitoring activities.

Monitoring Program Expenditures

In concert with its limited oversight of service delivery by mental health outpatient programs, the Office of Mental Health has also paid minimal attention to these programs' expenditures and actual unit-of-service costs. As mentioned above, historically the Office of Mental Health has not maintained program or service expenditure data for many non-State-operated mental health outpatient programs. Additionally, even available program expenditure reports have had little fiscal accountability, because guidelines to ensure that costs are reasonable, necessary, and related to people's care have been vague and there has been no requirement that submitted expenditure reports be audited by an independent certified public accountant.

Compounding these problems, Office of Mental Health reviews of submitted cost reports have not aggressively addressed possible problems reflected by unreasonably high or unreasonably low unit-of-service costs identified in these reports or the issue of very low reported revenues from Medicaid/Medicare and other third party insurance plans. There is no regular State monitoring of provider practices in carefully evaluating individuals for Medicaid/Medicare eligibility or for their enrollments in private health insurance plans which may reimburse outpatient mental health services. Additionally, State program

certification reviews also do not assure significant oversight of relevant record-keeping and billing practices of outpatient programs or basic operating practices which can critically impact on program costs and revenues. On the contrary, many providers have maintained a low revenue profile and/or very high unit costs for many years with little intervention from State officials, and the State and local governments have simply "made up" for these low revenues, through net-deficit funding with State and local tax dollars.

The Office of Mental Health has recently indicated its intention, both through the to-be-implemented Consolidated Fiscal Report and other pro-

gram performance monitoring efforts, to address the Office's historically minimal oversight of outpatient providers' expenditures and revenues. Through these efforts, the Office hopes to provide more effective oversight of the cost-efficient operation and revenue maximization of outpatient programs. Equally important, Office of Mental Health officials hope that analysis of individual program expenditures and their relative cost-effectiveness will assist the State in developing reliable benchmarks for reasonable and appropriate costs of mental health outpatient service delivery, and in directing State tax dollars subsidizing the costs of these services.

Chapter V

Recommendations

1. The New York State Office of Mental Health should provide more direction and oversight of the planning and development process for mental health outpatient services by:

 - (a) establishing a valid data base on the availability, capacity, and utilization of mental health outpatient services for all counties of the State;
 - (b) establishing minimum requirements for the provision of basic needed outpatient services in each county, by type of service and capacity of service; and,
 - (c) establishing an objective needs assessment methodology to guide local government decision-making and the State's certificate-of-need process in the evaluation of proposals for new or expanding mental health outpatient programs.
2. Until a reliable needs assessment methodology is available, the Office of Mental Health should declare a moratorium on certifying new or expanded clinically oriented outpatient programs, except for those specifically targeted to multi-problem persons, including persons with concomitant drug and alcohol problems.
3. While recognizing the validity and appropriateness of a provider and local government role in developing service priorities for outpatient mental health services which are partially funded by non-State funds, the New York State Office of Mental Health should take more aggressive steps to ensure that State tax dollar investments in publicly funded mental health outpatient services promote the accessibility and availability of the full range of needed clinical and non-clinical rehabilitative and support services for persons who are seriously and persistently mentally ill. These steps should include, but not necessarily be limited to:

 - (a) establishing effective mechanisms, at the local government level, to coordinate needed service access and service delivery to individuals who are seriously and persistently mentally ill, and particularly to the subgroup of these people who are service-resistant and who have

- multiple problems and service needs;
- (b) identifying and fixing by contract the responsibility of particular programs to serve directly, or through coordination with other programs, individuals who are identified as most at risk of rehospitalization without adequate outpatient mental health services;
- (c) examining the utility of a continued State role in the direct delivery of outpatient services, particularly services which duplicate those available from other providers in the area, and considering the redirection of resources to fill in gaps in rehabilitative, social, and support services, or in services to multi-problem persons;
- (d) evaluating current expenditures of State tax dollars to non-State programs receiving deficit funding to determine if these funds can be redirected to assure a better balance of clinical and non-clinical rehabilitative and support services, especially to persons who are seriously and persistently mentally ill and, within this group, to multi-problem or service-resistant persons;
- (e) evaluating the current provision of publicly funded case management services and ensuring in the future that these services are targeted to seriously and persistently mentally ill individuals most in need of a case manager
- to assist them in solving problems of daily living and in gaining access to needed services;
- (f) requiring all publicly funded mental health outpatient programs to develop on-going procedures and practices which encourage individuals who are seriously and persistently mentally ill and their families to be actively involved in decision-making related to admission criteria, program participation requirements, service offerings, and operating practices (e.g., hours of operation, outreach practices, availability of on-call crisis services, etc.); and,
- (g) developing an objective monitoring procedure for measuring the progress of counties and individual mental health outpatient providers in improving the access and availability of core mental health outpatient services for individuals who are seriously and persistently mentally ill and, within this group, to service-resistant and multi-problem persons.
4. The New York State Office of Mental Health should set fixed time frames for the achievement of on-going initiatives to assure more effective programmatic and fiscal accountability for publicly funded mental health outpatient services. These initiatives include:
- (a) developing admission and operating guidelines, as well as measurable performance standards, for publicly funded mental health outpatient services,

- which encourage service access and promote quality service delivery to the multi-problem, seriously and persistently mentally ill individual;
- (b) enhancing the quality and reliability of Regional Office monitoring and certification reviews of publicly funded mental health outpatient programs;
- (c) establishing a certification standard whereby outpatient programs will be required to solicit and respond to consumer and family evaluative input on a regular and at least annual basis;
- (d) implementing fully the consolidated fiscal report system;
- (e) assuring criterion-based reviews of submitted consolidated fiscal reports from publicly funded mental health outpatient providers; and,
- (f) setting discrete Medicaid rates based on analyzed agency costs and efficient service delivery.
5. The New York State Office of Mental Health should continue its efforts in recognizing and assisting families who often provide critical support services for persons who are seriously and persistently mentally ill by providing funding allocations to promote the expansion of family support groups and family educational and training sessions.
6. The New York State Office of Mental Health should establish a formal grievance procedure whereby problems of access to or delivery of mental health services can be openly discussed and addressed at the local level and, as needed, appealed to the Regional Office and/or Central Office of the Office of Mental Health. This grievance procedure should be appropriately promulgated among consumers, families, community residential providers, shelter providers, in-patient psychiatric providers, and the public, and it should be periodically evaluated by the Office of Mental Health to ensure its use and effectiveness in all counties of the State.

Appendix

**Response of the New York State
Office of Mental Health**



NEW YORK STATE
OFFICE OF MENTAL HEALTH

44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

May 19, 1989

Clarence Sundram, Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue - Suite 1002
Albany, NY 12210

Dear Mr. Sundram:

Your draft report of the findings and recommendations of the Commission's Review of Mental Health Outpatient Services has been reviewed with keen interest. The report is thorough in its analysis of the outpatient mental health system's response to the needs of our most seriously mentally ill citizens and its assessment of the use of public funds which support these programs.

I concur with your finding that the outpatient mental health system has not been sufficiently responsive to the needs of the seriously and persistently mentally ill. In particular, I am in agreement that present outpatient services do not adequately address the needs of "service resistant" clients, especially their need for rehabilitative and supportive services. We are deeply committed to addressing these issues system-wide. As detailed in the attached response to your recommendations, several major programs have been initiated to improve our response to the service needs of this population.

The Office of Mental Health agrees with your finding that accountability for service development, program performance, and cost effectiveness of outpatient programs has been lacking. Your emphasis on the need for improved information systems to support an informed planning process and a sound basis for fiscal decision making is strongly supported.

Additionally, we concur that there is a need to improve oversight of local program performance. Current Office of Mental Health initiatives discussed herein are designed to improve local government and provider accountability. Briefly, these include improvements in the planning process, increased consumer involvement, development of the performance contracting system and implementation of the consolidated fiscal reporting system.

Finally, although the Office of Mental Health has a number of existing practices aimed at informing patients of their rights and a means of expressing grievances as well as informal practices within our facilities, we feel that increased involvement of recipients, as you recommend, is a worthwhile endeavor.

Once again, I would like to thank you for a comprehensive report. I am confident that as we move forward with current efforts and incorporate your recommendations we will be able to make significant improvements in the outpatient mental health service system.

I trust that the enclosed response provides you with adequate information. If any additional information is needed, please contact Dr. Sandra Forquer, Deputy Commissioner for Quality Assurance.

Sincerely,


Richard C. Surles, Ph.D.
Commissioner

RECOMMENDATION #1

The New York State Office of Mental Health should provide more direction and oversight of the planning and development process for mental health outpatient services by:

- a. establishing a valid data base on the availability, capacity and utilization of mental health outpatient services for all counties of the State;
- b. establishing minimum requirements for the provision of basic needed outpatient services in each county, by type of service and capacity of service; and,
- c. establishing an objective needs assessment methodology to guide local government decision-making and the State's certificate of need process in the evaluation of proposals for new or expanding mental health outpatient programs.

OMH RESPONSE

The Office of Mental Health is in agreement with the intent of this recommendation. For the past several years, we have been significantly increasing our capacity to improve the relevance, objectivity and validity of our planning tools while fostering greater local participation in the planning process.

The OMH has recently undertaken five initiatives which will substantially improve the validity of data on the availability, capacity and utilization of mental health services (including outpatient services) for all counties of the State. These projects are as follows:

- A Dictionary of Mental Health Programs is being developed which serves to clarify and standardize the planning and reporting functions of OMH. When complete, the dictionary will standardize the data collection for all mental health service providers and will improve the consistency of reporting.
- There has been an expansion in the amount of information included in the Annual Survey of Mental Health Facilities which covers every public mental health service provider in the State. In addition, beginning in 1989, the annual survey forms will include copies of the previously submitted Facility Survey and the Patient Characteristics Survey. These reports contain facility level information which will provide a clear incentive for accurate reporting.
- A new Consolidated Fiscal Reporting system is being implemented for OMH funded and non-funded agencies. This major development will greatly enhance our ability to determine the type and volume of services provided in each county while providing a complete analysis of elements which comprise the costs of delivering each service.
- A Performance Contracting system is currently being developed which will integrate data from the Patient Characteristics Survey, the Con-

solidated Fiscal Report and other data sets. As with the other initiatives, the use of these data in CMH management of county mental health systems should greatly improve attention to the data and, ultimately, its quality.

- The comprehensive Chartbook of Mental Health Information contains county data from a wide variety of sources. This document was distributed to all counties as part of the 1990 Planning Guidelines. Although not a needs assessment, it provides counties with a basis of comparison to other counties in terms of existing service levels. This document will serve as the Regional Office tool in the review and approval of the Local Government Plan for services. Making this compendium of demographic, prevalence, utilization, and expenditure data available to every public mental health service provider and using it to review and approve local plans is expected to greatly improve the quality of the data reported in all of the information systems used as a source for the chartbook. It will also improve the quality of the local planning process which relies on accurate information.

The CMH has recently developed and administered family member and provider needs assessment questionnaires and is currently determining the appropriateness of using these data in the creation of minimum requirements for basic services. A survey to gather consumer perspectives for the needs assessment process is currently being designed and will be administered during 1990.

The CMH has for the past several years been developing prevalence estimation techniques which are improving the objectivity and comprehensiveness of the Certificate of Need and resource allocation processes. Additionally, computer models of alternative service options are already available to assist State and county planners in designing comprehensive mental health systems.

RECOMMENDATION #2

Until a reliable needs assessment methodology is available, the Office of Mental Health should declare a moratorium on certifying new or expanded clinically oriented outpatient programs, except for those specifically targeted to multi-problem clients, including clients with concomitant drug and alcohol problems.

OMH RESPONSE

The OMH believes that a moratorium is a worthwhile concept, particularly to signal that changes are underway in the mental health system and to provide time for necessary staff work regarding outpatient needs assessment. Accordingly, concentrated staff work is underway analyzing several options to implement a freeze on new programs and reviewing those options from programmatic, legal and fiscal perspectives. Such a moratorium could apply to all project applications yet to be received as well as to projects already under review in The Certificate of Need (CON)

"pipeline". Efforts to date have focused upon identifying potential criteria for exemption from a moratorium and the relative impact of each of these criteria. For example, we are reviewing the effects of exempting programs which target children or homeless individuals, programs for the seriously and persistently mentally ill (already approved in the State budget) as well as programs which involve changes of sponsorship, renovation without service expansion, or change in location.

Since we have about 130 projects in the pipeline and would expect to receive approximately 100 new outpatient applications during the coming year, these decisions are a high priority for OMH. The Commission will be notified shortly of final strategies.

RECOMMENDATION #3

While recognizing the validity and appropriateness of a provider and local government role in developing service priorities for outpatient mental health services which are partially funded by non-State funds, the New York State Office of Mental Health should take more aggressive steps to ensure that State tax dollar investments in publicly funded mental health outpatient services promote the accessibility and availability of the full range of needed clinical and non-clinical rehabilitative and support services for persons who are seriously and persistently mentally ill. These steps should include, but not necessarily be limited to:

- a. establishing effective mechanisms, at the local government level, to coordinate needed service access and service delivery to individuals who are seriously and persistently mentally ill, and particularly to the subgroup of these clients who are service-resistant and who have multiple problems and service needs;
- b. identifying and fixing by contract the responsibility of particular programs to serve directly or through coordination with other programs, clients who are identified at risk of rehospitalization without adequate outpatient mental health services;
- c. examining the utility of a continued State role in the direct delivery of outpatient services, particularly services which duplicate those available from other providers in the area, and considering the redirection of resources to fill in gaps in rehabilitative, social and support services, or in services to multi-problem clients;
- d. evaluating current expenditures of State tax dollars to non-State programs receiving deficit funding to determine if these funds can be redirected to assure a better balance of clinical and non-clinical rehabilitative and support services, especially to persons who are seriously and persistently mentally ill and, within this group, to multi-problem or service-resistant clients;

- e. evaluating the current provision of publicly funded case management services and ensuring in the future that these services are targeted to seriously and persistently mentally ill individuals most in need of a case manager to assist them in solving problems of daily living and in gaining access to needed services;
- f. requiring all publicly funded mental health outpatient programs to develop on-going procedures and practices which encourage individuals who are seriously and persistently mentally ill and their families to be actively involved in decision-making related to admission criteria, program participation requirements, service offerings, and operating practices (e.g., hours of operation, outreach practices, availability of on-call crisis services, etc.); and,
- g. developing an objective monitoring procedure for measuring the progress of counties and individual mental health outpatient providers in improving the access and availability of core mental health outpatient services for individuals who are seriously and persistently mentally ill, and within this group to service-resistant and multi-problem clients.

OMH RESPONSE

Efforts are underway in three areas which will increase the accessibility and availability of outpatient services to the seriously and persistently mentally ill (SPMI) population. They are: planning processes, program initiatives, and performance contracting. Each of these efforts impacts several specific recommendations as follows:

PLANNING PROCESS

Improvements in the planning process will facilitate the development of effective coordination mechanisms at the local government level for the SPMI population, reduce service duplication, encourage participation by SPMI consumers, and enhance program monitoring.

OMH is presently integrating and simplifying the local planning process. In this revised process, all State and local service providers within each county will together plan a single comprehensive system of mental health services. Provisions in the planning process allow for small counties to join with neighboring counties to produce a joint comprehensive services system, as well as allow very large counties to subdivide into a series of separate but related service systems. To assist in these processes, OMH will provide planning data such as the Patient Characteristics Survey to local decision makers. Such data can improve performance monitoring and decision making.

Furthermore, consumers are being included in all State and local planning processes. Each Planning Advisory Committee Task Force, established as part of the Mental Health Planning Advisory Committee, as well as the Mental Health Services Council, has consumer and family participation.

Regional Planning Advisory Committees have also been formed. This participation provides a method for client input to better coordinate services and identify unmet needs.

OMH is planning to conduct within the 1990 calendar year a Consumer Preference Survey which will systematically survey the non-clinical outpatient needs as well as the clinical mental health needs of the SPMI population. Not only service needs but also barriers to program participation will be identified. These data will identify service gaps from a representative sample of SPMI clients, and will formally incorporate the SPMI client perspective into the planning processes.

PROGRAM INITIATIVES

The Intensive Case Management Program provides services for clients most at risk for re-hospitalization and specifically targets SPMI and service resistant clients. Professional case managers provide advocacy and service coordination for clients identified as heavy users of inpatient services, long stay psychiatric center patients and homeless individuals, particularly those who are resistant to services and have multiple problems. Case managers typically serve 10 clients and are available 24 hours a day. This Intensive Case Management model focuses service accountability on the highest levels within State and County Mental Health Systems and includes evaluation activities which provide a system to monitor performance. In addition, a comprehensive Statewide evaluation is being conducted to assess overall program effectiveness and identify program components which are strongly related to positive SPMI client outcome.

PERFORMANCE CONTRACTING

The performance contracting system will facilitate the development of effective mechanisms for monitoring outpatient programs at the local government level as well as establish responsibility for service. In this system, each county will be required to specify program capacities and utilization of services by SPMI clients for each type of outpatient service. (The service needs will be developed through the planning process discussed earlier.) Future funding will be tied to contract performance. This model will establish the county as primarily responsible for all mental health services in its jurisdiction and will focus responsibility and accountability for the SPMI population at the county level.

Thus, performance contracting provides a tool which can be used to reduce duplication of outpatient services, examine deficit funding arrangements and, if appropriate, remove the State from directly funding programs. Performance contracting will also enable the provision of increasingly more comprehensive monitoring and evaluation activities.

In addition to monitoring the volume of services via the performance contracting system, OMH is developing and will implement a series of reliable performance indicators against which to measure the quality of outpatient service.

Finally, performance contracting, along with the use of the standardized dictionary of program services, will clarify program definitions and guidelines which will facilitate comparisons between programs. Furthermore, performance contracting will ease the need for highly structured programmatic regulations, thereby making programs more flexible and adaptable to the changing and unique need of the seriously and persistently mentally ill clients.

RECOMMENDATION #4

The New York State Office of Mental Health should set fixed time frames for the achievement of ongoing initiatives to assure more effective programmatic and fiscal accountability for publicly funded mental health outpatient services. These initiatives include:

- a. developing admission and operating guidelines, as well as measurable performance standards for publicly funded mental health outpatient services, which encourage service access and promote quality service delivery to the multi-problem, seriously and persistently mentally ill individual;
- b. enhancing the quality and reliability of Regional Office monitoring and certification reviews of publicly funded mental health outpatient programs;
- c. establishing a certification standard whereby outpatient programs will be required to solicit and respond to consumer and family evaluation input on a regular and at least annual basis;
- d. full implementation of the consolidated fiscal report system;
- e. assuring criterion-based reviews of submitted consolidated fiscal reports from publicly funded mental health outpatient providers; and
- f. setting discrete Medicaid rates based on analyzed agency costs and efficient service delivery.

OMH RESPONSE

As the Commission noted in the body of the report, over 80% of the Office of Mental Health's certified programs now have current operating certificates. The target date for total compliance is July 1, 1989. The agency remains on target in a process which was initiated over 18 months ago to raise the percentage of current licenses from 48% to 100%.

Additionally, as part of a restructuring of the Quality Assurance Division, improvements are underway concerning the content of the protocols utilized for on-site reviews of outpatient programs.

The establishment of a program level mechanism for family and consumer evaluative input regarding ongoing operations will be included as part of revisions to the outpatient regulations.

OMH agrees that there should be fixed time frames for the achievement of ongoing initiatives to assure more effective fiscal accountability. The Consolidated Fiscal Report is being implemented with the cost report period beginning this July 1st in New York City and January 1, 1990 in the rest of the State. As a result, OMH expects to have a reliable data base for New York City providers by the end of 1990 and for other than New York City providers by mid-1991. At that time, we expect to perform various analyses to determine the best Medicaid rate-setting methodology and the best local assistance funding methodology. Without having such a data base in place, it is too early for us to be specific as to the best methodologies. We do agree that important elements of funding methodologies should include criterion-based review of submitted fiscal reports and efficient delivery of services.

RECOMMENDATION #5

The New York State Office of Mental Health should continue its efforts in recognizing and assisting families who often provide critical support services for persons who are seriously and persistently mentally ill by providing funding allocations to promote the expansion of family support groups and family education and training sessions.

OMH RESPONSE

There are currently two major initiatives in Family Support Services which will continue OMH's efforts in recognizing and assisting families who often provide critical support services for persons who are seriously and persistently mentally ill.

The Bureau of Education and Training in the Clinical Support Division has been working on the establishment of Family Support Services as a core curriculum in OMH's training package. A principal aspect of this core curriculum will be the implementation of the Family Psychoeducation Project developed by Dr. William McFarlane from New York Psychiatric Institute. Dr. McFarlane has demonstrated that by engaging the families of outpatients in this program, patient functioning and family satisfaction have significantly increased while relapse and rehospitalizations have decreased. The plan for 1989-90 is to expand the psychoeducation treatment model to ten other locations throughout the OMH system.

In addition, the agency is presently working on the development of a Family Support Services video. The purpose of this video is to highlight

the importance of the family in the treatment of the person with mental illness.

RECOMMENDATION #6

The New York State Office of Mental Health should establish a formal grievance procedure whereby problems of service access or service delivery for mental health services can be openly discussed and addressed at the local level, and, as needed, appealed to the Regional Office and/or Central Office of the Office of Mental Health. This grievance procedure should be appropriately promulgated among consumers, families, community residential providers, shelter providers, inpatient psychiatric providers, and the public, and it should be periodically evaluated by the Office of Mental Health to ensure its use and effectiveness in all counties of the State.

OMH RESPONSE

Both recipients and families have legitimate issues regarding access to services and the appropriateness of available services. The recommendation suggests as a remedy the establishment of a "formal grievance procedure" with a right to appeal to regional and central offices.

Issues of access, capacity, and the appropriateness of available services permeate the mental health system generally. Decisions regarding these issues traditionally have been made without considering the opinion of the recipients and families most affected. OMH has taken a number of steps to assure that families and recipients will be heard. For example, the local planning guidelines require family and recipient participation. OMH has entered contracts with the New York State Alliance for the Mentally Ill and the New York State Mental Health Association. These contracts are designed to allow families and recipients to organize. For the first time, AMI has hired a full time executive director. The Mental Health Association also has hired a full time person who has conducted many "town meetings" and self-help groups around the State. For the first time, a group of recipients and a group of family members addressed the OMH Director's Conference on their experiences.

While these efforts should assure general access to decision-making, they do not address individual grievances or complaints. People with grievances must have an opportunity to be heard. The question is the manner in which the opportunity should be afforded. OMH currently employs several means to inform recipients of their rights and voice their concerns. Upon admission, each client receives a booklet entitled, Rights of Inpatients. Also, "Patients' Rights" posters are displayed throughout each facility. Included in this material is information concerning how recipients can contact and address complaints to the facility Board of Visitors, Commission on Quality of Care for the Mentally Disabled, and/or the Mental Hygiene Legal Service. Rights of Inpatients also informs clients of their personal rights and their rights to quality care. Formal procedures also exist for clients to

object to their treatment.' The Rivers vs. Katz court decision has further served to expand these rights.

New York State already has a high degree of institutionalized advocacy (CQC, Mental Hygiene Legal Services, Protection and Advocacy Groups, Boards of Visitors, etc.). It is an open question as to whether advocacy which often may be adversarial in nature increases the respect and understanding for families and recipients that OMH is interested in achieving. It could be argued that creating a formal grievance procedure could serve to further polarize the parties to such a procedure.

There are a variety of ways in which the issue could be addressed. Some, such as patient advisory councils, are already in use at some facilities; others could be created. There may be a place for a formal process among these. It should not, however, be the only model. We will continue to explore this issue with families and recipients.