

MENTAL HEALTH IN CONNECTICUT: SERVICES IN TRANSITION

LEGISLATIVE PROGRAM REVIEW AND
INVESTIGATIONS COMMITTEE

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TABLE OF CONTENTS

	SUMMARY.....	iv
I.	INTRODUCTION.....	1
	Purpose.....	3
	Scope.....	3
	Evaluation Objectives.....	4
	Chapter Summaries.....	4
	Sources.....	5
	Acknowledgments.....	5
II.	OVERVIEW.....	6
	Introduction.....	6
	Relationship Between DMH's Policy and Mandates.	7
	Regionalization.....	7
	Program coordination and statewide planning..	7
	Patient rights.....	9
	Alcohol and drug programs.....	9
	Organizational Structures and Roles.....	9
	Important organizational roles.....	12
	Fragmented Legislative Oversight.....	15
	Fiscal Analysis.....	16
	Modest progress toward goals.....	18
	Consensus for Change.....	23
III.	DEINSTITUTIONALIZATION.....	25
	Deinstitutionalization Defined.....	25
	DMH's 1975-1980 deinstitutionalization goal..	25
	Deinstitutionalization Progress, 1975-1978.....	26
	Preventing inappropriate admissions and	
	reducing readmissions.....	26
	Preventing unnecessary institutional	
	retention.....	28
	Improving patient conditions, care and	
	treatment.....	28
	Insufficient Staff.....	30
	Comparison of staffing levels.....	31
	Recrutiment and turnover problems.....	36
	Important public policy questions.....	38
	Reliance on Drug Therapy.....	38
	Upholding Patients' Rights.....	40
	Procedural safeguards.....	40

	Procedural weaknesses.....	43
	Right to treatment.....	44
	Judicial oversight of deinstitutionalization and the continuum of care.....	46
IV.	THE CONTINUUM OF CARE.....	47
	Introduction.....	47
	Limited Federal Role.....	47
	Network of DMH Supported Services.....	48
	Types of providers.....	48
	Types of services.....	48
	Distribution of DMH Funded Community Mental Health Services.....	49
	Findings.....	59
	Recommendations.....	59
	Obstacles to a Continuum of Care.....	60
	Lack of service coordination.....	61
	Insufficient aftercare.....	62
	Nursing home reinstitutionalization.....	64
V.	REGIONALIZATION.....	67
	Creating a Regional Mental Health Constituency.....	67
	Regionalization Progress.....	67
	Formula Funding.....	68
	Regional Budgeting.....	70
	Confusion in implementation.....	70
	The Commissioner's intended implementation procedure.....	72
	Regional budgets and formula budgets.....	73
	Findings.....	74
	Recommendations.....	74
	Departmental and Citizen Participation Structures.....	75
	Catchment Area Council procedural problems...	76
	Regional Mental Health Board procedural problems.....	77
	Role of Regional Directors.....	78
VI.	STRENGTHENING SERVICE REDIRECTION.....	81
	Overview.....	81
	The Facilities Plan 1980-1985.....	83
	Necessary Data.....	84
	Limitations of the Facilities Plan.....	86
	Three critical assumptions.....	86
	Undefined appropriate quality of care.....	86

Special Problems Facing State Facilities.....	87
Staffing needs.....	88
Building conversions.....	88
DMH Future Provider Role.....	89
Preadmission Screening.....	90
Conclusion--And Future Considerations.....	91
APPENDICES.....	94
I-1. Glossary.....	95
I-2. Agency Response.....	103
IV-1. Description of State-Owned Facilities.....	116

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Mental Health in Connecticut: Services in Transition

SUMMARY

Care of the mentally ill has been a public responsibility in Connecticut for more than a century. Initially contracted by municipalities to the Hartford Retreat (now The Institute for Living), mental health programs gradually evolved into state-operated inpatient services primarily at the three large state hospitals. These hospitals, now operated under the direction of the Department of Mental Health, continue as the primary mental health providers in Connecticut.

During the past two decades, the Department of Mental Health (DMH) has responded to federal policy, new medication therapy and widespread professional advocacy to treat the mentally ill in less restrictive settings. This includes "deinstitutionalization" of hospitalized patients and delivery of a variety of services and settings to those in need of mental health services.

To implement new policy directives and move towards a "continuum of care", DMH slowly began to develop community-based services during the 1960's. This effort gradually accelerated following enactment of the Mental Health Services Act (P.A. 74-224 as amended by P.A. 75-563) which required establishment of a regionalized system of services. Service expansion was made possible by increased state appropriations and federal "seed money" grants.

At the same time DMH was developing this continuum of care, changes were introduced at the state hospitals. Inpatient programs were adopted to reflect statutory "due process" guarantees and minimum standards of care. These changes were underscored by requirements of third party fiscal intermediaries and recent judicial decisions.

This study examines the separate components which comprise DMH subsidized mental health services including:

- three large state hospitals operated by DMH;
- five community-based facilities operated by DMH¹;

¹ Other specialized services are beyond the scope of this report.

- eighty-three non-profit agencies which receive operating grants from DMH; and
- one DMH community facility which contracts for service with the University of Connecticut.

Also examined is the organizational structure designed to assure integration of the components into a single system of regionalized services.

The central focus of the study is the Department's progress in achieving its articulated goals and policies including deinstitutionalization, developing a continuum of care and providing the most appropriate level of services in the least restrictive setting. The LPR&IC finds that the Department has made modest progress in the following areas:

- unnecessary retention in state hospitals has been reduced;
- the physical environment for patients in state hospitals has been improved;
- funding for community services has increased;
- distribution of funds on a regional basis has been partially initiated on a trial basis; and
- the regional organizational structure has been established.

The major finding of the report, however, is that the Department has had only limited success in translating its goals and policies into programs which adequately respond to Connecticut's mental health needs. The major problem areas which have inhibited this progress are identified:

- state hospital inpatient programs continue to dominate funding priorities despite Departmental policy to expand the variety of community programs and the service settings;
- insufficient community-based services intensify the difficulty in reducing state hospital utilization; and
- perpetuation of two separate service delivery systems - the state hospitals and community focused programs - hampers integration into the mandated "system of regionalized services" and frustrates citizen participation.

The thirty-six recommendations in this study are focused on improving implementation of the Department's statutory mandates, policies and goals within imposed fiscal constraints. Thirty-three of the recommendations are administrative. They address the need to clarify, expand and modify existing Departmental procedures and programs to minimize impediments to timely implementation. Three recommendations, also procedural, require legislative action.

Ultimate measurement of the success of these recommendations will be the Department's establishment of a comprehensive system of mental health services in each region. Each recommendation is listed below.

RECOMMENDATIONS

CHAPTER II: Overview

1. JOINT RULES CHANGE.

To improve planning and implementation of legislative oversight, responsibility for DMH and state mental institutions should be placed with the Public Health Committee.

CHAPTER III: Deinstitutionalization

2. STAFFING LEVEL PROJECTIONS.

To inform the General Assembly, DMH should prepare realistic projection of staffing levels needed at state hospitals.

3. TREATMENT PROGRAM GUIDELINES.

To prepare discharged patients for community readjustment more adequately, guidelines for implementing and evaluating statutorily mandated treatment programs at state hospitals should be established.

4. PROBATE COURT PROCEDURE.

To strengthen the patient's procedural safeguards, payment should be allowed for an independent physician selected by the patient or attorney. The Probate Court should be limited to assistance from one independent physician.

5. RECOMMITMENT HEARING.

To eliminate unjustified restraints on a patient's right to due process, a yearly state-initiated recommitment hearing should be required.

CHAPTER IV: The Continuum of Care

6. INVENTORY AND PRIORITIZATION OF SERVICES.

To develop relative needs between and within regions, each Catchment Area Council should develop an inventory of all public and private mental health services and submit it to the Regional Mental Health Board and the Department.

7. RANKING OF CATCHMENT AREAS BY NEED.

To assist the neediest catchment areas, DMH should first, rank each catchment area and second, provide technical assistance to develop federal funding applications.

8. ALTERNATIVES TO GRANT MECHANISM.

To more effectively target community service subsidies to need, DMH should develop alternatives to the present grant mechanism including units-for-service contracts and co-insurance.

9. DISTRIBUTION OF GRANTS.

To reduce service disparities between and among regions, the Commission should distribute FY 1980 community grants more equitably. (See also recommendation 21.)

10. INFORMATION AND DIRECTION CENTERS IN RMHB OFFICES.

To facilitate coordination of all services needed by mentally disturbed patients, DMH should establish regional information and direction centers located in the offices of the Regional Mental Health Boards.

11. PROCEDURAL GUIDELINES FOR DISCHARGE PLANNING AND FOLLOW-UP CARE.

To provide more adequate aftercare for deinstitutionalized patients, the Commissioner should establish guidelines for discharge planning and follow-up activities.

12. DMH DEVELOP MINIMAL CARE SETTINGS.

To provide more adequate aftercare for deinstitutionalized patients, the Department should develop minimal care community residential facilities.

13. DMH PURSUE FEDERAL FUNDING FOR HOUSING.

To enable more adequate aftercare for deinstitutionalized patients, the Department should pursue federal funding for housing for the chronically mentally ill.

14. MAXIMIZE THIRD-PARTY AND OTHER PAYMENTS.

To assure more adequate aftercare for deinstitutionalized patients, DMH, together with the Departments of Income Maintenance and Health Services, should develop ways to maximize third-party and other support payments and services.

15. DISCHARGE PLANNING AND FOLLOW-UP AS REIMBURSABLE SERVICES.

To assure more adequate aftercare for deinstitutionalized patients, DMH and community nursing agencies should formally describe their discharge planning and follow-up activities as medically necessary and, therefore, reimbursable.

16. CHANGES IN PUBLIC HEALTH CODE.

To provide for the service needs of psychiatric patients in nursing homes, the Public Health Code should be revised to specify minimum levels of mental health services.

17. MONITOR MENTAL HEALTH PATIENTS IN NURSING HOMES.

To provide for the service needs of psychiatric patients in nursing homes, psychiatric visits should be monitored.

18. INCREASE REIMBURSEMENT FOR FOLLOW-UP VISITS.

To provide for the service needs of psychiatric patients in nursing homes, the Department of Income Maintenance should increase the reimbursement for follow-up visits by a psychiatrist.

19. REIMBURSE MENTAL HEALTH NURSING HOME VISITS.

To provide for the service needs of psychiatric patients in nursing homes, the Department of Income Maintenance should classify other mental health professional nursing home visits as Medicaid reimbursable services.

CHAPTER V: Regionalization

20. CLARIFICATION MEMORANDUM FROM COMMISSIONER.

To clarify ambiguities and rectify misconceptions, the Commissioner should send a memorandum to all statutorily mandated participants describing regional budgeting, formula funding and citizen participation. (See also recommendation 23.)

21. ESTABLISH FORMULA EMPHASIZING NEED.

To achieve parity, the Commissioner should establish the statutorily mandated regional per capita formula reflective of service need as represented by per capita income and availability of state-owned community facilities.

22. RESTRICTED FORMULA APPLICATION UNTIL FY 1984.

To smooth the transition to regional budgeting, application of formula funding should be restricted to new community grant account funds until FY 1984 budgeting.

23. ADDITIONAL PROVISION FOR COMMISSIONER'S CLARIFICATION MEMORANDUM.

To clarify future procedures and expectations, the Commissioner should specify an implementation timetable for regional budgeting and formula funding, specifying projected impacts and the future role for citizen participants. (See also recommendations 20 and 24.)

24. STAGED IMPLEMENTATION OF REGIONAL BUDGETING.

To assure the success of regional budgeting and meaningful citizen participation, the Department should develop both actual regional budgets and formula budgets until FY 1984, at which time full regional budgeting by formula should be introduced.

25. NOTIFICATION OF CATCHMENT AREA COUNCIL (CAC) VACANCY.

To reduce vacancies on CACs, DMH regulations should specify follow-up provisions where delays exist.

26. ADOPTION OF REGULATIONS CONCERNING EVALUATION.

To comply with statutory provisions, DMH should establish regulations regarding evaluation procedures.

27. CHANGE IN REGULATIONS REGARDING LOCAL SUPPORT FOR RMHBs.

To encourage and recognize local support of the Regional Mental Health Boards, the regulations regarding annual reporting should be amended immediately and possibly changed substantively in FY 1983.

28. REGIONAL PLANNING AS INPUT INTO A COMPREHENSIVE STATE PLAN.

To encourage comprehensive planning, the RMHBs should draft regional plans as advisory documents for the State Plan. Clarification of regional planning responsibilities should be specified.

29. REVIEW OF REGIONAL STRUCTURE.

Recognizing the Legislative Task Force directive to review the regional structure, the Task Force should address key issues including citizen participation, Departmental accountability and service refocusing.

30. SUBMISSION OF DATA TO GENERAL ASSEMBLY.

To elucidate policy choices, specific program cost data should be submitted to the General Assembly by DMH.

31. CLARIFICATION OF FACILITIES PLAN ASSUMPTIONS.

To increase the feasibility of implementing the Facilities Plan, the Commissioner in conjunction with the RMHBs and the Advisory Council, should explain what the Department will do if any or all of the three assumptions do not hold.

32. CLARIFICATION OF "APPROPRIATE QUALITY OF CARE."

To achieve the desired level of care, the Commissioner should identify needed staffing requirements.

33. REDEPLOYMENT OF STATE HOSPITAL STAFF.

To anticipate reduced staffing at state hospitals, DMH should redeploy and retrain staff wherever needed.

34. CONVERSION OF STATE HOSPITAL BUILDINGS.

Recognizing the difficulty in obtaining local permits, DMH should make smaller buildings at state hospitals available to non-profit agencies for transitional living facilities.

35. CLARIFICATION OF DMH'S PROVIDER ROLE.

To demonstrate movement towards its stated increased indirect service provider role, DMH should specify five-year projections for direct and indirect service delivery.

36. PLANNING PREADMISSION SCREENING.

To assure realization of the proposed prescreening program by 1985, DMH should specify the cost and implementation steps proposed.

Chapter I

INTRODUCTION

Purpose
Scope
Evaluation Objectives
Chapter Summaries
Sources
Acknowledgments

CHAPTER I
INTRODUCTION

The program review of the Connecticut Department of Mental Health (DMH) was initiated by the Legislative Program Review and Investigations Committee in March 1978 to evaluate the state's public mental health service delivery system. At the time, the Committee was especially interested in examining the administration of state owned and supported adult mental health services in both institutional and community settings. The Committee's interest in these programs was originally generated by its proposed study of the Department of Children and Youth Services (DCYS). That study was to address, among other topics, the problems involved in implementing the mandated transfer of children's and adolescents' mental health services from DMH to DCYS.

As the DMH program review progressed, it became apparent that while the two departments shared common features, for example, responsibility for the development and delivery of mental health services and the implementation of recent statutory changes in administrative jurisdiction, they were dissimilar in at least two important respects. First, recent changes in DCYS' mandate increased that department's administrative jurisdiction, while changes in DMH's mandate either eliminated or significantly reduced its jurisdiction in certain program areas. The two departments, therefore, were experiencing different kinds of strains; one having to do with direct service expansion, the other with direct and indirect service reduction.¹

Second, and most important, DMH was undergoing a major reorientation in service delivery involving deinstitutionalizing mental health services and creating a statewide continuum of care. This reorientation was taking place as a result both of federal and mental health professional pressures to treat the mentally ill in the least restrictive settings. Ideally, deinstitutionalization and the continuum of care should be inextricably connected. That is, efforts to reduce state hospital

¹ P.A. 75-524 transferred state-operated children's psychiatric services and supervision of grants for private children's mental health services to DCYS. P.A. 78-127 made the Connecticut Alcohol and Drug Abuse Council (CADAC) the "single state agency" for all state and federal grants for alcohol and drug abuse treatment services. CADAC is in DMH for administrative purposes only.

populations should be equally matched by efforts to provide appropriate care and treatment in community-based settings.

While the Connecticut deinstitutionalization experience does not achieve the desirable balance between these two program goals, the state so far has avoided some of the more serious deinstitutionalization problems of other states. Connecticut, for example, has not experienced either a class action "right to treatment" suit brought on behalf of involuntarily confined state mental hospital patients,¹ or charges of "dumping" massive numbers of poor, chronically mentally ill patients into the community.²

Although Connecticut's deinstitutionalization problems are not of this magnitude, they do warrant serious consideration. Staffing levels in the state mental hospitals, for example, might very well spark a future class action suit. In addition, the experience of communities such as Norwich, which are faced with inadequate community resources to provide for the needs of deinstitutionalized patients, already has led to charges of "patient dumping" and has mobilized community sentiment against both the state mental hospitals and DMH.

Furthermore, in December 1978, an unprecedented federal court consent decree set the terms under which both deinstitutionalization and the continuum of care are to be implemented in western Massachusetts. The decree resulted from a class action lawsuit on behalf of institutionalized patients who were discharged into communities lacking adequate mental health aftercare services. Under the terms of the consent decree, patients are to be discharged from western Massachusetts' only state mental hospital by 1981 and offered treatment in community-based facilities. In addition, the state must significantly reduce the hospital's budget and correspondingly increase community service funding.

¹ Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), detailed minimum medical and constitutional requirements to be met in state mental institutions.

² In New York State, an estimated 40,000 former state mental hospital patients live in decrepit conditions in New York City alone. See Peter Loenig, "The Problem That Can't Be Tranquilized," The New York Times Magazine, May 21, 1978.

Purpose

Connecticut, in other words, may be faced with the possibility of court-issued change in its mental health services or, more immediately, with community backlash to DMH's deinstitutionalization policy. Therefore, the state should now increase its efforts to implement more effectively and humanely deinstitutionalization and the continuum of care.

The purpose of this program review is to help direct the Department of Mental Health achieve this goal. Recommendations have been made by the Committee, therefore, to identify areas in which legislative and administrative changes are needed.¹

Scope

The review of the Department of Mental Health is limited to state owned, operated or supported mental health programs including alcohol and drug abuse services. Private or public mental health programs that do not receive state money through DMH are not reviewed. Examples of excluded programs are private psychiatric hospitals and non-profit alcohol and drug treatment services funded by the Connecticut Alcohol and Drug Abuse Council (CADAC).

Included in the review are services delivered by the ten facilities owned and/or operated by DMH, and the eighty-three public and private non-profit agencies receiving DMH community grants account funds. (See Appendix IV-1 for descriptions of DMH facilities and Table IV-1 for a listing of FY 1979 DMH grantees.)

The review's primary focus is on DMH's current progress with its five year (1975-1980) deinstitutionalization policy. The major goals of this policy are reducing the use of the three large state mental hospitals and developing appropriate community service alternatives. A critical element in achieving these goals is the Department's implementation of its most important recent legislative mandate--regionalizing mental health services and providing for citizen participation in planning, budgeting and evaluating mental health services.

¹ The report is also a timely response to the Governor's recent support for expansion of DMH funded community programs.

Evaluation Objectives

The LPR&IC is mandated to examine state programs and their administration for effectiveness, efficiency, compliance with legislative mandates, or need for modification or elimination (C.G.S. 2-53d). Therefore, the following evaluation questions are central to the program review of the Department of Mental Health:

1. How effectively has DMH pursued its deinstitutionalization goals to reduce state hospital use and increase community services?
2. How efficiently have the Department of Mental Health's resources been allocated to accomplish deinstitutionalization?
3. Are the Commissioner, state hospital superintendents, regional directors, and citizen participants fulfilling mandated responsibilities?
4. How can existing programs be modified or eliminated to meet the criteria of effectiveness, efficiency or statutory compliance?

Chapter Summaries

Chapter II - Examines the relationship between DMH's policy goals and statutory mandates; describes the departmental and regional organizational structures and identifies important organizational actors and their mandated responsibilities; addresses problems with legislative oversight; analyzes the Department's fiscal progress toward deinstitutionalization and the continuum of care; and discusses the creation of consensus for change.

Chapter III - Analyzes DMH's current progress with the first three of four deinstitutionalization activities: preventing inappropriate state hospital admissions and reducing readmissions; preventing unnecessary institutional retention; and improving the conditions, care and treatment of state mental hospital patients. Additional topics include alcohol and drug treatment programs in the state mental hospitals and patient rights issues, such as "due process" guarantees for state hospital civil commitments.

Chapter IV - Examines the Department's progress to date with its fourth deinstitutionalization activity: developing community mental health services. The chapter also provides an overview of the public and private mental health services in Connecticut;

identifies ways of increasing these services, particularly through federal Community Mental Health Center (CMHC) funding; and analyzes the current distribution of state-owned and supported mental health services by region and catchment area.

Chapter V - Describes DMH's implementation of regionalization; identifies activities, such as formula funding and regional budgeting, which are critical to the success of regionalization; and presents a timetable for undertaking these activities. Proposed changes in the regional structure are also examined, as is the issue of the extent and degree of shared power between the Department and the citizen advisory groups.

Chapter VI - Reviews the need for clarification of specific planning objectives and generation of important data, especially relating to DMH's Facilities Plan, 1980-1985.

Appendices - Appendices follow containing more detailed information on a variety of mental health issues. Appendix I-1 is a glossary of terms and Appendix I-2 contains an "agency response" from the Commissioner of Mental Health. Appendix IV-1 is a description of state-owned mental health and alcohol facilities.

Sources

The primary sources for the program review of the Department of Mental Health were LPR&IC staff interviews with departmental personnel and citizen participants and site visits to selected DMH facilities and grantee agencies. Secondary sources included DMH prepared budget and program data and public and private mental health publications.

Acknowledgments

The Legislative Program Review and Investigations Committee and its staff wish to thank the many Department of Mental Health staff and citizen participants for their exceptional cooperation and candor. In addition, we wish to express our appreciation to Commissioner Eric A. Plaut, Hal Mark, Ph.D., Janet E. Meleney and Regional Directors of the Department of Mental Health and to each of the Regional Mental Health Board Chairmen. Finally, the Committee thanks Stephanie Cameron of the Office of Fiscal Analysis for her assistance.

Chapter II

OVERVIEW

Introduction

Relationship Between DMH's Policy and Mandates

 Regionalization

 Program coordination and statewide planning

 Patient rights

 Alcohol and drug programs

Organizational Structures and Roles

 Important organizational roles

Fragmented Legislative Oversight

Fiscal Analysis

 Modest progress toward goals

Consensus for Change

CHAPTER II

OVERVIEW

Introduction

The reorientation of Connecticut's public mental health service delivery system formally began in 1977 when the Department of Mental Health committed itself to, "Create an integrated mental health, drug and alcohol services system...with new services and existing services linked to form a comprehensive community-oriented network...designed to foster deinstitutionalization."¹ This explicit commitment to create a community rather than institutionally-based continuum of mental health care was made to intensify the Department's attempts to attract federal community mental health funds.²

While federal dollars play a role in Connecticut's deinstitutionalization policy, the state's reorientation of its service delivery system was also influenced by a national trend toward community mental health. This trend gained momentum in the nineteen-sixties and found expression in professional, especially non-medical, mental health attitudes and practice and in federal court decisions favoring treatment of the mentally ill in least restrictive settings.

In addition, by the mid-seventies, Connecticut's state mental hospitals already were experiencing considerable decreases in patient population and length of stay for more than a decade. These decreases largely were due to the increased use of psychotropic drugs in treating mental illness. Indeed, the introduction of these drugs in the nineteen-fifties played an important role in the national community mental health movement because they facilitated more and earlier discharges of institutionalized patients. In 1955, for example, Connecticut's three large state

¹ Connecticut Department of Mental Health State Plan, 1977; p. 3-2. It should be noted, however, that efforts to redirect services to the community have been made since the early nineteen-seventies.

² The federal Community Mental Health Centers Act (CHMCA) was passed in 1963. See Chapter IV for discussion of Connecticut's response to this federal initiative.

mental hospitals had a combined resident patient population of 8,668 and an average length of inpatient stay of nine years. Today, the resident population of these institutions is 2,213 and their average length of stay is five months, nine days.

In other words, the use of Connecticut's state mental hospitals, as measured by inpatient population and length of stay, had been decreasing steadily since the early nineteen-sixties. The significance of DMH's goal of "aiming toward a ten percent reduction in state hospital utilization each year over the next five years (1975-1980)," is that it programmatically ties deinstitutionalization to the continuum of care.¹ Systematic reductions in institutional services are to take place "providing there are sufficient resources in the community."² Furthermore, by committing itself to an integrated statewide system of care, the Department must assume a large part of the responsibility for developing that system.

Relationship Between DMH's Policy and Mandates

DMH's two most important policy goals--deinstitutionalization and the continuum of care--are not statutorily mandated. However, several of the Department's mandates directly or indirectly have influenced the implementation of these goals.

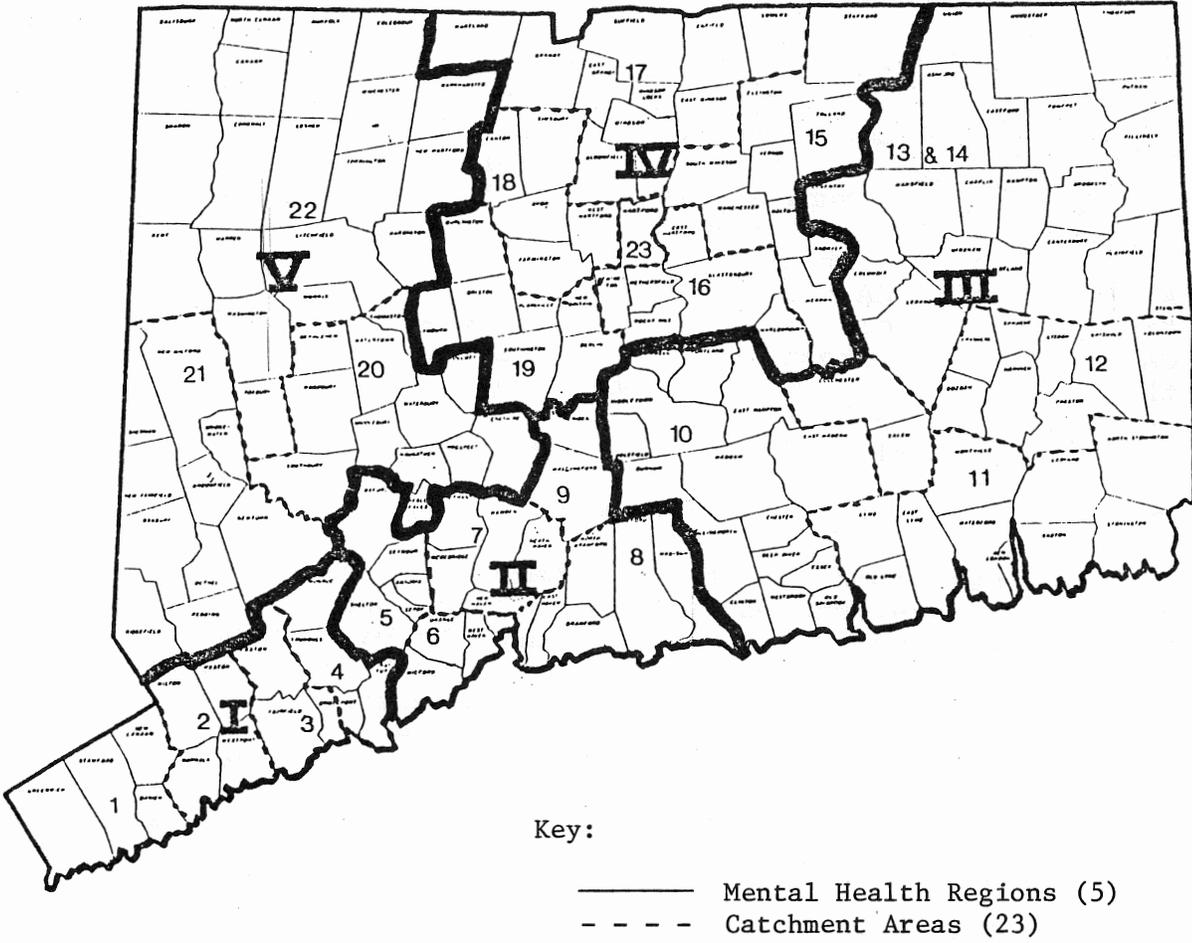
Regionalization (C.G.S. 17-226e-m). The most important of these mandates is the designation of five mental health service regions and the establishment of regional and local (or "catchment area") citizen advisory boards (see Figure II-1). The effect of this mandate on departmental policy has been to "regionalize" DMH's efforts to create a continuum of mental health care and to introduce citizen participation as a catalyst for increasing community mental health services.

Program coordination and statewide planning (C.G.S. 17-210a; 17-215b). At least three of the Department's existing statutory responsibilities can be interpreted as mandating the continuum of care. These are the Commissioner's dual responsibilities to coordinate community programs receiving state funds with programs of state-operated facilities and plan for the statewide development of mental health services. In addition, the state hospital superintendents are responsible for coordinating the policies of their facilities with community programs.

¹ DMH State Plan, 1977; p. 3-7.

² Ibid.

Figure II-1. Map of Connecticut by mental health regions and catchment areas.¹



¹ Catchment areas 11 and 12, 13 and 14 are grouped together for administrative purposes.

Source: Department of Mental Health.

Patient rights (C.G.S., Chapter 306, Part I). The various statutory "due process" guarantees which protect the civil rights of voluntary and involuntary (or civilly committed) mental patients have made "mental illness" a legal as well as a medical judgment. In so doing, these guarantees have influenced the Department's deinstitutionalization policy, for example, by helping to decrease the numbers and length of stay of involuntarily hospitalized patients.

Alcohol and drug programs (C.G.S. 17-155q). DMH's deinstitutionalization and continuum of care policies have been affected as well by the Department's mandated responsibility for alcohol and drug treatment programs. The large percentage of alcoholism admissions and readmissions to the three state mental hospitals, for example, are obstacles to reducing use of these facilities. In addition, the creation of the Connecticut Alcohol and Drug Abuse Council (CADAC) (C.G.S. 17-155gg) has split the jurisdiction over alcohol and drug services between DMH facilities and CADAC community grantees. This jurisdictional separation means that DMH, CADAC and the Regional Mental Health Boards (RMHBs) must actively coordinate their efforts if the continuum of care is to include alcohol and drug programs.

Organizational Structure and Roles

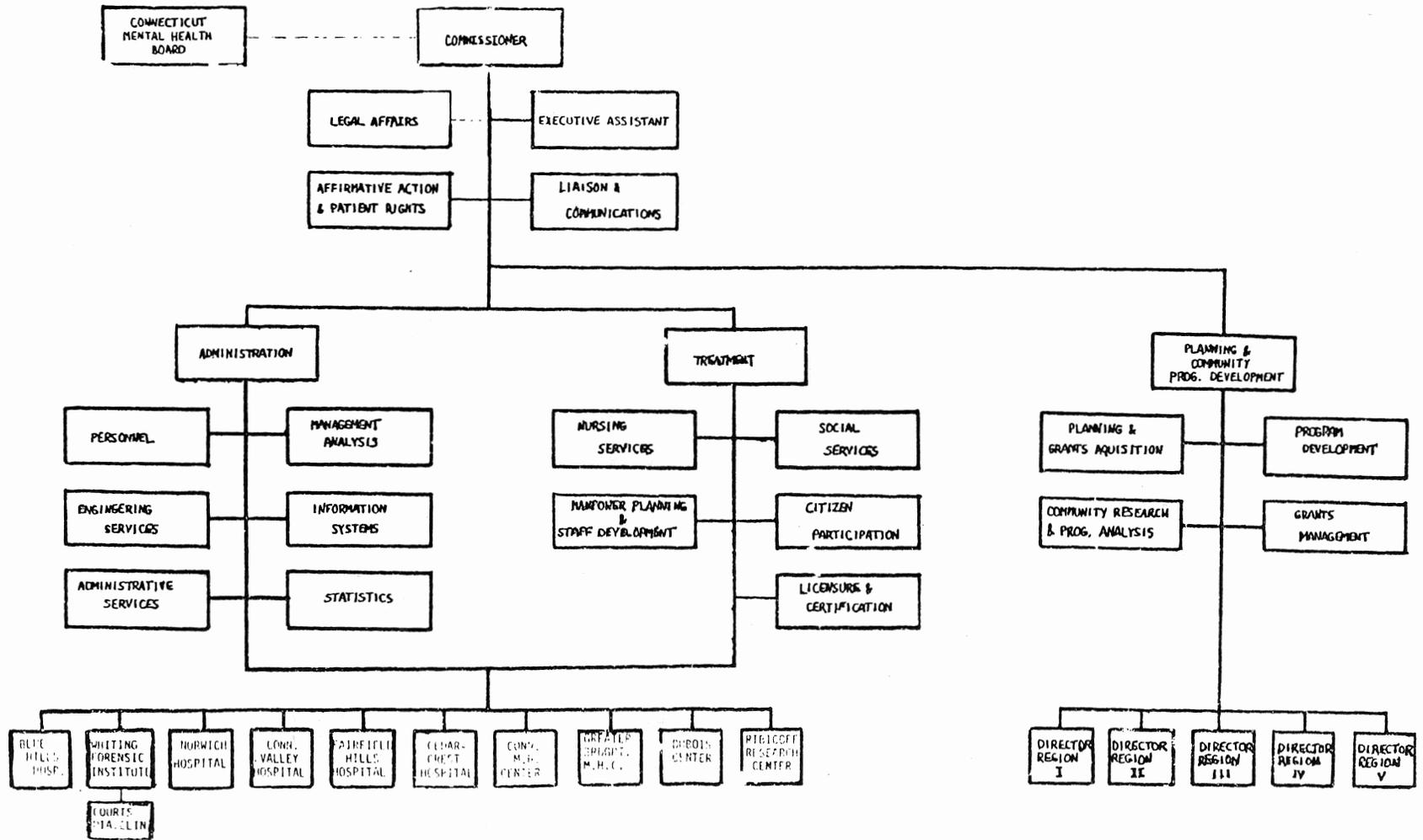
Organizationally, the Department of Mental Health encompasses two separate, unclearly related structures: the departmental/facility structure (Figure II-2) and the citizen advisory structure (Figure II-3). If the two structures were combined, the organizational chart would be unbalanced since the entire citizen advisory structure would appear under the five regional directors at the bottom right end of Figure II-2. The asymmetry of such a combined chart raises important questions regarding the hierarchy of authority, access to the Commissioner, and the relationship between "departmental" and "citizen" roles.

DMH's bifurcated organizational structure obviously is ill suited for planning and implementing comprehensive goals such as deinstitutionalization and the continuum of care. Both these goals necessitate an integrated network of services and the Department's current organizational structure reflects the status quo of two indistinctly related service systems.

This unclear relationship between DMH's facilities and its community services is found in the statutes. For example, Section 17-226e of the general statutes, which establishes the

Figure II-2. DMH/Facility Structure.

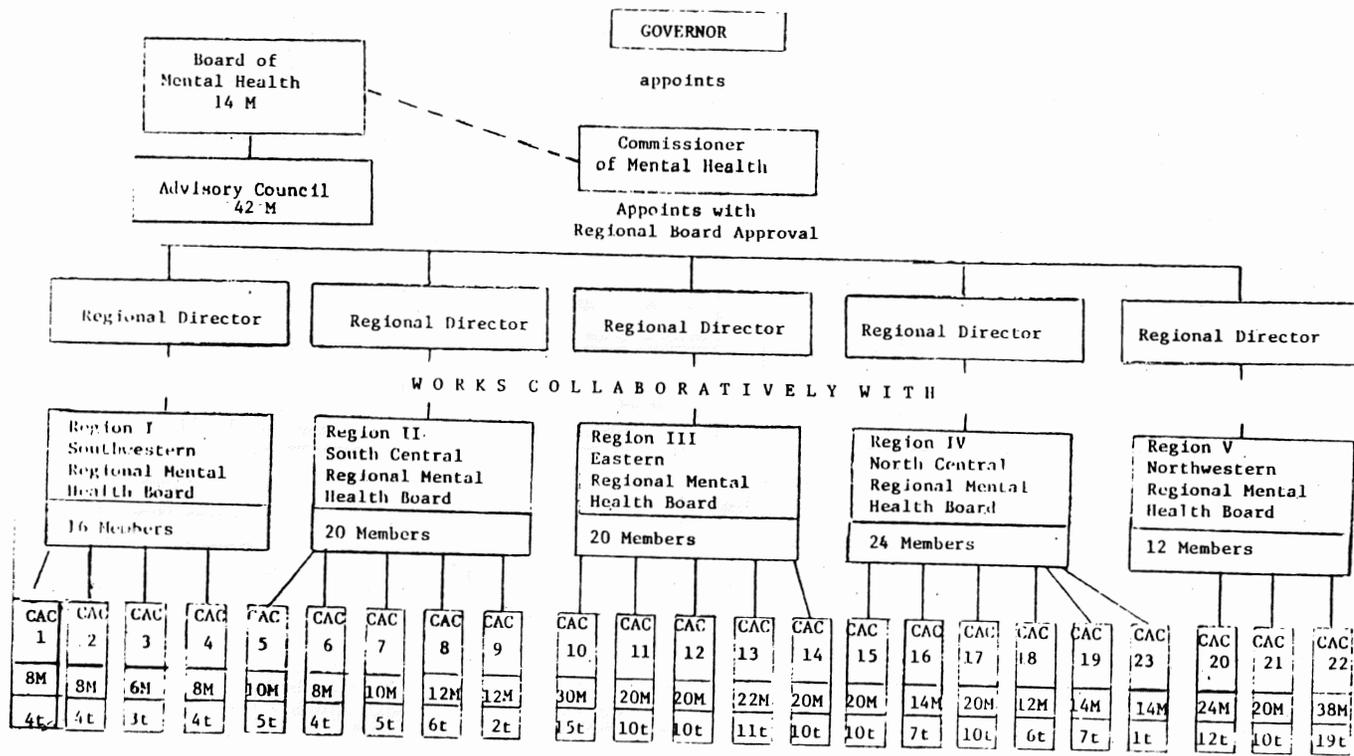
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Source: Department of Mental Health.

Figure II-3. DMH/Citizen Advisory Structure.

11



Key: CAC = Catchment Area Council
 M = Member
 t = town

Source: Department of Mental Health.

mental health service regions, at one point includes and at another excludes the Department's facilities among the regional services. In addition, certain statutorily defined roles have the potential of setting up competing and even adversary relationships between state hospital superintendents, for example, and regional directors; each group representing different interests and each having direct access to the Commissioner (C.G.S. 17-215b and 17-226g).

Important organizational roles. DMH's complicated organizational structure may be understood in terms of the following list of important organizational actors or roles, divided into "departmental" and "citizen" categories:

Departmental

Commissioner of Mental Health
State Hospital Superintendents
Regional Mental Health Directors

Citizen

Catchment Area Councils (CACs)
Regional Mental Health Boards (RMHBs)
Board of Mental Health (BMH)
Advisory Council, Board of Mental Health
Advisory Boards, State Hospitals and Facilities¹

The Commissioner of Mental Health is appointed by the Governor with the advice of the Board of Mental Health. As part of his executive duties, the Commissioner is responsible to: prepare and issue regulations for state-operated facilities and community programs providing care for mentally disordered adults; coordinate community programs receiving state funds with programs of state-operated facilities; collaborate and cooperate with other state agencies providing mental health services; establish and enforce standards and policies in public and private mental health facilities; establish and direct research, training and evaluation programs; develop a statewide mental health service plan; prepare a consolidated agency budget request, and; prepare an annual report for the Governor (C.G.S. 17-210a).

The eight State Hospital Superintendents and Facility Directors are appointed and removed by the Commissioner and are responsible for daily hospital operations subject to the standards

¹ The State Hospital and Facility Advisory Boards should appear at the bottom left half of Figure II-2.

established by the Commissioner. The superintendents are also required to cooperate and coordinate with community programs in establishing hospital policies and procedures concerning program planning and development, patient admissions, rehabilitation and follow-up services, and; meet periodically with the hospital advisory board, representatives from community programs receiving state funds, and at least annually with the Commissioner (C.G.S. 17-215b).

The five Regional Mental Health Directors are appointed by the Commissioner with the consent of the Regional Mental Health Boards and "serve at the Commissioner's pleasure...and under his direction." The Regional Directors are required to supervise, plan and coordinate mental health services within their respective regions; make recommendations to the Commissioner concerning all requests for community program grants and all contract proposals; evaluate and monitor mental health service delivery within the regions; report annually to the Commissioner and the Regional Mental Health Boards on the status of regional program and needs, and; report to the Commissioner information that may be requested. All of the Directors' responsibilities are to be executed in conformity with departmental programs, budget, plans, policies, regulations and standards (C.G.S. 17-226g).

The twenty-three Catchment Area Councils are the grass-roots organizational level of the citizen advisory structure. Their memberships are comprised of mental health service "consumers" appointed by local governing officials, and "providers" and "consumers" elected by the appointed representatives. "Consumers" are to be no less than fifty-one percent and no more than sixty percent of each CAC's membership. Each council is to evaluate the mental health service delivery in its catchment area in accordance with regulations adopted by the Commissioner, and to make recommendations to the Regional Mental Health Boards (C.G.S. 17-226k).

The five Regional Mental Health Boards are composed of elected CAC members, four members from each Council, with a maximum of two mental health service providers. The Boards function as citizen advisory groups to the mental health regions established by the Commissioner. They are to study the needs of the region and develop plans for improved and increased mental health services.

Together with the Regional Directors, the RMHBs are to "plan, endeavor to stimulate and coordinate additional and expanded mental health services, review all applications for funds, make

joint recommendations" to the Commissioner regarding these services and applications and "make specific recommendations to the Commissioner...concerning the annual budget of the region and state subsidies for regional mental health programs." In addition, the Boards are to report annually to the Commissioner and the Regional Mental Health Directors regarding their findings, conclusions and recommendations for a comprehensive plan and priority ranking of regional mental health services. Also, they must employ necessary staff, funded through the Office of the Commissioner and local funds, and have a plan to ensure representation of alcohol and drug programs (C.G.S. 17-226k(c) and 17-226l).

The Board of Mental Health is composed of the five RMHB chairmen and nine members appointed by the Governor, three of whom are state licensed physicians with psychiatric experience. None of the appointed members can be employed by the state. The Commissioner is an ex officio member without vote. The Board is an advisory group that meets monthly with the Commissioner to review the Department's programs, policies and plans. In addition, the Board advises the Governor concerning candidates for the position of Commissioner, may issue periodic reports to the Governor and the Commissioner, and examines the files and records of the Department's central office and state-owned facilities (C.G.S. 17-207 and 17-208a).

The Advisory Council to the Board of Mental Health advises and assists the Board on program development and community mental health center construction planning. The Advisory Council's membership is comprised of 30 to 60 members appointed by the BMH and includes representation of non-government organizations and state agencies concerned with planning, operation or utilization of community mental health centers and consumers of center services who are familiar with the need for such services (C.G.S. 17-209f).

The Advisory Boards for State Hospitals and Facilities (with the exception of Connecticut Mental Health Center and Whiting Forensic Institute) are each composed of 15 members appointed by the Commissioner. Advisory Board members must reside in the assigned geographic territory and at least one-third must also be members of CACs for the catchment areas served by the hospital or facility. Each Advisory Board is to meet periodically with the hospital or facility superintendent or director to advise him on institutional programs and policies; act as a liaison between the institution and the community and the state, and; issue reports and recommendations to the Governor and Commissioner (C.G.S. 17-213a and 17-214a).

Summary. Important points to note in these statutory role descriptions are:

1. The central role played by the Commissioner of Mental Health in establishing policy and directing change.
2. The unusual variety of types and levels of citizen participant groups, each with overlapping memberships yet also representing different geographic and service delivery interests.
3. The advisory nature of these citizen boards and councils.
4. The potential points of linkage between departmental/facility and citizen/community interests represented, for example, by the Regional Directors as "departmental" liaisons to the regional memberships and the State Hospital and Facility Advisory Boards as "citizen" liaisons to the state-operated facilities.

Fragmented Legislative Oversight

The organizationally and statutorily unclear relationship between the departmental/facility and citizen advisory structures reflects the fragmented legislative role in mental health. In this latter respect DMH is not different from other departments with jurisdiction over broad policy areas. Since the legislative process is governed by its committee structure, legislation affecting departments like DMH can fall under the purview of six to eight different joint standing committees in any session.

Committee responsibility for the Department of Mental Health remains dispersed even though the joint rules adopted in January 1979 reduced the total number of legislative committees. In fact, committee reorganization may have further weakened legislative oversight of DMH by separating committee responsibility for state mental institutions (now assigned to the Human Services Committee) from responsibility for the Department as a whole (assigned to Public Health). This particular division of oversight responsibility will reduce, if not preclude, the legislature's ability to evaluate DMH's implementation of deinstitutionalization and the continuum of care.

The Legislative Program Review and Investigations Committee recommends that the joint rules of the General Assembly be amended

to place responsibility for the Department of Mental Health and for state mental institutions with the Public Health Committee. This change will facilitate the legislature's ability to view comprehensively DMH's planning and implementation of its stated goals. In particular, the change will enable legislative oversight of the Department's progress toward reduced utilization of the state mental hospitals and increased effort to provide an integrated network of community-based services.

Fiscal Analysis

The most frequently asked question of DMH is: "If the use of the three large state mental hospitals has been decreasing, why haven't the hospital budgets decreased and the community program budget increased commensurately?"

This question is based on the following facts for the first three fiscal years (1976-1978) of DMH's deinstitutionalization policy:

- The use of the three state hospitals, as measured by total patient days, resident population and median length of stay, decreased by 29.6%, 29.4% and 38.6% respectively (Table III-2);
- The three state hospitals' combined expenditures increased 11.3%, or by approximately \$5 million¹ (Table II-1); and
- The community mental health services grants account increased 53.7%, but this represents an increase of less than \$1 million² (Table II-1).

These facts must be qualified by the following points:

- The use of the state hospitals, as measured by total, new and readmissions, decreased 12.6%, 15.2% and 11.2% respectively (Table III-1).

¹ Subtract (FY '76) \$44,092,788 from (FY '78) \$49,091,892 for a total of \$4,999,104.

² Subtract (FY '76) \$1,760,133 from (FY '78) \$2,704,731 for a total of \$944,598.

Table II-1. DMH General Fund Expenditures by State Hospital and Community Service, FY 1976-80.

	1975-76 (Actual)	1976-77 (Actual)	1977-78 (Actual)	1978-79 (Estimated)	1979-80 (Estimated)
<u>State Hospitals:</u>					
Connecticut Valley					
Fairfield Hills	\$44,092,788	\$44,084,570	\$49,091,892	\$52,100,000 ¹	\$51,409,410 ¹
Norwich					
<u>Community Mental Health Facilities:</u> ²					
Cedarcrest					
Conn. MHC	7,533,318 ³	9,531,900	11,338,194	13,670,000 ¹	14,089,709 ¹
Bridgeport MHC					
Dubois Day Treatment					
<u>Community Mental Health Grants and Contracts</u> ⁴					
	2,115,577	2,265,353	3,354,709	4,866,157 ¹	6,589,357 ¹
TOTAL COMMUNITY SERVICES	\$9,648,895	\$11,797,253	\$14,692,903	\$18,536,157 ¹	20,679,066 ¹
TOTAL DEPARTMENT ⁵	\$63,786,969	\$63,504,273	\$71,132,883 ⁶	\$78,807,503 ⁶	\$80,050,740 ⁶

¹ Approximated.

² Excludes Blue Hills and alcohol and drug programs.

³ Conn. MHC, Bridgeport MHC and Dubois only.

⁴ Includes service contract at Capitol Region MHC.

⁵ Includes categories other than those listed in table.

⁶ CADAC general fund not included.

⁷ Governor's recommended is \$84,817,000 (including CADAC general fund).

⁸ Not including fuel and energy contingency of \$287,100.

Source: Office of Fiscal Analysis, Connecticut General Assembly; Annual Reports of the State Comptroller, 1976-78; DMH Budget FY 1980.

These decreases are significantly lower than the decreases in the patient population and length of stay variable cited above, indicating a significantly slower rate of progress toward reduced use of the state hospitals.

- Inflation, collective bargaining agreements and annual personnel increments increase the costs of the state hospitals. Since these increases occur independently of departmental policy, they must be viewed as "uncontrollable" expenses accounting for an indeterminate portion of the total increase in state hospital budgets.¹
- DMH owns and operates² several community service facilities. When the budgets of these facilities are added to the community grants account, the total increase in community services almost quadruples, from \$1,239,132 to \$5,044,008³ (Table II-1).

In other words, the budgetary evaluation of DMH's progress toward deinstitutionalization and the continuum of care varies depending on the type of information chosen and the context in which the information is presented. Although this observation applies to any evaluation effort, it is particularly relevant here because the net fiscal change is modest and therefore subject to varying interpretations regarding its significance.

Modest progress toward goals. The following measurements demonstrate modest net fiscal achievement of deinstitutionalization and the continuum of care during FY 1976-78.

¹ How much of the 11.3% increase in the state hospital budgets is due to these three "uncontrollable" expenses is difficult to calculate precisely. This limitation especially applies to inflation which affects different budget line items at different rates.

² Connecticut Mental Health Center is operated jointly by DMH and Yale University; Capitol Region Mental Health Center is operated by the University of Connecticut under contract with DMH.

³ Subtract (FY '76) \$9,648,895 from (FY '78) \$14,692,903 for a total of \$4,749,474.

- The change in state hospital expenditures as a percentage of the total DMH expenditure.

The \$5 million increase in expenditures (Table II-1) as a percentage of the total Department expenditures represents a net decrease of 0.1% or one-tenth of one percent (Figure II-4).

- The change in community service expenditures as a percentage of total Department expenditures.

The \$5,044,008 increase in DMH's community services (Table II-1) represents a 5.6% increase in community service expenditures as a percentage of total Department expenditures (Figure II-4).

- The percent change in state hospital expenditures compared to the percent change in community service expenditures.

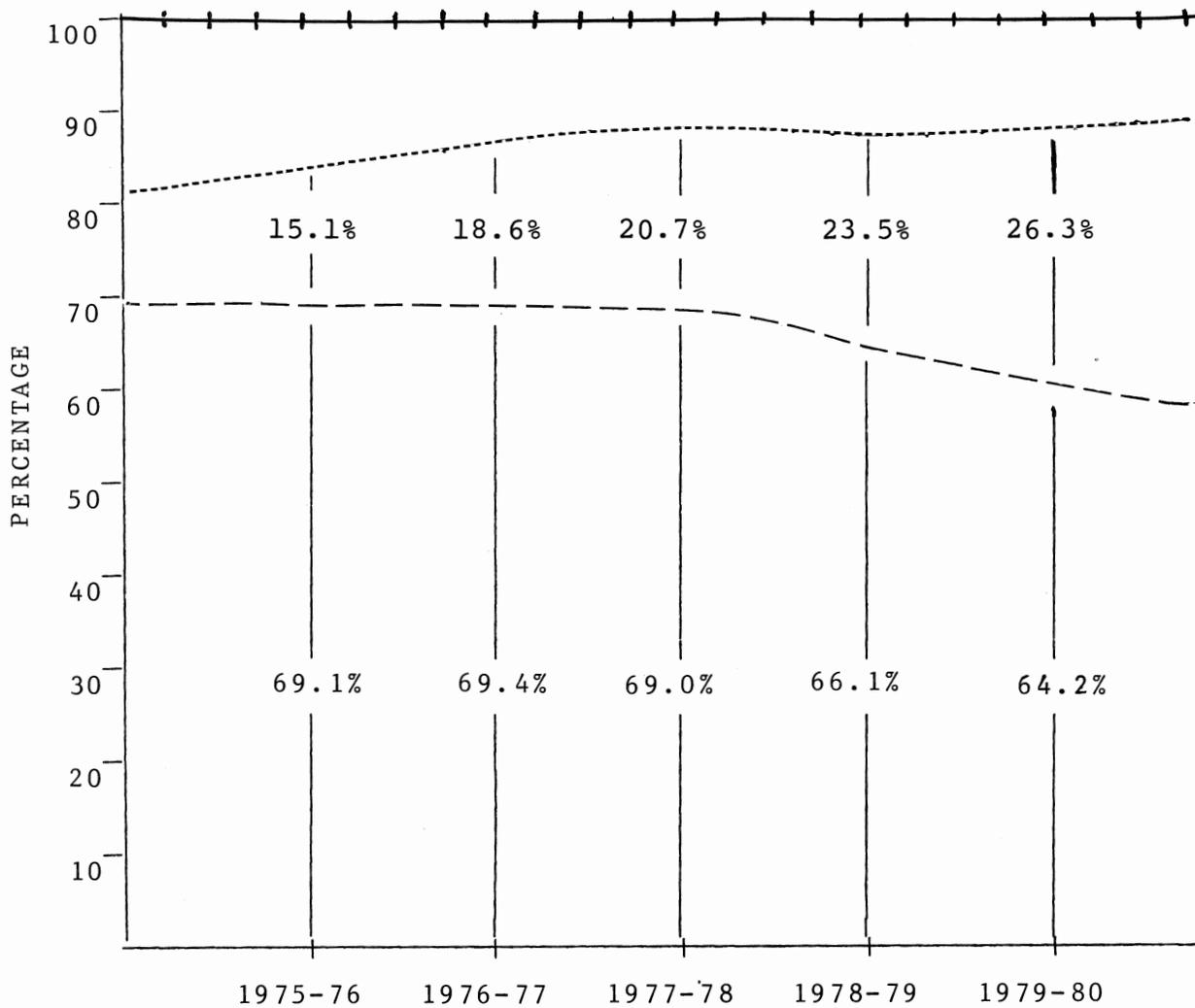
The 11.3% increase in state hospital expenditures is significantly less than the 52.3% increase in community services (Figure II-5). However, the significance of this comparison must be qualified by the fact that the FY 1978 state hospital expenditures totaled \$49,091,892 while the community service budgets totaled \$14,692,903 (Table II-1). Therefore, the comparable absolute increases in state hospital (\$4,999,104) and community service \$5,044,008 expenditures appear as significantly different percent changes.

- The number and percent change in state hospital authorized/funded positions compared to the number and percent change in community service authorized/funded positions.

The state hospital authorized/funded positions decreased by 443 or 11.8%, while the community service positions increased by 144 or 34% (Figures II-6 and II-7).¹ The disparity between the

¹ When Cedarcrest (FY '77, '78) is excluded, community service positions increase by only 11 or 2.7%.

Figure II-4. State Hospital and Community Service Expenditures as Percentages of Total DMH Expenditures, FY 1976-80.



Key:

- ++++ Total DMH Budget Expenditures.
- DMH Community Services: Cedarcrest (excluding FY '76), Conn. MHC, Bridgeport MHC, Dubois Day Treatment, Capitol Region MHC, Community MH Grants Account.
- . - . - . State Mental Hospitals: Conn. Valley, Fairfield Hills, Norwich.

Sources: Office of Fiscal Analysis, Connecticut General Assembly; Annual Reports of the State Comptroller, 1975-1978; DMH.

number and percent change is due to the fact that in FY 1978 there were 3,297 state hospital positions and 565 community service positions. The smaller absolute change in community service positions, therefore, appears as a significantly larger percent change than does the larger absolute change in state hospital positions.

Figure II-5. Percent Change in State Hospital and Community Service Expenditures, FY 1976-78.



Key: (See Figure II-4.)

----- DMH Community Services
----- State Mental Hospitals

Sources: (See Figure II-4.)

Progress toward DMH's goal during FY 1979 and anticipated during FY 1980 is demonstrated by the following measurements:

- The estimated change in state hospital budgets as a percentage of the total Department budget: The combined state hospital budgets will decrease from 66.1% in FY 79 to 64.2 in FY 80 of DMH's budget (Figure II-4). This reflects the 1979 Appropriations Act which maintained state hospital budgets while increasing the community grants account by \$1.4 million. The result is that state hospital budgets will decrease as a percentage of the total Department budget by 4.9% between FY 1976 and FY 1980.
- The projected change in community service budgets as a percentage of the total DMH budget: The combined community service budget is estimated to increase from 20.7% to 25.6% of the Department's budget (Figure II-4). Increases in both state-operated community facilities (direct services) and subsidies to private and public non-profit agencies (indirect services) account for this change which will approximate 11% between FY 1976 and FY 1980.

Consensus for Change

Since his appointment in 1976, the present Commissioner of Mental Health has attempted to effect change by articulating a statewide goal for mental health service delivery. This goal includes not only replacing institutional with community care, but also replacing old categories of thinking (for example, state hospitals versus community services) with new ones and substituting, to the extent possible, a comprehensive approach to mental health planning for the traditional "disjointed incrementalism."¹

The evaluation of DMH's progress toward deinstitutionalization and the continuum of care should acknowledge this attempt to create consensus in support of a significant reorientation in policy. Although "consensus" is difficult to measure, it is a necessary part of the backdrop for change.

¹ David Braybrooke and Charles E. Lindblom, A Strategy of Decision (New York: The Free Press, 1963).

In this regard, the Department, under the Commissioner's direction and citizen pressure, has helped create agreement among mental health service providers and consumers that change is necessary, desirable and feasible. Now that this agreement exists, it is time for DMH to move more decisively in the direction of its stated goals.

In particular, the Department must plan realistically for the deinstitutionalization and continuum of mental health care in 1980-1985, so that appropriate care in alternative settings is available.

Chapter III

DEINSTITUTIONALIZATION

Deinstitutionalization Defined

DMH's 1975-1980 deinstitutionalization goal

Deinstitutionalization Progress, 1975-1978

Preventing inappropriate admissions and
reducing readmissions

Preventing unnecessary institutional retention

Improving patient conditions, care and treatment

Insufficient Staff

Comparison of staffing levels

Recruitment and turnover problems

Important public policy questions

Reliance on Drug Therapy

Upholding Patients' Rights

Procedural safeguards

Procedural weaknesses

Right to treatment

Judicial oversight of deinstitutionalization and
the continuum of care

CHAPTER III
DEINSTITUTIONALIZATION

Deinstitutionalization Defined

In Connecticut, as elsewhere in the United States, the process of reorienting mental health service delivery from institutional to community settings is known as "deinstitutionalization" and involves the following activities:

1. preventing inappropriate institutional admissions and reducing readmissions;
2. preventing unnecessary retentions in institutions;
3. improving the conditions, care and treatment of institutionalized patients; and
4. finding and developing appropriate alternatives in the community for housing, treatment, training, education and rehabilitation of the mentally disabled who do not need to be in institutions.¹

Deinstitutionalization was initiated in 1963 as a national mental health policy and subsequently implemented in at least 135 federal programs administered by eleven major federal departments and agencies. The underlying principle of this policy is the belief that "mentally disabled persons are entitled to live in the least restrictive environment necessary and lead as normal and independent a life as possible."²

Chapter III evaluates DMH's progress in implementing the first three deinstitutionalization activities; Chapter IV evaluates the fourth activity.

DMH's 1975-1980 deinstitutionalization goal. In 1977, DMH retroactively committed itself to achieving "a ten percent reduction in state hospital utilization over (each of) the next five

¹ "Returning the Mentally Disabled to the Community: Government Needs to Do More," GAO, January 7, 1977; p. 1.

² Ibid.

years (1975-1980)."¹ The significance of this five year deinstitutionalization goal is not solely the targeted reduction in state hospital use, since the patient populations and length of stay of these institutions had been decreasing steadily for more than a decade. Rather, the goal's importance is the clear identification of the state hospitals as the object of substantial change in the Department's reorientation of its service delivery system.

No longer are these hospitals to be regarded as the major providers of both acute and long term care, but as "providers of last resort" situated within an integrated system of community-based mental health care. Ultimately, deinstitutionalization means that the three large state hospitals no longer would command the major portion of DMH's budgetary and program resources.

Deinstitutionalization Progress, 1975-1978

DMH's progress in implementing the first three deinstitutionalization activities during FY 1975-1978 is analyzed in the following sections.

Preventing inappropriate admissions and reducing readmissions.² DMH has made no significant progress toward preventing inappropriate admissions to the state hospitals. This is because the Department has left the responsibility for determining appropriateness of admission to the medical staff of individual facilities. In other words, the Commissioner has regarded the determination of "appropriate" admission as part of the hospital's "day-to-day operations" (C.G.S. 17-215b) and, therefore, has not established standardized criteria for the state mental hospitals. Since these hospitals lack the staff and community referral network to prescreen effectively, very few patients are refused admission. (See recommendation p. 90 f.).

Further, if changes in hospital admissions are applied as indicators of DMH's progress in reducing the use of the state

¹ Connecticut Department of Mental Health State Plan, 1977; pp. 4-6.

² Although this first deinstitutionalization activity technically refers to two separate activities, it is treated as one "admissions" activity because of the programmatic and statistical connections between diagnostic types of patients admitted and the rate of readmission.

hospitals by ten percent per year, then the Department has not achieved its deinstitutionalization goal. Table III-1 shows that the total percent decrease in total, new and readmissions to the three large state hospitals during the first three years of DMH's deinstitutionalization goal is significantly less than 30%. Statistically, this fact is due mainly to the increases that occurred in 1977 in all three admissions categories. Table III-1 also indicates that progress toward reducing readmissions lags behind progress in reducing new admissions.

Table III-1. Percent change in total, new and readmissions to the three large state mental hospitals, FY 1975-1978.¹

<u>FY</u>	<u>Admissions</u>		<u>New Admissions</u>		<u>Readmissions</u>	
	<u>Number</u>	<u>Percent Change</u>	<u>Number</u>	<u>Percent Change</u>	<u>Number</u>	<u>Percent Change</u>
1975	14,427		4,855		9,572	
1976	12,538	-13.1	4,218	-13.1	8,320	-13.1
1977	13,361	+ 6.6	4,433	+ 5.1	8,928	+ 7.3
1978	12,615	- 5.6	4,119	- 7.1	8,496	- 4.8
TOTAL CHANGE ²		<u>-12.6%</u>		<u>-15.2%</u>		<u>-11.2%</u>

¹ State hospitals surveyed: CVH, NH, FHH. (See Table III-2 for comparison patient population data.)

² Percent reduction calculated from base year FY 1975 to 1978.

Sources: DMH Annual Review and Progress Plan, 10/1/78 to 9/30/79; DMH Inpatient Statistics, FY 1977,'78.

Apparently recognizing the lack of progress in preventing inappropriate admissions and reducing readmissions, the Department recently outlined its plans both to standardize hospital admission criteria and establish community-based prescreening capacities within each catchment area by 1985. (See pp. 83 ff.) The Department intends by these means to narrow both the diagnostic scope and numbers of state hospital patients, thus eliminating

patient populations more effectively treated in less restrictive environments (for example, geriatrics) as well as patient populations with inordinately high readmission rates (for example, alcoholics).¹

Preventing unnecessary institutional retention. DMH's progress toward preventing or reducing unnecessary retention in institutions is measured here by changes in patient days, resident population and median length of stay in the three state mental hospitals. Table III-2 shows significant decreases in these three variables during FY 1975-78. The percent changes in patient days and resident population are very close to achieving the ten percent per year reduction in state hospital use projected in DMH's 1975-80 deinstitutionalization goal; the percent change in median length of stay exceeds this goal.

Progress in implementing this second deinstitutionalization activity is due largely to the following factors affecting the state hospitals:

1. medical reliance on psychotropic drugs to facilitate early discharges;
2. financial pressure exerted by third-party fiscal intermediaries to have the hospitals justify the need for active psychiatric treatment (Medicare) and for continued hospitalization (Medicaid) or forego reimbursement; and
3. Legal challenges to purely medical decisions regarding length of stay for involuntarily committed patients (see pp. 40 ff. for discussion of mental health legal issues).

Improving patient conditions, care and treatment. Progress toward improving the physical conditions of wards in the state hospitals has been made to meet the Joint Commission on Accreditation of Hospitals (JCAH) accreditation standards regarding patient privacy and safety.

¹ Source: DMH Inpatient Statistics, FY 1978. In FY 1978, 72% of "alcoholism" admissions were readmissions. The second highest readmission rate was for "schizophrenia and other paranoid states:" 68% of all such admissions were readmissions. The percentages are based on admissions data for all DMH inpatient facilities.

Table III-2. Percent change in state hospital patient days, resident population and median length of stay, FY 1975-1978.¹

FY	<u>Patient Days</u>		<u>Resident Population</u>		<u>Median Length Of Stay (Days)</u>	
	<u>Number</u>	<u>Percent Change</u>	<u>Number</u>	<u>Percent Change</u>	<u>Number</u>	<u>Percent Change</u>
1975	1,141,153		3,008		259	
1976	1,044,544	-8.5	2,816	-6.4	254	-1.9
1977	981,580	-6.0	2,604	-7.5	223	-12.2
1978	803,000	-18.2	2,124	-18.4	159	-28.7
Total Change ²		<u>-29.6%</u>		<u>-29.4%</u>		<u>-38.6%</u>

¹ State Hospitals Surveyed: CVH, NH, FHH (See Table III-1 for comparison with admissions data.)

² Percent reduction calculated from base year FY 1975 to FY 1978.

Sources: DMH Annual Review and Progress Plan, 10/1/78 to 9/30/79; DMH Inpatient Statistics, FY 1977, 78.

Improvements in patient care and treatment, however, are not as easily observed or measured. Minimum standards of care and treatment required by statute are:

1. "humane and dignified treatment...in accordance with a specialized treatment plan suited [to a patient's mental] disorder" (C.G.S. 17-206c);
2. "a physical examination within five days of [a patient's] hospitalization, and at least once each year thereafter" (C.G.S. 17-206f); and
3. "[examination] by a psychiatrist within forty-eight hours of [a patient's] hospitalization, and at least once each six months thereafter" (C.G.S. 17-206f).

The implementation and review of these standards are the responsibility of hospital medical staff committees. As a result, the execution of these statutorily mandated activities and other activities required by JCAH and Medicare/Medicaid Standards is subject to the budgetary and especially staff limitations of each hospital.

The statutes note the constraints on therapy services due to these limitations. For example, C.G.S. 17-215c requires each hospital to "develop a written policy detailing requirements for individual patient treatment plans and methods for patient evaluation." These plans and evaluations are to be reviewed by "at least three members of the facility's medical personnel...[and are to] include, but not be limited to, an evaluation of medication being administered." However, the development of policy and the review and evaluation of treatment plans are all to be carried out "within the budget limits of each such facility." Thus, the statutes both contain standards for improved patient treatment and acknowledge limitations to implementation.

Therefore, the LPR&IC finds that while all three state mental hospitals currently are accredited by both JCAH and HEW, the reality of daily care and treatment often falls short of external and statutory standards.

Insufficient Staff

The quantity and quality of care in the state hospitals is affected by the low professional staff to patient ratio.¹ Although there is disagreement within mental health professions regarding optimum levels of staffing required for "appropriate" patient care, agreement does exist that the "staff/patient ratio seems to be the best general measure of the amount of interaction possible between staff and patients" and that the "amount of staff attention to patients is correlated with treatment effectiveness."²

¹ Professional patient care staff includes: psychiatrists, nurses, psychologists and psychiatric social workers. Non or paraprofessional staff are psychiatric aides.

² Marjorie Bayes, Ph.D., and Karen Kmetzo, R.N., "Staffing Needs and Standards for Psychiatric Inpatient Facilities in the State of Connecticut (report commissioned by Eric Plaut, M.D., Commissioner, DMH) February 1979; p. 4.

In other words,

...When the ratio is low, staff members must spend most of their time in routine ward management duties, with little time to spend in thoughtful, individualized interaction with patients...Decreased staffing creates a more rigid ward structure, increases staff need to control patients, decreased patients' independence and responsibility and...leads to a more custodial type of care...(on the other hand,) and increase in staff/patient ratio results in an increase in quality of care.¹

Comparison of staffing levels. Table III-3 compares, on both the national and state levels, staff/patient ratios and the percent of total patient days for general hospital psychiatric units, private mental hospitals, and state and county mental hospitals. The table shows that:

1. Nationally and in Connecticut, general hospital psychiatric units and private mental hospitals have significantly higher staff/patient ratios than state hospitals;
2. State hospitals provide the greatest percentage of patient care in the nation and in Connecticut; and
3. Connecticut's state hospital staff/patient ratio is close to the national average for state hospitals.²

¹ "Staffing Needs and Standards for Psychiatric Inpatient Facilities in the State of Connecticut," p. 4.

² In 1975, the last year for which such information is available, Connecticut's state mental hospitals had the second highest admission per capita in the nation, indicating greater use of these hospitals in Connecticut than in other states. Staffing needs of Connecticut's state hospitals, therefore, may be greater than the national average.

Table III-3. F.T.E.¹ Staff/Patient² ratio per 100 average resident patients in general hospital psychiatric units, private and state and county mental hospitals, 1976.

<u>Type of Inpatient Facility</u>	<u>Ratio</u>	<u>Total Patient Days</u> <u>(% distribution)</u>
General Hosp., Psych. Units		
National	123	8%
Connecticut.	122	6%
Private Mental Hospitals		
National	134	5%
Connecticut.	127	16%
State & County Mental Hospitals		
National	70	87%
Connecticut.	71	78%

¹ F.T.E.=Full-Time Equivalent Employees; number obtained by adding the amount of time worked by full-time employees, part-time employees, and sometimes trainees, and dividing by the number of hours in the average work week.

² Patient Care Staff

Source: Developed from data in computer printout sent from NIMH by Paul Henderson, Dec. 1978, in Bayes and Kmetzo, "Staffing Needs and Standards for Psychiatric Inpatient Facilities in the State of Connecticut," February 1979.

Table III-4 compares the percent distribution of professional and non-professional staff in the same three types of inpatient mental health facilities. The table shows that:

1. Professionals are the majority of staff in general hospital psychiatric units and private mental hospitals nationally and in Connecticut;

2. Nonprofessionals are the majority of staff in state hospitals nationally and in Connecticut; and
3. Connecticut's percent distribution of professional and nonprofessional staff is close to the national average for state hospitals.

Table III-4. Percent Distribution of Professional and Nonprofessional Staff¹ in general hospital psychiatric units, private and state and county mental hospitals, 1976.

<u>Type of Inpatient Facility</u>	<u>% Professional</u>	<u>% Nonprofessional</u>
General Hosp. Psych. Unit		
National.....	56%	44%
Connecticut.....	70%	30%
Private Mental Hospital		
National.....	56%	44%
Connecticut.....	66%	34%
State & County Mental Hospital		
National.....	32%	68%
Connecticut.....	34%	66%

¹ Patient Care Staff

Source: See Table III-3

Table III-5 compares staff/patient ratios for selected professional disciplines in the three types of inpatient facilities. The table shows that:

1. Staffing of psychiatrists, psychologists, social workers and R.N.s is significantly greater in general hospital psychiatric units and private mental hospitals than in state hospitals nationally and in Connecticut; and

2. Connecticut's state hospitals have somewhat more psychiatrists, psychologists and nurses per 100 patients and somewhat fewer social workers than the national average for state hospitals.¹

Table III-5. Staff/Patient ratios¹ for selected professional disciplines in general hospital psychiatric units, private and state and county mental hospitals, 1976.

Type of Inpatient Facility	Psychiatrists	Psychologists	Social Workers	RN's
General Hosp. Psych. Units				
National	8.4	2.3	4.8	40
Connecticut.	13.8	3.7	8.4	52.5
Private Mental Hospitals				
National	10.9	4.5	6.3	27.3
Connecticut.	14.1	5.9	7.4	24
State & County Mental Hospitals				
National	2.2	1.5	3	8.4
Connecticut.	3.2	1.7	2.3	12

¹ Per 100 average resident patients.

Source: See Table III-3.

Tables III-3, III-4 and III-5 demonstrate that although staffing levels in Connecticut's state hospitals compare favorably with staffing in other state mental hospitals, these levels are significantly lower than those in private or non-state owned inpatient facilities.

¹ The significance of these relatively small disparities in size is unclear since the national average is skewed by the inclusion of states with very high or very low staff/patient ratios.

Tables III-6 and III-7 indicate staffing levels in the three state hospitals based on different staffing data collection methods. Although each set of data were compiled by DMH, large discrepancies exist between the two. Table III-6 shows the reality of comparatively low levels of state hospital staffing in an average day. The table is based on a survey of ward staffing patterns taken for one day in July 1978. The ward totals for each type of patient care staff were combined to give a facility-wide total for each of nine staff types. The nine staff columns show the total and average number of staff per shift during the twenty-four hour ward coverage the day of the survey.¹ Thus, during an average twenty-four hour day in July 1978, the 798 inpatients in Fairfield Hills Hospital, for example, were attended by an average of 9.6 nurses, 55.8 psychiatric aides, .20 (or less than one) psychiatric social workers or psychologists per shift on any given ward (Table III-6).

Table III-6. Total and average number of patient care staff in CVH, NH and FHH, July 1978.

Hospital	Population	Head Nurse	Staff Nurse	Psychiatric Aide 1	Psychiatric Aide 2	Psychiatric Aide 3	Psychiatrist	Psychiatric Social Worker Assistant	Psychiatric Social Worker	Psychologist
Fairfield Hills	798	21 (4.2)	27 (5.4)	96 (19.2)	98 (19.6)	85 (17.0)	1 (.20)	7 (1.4)	-	-
Conn. Valley Hospital	566	40 (8.0)	17 (3.4)	123 (24.6)	239 (47.8)	4 (.80)	2 (.40)	7 (1.4)	7 (1.4)	3 (.6)
Norwich Hospital	731	54 (10.8)	25 (5.0)	87 (17.4)	320 (64.0)	28 (5.6)	-	7.3 (1.5)	18 (3.6)	3.5 (.7)

Source: Developed by LPR&IC staff from Connecticut Department of Mental Health Facilities Plan, 1980-1985; pp. A-20 - A-36.

¹ The average number of staff was computed by dividing the total number for each staff type by five since one position equals one 35-hour per week shift and one staff slot requires five positions for 24-hour per seven day per week coverage.

Table III-7. General Fund Filled Staff Positions in CVH, NH and FHH, August 31, 1978.

<u>Hospital</u>	<u>Nurses</u>	<u>Psychiatric Aides</u>	<u>Psychiatrist</u>	<u>Social Worker</u>	<u>Psychologist</u>	<u>Doctors</u>	<u>Residents</u>
FHH	94	430	23	17	12	9	16
CVH	57	391	13	15	8	7	13
NH	123	430	16	14	8	5	13

Source: DMH

Table III-7 is abstracted from the Department's monthly tabulation of actual staffing compiled from the Monthly Status Reports of each facility. According to these data, staffing, especially at Fairfield Hills Hospital, is considerably higher. The Commissioner considers Table III-7 reliable, citing the discrepancy between data as the result of methodological problems caused by the "floating" of staff between wards.¹

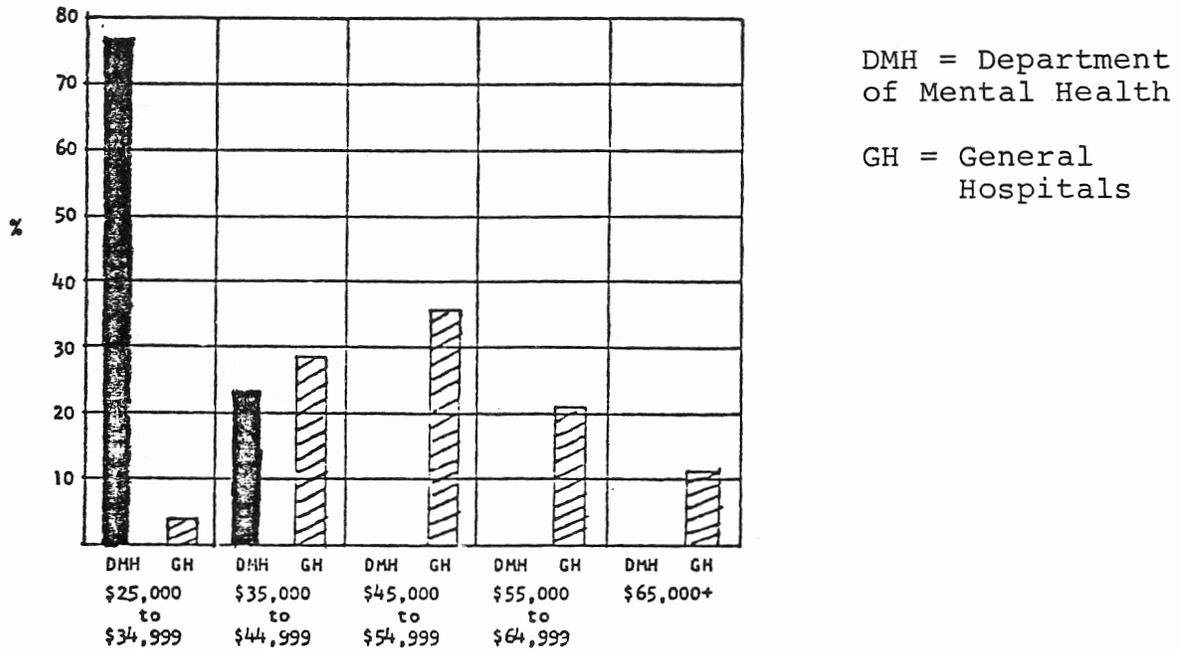
The wide margin between the two tables is of concern to the LPR&IC. First, despite latitude given for a degree of inaccuracy in "soft data," the accuracy of data generated by the Department must be questioned. Second, because the data were utilized by the Department for long-range planning, the reports themselves are subject to challenge. What both tables disclose, however, is that a majority of patient care is delivered by nonprofessionals.

Recruitment and turnover problems. The comparatively low staff/patient ratios in the state hospitals are a result not only of the number of authorized/funded positions, but also of the difficulty in filling these positions. For example, salary and other job-related differentials between state and general hospital employment in Connecticut put the Department at a distinct disadvantage in attracting psychiatric personnel, especially from the limited number of American medical students opting for psychiatry (Figure III-1). Further, recent federal immigration restrictions are likely to aggravate the problem of recruiting resident psychiatrists since foreign born and trained

¹ Meeting with Commissioner Plaut, June 8, 1979.

Figure III-1. Salary comparison between DMH and Connecticut General Hospital Psychiatrists, 1976.

STATE DEPARTMENT OF MENTAL HEALTH AND CONNECTICUT
GENERAL HOSPITAL PSYCHIATRISTS (DMH = 61, GH = 28)



Source: Department of Mental Health

physicians traditionally have comprised the recruiting pool for the state mental hospitals.

In addition, the medical, especially psychiatric staffs suffer a significantly high turnover rate in filled positions (34% for psychiatrists in FY 1977) and a similarly high vacancy rate in authorized positions (21% for psychiatrists and 19% for resident psychiatrists in FY 1977).¹ Turnover negatively affects the quality of care.

¹ Office of the Commissioner, DMH.

Important public policy questions. The facility-wide totals and averages in Table III-6 show intra-institutional variations in staffing levels that exist on different wards. Staffing levels, however, usually are higher on admission wards and vary between wards depending on the diagnosis, level of functioning and treatment intensity of patient populations. Nevertheless, the table raises serious questions regarding the quantity and quality of care available in the state hospitals:

1. Are these staffing levels adequate for treating the mentally ill?
2. If not, is the state justified in providing primarily custodial care for the mentally ill?

The important public policy issue is Connecticut's commitment to equalizing the disparity between two mental health systems chiefly differentiated by ability to pay for services.

In light of this issue, the LPR&IC recommends that the Department of Mental Health prepare for the General Assembly a FY 1980-85 realistic projection of patient care staffing levels needed to upgrade the quality of care and treatment in the state mental hospitals. This projection should include the following points:

1. Increases in numbers of authorized/funded positions by job type;
2. Upgrading of salaries and other professional inducements by job type;
3. Coordinating improvements in staff/patient ratios with overall Departmental program and budget plans;
4. Budgetary staging; and
5. Deployment of staff.

Reliance on Drug Therapy

The low staff/patient ratio in the state hospitals results not only in a more custodial type of care, but also in a greater reliance on drug therapy as primary treatment. Drug-induced behavior control usually is explained as necessary and appropriate because of the high percentage of seriously disturbed, chronically ill and violent patients in the state hospitals.

However, reliance on drug therapy presents long-term problems for patients because of the physically debilitating aftereffects they may suffer as a result of extended use of psychotropic drugs.¹

Further, although psychotropic drugs have led to earlier hospital discharges, their use does not always facilitate re-adjustment to community life. In fact, the reliance on drugs may impede progress toward community readjustment unless patients also have received intensive rehabilitative treatment and care while in the hospital. The Department has found that a significant number of patients discharged from state mental hospitals simply refuse to use the follow-up treatment recommended for their level of functioning in the community.² This finding suggests that a significant number of state hospital patients are discharged without adequate preparation or motivation to assume that responsibility.

Finally, reliance on drug therapy as the primary therapy modality in the state hospitals needs to be reevaluated in light of the recent statutory requirement that "Medication shall not be used as a substitute for an habilitation program" (C.G.S. 17-206e(b)).³

The LPR&IC recommends that DMH set guidelines for implementing and evaluating the compliance of C.G.S. 17-206e(b) with the state mental hospitals. These guidelines should include the definition of "habilitation program," particularly with respect to how such a program differs from a medication program.

¹ The most serious physical disorder that may result from extended use of these drugs is "tardive dyskinesia." A person afflicted with this neurological disorder is subject to grotesque, involuntary movements of the face or body. The disorder is chronic, can appear even after use of psychotropic drugs is discontinued and has no effective treatment. Marion Steinmann, "The Catch-22 of Antipsychotic Drugs," The New York Times Magazine, March 18, 1979; p. 114.

² "Aftercare Hospital Resource Study," DMH, August 8, 1978.

³ P.A. 78-219.

Upholding Patients' Rights

Patients' rights in state mental hospitals are statutorily protected in the following four areas:

1. Restrictions on the state's authority to confine individuals against their will;
2. Obligation of the state to provide treatment;
3. Patients' right to refuse treatment; and
4. State's responsibility to protect the confidentiality of patients' records.

Although the impact of patients' rights on deinstitutionalization is difficult to measure, there is little doubt that legal challenges to purely medical judgments regarding the mentally ill have accelerated the rate of discharge from state hospitals.

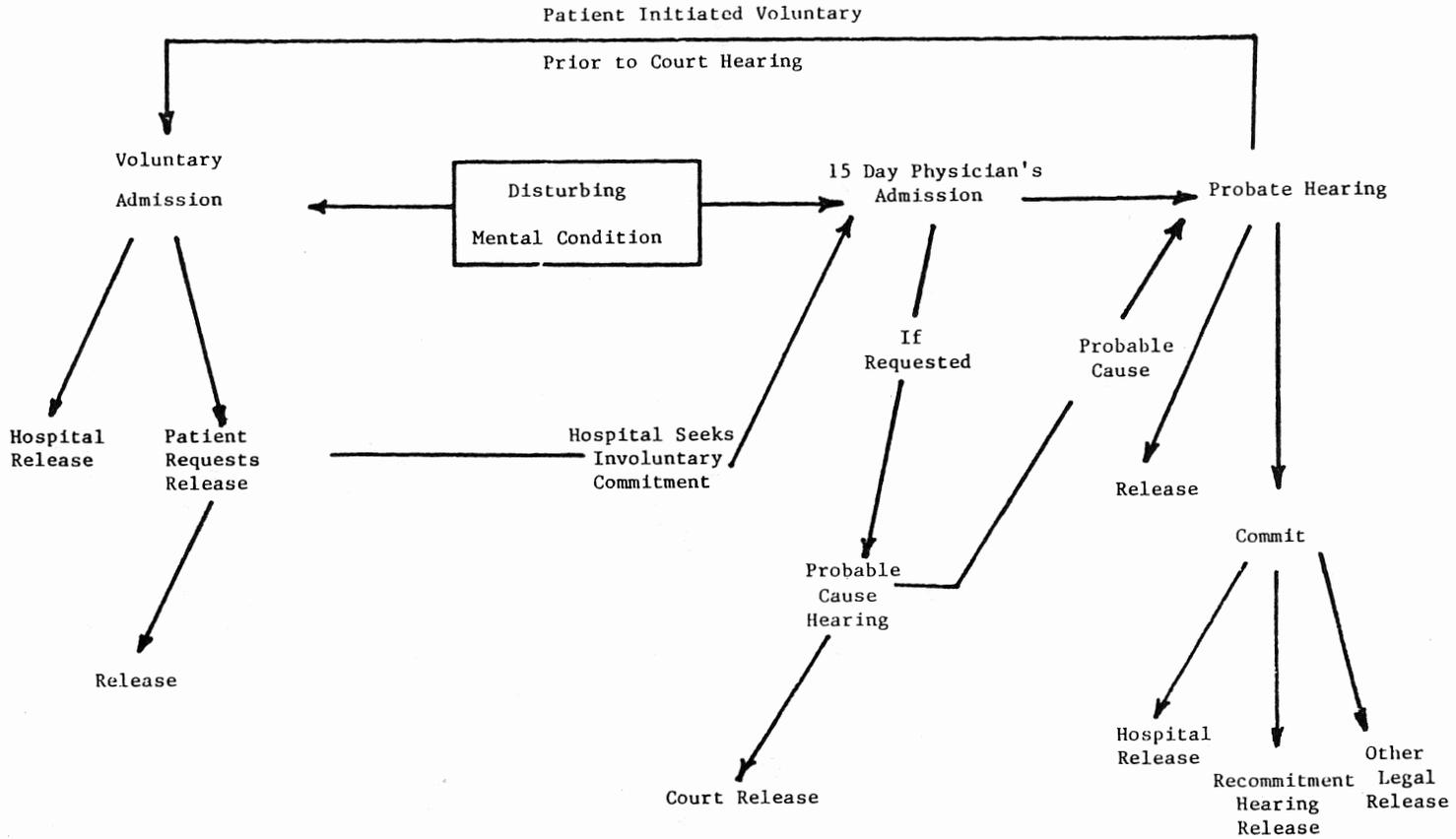
Procedural safeguards. The important legal challenges in Connecticut have occurred in the first patients' rights area; that is, placing restrictions on the state's authority to confine individuals against their will. As a result, the statutes provide the following procedural safeguards against arbitrary state action in emergency and involuntary commitments to the state hospitals.¹ (See Figure III-2 flow chart depicting civil commitment to and release from the state mental hospitals.)

1. A "probable cause" hearing in the probate court for patients confined on a fifteen day emergency certificate. The hearing is scheduled within seventy-two hours of a patient's written request and concludes with the probate judge's determination of whether or not the patient's mental

¹ Emergency commitment is a form of involuntary confinement except that it is instituted by a physician rather than the probate court, and carries a fifteen day commitment limitation rather than indefinite confinement.

Figure III-2. Civil commitment and release for mentally ill persons.

41



Source: LPR&IC Staff.

condition requires the full fifteen day confinement.¹ The statutorily defined criteria for this determination are: "that a person is mentally ill, and is a danger to self or others or gravely disabled, and is in need of care and treatment in a hospital for the mentally ill (C.G.S. 17-183)." Court appointed legal counsel must be provided if the patient is unable to pay.

2. A probate court hearing for patients being involuntarily committed to the state hospitals. The hearing automatically is held within ten days of the hospital's application for civil commitment and concludes with a determination of "whether or not the (patient) is dangerous to himself or herself or others, whether or not such illness has resulted or will result in serious disruption of the (patient's) mental and behavioral functioning, whether or not hospital treatment is both necessary and available, whether or not less restrictive placement is recommended and available and whether or not (the patient) is incapable of understanding the need to accept the recommended treatment on a voluntary basis (C.G.S. 17-178(c))." Court appointed legal counsel is provided for indigent patients.
3. The opportunity presented to the patient at the beginning of the probate hearing to request voluntary admission papers. Once admitted voluntarily, he or she can be confined no more than five days after giving written request for release unless the hospital institutes involuntary commitment proceedings (C.G.S. 17-187).
4. An annual probate court review of involuntarily committed patients. The review must be requested by the patient and is conducted in the manner of a probate hearing (C.G.S. 17-178(g)).

¹ Probate judges in Middletown, Norwich and Newtown estimate that 25-40% of all probable cause hearings for state hospital emergency commitments end in the patient's release. Judges feel this rate of release is due mainly to the fact that a patient's mental condition can improve rapidly following drug therapy administered at the state hospitals.

5. An annual review updated monthly by a court appointed psychiatrist of patients involuntarily confined without release for one year. The psychiatrist determines whether or not the patient's commitment status should be reviewed by the probate court (C.G.S. 17-178(g)).

Procedural weaknesses. There are two important weaknesses in the procedural safeguards outlined above. First, C.G.S. 17-178 requires that the expert testimony in a probate hearing be given by two court selected physicians, one of whom is a practicing psychiatrist. Since the majority of patients cannot pay for an independent psychiatric diagnosis, the probate judge's decision rests on the testimony of the court selected psychiatrist. Thus, the ability of the patient's attorney to challenge the court's commitment finding is limited to the testimony of this one psychiatrist. In addition, "dangerousness" appears, at first glance, to be the most objective criterion for commitment; in practice there is considerable disagreement among psychiatrists as to what constitutes "dangerousness," "violence" or "harmful conduct." Further, there are very few specified dangerous human acts which can be predicted reliably by psychiatrists or judges.¹

Given the variation that exists in psychiatric testimony, the LPR&IC recommends that C.G.S. 17-178 be amended to include payment of an independent physician selected by the patient or his or her attorney. In addition, the Committee recommends that the Probate Court be allowed to appoint only one independent physician to assist the court in the evaluation of the respondent's mental condition. The additional testimony by an independent physician will strengthen the procedural safeguards surrounding probate court hearings.²

The second procedural weakness is in the review process for "probated" patients. Currently, the statutes require annual review of involuntary commitments only where such review is requested by the patient or the court appointed psychiatrist. This requirement conflicts with a 1977 Connecticut Supreme Court ruling on behalf of a patient involuntarily confined at Connecticut Valley Hospital for twenty-six years. The court held that

¹ Alan A. Stone, M.D., Mental Health and Law: A System in Transition (Maryland: National Institute of Mental Health, 1975); pp. 5, 25.

² DMH estimates the annual cost for providing this service to be \$75,000.

the patient was

...denied (her) due process rights under the Connecticut constitution by the state's failure to provide (her) with periodic judicial review of (her commitment) in the form of state initiated recommitment (hearing) replete with the safeguards of the initial commitment (hearing) at which the state bears the burden of proving the necessity for (her) continued confinement (emphasis added).¹

In an attempt to resolve the conflict between the commitment statutes and the Fasulo decision, the Commissioner of Mental Health instituted a policy of mandatory review for any patient involuntarily committed for two years without a probate court recommitment hearing.²

The Department's policy, in other words, establishes two standards of periodic review. Patients requesting recommitment hearings or patients for whom such hearings are requested by the court appointed psychiatrist receive annual probate court reviews; all other involuntary patients must wait an additional year before receiving recommitment hearings.

Since both the statutory requirements and Department policy regarding periodic review of involuntary commitments place unjustified restraints on a patient's right to due process, the LPR&IC recommends that C.G.S. 17-178(g) be amended to require a yearly state initiated recommitment hearing that includes the procedural safeguards of the initial commitment hearing.

Right to treatment. The procedural safeguards against the state's authority to confine individuals involuntarily were developed largely in response to the 1975 United States Supreme Court ruling in O'Connor v. Donaldson.³ The court held that patients "who are not dangerous to themselves or others, are receiving only custodial care, and are capable of surviving safely

¹ Fasulo v. Arafah, 173 Conn. 473 (1977).

² "Periodic Review of Patient's Commitments," Policy Statement #33, Commissioner Eric A. Plaut, M.D., DMH, July 6, 1978.

³ O'Connor v. Donaldson, 472 U.S. 563 (1975).

in freedom alone or with the help of family or friends," constitutionally cannot be hospitalized against their will, "even if (they have) been found mentally ill and able to benefit from treatment."¹

Although Donaldson raised the principle of individual freedom to a level equal with and even superceding that of medical judgments regarding the need for care and treatment of the mentally ill, the decision itself was limited to minimal constitutional safeguards for a single category of patients. Donaldson, for example, did not sufficiently define "dangerousness," "custodial care," "capability of survival," nor did it explain whether all or only one of the criteria must be met in order to confine a patient.²

As a result, the impact of the Donaldson criteria on deinstitutionalization in Connecticut and other states is difficult to measure since the implementation of these criteria involves broad judicial discretion. Further, in the opinion of those who feel that states have a moral responsibility to treat the mentally ill, legal challenges to medical standards and procedures have achieved little for the mentally ill except the freedom to suffer outside an institution.³

Class action suits brought on behalf of involuntary state hospital patients address the broader issue of the quality of institutional care. In Wyatt v. Stickney, for example, the federal district court in Alabama held that,

To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane and therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.⁴

¹ Lansing Crane, J.D., Howard Zonana, M.D., Stephen Wizner, J.D., "Implications of the Donaldson Decision: A Model for Periodic Review of Committed Patients, Hospital and Community Psychiatry, Vol. 28, No. 11, November 1977; p. 827.

² Ibid.

³ Stone, p. 43.

⁴ Wyatt v. Stickney, 325 F. Supp. 785 (M.D. Ala. 1971).

Since Wyatt was a class action suit, the federal judge went as far as defining standards of adequate treatment for all patients in the state hospital.¹

This expansion of the scope of patients' rights to include voluntary as well as involuntary mental hospital patients is significant because most of mental health litigation is predicated on the assumption "that rights to anything become salient only when rights against the state have been obstructed."² In other words, a patient first must suffer a loss of freedom by involuntary commitment before he or she can exercise the right to due process.

If this assumption were widely applied, then states could avoid their responsibility to the mentally ill by liberalizing their involuntary commitment laws. Such action would speed the process of deinstitutionalization without providing a continuum of care. Patients who could not afford mental health services simply would not receive them and the disparity between the two mental health systems based on ability to pay would increase.

Judicial oversight of deinstitutionalization and the continuum of care. In light of the above, the recent federal court consent decree in western Massachusetts is significant because it indicates a judicial willingness to oversee the implementation of deinstitutionalization and the continuum of care (see p. 2). The terms specified in the consent decree also draw attention to the fact that judicial remedy is possible only when both sides agree to the recommended change.³ Thus, the state must acknowledge its responsibility for the care and treatment of the mentally ill both in and out of state hospitals.

Connecticut so far has had neither a class action suit nor court issued change in its mental health services. However, the Department of Mental Health is undergoing reorientation of its service delivery system. The question of whether this reorientation will lead to less rather than more treatment for the mentally ill depends largely on the state's commitment to upgrading its institutional care and developing a network of community services. Without this legislative and executive commitment, judicial remedies not only are unenforceable, but also inappropriate.

¹ Stone, p. 87.

² Ibid., p. 94.

³ The "separation of powers" question was resolved similarly in Wyatt by having both sides agree to the court defined standards of adequate care. Stone, p. 89.

Chapter IV

THE CONTINUUM OF CARE

Introduction

Limited Federal Role

Network of DMH Supported Services

Types of providers

Types of services

Distribution of DMH Funded Community Mental Health Services

Findings

Recommendations

Obstacles to a Continuum of Care

Lack of service coordination

Insufficient aftercare

Nursing home reinstitutionalization

CHAPTER IV
THE CONTINUUM OF CARE

Introduction

The fourth deinstitutionalization activity is the development of a continuum of care which provides community alternatives to state hospital treatment and care. In theory, community mental health services should forestall and even prevent hospitalization and rehospitalization by responding to an individual's need when the traditional community support system of family, friends and clergy is inadequate. Above all, community mental health should direct services to those areas where priority needs exist rather than where private resources are available.

The introduction of community mental health to Connecticut was different from the experience of many other states. Most important, private psychiatric services in Connecticut were established firmly and enjoyed high national esteem. Thus, when the trend to develop non-institutional community-based services took hold in the early 1960's, the framework for such a service network was at least partially in place in the private sector. Further, for more than a decade preceding the federal community Mental Health Centers Act in 1963, DMH was statutorily enabled to provide grants to general hospitals for psychiatric services. In addition, in 1960, DMH and Yale University jointly undertook research and community-based service delivery at the Connecticut Mental Health Center.

Thus, by the early 1960's Connecticut had experience in both community-based service delivery and public and private sector service integration. This experience however, was limited and further progress seemed unlikely because of the mutual suspicion and antagonism between advocates of institutional and community mental health care.

Limited Federal Role

The lack of consensus regarding mental health service delivery was an important factor in DMH's initially weak response to federal Community Mental Health Center (CMHC) dollars. Greater Bridgeport Mental Health Center was the one exception; in 1965, it was awarded one of the largest federal construction grants in the country.

In general, federal "seed" money did not play as large a role in developing Connecticut's mental health services as it did in other states. Instead, the development of these services occurred more as a result of DMH's deinstitutionalization policy, the statutory mandate to develop a system of regionalized services, and increased general fund appropriations, than as a result of federal dollars, particularly the early CMHC dollars.

Network of DMH Supported Services

The variety of programs supported by DMH and their availability to the community or "catchment area" are shown in Table IV-1. The table does not include private and public non-DMH funded mental health services in the state since the extent of these services is not known. In addition, although DMH-owned and operated alcohol and drug services appear in Table IV-1, this chapter focuses on the network of community mental health programs generally and community mental health grants specifically.¹

Types of providers. Table IV-1 lists the state and non-state DMH supported service providers as either "hospital," "community mental health center" or "other." Included in this breakdown are the DMH facilities (excluding Ribicoff Research Center and Whiting Forensic Institute) and alcohol and drug programs, twenty-four of the state's 30 general hospitals, approximately 50 private non-profit agencies, and 5 municipal agencies.² The non-state owned facility providers receive grants to subsidize a portion of their services.

Types of services. DMH-supported services fall into two categories: medical and non-medical. Medical services are administered by physicians or delivered in medical settings, primarily hospitals. Included in this category are inpatient, outpatient/medication, and partial hospitalization/day treatment services. Most of the other services listed in Table IV-1 are

¹ DMH's alcohol and drug programs are those currently administered by Blue Hills Hospital. Community alcohol and drug service grants are now under the jurisdiction of CADAC.

² Some of these hospitals and agencies are affiliates of separate corporations which act as single agencies for grant purposes. In these cases, the single grantee agency appears in Table IV-1 rather than the hospital or agency affiliate.

delivered by mental health professionals in non-medical settings. This second category includes crisis intervention, follow-up care, counseling, transitional living, vocational rehabilitation, social club, and prevention and education services. Some services, like discharge planning, are shared by medical and non-medical providers. (See Glossary for service definitions.)

Distribution of DMH Funded Community Mental Health Services¹

Table IV-1 shows regional and catchment area (CA) disparities in community mental health services by service type and funding level.² It should be noted that some regions and catchment areas have a greater number of DMH-supported services and/or levels of DMH funding than others. For example, Region III has a greater number of funded services than Region V. However, Region V's level of funding per service grantee generally is larger than Region III's. In addition, a large number of Region III's community services are in CA 10 while services in Region V are distributed more equitably between catchment areas.

Given the variety of service types and funding levels and the fact that exceptions tend to outnumber rules, it is difficult to make reliable generalizations regarding the distribution of community services. Further complicating this effort are significant socio-economic differences between and within the regions, such as population, geographic size and per capita income (see Table IV-2). In addition, evaluation of the extent to which DMH funded services are distributed according to need is handicapped by a scarcity of information on non-subsidized mental health services.

Despite these limitations, a meaningful analysis of the distribution of DMH supported services or, more specifically, the regional disparities in levels of funding, is possible when the following four points are noted:

¹ Mental health regions and catchment areas referred to in the following discussion appear in Figure II-1.

² The analysis of the regional distribution of DMH funded community mental health services includes the community outpatient services at CVH and NH, but otherwise excludes the services and budgets of the three large state hospitals since each hospital serves more than one region. Also excluded are DMH owned and operated alcohol and drug services.

Table IV-1. Department of Mental Health Supported Services by Region. ¹

KEY	
•	State supported service
S	State owned facility
N	Non-state owned hospital or agency

Region I	BRIDGEPORT	Facility or Agency	hospital	cmhc	other	inpatient	outpatient/ medication service	partial hospitalization /day treatment	crisis intervention	discharge planning	follow up care	counseling	transitional living	vocational rehabilitation	homecare service	social club	prevention and education	detoxification	alcohol treatment	drug treatment/ methadone maintenance	catchment area(s) served	Funding 10-1-78 9-30-79
		Fairfield Hills Hospital	S			•				•				•				•	•	•	1-4	(1) (2)
		Dubois Day Treatment Center			S		(3)														1-2	\$ 302,463
		Easter Seal Rehabilitation			N									•							1	12,330
		Family & Children Services			N							•									1	20,000
		Gateway Communities			N								•								1	58,334
		Greenwich Hospital					•														1	21,820
		Stamford Hospital		(4)			•														1	109,221
		Carver Foundation of Norwalk			N					•											2	22,000
		Catholic Family Services			N				•		•										2	16,967
		Elderhouse			N		•														2	14,500
		Keystone House			N								•								2	61,807
		Norwalk Dept. of Health			N					•	•										2	15,500
		Norwalk Hospital Asso.	N				•	•													2	274,157
		Gr. Bridgeport Mental Health Center		S		•	•	•	•									•			3-4	3,593,865
		Bridgeport Hospital	N				•														3-4	72,229
		Jewish Family Services			N							•									3-4	22,206
		Mental Health Association			N											•					3-4	1,870
		Y.W.C.A. of Bridgeport			N							•									3-4	46,020
		Town of Monroe			N							•									4	10,200

¹ End-notes described on page

Table IV-1 (continued)

Region II NEW HAVEN Facility or Agency	hospital	cmhc	other	inpatient	outpatient/ medication service	partial hospitalization /day treatment	crisis intervention	discharge planning	follow up care	counseling	transitional living	vocational rehabilitation	homecare service	social club	prevention and education	detoxification	alcohol treatment	drug treatment/ methadone maintenance	catchment area(s) served	Funding 10-1-78 9-30-79
	Connecticut Valley Hospital	S			•	•	•		•			•	•				•	•	•	5-9
Dartec			S													•		•	5-9	(1)(6)
Griffin Hospital	N				•														5	\$ 85,779
Lower Naugatuck Community Council			N				•	•			•								5	75,933
Public Health Nursing & Homemaker Service			N					•											5	8,837
Stand, Inc.			N						•										5	7,070
Valley Association for Retarded			N						•										5	5,774
Connecticut Mental Health Center		(7)	(7)	•	•	•									•	•	•	•	6-8	4,439,368.(8)
Fellowship Club			N											•					6-8	15,121
New Haven Halfway House			N								•								6-8	31,641
St. Raphael's Hospital	N				•														6-8	80,193
Yale-New Haven Hospital	N				•														6-8	54,200
Coordinating Committee for Children in Crisis			N						•										6	3,000
Guilford Family and Child Guidance			N						•										6	75,895
Dixwell Opposes Alcoholism (9)			N						•										7	12,000
Hamden Mental Health Service			N				•		•										7	106,550
Newhallville Neighborhood Corp.			N						•										7	50,086
Town of North Haven			N						•										8	54,996
Community Provider Consortium			N	•	•	•	•	•	•				•						9	334,745

Table IV-1 (continued)

Region III NORWICH Facility or Agency	hospital	cmhc	other	inpatient	outpatient/ medication service	partial hospitalization /day treatment	crisis intervention	discharge planning	follow up care	counseling	transitional living	vocational rehabilitation	homecare service	social club	prevention and educatic	detoxification	alcohol treatment	drug treatment/ methadone maintenance	catchment area(s) served	Funding 10-1-78 9-30-79
Connecticut Valley Hospital	S			•	•	•		•			•	•				•	•	•	10	(1) (10)
Norwich Hospital	S			•	(11)	•					•	•			•	•	•		11-14	(1) (6)
Norwich Methadone Clinic			S													•		•	10-14	\$41,000 (12)
Elmcrest Community Mental Health Clinic			N												•				10	9,500
Gateway Counseling			N					•	•										10	23,183
Gilead House			N								•								10	15,637
Lower Valley Mental Health Services			N				•	•											10	4,000
Mental Health Association			N											•					10	1,886
Mental Health Association			N												•				10	11,193
Middlesex Community Mental Health Services			N					•											10	12,000
Middlesex Hospital	N				•		•			•									10	79,149
First Step			N								•								11	34,968
Lawrence and Memorial Hospital	N				(13)	•													11	164,591
First Step			N								•								12	25,945
Leisure Center			N					•	(14)										12	25,945
Thames Valley Council			N												•				12	18,000
United Workers								•											12	25,453
Community Health Home Care								•	•										13-14	4,866
Mental Health Association														•					13-14	2,566
Mental Health Association			N											•					13-14	1,738
Natchaug Valley Community Health Service			N					•											13-14	1,532
United Social and Mental Health Services		N		•	•	•	•	•	•	•									13-14	242,348(15)

Table IV-1 (continued)

Region IV HARTFORD Facility or Agency	hospital	cmhc	other	inpatient	outpatient/ medication service	Partial hospitalization /day treatment	crisis intervention	discharge planning	follow up care	counseling	transitional living	vocational rehabilitation	homecare service	social club	Prevention and education	detoxification	alcohol treatment	drug treatment/ methadone maintenance	catchment area(s) served	Funding 10-1-78 9-30-79
Connecticut Valley Hospital	S			•	•	•		•			•	•				•	•	•	19	(1) (16)
Norwich Hospital	S			•	•	•		•	•		•	•			•	•	•		15-18, 23	(1) (17)
Cedarcrest Hospital	S			•				•											15-18, 23	\$2,784,000 (18)
Blue Hills Hospital	S															•	•	•	15-19, 23	1,598,000 (19)
Community Services Center			S													•	•	•	15-19, 23	123,000 (20)
Compass Club			S													•	•		15-19, 23	167,000 (21)
Dartec			S													•		•	15-19, 23	(1) (22)
Hartford Regional Clinic			S													•	•	•	15-19, 23	208,000 (23)
Hockanum Valley Community Services Center			N												•				15	17,755
Manchester Memorial Hospital	N				•		•												15	146,250
Manchester Public Health Nursing			N					•											15	3,535
Catholic Family Services			N							•									16,23	17,674
Hartford Hospital	N				•		•	•			•								16,23	182,750
Capitol Region Mental Health Center			(24)		•	•					•								17,23	729,000
Greater Hartford Social Club			N								•			•					17,23	60,094
Hartford Visiting Nurse Association			N					•											17,23	21,820
Enfield Mental Health Center			N		•						•								17	69,000 (25)
St. Francis Hospital	N				•		•	•											18,23	95,735
Catholic Family Services - New Britain			N					•											19	12,787
Central Conn. Community Mental Health Affiliates		N			•	•	•	•	•	•	•								19	330,411 (26)
Greater Bristol Visiting Nurse Association			N					•											19	5,716

Table IV-1 (continued)

Region V WATERBURY Facility or Agency	hospital	cmhc	other	inpatient	outpatient/ medication service	partial hospitalization /day treatment	crisis intervention	discharge planning	follow up care	counseling	transitional living	vocational rehabilitation	homecare service	social club	prevention and education	detoxification	alcohol treatment	drug treatment/ methadone maintenance	catchment area(s) served	Funding 10-1-78 9-30-79
Fairfield Hills Hospital	S			•				•				•				•	•	•	20-22	(1) (22)
Catholic Family Services			N					•	•										20	\$ 16,896
Central Valley Help Inc.			N								•								20	51,707
Mental Health Association			N											•					20	1,886
St. Mary's Hospital	N				•														20	73,066
Waterbury Hospital	N				•	•													20	144,324
Waterbury Visiting Nurse Association			N					•	•										20	23,812
Danbury Catholic Family Service			N						•	•									21	31,307
Danbury Hospital	N				•	•													21	130,697
Interlude, Inc.			N								•								21	60,000
Mental Health Association			N											•					21	1,886
New Milford Hospital	N				•														21	34,953
New Opportunities for Waterbury			N								•								21	42,105
Bridgeway			N								•								22	63,404
Charlotte Hungerford Hospital		N			(27)														22	137,420
Housatonic Mental Health Center			N		•														22	15,000
Mental Health Association			N											•					22	1,886
United Way of Connecticut			N				•												State- wide	20,000

Table IV-1 (continued)

End-notes

- (1) Funding breakdown by region not available.
- (2) Also serves Region V.
- (3) Diagnostic testing also.
- (4) Previously received construction grant as CMHC. Now operates as separate unit.
- (5) Also serves Regions III and IV. Ombudsman program also.
- (6) Also serves Region IV.
- (7) Owned by DMH; jointly operated with Yale University. Hill-West Haven Division is CMHC which receives federal grant of \$248,707.
- (8) Excludes research education and training.
- (9) Proposed vendor.
- (10) Also serves Regions II and IV.
- (11) Provides outpatient staff at four general hospitals:
Backus (CAC-12), L&M (CAC-11), Day Kimball (CAC 13-14), Windham (CAC 13-14). Also operates alcoholism outpatient clinic in City of Norwich.
- (12) Received federal grant of \$24,000.
- (13) Screening and consultation services also.
- (14) Includes transportation and nutrition program.
- (15) Also receives CMHC grant of \$713,811.
- (16) Also serves Regions II and III.
- (17) Also serves Regions III.
- (18) Received federal grant of \$200,000 and includes \$24,000 for equipment costs.
- (19) Received federal grant of \$71,000.
- (20) Received federal grant of \$34,000.
- (21) Received federal grant of \$35,000.
- (22) Also serves Region I.
- (23) Received federal grant of \$98,000.
- (24) Contracts with University of Connecticut.
- (25) Disposition unknown at this time.
- (26) Also received federal grant of \$330,410.
- (27) Includes an evening adult outpatient program.

55

Source: LPR&IC compilation from DMH Central and Regional Offices' data,
March 1, 1979.

Table IV-2. Population and per capita income by mental health region, FY 1975.

<u>Region</u>	<u>Population</u>	<u>Rank Size</u>	<u>Per Capita Income</u>	<u>Rank Income</u>
I	635,795	2	\$6,931	1
II	593,481	3	5,091	4
III	508,581	4	4,744	5
IV	887,811	1	5,395	2
V	476,628	5	5,231	3

Source: Data Element Listing, Entitlement Period #10, Office of Revenue Sharing, U.S. Department of the Treasury.

1. The analysis of regional disparities by levels of state support assumes that dollars correlate with services. However, this assumption may not apply in every case because the level of service can vary depending on the provider grantee. For example, a \$5,000 DMH grant to a private non-profit agency may help deliver more than \$5,000 worth of services because of that agency's ability to attract other state, federal and private funding.
2. The current distribution pattern of community mental health services largely is due to two facts: general hospitals were the first DMH grantees and hospital outpatient services have been considered the most critical type of community mental health service. As a result, DMH grants over \$100,000 are for general outpatient and partial hospitalization services.¹
3. In order to qualify for federal community mental health center (CMHC) funding, DMH must assume a moral commitment to fund a certain level of CMHC services in "encumbered"² catchment areas once the

¹ The exception is Hamden Mental Health Service in Region II which received its first year of DMH funding in 1979.

² A federally "encumbered" catchment area assumes a commitment to sustain delivery of the mental health service(s) for a period subsequent to secession of federal funding.

eight years of declining federal grants end. The Department so far has honored this commitment. As a result, encumbered catchment areas receive a certain level of mental health grant funding regardless of regional need. Currently, these catchment areas are 1, 3-4, 6, 13-14, 19, 21 and 22 in which there are two state-owned and five non-state owned federally designated CMHCs receiving DMH support.¹

4. Mental health agency grantees and contractors, unlike state-owned facilities, retain third-party payments for services delivered. Although these payments are not included in the grant and contract amounts received, they are generated by DMH monies and, therefore, indirectly increase the actual funding levels of these agencies.

Findings. Table IV-3 reveals two major findings regarding regional disparities in levels of community mental health service funding. First, when regional per capita income levels (Table IV-2) are used as indicators of service need, the greatest disparity in funding occurs between Regions I and III. Furthermore, the disparities between catchment areas within these regions also are significant, particularly the disparity in numbers of service grantees between CA 10 and other catchment areas in Region III (Table IV-1).² In other words, Region III not only has the lowest per capita income and next to the lowest level of mental health grant and contract funding of all five regions, but also the the widest disparity in local community service availability.

Second, Table IV-3 shows that regional disparities in levels of DMH community facility funding are proportionately greater

¹ The two state-owned centers are Greater Bridgeport MHC (CA 3-4 in Region I) and the Hill-West Haven Division of the Connecticut MHC (CA 6 in Region II). The five non-state owned centers are located at Stamford Hospital (CA 1 in Region I), United Social and Mental Health Services (CA 13-14 in Region III), Central Connecticut Mental Health Center (CA 19 in Region IV), Danbury Hospital (CA 21 in Region V), Charlotte Hungerford Hospital (CA 22 in Region V).

² Although a comprehensive level of services is available in CA 10 if the outpatient clinic at CVH is excluded, the level of funding is less than CA 11. In addition, the disparity between CA 10 and CAs 13-14 has been offset somewhat by the 1978 funding of a federal community mental health center in these catchment areas.

than regional disparities in funding for mental health grants and contracts. In addition, the column totals in Table IV-3 demonstrate that the Department spends the bulk of its community service funds in state-operated facilities. Thus, regions like III and V with no state-operated community facility¹ have significantly lower per capita funding levels and service availability.

Table IV-3. Total and per capita DMH mental health grants, contract and community facilities by region, FY 1979.

Region	Grants and Contract ¹		Community Facilities ²		Total ³	
	Amount	Per Capita	Amount	Per Capita	Amount	Per Capita
I	\$ 779,177	\$1.22	\$3,896,832	\$6.12	\$4,676,009	\$7.44
II	1,048,952	1.76	4,439,368	7.48	5,488,320	9.22
III	715,263	1.41	523,566	1.03	1,238,829	2.44
IV	1,712,527	1.93	2,900,000	3.26	4,612,527	5.19
V	834,559	1.75	-0-	-0-	834,559	1.75
TOTALS	\$5,090,478		\$11,759,766		\$16,850,244	

¹ Contract for services with Capitol Region MHC (Region IV).

² Greater Bridgeport MHC (Region I); DuBois Day Treatment Center (Region I); Connecticut Mental Health Center, excluding research, education and training (Region II); Outpatient services at CVH and NH (Region III); Cedarcrest Regional Hospital (Region IV).

³ Includes grants and contract and community facilities.

Sources: DMH, Office of Revenue Sharing, U.S. Department of the Treasury (FY 1975).

This second finding raises important questions regarding DMH's role as a service provider. The Commissioner, for example, has said that he is committed to a major shift in the Department's current 4:1 ratio of direct to indirect services and has cited the planned reduction of the three large state hospitals as evidence of prospective movement in this direction (see pp. 87 ff.). However, the discrepancy between the funding levels of mental health grants and contracts, on the one hand, and state-operated community facilities, on the other, indicates that the Department's proportionately greater reliance on direct service provision is repeated in its community mental health funding. More important,

¹ Region III's DMH community facility funding listed in Table IV-3 represents outpatient services provided by CVH and NH.

this funding disparity intensifies regional disparities in community service distribution.

Recommendations. The LPR&IC recommends that the following administrative and legislative actions be taken to reduce the disparities in regional and catchment area mental health service distribution:

1. In order to determine the availability of mental health services in Connecticut, the LPR&IC recommends that each CAC develop an inventory of all public and private mental health services according to Departmental definition of mental health services. Availability of services would be quantified by standard measurement such as units of services or number of staff. Based upon the inventory, CACs would annually develop a list of priority service needs, submitted to the RMHB and the regional director. The priority needs lists would be used by the RMHBs to determine relative need within the regions and by the Department to determine relative need among the regions.

2. In order to reduce service disparities between catchment areas, the LPR&IC recommends that DMH rank the twenty-three catchment areas by service need and provide technical assistance to the neediest catchment areas for developing federal community mental health center applications. Currently, catchment areas initiate application for federal money and the Department offers assistance when needed. As a result, community service redistribution is not effectively pursued since application for federal funding is made without comparative evaluation of regional and catchment area need.¹ Although regional mental health boards are responsible for prioritizing regional needs, DMH is best qualified to reduce service disparities statewide. Further, Departmental initiative in federal application is appropriate in view of DMH's moral commitment to maintain a level of funding in encumbered catchment areas.

¹ DMH does rank catchment areas according to federal criteria which include inpatient beds in state hospitals. Therefore, these criteria do not reflect actual community services.

3. In order to measure more effectively the amount and type of service delivered by each community mental health grantee, the LPR&IC recommends that DMH develop alternatives to the existing grant mechanism. Alternatives now being considered by DMH include the following: (a) substituting the present general terms of community grants with specific conditions under which grant money is to be spent; (b) supplementing the community grant mechanism with contracts for units of service delivered; (c) implementing a system of co-insurance in which DMH pays all or part of the service cost depending upon third-party coverage. Each of these three funding alternatives would help DMH more efficiently target community service support to service need.

4. In order to reduce mental health service disparities among and within regions, the LPR&IC recommends that the Commissioner of Mental Health distribute the FY 1980 community grants appropriation more equitably (see Chapter V, Formula Funding) and require the Regional Mental Health Boards to demonstrate reduction in any disparities at the catchment area level.

Obstacles to a Continuum of Care

The most important obstacle to creating a continuum of mental health care is the lack of coordination between and within the public and private service delivery sectors. As a result, the delivery of mental health services in Connecticut is fragmented rather than integrated, and chaotic rather than directed. Further, DMH has been more successful in reducing state hospital patient population and length of institutionalization than in creating "a continuum of care available to all patients so they may be returned to full and productive lives as soon as possible."¹

However, decreased reliance on the state mental hospitals and increased emphasis on alternative services are the two major components of DMH's 1975-1980 deinstitutionalization goal. The Department, therefore, needs to focus greater attention on developing community services in general and providing for the aftercare of state hospital patients in particular.

¹ Connecticut Department of Mental Health State Plan, 1977; p. 8.

Lack of service coordination. Connecticut's fragmented mental health service delivery system is primarily a result of the following three developments. First, until the establishment of the Department of Mental Health in 1953 and the passage of federal community mental health center legislation in the early sixties, Connecticut's public sector services lagged behind those in the private sector. In addition, the state's slow initial response to federal initiative limited the extent to which CMHC money could be used to bridge the gap between public and private mental health services.

Second, because community mental health challenges the dominant service role of the state hospitals, the development of publicly supported community-based services has generated antagonism rather than cooperation between institutional and community providers. Unfortunately, this adversarial relationship undoubtedly will be aggravated by the current fiscal policy of limiting new monies for human services so that any budgetary gain for one group of services involves a loss for another. Interest group competition usually is intensified under such threatening conditions; thus making cooperation even more difficult to achieve.

Finally, deinstitutionalization itself has created problems for coordinating mental health services. The emergence, for example, of nursing homes as primary care providers for the mentally ill means that a large proportion of psychiatric patients are now outside of the mental health service network. The likelihood that these people will receive appropriate treatment is thus lessened. Programmatically, this development increases the difficulty of planning for community-based services and especially for continuity of mental health care.¹ (See discussion below of nursing home reinstitutionalization.)

In order to facilitate the coordination of mental health services, the LPR&IC recommends that DMH establish regional information and direction centers to match individual client needs with available services and assist the interaction between service consumers and providers. Further, it is recommended that these centers be located in the offices of the Regional Mental Health Boards (RMHBs), and that responsibility for information coordination and client direction rest with Board staff and/or community volunteers. The RMHBs will be able to provide a geographically

¹ "A Report on Deinstitutionalization and Reinstitutionalization," prepared for Yale University's Department of Epidemiology and Public Health, April-October, 1977; p. 34.

comprehensive level of coordination and direction that is separate from DMH's service programs. This separation is necessary to insure the impartial status of the centers' activities.

Insufficient aftercare. The successful implementation of deinstitutionalization requires that a continuum of care be available to discharged state hospital patients and that DMH be responsible for providing appropriate aftercare services. Presently, the Department's ability to fulfill this responsibility is limited by the comparatively modest amount of its resources allocated to services other than inpatient.

This limitation is critical because mental illness very often is a chronic condition requiring extended treatment after hospitalization. Insufficient aftercare, therefore, means that deinstitutionalized patients become not only burdens to the communities in which they reside, but also recidivists within the state hospital system. The human tragedy created by these conditions is immense.

The LPR&IC recommends that the following actions be taken to provide more adequate aftercare for deinstitutionalized state mental hospital patients:

1. The Commissioner of Mental Health establish procedural guidelines for state hospital discharge planning and follow-up activities. These guidelines should include minimum full-time staffing requirements, staff training programs and community referral and liaison arrangements. Currently, the performance of these activities is determined by "the clinical preferences of hospital administrators and by staffing and economic realities with which they have to work."¹ As a result, the quantity and quality of discharge planning and follow-up vary considerably both between and within the three state mental hospitals. Effective implementation of aftercare is thus lessened.
2. The Department develop minimal care settings in the community including but not limited to foster care, sheltered homes and boarding homes.

¹ DMH, October 1978.

3. DMH pursue federal funding of community housing for the chronically mentally ill. This funding is available under the Department of Housing and Urban Development (HUD) "Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill," and consists of direct loans and rent subsidies to private contractors. DMH's 1978 application to HUD was rejected because of the lack of commitment to provide program support services, such as technical assistance and state program supervisory staff in a specifically designated state agency.¹ The demonstration of such commitment in the Department's FY 1980 application can be made by designating a portion of the new community grant account appropriation for support services and indicating that the provision of these services will continue for a specified number of years.
4. DMH together with the Departments of Income Maintenance and Health Services develop ways of maximizing third-party payments and other support payments and services for deinstitutionalization patients. The fact that insurance policies generally are set up to cover physical illness requiring medical treatment in a hospital creates special difficulties for discharged mental patients because their aftercare involves important non-medical therapies such as family counseling, sociotherapy or vocational rehabilitation.² The Department and related state agencies should calculate the costs and benefits of legislatively requiring a minimum level of coverage for non-medical community mental health services in group health insurance policies.
5. DMH and community nursing agencies formally describe their discharge planning and follow-up activities as medically necessary and, therefore, reimbursable.

¹ Office of Independent Living, Department of Housing and Urban Development, Washington, D.C.

² Clara Claiborne Park and Leon N. Shapiro, M.D., You Are Not Alone (Canada: Little Brown & Co., 1976) pp. 309-311.

Deinstitutionalized patients in need of a community nursing and home health service are faced with the reluctance of public and private insurers to reimburse mental health nursing visits. Medicare fiscal intermediaries, for example, require that such visits be performed by psychiatric nurses to be considered for reimbursement. This restriction, which is not applied to community nursing care for other types of discharged hospital patients, effectively excludes Medicare-eligible patients from receiving reimbursement for regular skilled nursing services, such as medication monitoring, follow-up care, home safety and linkage with other community and social service agencies.

Nursing home reinstitutionalization. The reinstitutionalization of psychiatric patients in nursing homes is another obstacle to a continuum of mental health care. DMH estimates that there are 2,000-3,000 patients with primary diagnoses of mental illness in nursing homes, or about 12% of the nursing home population, not including patients who are senile.¹ This percentage very likely would be higher if secondary diagnosis were taken into account. In a 1977 study of three skilled nursing facilities (SNFs) in Region II, it was estimated that, "If secondary diagnoses are taken into account, more than 40% of all residents in the nursing homes studied could be classified as psychiatric patients."²

The emergence of nursing homes as primary care providers for the mentally ill is due largely to the fact that mental health services have been the principal alternative mental health service beneficiaries of Medicaid programs. Development of alternatives under Medicaid, such as mental health clinic services, day care, small residential facilities and home care has been limited.³

Inappropriate reinstitutionalization of the mentally ill in nursing homes not only defeats the goal of deinstitutionalization

¹ Some of these patients are legal residents of New York State which pays a higher reimbursement rate. As a result, some nursing homes in western Connecticut give preference to New York State residents.

² "Deinstitutionalization and Reinstitutionalization;" p. 32.

³ "Returning the Mentally Disabled to the Community: Government Needs to Do More," General Accounting Office, January 7, 1977, p. 11.

to provide care in least restrictive settings, but also removes mentally ill persons from the network of mental health services. As a result, these patients very often receive inappropriate or inadequate treatment and care. Approximately 90% of the state's 221 chronic and convalescent nursing homes and 70 rest homes with nursing supervision are licensed by the DOHS to care for persons "with manageable psychiatric conditions as determined by a board qualified or certified psychiatrist."¹ This admission examination is the only required psychiatric examination or consultation required by the Public Health Code for psychiatric patients in nursing homes.² The code, in other words, makes no provision for ongoing psychiatric treatment for these patients, and nursing homes are reluctant to provide this treatment because of the reimbursement problems, especially for the many nursing home patients who are on state aid. The state in turn requires the prior approval of psychiatric visits to nursing homes and will pay only a percentage of the psychiatrist's fee.³ Presently, the Department of Income Maintenance pays \$36.00 for a psychiatric initial visit, and \$11.25 for follow-up visits as long as these visits do not exceed one per week. No other mental health professional nursing home visits (eg. a psychologist, psychiatric social worker or psychiatric nurse) are Medicaid reimbursable.

The LPR&IC recommends that the following actions be taken to provide the service needs of psychiatric patients in nursing homes.

1. The Connecticut Public Health Code be revised to (a) specify the types and minimum levels of mental health recreation and physical therapy services and/or staff in licensed nursing homes authorized to care for persons with manageable psychiatric

¹ Connecticut Public Health Code, 19-13 D9.

² Joan Barbuto, "Mental Patients Get Little Therapy in Nursing Homes," New Haven Register, November 15, 1978.

³ Ibid.

conditions;¹ (b) provide minimum requirements for in-home staff or consulting psychiatric or other mental health professional services (for example, psychological, psychiatric nursing or social work services); (c) specify the minimum number of monthly, quarterly or yearly visits, as well as minimum levels of treatment intensity of required psychiatric and other mental health professional nursing home services.

2. DMH together with the Department of Health Services monitor the number, frequency and level of treatment intensity of psychiatric visits to mental health patients in nursing homes.
3. The Department of Income Maintenance increase the level of reimbursement for follow-up visits by a psychiatrist.
4. The Department of Income Maintenance classify other mental health professional nursing home visits as Medicaid reimbursable services.

¹ Recent amendments to the Public Health Code have specified, for the first time, minimum requirements regarding program content, qualifications and responsibilities of therapeutic recreation staff in nursing homes. These requirements, however, do not extend beyond broadly requiring "mentally and physically stimulating activities" to include therapeutic activities specifically geared to the mentally ill. Connecticut Public Health Code, Sections 19-13-D7(j) and D8(h)(2).

Chapter V

REGIONALIZATION

Creating a Regional Mental Health Constituency
Regionalization Progress
Formula Funding
Regional Budgeting
 Confusion in implementation
 The Commissioner's intended implementation procedure
 Regional budgets and formula budgets
 Findings
 Recommendations
Departmental and Citizen Participation Structures
 Catchment Area Council procedural problems
 Regional Mental Health Board procedural problems
 Role of Regional Directors

CHAPTER V

REGIONALIZATION

Creating a Regional Mental Health Constituency

DMH's implementation of deinstitutionalization and the continuum of care has coincided with the implementation of its most important recent legislative mandate--the establishment of regionalized mental health services and citizen advisory boards. The implementation of these changes at times has impeded and at other times prompted the Department's progress in reorienting its mental health delivery system.

Although deinstitutionalization and regionalization both involve the development of community based mental health services, they address this task on two separate and competing levels--state and regional. While this competition has generated hostility, it has also created pressure for change. The Commissioner, therefore, must move carefully, yet steadily, in the direction of service reorientation if he is to mobilize successfully the support of the regional citizen participants on behalf of Departmental policies. Such support is critical because mental health traditionally has lacked an organized, articulate constituency.

Regionalization Progress

Five years have passed since the initial regionalization legislation was enacted. During this time, the Commissioner designated five mental health regions advised by regional boards and catchment area councils (see Chapter II, Important Organizational Roles), and hired five regional directors to be liaisons between the Department and the Regional Mental Health Boards. However, the system of regionalized mental health services which is the statutorily declared purpose of the mental health regions (C.G.S. 17-226f) has not been implemented. Indeed, the Commissioner's intended utilization of the implementation mechanisms--regional budgeting, formula funding and citizen participation--remains unclear. This is because the following issues have not been resolved:

- Design of the per capita formula for funds of the mental health service regions;
- Inclusion of state hospital budgets in regional budgeting;

- Redistribution of regional institutional and community mental health services; and
- Integration of the Departmental and regional organizational structures.

The LPR&IC finds that the absence of clarification by the Commissioner has resulted in confusion and misinterpretation concerning the regionalized mental health delivery system and the roles of the various participants. Therefore, the LPR&IC recommends that the Commissioner define, describe and interpret the experience to date of regional budgeting, formula funding and citizen participation. This information should be incorporated into a memorandum sent to all participants whose roles were established under the regionalization legislation.

The LPR&IC recommendations for improving regionalization implementation in the future are set forth below.

Formula Funding

The statutes (C.G.S. 17-226i) specify that funds are to be distributed to each mental health service region by the Commissioner. This regional allocation is to be determined by a formula developed by the Commissioner based on regional "population, need for and utilization of existing mental health services, and any other factors which the Commissioner considers important and relevant."

A trial formula was first developed in FY 1979 by an ad hoc committee appointed by the Commissioner. The formula was applied to \$327,426 of new community grant account funds and included the variables of regional population, per capita income, state hospital inpatient population and unemployment. However, because this formula was weighted heavily on the basis of population rather than need, (see Table V-1), the resultant funding distribution (see Table V-2 formula funding columns) perpetuated the per capita disparities discussed in Chapter IV (see Table IV-3). In addition, the General Assembly appropriated \$300,000 specifically designated to be divided equally among regions (see Table V-2 fixed funding columns). This appropriation enabled a slightly more favorable per capita distribution to the two most underserved regions (III and V) because they are the least populous. As a result of the combined funding distributions, the disparity among regions neither expanded nor contracted significantly.

Despite the trial formula's ineffectiveness in reducing inequities in FY 1979, the ad hoc committee did not recommend

Table V-1. Trial Formula Funding Variable - FY 1979 and FY 1980.

<u>Variable</u>	<u>Weight</u>
Population	.85
Per capita income	.07
Unemployment	.05
State hospital inpatient admission	.03
	<u>1.00</u>

Source: DMH

Table V-2. Allocation for New Community Grants, FY 1979.

<u>Region</u>	<u>Trial Formula</u>			<u>General Assembly</u>		<u>Total</u>	
	<u>Share</u>	<u>Funding</u>	<u>Per Capita</u>	<u>Fixed Regional Funding</u>	<u>Distribution Per Capita</u>	<u>Combined¹</u>	<u>Per Capita</u>
I	.205	\$67,122	.11	\$60,000	.09	127,122	.20
II	.195	63,848	.11	60,000	.10	123,848	.21
III	.168	55,008	.11	60,000	.12	115,008	.23
IV	.274	89,715	.11	60,000	.07	149,715	.18
V	.158	51,733	.11	60,000	.13	111,733	.24
	1.000	\$327,426		\$300,000		\$627,426	

¹ Formula Funding plus Fixed Funding.

Sources: DMH, Office of Revenue Sharing, U.S. Department of the Treasury (FY 1975).

revision of the trial formula for the FY 1980 new community grants. Instead, allocations will be heavily weighted, once again, towards population. The LPR&IC finds that Regions III and V will receive the lowest allocations (see Table V-3) despite higher levels of need.¹

¹ Although \$1.4 was appropriated for new grants, the Department intends to use \$500,000 for annulazation of FY 1979's new grants which were awarded for the nine months beginning October, 1978.

In order to prevent reoccurrence of this maldistribution, the LPR&IC recommends that prior to July 1, 1980, the Commissioner establish the statutorily mandated regional per capita formula. So that this formula is more reflective of service need than the present trial formula, greater weight should be given these variables as represented by per capita income and the extent of state-owned community facilities.

Table V-3. Proposed Allocation for New Community Grants, FY 1980.

<u>Region</u>	<u>Formula Share</u>	<u>Formula Funding</u>	<u>Per Capita</u>
I	.205	\$184,500	.29
II	.195	175,500	.29
III	.168	151,200	.29
IV	.274	246,600	.29
V	.158	142,200	.29

Source: Department of Mental Health.

Furthermore, the LPR&IC recommends that formal application of the established formula be limited to new community grant account funds until FY 1984 budgeting. At that time, the formula's application should be extended to DMH's entire service budget (see discussion below on Regional Budgeting).

Regional Budgeting

Despite statutory reference to regional budgeting,¹ no statutory definition exists and no regional budgets have been adopted to date. Instead, the Commissioner has continued to rely on the "consolidated budget" (C.G.S. 17-210a(i)) which is a composite of state facilities and central office budgets. At the same time, he has stated his intention to introduce regional budgets for FY 1981.

Confusion in implementation. Despite approaching implementation, the effect of citizen participation on the

¹ C.G.S. 17-2261 - Each RMHB, together with the regional director shall "make specific recommendations to the Commissioner of Mental Health concerning the annual budget of the region."

regional budgeting process and the impact of regional budgets on the statutorily mandated system of regionalized services remain unclear. Clarification depends upon resolution of two important issues. First, will state budgets be integrated in regional budgets? Second, will regional budgets reflect meaningful citizen participation input?

The Commissioner has addressed these issues to the extent that he has (1) established that state-owned facilities budgets be included in regional budgets and (2) articulated his commitment to meaningful citizen participation. While these assurances have succeeded in establishing initial credibility with the citizen participants, the long-standing mistrust towards the Department has not been eliminated entirely. The primary reason for the citizen participants' skepticism is the Commissioner's reluctance to redistribute immediately resources from state hospitals to community-based services. This reluctance became policy in the Department's Facilities Plan 1980-1985 which specifies maintenance of state hospital budgets until FY 1984 at which time redistribution would be initiated (\$2 million the first year). The LPR&IC finds that the differing goals of the Commissioner and the regional citizen participants are mutually exclusive and thus increase the potential for conflict.

The Commissioner is aware that he has ultimate decision-making authority. However, it became apparent to LPR&IC staff that many citizen participants entertain unrealistic expectations of their role. In many cases, the statutorily mandated advisory role has been misunderstood and participants anticipate regional autonomy. In other instances, citizen participants acknowledge that their role is limited to an advisory one but, nevertheless, expect that the RMHBs will make recommendations on specific program funding levels for all state-owned programs and community grants.

Although the differing interpretations have generated uncertainty, direct conflict has been avoided to date by the absence of regional budgeting. This is because without regional budgeting, the Catchment Area Councils and the Regional Mental Health Boards have been limited to overseeing the non-profit agencies which receive DMH subsidies through the grants account. While the RMHBs resent the Commissioner's delay in establishing regional budgeting, their frustrations have been tempered by the belief that they will have increased jurisdiction when implementation becomes effective. However, when this occurs, the Commissioner's commitment to maintaining direct patient

care at state hospitals through 1983 will conflict with the RMHBs' inclination to immediately redirect resources to community-based services.

The Commissioner's intended implementation procedure. Although the RMHBs and the Commissioner have not discussed jointly how the regional budget will be derived, the implementation timetable for redirecting program funds in the Facilities Plan reveals that priority will be given to maintenance of state hospitals over the short term. In conformance with the Plan, the Commissioner intends to reserve the majority of each regional budget for state-owned facilities which operate within the region. Thus, only if savings were realized at state hospitals in one year would there be a reduction in the subsequent year's hospital allocation within the regional budget. In effect, state hospital funding, allocated from the various regional budgets, would be "held-harmless."

To determine how this allocation will be made, the Commissioner will rely upon regional cost utilization data generated by the Fiscal Management Information System (FMIS).¹ For this reason, the Commissioner has delayed regional budgeting until the FMIS becomes operational. After the allocation for state facilities has been deducted from the regional budgets,² the RMHBs will make recommendations regarding the remaining funds. However, because the balance will be limited to the grants account there will not be any expansion of the purview of the RMHBs.

The Commissioner's "hold-harmless" approach for state hospitals is inconsistent with the RMHBs' contention that all regional services should be reviewed and prioritized annually. Acknowledging that his predetermined prioritization raises the potential for conflict with the RMHBs, the Commissioner also believes that resolution is possible if the Department is given administrative flexibility. Specifically, the Commissioner would like to have authority to transfer to community programs the savings realized at state hospitals. Early closings of buildings at these facilities are cited as major savings sources. Though a reduction in state hospital utilization would allow a realization in savings, it is questionable

¹ The FMIS will enable assignment of direct state hospital costs per day per patient per ward by catchment area and by region.

² Central office, research, training and education and Whiting Forensic Institute will probably be excluded from regional budgets.

whether the amount would approximate the level advocated for redistribution by the RMHBs (see Chapter VI, Necessary Data).

Regional budgets and formula budgets. Although the preceding section discussed the intended procedure for implementation of regional budgeting, the resultant actual fiscal impact on each region was not reviewed. This review is not possible because (1) the formula for derivation of the regional budgets has not yet been established by the Commissioner (see Formula Funding), and (2) the categories of exclusions have not yet been determined.¹ Furthermore, because the FMIS system is not yet operational, it is not possible to determine the regional utilization cost which will be allocated to each region. Thus, because the extent of known regional expenditures are those indicated in Table IV-1, there is no way to approximate the impact of the "hold-harmless" allocations on the different regions.

It is conceivable that high state hospital inpatient utilization in one region² could result in a regional utilization cost for the following year which equals or exceeds the entire formula allocation of the regional budget (herein "formula budget"). Similarly, a region could have a relatively high level of community-based services,³ and an average utilization of state hospitals which could also result in regional expenditures in excess of the formula budget. Conversely, regional utilization costs could be significantly lower than the formula budget, reflecting poor access to mental health services or high utilization of non-DMH subsidized services. Thus, there is no guarantee that the formula budget would be equal to the actual regional budget (regional utilization costs plus existing contracts and grants plus new funding allocated by formula for new and expanded services.)

In fact, the difference between the actual regional budget and the formula budget will demonstrate (1) the disparities between regions (discussed in Chapter IV), or (2) overutilization

¹ See footnote 2, preceding page.

² This high utilization could be the result of an absence of less intensive service alternatives such as outpatient clinics or structured living arrangements.

³ This applies especially where state-operated facilities exist since they do not retain third-party payments.

of state hospitals in the absence of community facilities. The former will result in a formula budget in excess of the regional budget; the latter will produce a regional budget in excess of the formula budget. Where these conditions exist, careful targeting of new state and federal money will achieve a balance between regional budgets and formula budgets in time. If, however, new funding is not available, redistribution of funds among regions will be necessary.

Findings. The LPR&IC finds that the Mental Health Services Act intended the following:

1. Inclusion of state facilities in the system of regionalized services and, therefore, in regional budgets.
2. Regional Mental Health Boards advisory input in the regional budget preparation.
3. Final determination of regional budgets left to the Commissioner.

Therefore, it is necessary and appropriate to (1) initiate regional budgets which include state facilities budgets and (2) extend RMHBs' specific budgetary recommendations to all state-owned facilities. At the same time, while LPR&IC is critical of the delay in implementing the regionalization legislation, the Committee finds that immediate implementation of regional budgeting could create disruptions in service delivery and in the development of meaningful citizen participation. Therefore, the LPR&IC finds that actual regional budgeting by formula cannot be implemented realistically by FY 1981.

Recommendation. In order to eliminate the potential for disruptions in service at both state hospitals and community-based services, the LPR&IC recommends that the Department include in the aforementioned recommended memorandum the following information: an implementation timetable, projected impact of regional budgeting and formula budgeting, and an analysis of the future role of regional citizen participants.

Furthermore, the LPR&IC recommends that the timetable adopted reflect informal use of both regional budgets and formal budgets from FY 1981 through FY 1983. Regional budgets would be derived from the consolidated budget including (1) regional utilization costs for the previous year, unless modified by the Commissioner at the suggestion of the RMHBs and (2) all proposed grants and contracts as recommended by the RMHBs including new funding allocated by formula. Prior to

FY 1984, formula budgets would be developed for the sole purpose of providing guidelines for eliminating disparities between regions. While the RMHB input will be limited by the "hold-harmless" provision for state hospital funding, the formula budget will provide documentation if the RMHBs press recommendations advocating increased community services.

Finally, the LPR&IC recommends that beginning with the FY 1984 budget, formula budgets become the actual regional budgets with the previous "hold-harmless" provision for state hospitals no longer applicable. At this time, it will be incumbent upon the RMHBs, through effective organization and articulated interests, to exert leverage on the Commissioner and the legislature to see their budgetary recommendations approved.

Departmental and Citizen Participation Structures

DMH's bifurcated organizational structure (see Chapter II Organizational Structure and Roles) is the final obstacle to regionalizing mental health services. This structure not only is ill-suited for planning and implementing comprehensive goals such as deinstitutionalization and the continuum of care (see Chapter II, p.6), but also raises important questions regarding the relationship between the Department and the citizen participants.

The most important of these questions is the extent and degree of decision-making power that is shared between the Commissioner and the regional advisory boards. Presently, the Department's organizational structure encompasses two indistinctly related service systems - the facility or direct services, and community grantee or indirect service systems. The service integration of these two systems requires a greater amount of organizational integration than now exists to encourage competing interests to recognize common goals. While implementation of regional budgeting requires service integration, the form that organizational integration takes will help determine DMH's success in reorienting its service delivery system from institutional to community-based programs.

Citizen participation, an organizational component of both service systems, is integrated to the extent that overlapping memberships within and between the regionalization structure and the facility advisory boards are statutorily mandated (see Chapter II - Important Organizational Roles). As a result, many of the approximately 500 citizen participants serve in several roles. For example, a regional board chairman must serve on both a Catchment Area Council and the (State) Board of Mental Health and may also serve on the advisory board

of the state-owned facility serving the catchment area.

Today, however, citizen participation in mental health is dominated by the newer RMHBs rather than the long-established facility advisory boards. The RMHBs have successfully developed a mental health constituency advocating increased community-based services and emphasizing service decentralization through increased community grants. Already critical of the Commissioner's delay in implementing the 1974-1975 regionalization legislation, the RMHBs will not condone indefinite postponement. The Boards and the CACs remain skeptical of the degree to which the Commissioner is willing to share decision-making responsibility.

On the other hand, because the largest proportional increases in the Departmental budget have been directed to community grant recipients in the past two years, the Catchment Area Councils and Regional Mental Health Boards have been able to initiate implementation of their planning, evaluation and coordinating activities. Most important, the delay has allowed the RMHBs to proceed carefully and slowly developing a strong community mental health constituency which has both challenged and supported the Commissioner on mental health issues. For example, the \$1.4 million increase in the community grants account for FY 1980 is at least partially due to the RMHBs' support demonstrated to the Governor and the legislature.¹

Catchment Area Council procedural problems. The three years of Catchment Area Council and Regional Mental Health Board operation have not been without flaws. However, participants cite the experiences as generally positive. Yet, vacancies and non-appointment of municipal representatives continue to concern some CACs. To correct this problem, the LPR&IC recommends that DMH regulations include a provision whereby a CAC must notify the RMHB and the Regional Director if a municipality fails to fill a vacancy within 60 days. The Regional Director, in turn, would be required to contact the chief municipal officer.

The quality of the annual evaluations also is problematic. To date, these evaluations have focused on non-profit agencies receiving grants from DMH. State-owned facility evaluations

¹ Indeed, it may be that because the RMHBs failed to demonstrate the strength of their constituency to the Appropriations Committee that the final appropriation transferred \$600,000 of the \$2 million in the Governor's budget to CADAC for deinstitutionalization programs (see Chapter VI).

have seldom been attempted, reflecting the narrow purview of CACs and RMHBs without the regional budgeting process. In the case of a large facility--usually a state-owned facility or a non-profit general hospital--the host agency has not always been receptive to citizen evaluation, citing operational complexities and the need for professional expertise.

DMH has observed an overall improvement in the quality of evaluations during the two-year history of the regional structure. However, DMH does note that the quality of evaluations varies considerably between regions. DMH's technical assistance to CACs has been limited to educating them in evaluation procedures and developing an application which should provide measurement standards in the future. The LPR&IC finds that despite the statutory mandate (C.G.S. 17-226k(b)) to adopt regulations concerning the "study and (evaluation) of mental health services," no regulations have been promulgated. Therefore, the LPR&IC recommends that DMH promulgate the regulations specified in C.G.S. 17-226k(b), but heretofore not adopted, regarding evaluation procedures to be followed.

Regional Mental Health Board procedural problems. In addition to the advisory role regarding the regional budget (see preceding section - Regional Budgeting), a primary responsibility of the RMHBs is the planning and coordination of regional mental health services (see Chapter II - Important Organizational Roles). DMH provides \$35,000-\$40,000 annually to each RMHB for operating expenses including staff, office space and equipment. Departmental regulations (Sec. 17-2261-6) specify that DMH funding to RMHBs is contingent upon a 5% local match which is usually met through in-kind services. In fact, municipal cash contributions have been received in two regions only.

While the LPR&IC encourages development of local support for RMHBs including funding and in-kind support, the Committee finds that the regulation fails to acknowledge that where local funding sources are least available, mental health services are also likely to be in shortest supply. Therefore, it is recommended that this regulation be deleted. Instead, the LPR&IC recommends that regulations regarding annual reporting (Section 17-2261-8) be amended to require documentation of local commitment to the RMHBs as demonstrated by contributors of cash and in-kind services. Furthermore, the Commissioner should review local commitments following submission of the FY 1983 annual reports and constitute a more specific funding requirement if necessary.

In spite of the regional planning mandate, the RMHBs have been considerably limited thus far. This is because regional plans must conform to the State Plan which is primarily a federal compliance report rather than a comprehensive plan. The Department has acknowledged the need for comprehensive planning and has initiated development of such a Plan.¹ However, synchronizing the various planning cycles and mandates to enable the preparation of a single comprehensive plan constrains RMHB input (see Figure V-1 for the process now necessary for reviewing the existing non-comprehensive State Plan).

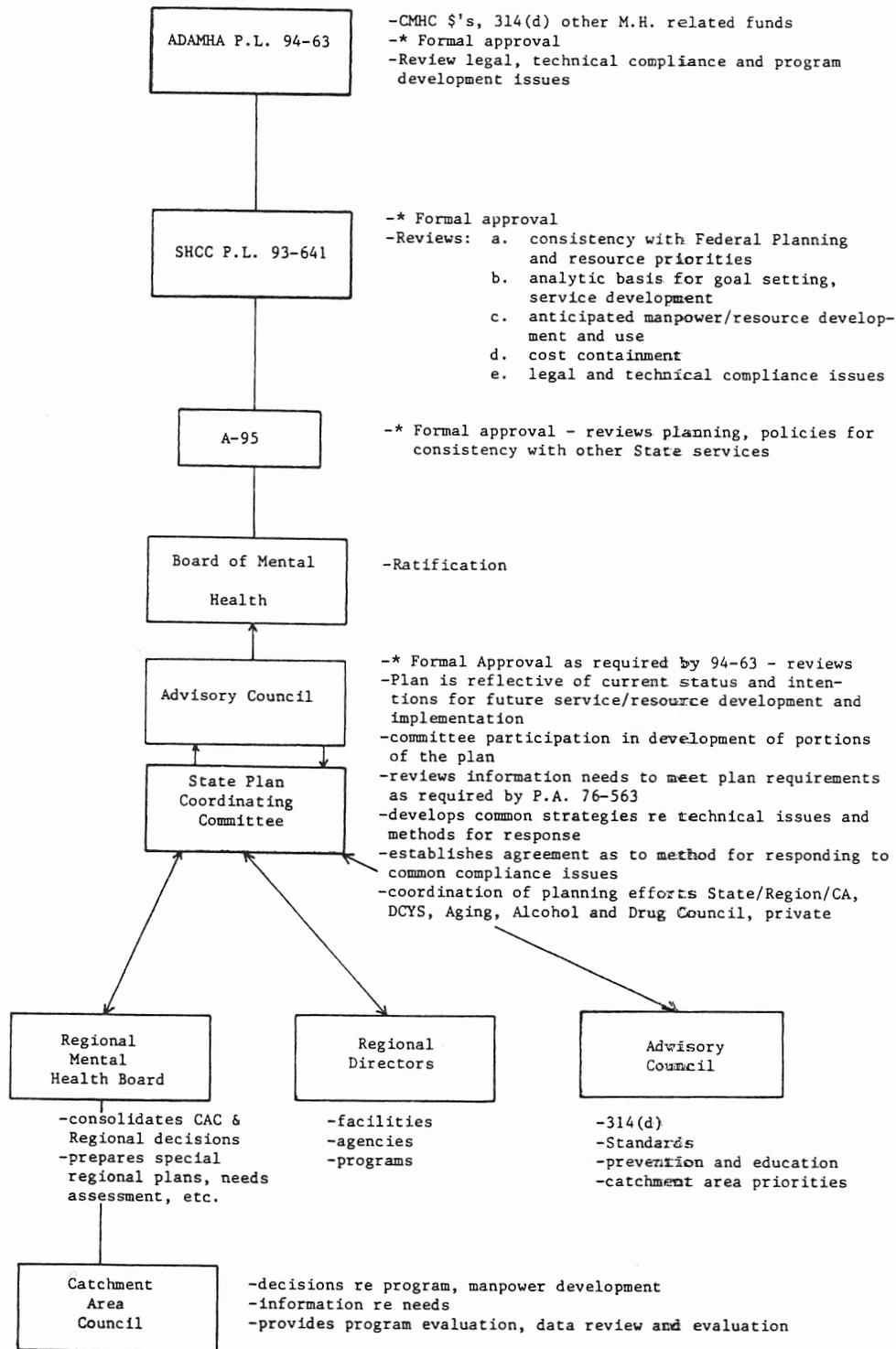
Nevertheless, the LPR&IC recommends that the RMHBs immediately undertake development of regional comprehensive plans to be utilized by the Commissioner as advisory documents for the comprehensive State Plan. Furthermore, the LPR&IC recommends that references to a comprehensive plan be deleted from Departmental regulations (Sec. 17-2261-8) since (1) recommendations for regional comprehensive plans are statutorily mandated and (2) the time frame for submission in the regulations may place unrealistic parameters on the regional plan given the need to synchronize regional and state planning.

Role of the Regional Directors. Regional Directors, (see Chapter II - Important Organizational Roles) appointed in 1977, are the conduit between the citizen participants and DMH. In fact, many attribute the success of the present citizen participation element to the fact that the regional directors afford direct access to the central office of DMH, a provision lacking in earlier legislation. For this reason, the RMHBs oppose any change which would alter their participatory role in the regional organization structure.

Thus, when the Commissioner put forth a three-part proposal to restructure the regional organization, strong and immediate opposition came from the Regional Mental Health Boards. The recommendations (1) to merge the facilities advisory boards into the RMHBs and (2) to assure collaboration between the RMHBs and the Health Systems Agencies were not the center of the controversy. Instead, it was the recommendation to merge existing DMH regional offices, staffed by regional directors, into regional superintendent's offices which was vigorously opposed. Implied and later confirmed was the Commissioner's intention that state hospital superintendents would become regional superintendents with the regional directors reporting

¹ See memorandum on "Mental Health Planning," July 28, 1978.

Figure V-1. State Plan Preparation and Review.



Source: Department of Mental Health.

to them rather than the Commissioner.

If this occurred, the RMHBs were concerned that community-based services would become adjuncts of state hospital programs where the primary responsibility of the superintendents is to operate in-patient programs which maintain national accreditation. Emphasizing the weakness of such an administrative structure, another state review noted that "despite the best of intentions, (it) stands the mental health system on its head. Rather than concentrating on programs to keep patients out of hospitals, top administrators have as their first concern the patients who are in the hospitals."¹

Demonstrating their common concerns, the RMHBs were successful in delaying proposed legislative changes until 1980 by which time the Board of Mental Health's Legislative Task Force will have submitted its recommendations.

While the LPR&IC supports establishment of the Legislative Task Force to review the existing regional structure and to propose modifications or changes, it recommends that the following priority issues be addressed:

1. The need to tailor the citizen participation structure so that the efforts of the RMHBs and Facilities Advisory Boards are channeled effectively in the pursuit of a regionalized service delivery system.
2. The need to balance the accountability of the Department with meaningful citizen participation.
3. The need to refocus the Department's service priorities from state hospitals to community services in the coming years.

Means of achieving reorientation have been outlined in this chapter. The Department must now assert definite directives that will fulfill its mandate to "establish a system of regionalized services for care and treatment of the mentally ill.....".

¹ Georgetown University Health Policy Center, Revitalizing Oklahoma's Commitment to the Mentally Ill, April, 1978, p. 6.

Chapter VI

STRENGTHENING SERVICE REDIRECTION

Overview

The Facilities Plan 1980-1985

Necessary Data

Limitations of the Facilities Plan

Three critical assumptions

Undefined appropriate quality of care

Special Problems Facing State Facilities

Staffing needs

Building conversions

DMH Future Provider Role

Preadmission Screening

Conclusion--And Future Considerations

CHAPTER VI

STRENGTHENING SERVICE REDIRECTION

Overview

Development of community alternatives to traditional institutionalization evolved gradually in Connecticut during the past decade. However, it was not until 1977, three years following enactment of the regionalization legislation (see p. 7), that the Department first adopted the companion goals of deinstitutionalization and the continuum of care (see p. 6). Since that time the Department's commitment has become more explicit.

Specifically, the Facilities Plan 1980-1985, released in 1978, articulated the Department's principal goal to "redirect the service delivery and funding focus from its present concentration in the state hospitals to a community oriented comprehensive, balanced service system of private and public care in which the state hospital has a defined role in the continuum of care."¹ Most recently, the Department has incorporated a new goal of service provision in the "least restrictive" setting.

Today the Department has expanded the variety of settings for mental health care by establishing state-owned facilities and providing subsidies to non-profit public and private agencies. However, despite the increase in service availability, the progress towards achievement of the Department's goals has been modest. These accomplishments are limited to:

- Increasing community-based service expenditures (see Chapter II);
- Increasing the community grants account (see Chapter II and IV);
- Decreasing the patient populations and lengths of stay in the three large state mental hospitals (see Chapter III); and
- Establishing the structure for a regionalized system of mental health services (see Chapter V).

¹ DMH, "The Facilities Plan 1980-1985," August 1978, p. 2.

If the Department's goals had been achieved, each region would be served by a network of services utilizing public and private community facilities and, to a reduced extent, state hospitals. Instead, the Department has been unable to achieve its goals because:

- Decreases in the state hospital patient population and length of stay have been offset by corresponding increases in admissions and readmissions to these institutions (Chapter III). These increases raise questions concerning the Department's ability to decrease the utilization of the state hospitals and establish institutional policies counteracting the "revolving door" that exists for persons diagnosed as alcoholics and paranoid schizophrenics.
- Increases in the community grants account have not lessened the funding disparities between and within mental health regions (Chapters IV and V). Furthermore, the FY 1980 loss of \$600,000 in community grants money to CADAC undermined the success of the Department and its citizen advisory groups in winning the Governor's support for \$2 million in new community grants account money. More important, this legislative defeat points out the need for DMH to improve its legislative credibility and support and to coordinate its program planning with CADAC.
- The increase in community-based service expenditures has reinforced the disparity between DMH's direct and indirect services (see Chapter IV). This disparity raises questions concerning the planned reorientation of the Department's service provider role, particularly the Commissioner's goal of moving DMH in the direction of indirect service provision.

Ideally, a full range of community services should be developed simultaneously with state hospital programs until the separate parallel systems can be merged and state hospital budgets reduced to reflect reduced needs. This requires "seed money" for capital and operating expenses for new community facilities while state hospital budgets are maintained. Reductions in

state hospital budgets are realized subsequent to full operation of the community facilities. Alternatively, program funds may be transferred from state hospitals to community services in order to enable development of comprehensive community programs. While avoiding the need for new funding, this alternative causes interruptions in service delivery during the transition period and may not allow for needed capital expenditures unless other funding services are available.

During the first decade of CMHC funding, federal policy provided the incentive for many states to develop community services. Using federal seed money to supplement state funds transferred from state hospital budgets, new community service programs replaced state hospital programs.

Connecticut's delayed entry into comprehensive service re-orientation enabled the Department to avoid problems encountered elsewhere (see p. 2). The Commissioner opted to avoid abrupt shifts in program funding within the budget. He adopted a policy of gradual implementation whereby funding for new community services would be obtained incrementally through modest increases in budget allocations. Also, federal and other state monies would supplement DMH funding for community programs.

Critics of the Commissioner cite the delay in reallocation of departmental budgets as evidence that the Commissioner is not committed to the Department's articulated goals. The Commissioner, on the other hand, justifies the delay in redistributing funds as necessary to assure a smooth transition and to avoid pitfalls experienced in other states.

The Facilities Plan 1980-1985

The Facilities Plan 1980-1985,¹ released in September 1978, introduced a specific implementation plan to achieve the regionalization mandate. The thrust of the Plan is on reducing utilization of state hospitals by the following means (listed in chronological order of projected completion):

¹ According to C.G.S. Sec. 4-266 effective September 1978, all state agencies and departments must submit a plan annually to the Office of Policy and Management and the Department of Administrative Services projecting their facility and real estate needs for a minimum of three years. DMH opted to prepare a five year plan for 1980-1985 in order to synchronize its facility and capital plan with other federal planning requirements.

- establishing patient characteristic profile criteria for hospital admission (1982);
- converting state hospital beds to community-based beds (1983);
- reducing the number of occupied beds in CVH, NH and FHH from an estimated 1,640 (1979) to 980 (1985);
- establishing community-based preadmission screening capabilities within each catchment area (1985); and
- scheduling the transfer, demolition, or alternative use of a number of state hospital buildings (1985).

By these means, the Department hopes to restrict state hospitals to long-term care facilities for patients not appropriately served in the community. In summary, the Department intends to:

- provide state hospitals with the ability to prevent inappropriate admissions and to decrease readmissions by narrowing the patient profiles acceptable for admission to the state mental hospitals;
- assist in finding and developing alternative community treatment and aftercare services by increasing the funding level of the community grants account; and
- improve hospital discharge planning and follow-up by providing administrative and fiscal management information necessary for the more effective delivery of these services.

LPR&IC finds that the intended implementation plan to reorient mental health services needs further clarification and explanation. The remainder of this chapter identifies problem areas and specifies areas needing resolution.

Necessary Data

The preceding chapters noted limitations such as data gaps and inadequate measurement standards. For example, data

regarding actual staffing levels at the state hospitals are inconsistent (see Table III-6, Table III-7 and narrative), programmatic needs non-quantified, and treatment costs between public and private sector services are not always comparable.

Cognizant of the need to improve data collection, DMH now intends to introduce the following:

- The FMIS system (see p. 72) which will generate cost data initially for state hospital patients and eventually for all DMH supported services;
- Introduction of contracts for service rather than grants for non-profit agencies receiving subsidies (see p.60); and
- Application of the National Institute of Mental Health's "levels of functioning" concept¹ to public and private services as an outcome measurement.²

While the LPR&IC recognizes the need for developing these data sources, the Committee is also aware of the need for immediate data to support policy alternatives for the General Assembly. This is especially important given the division of oversight responsibility among the various legislative committees responsible for mental health (see pp. 15-16).

Therefore, the LPR&IC recommends that the Commissioner provide data to the General Assembly which will facilitate policy development and rational decision-making. These data should include but not be limited to, the effect of closing at least one state hospital and transferring funds to community programs, the cost of direct service-delivery as compared to state subsidies for non-profit agencies, the cost of maintaining deinstitutionalized patients in nursing homes and the cost and feasibility of relying on general hospitals to provide service for involuntary patients.

¹ A scale of 1-10 which equates a person's ability to function with the level of care needed.

² By requiring the proposed level of functioning of clients both prior and subsequent to delivery of service, needs assessment, service utilization and evaluation data will be generated.

Limitations of the Facilities Plan

Three critical assumptions. In the introduction to its Facilities Plan, the Department identifies three critical assumptions underlying the realization of the projected goals. The assumptions are:

- that federal Connecticut Mental Health Centers Act money will be available to help develop the 250 community psychiatric beds and other needed community services;
- that state money will be available for the development of transitional living support and other needed community services; and
- that the Connecticut Alcohol and Drug Abuse Council (CADAC) will develop at least 125 community alcohol beds.

The Department believes that these assumptions are both reasonable and realistic. However, there are no indications either in the plan or elsewhere of what specific actions are required or will be taken to realize these goals. Importantly, the Commissioner relies on other sources--the federal government for CMHC funds, CADAC, and other state commissioners--to provide funding and/or programs to transform the Department's goals into programmatic directives.

The LPR&IC finds that the critical nature of these assumptions makes further clarification necessary. Therefore, the LPR&IC recommends that DMH reassess these assumptions and include in the FY 1980 Facilities Plan the following information:

- an elucidation of the Department's responsibility for helping to develop the additional 250 community psychiatric beds and other needed community services with specific and detailed steps to be accomplished within an explicit timetable;
- an outline of the Department's plans for developing transitional living support and other needed community services; and
- an explanation of what actions the Department will be taking to cooperate and coordinate with CADAC in developing the 125 additional community alcohol beds.

The LPR&IC further recommends that DMH actively involve the Advisory Council of the Board of Mental Health and the RMHBs in developing departmental policy on these points.

Undefined appropriate quality of care. DMH reiterates in its Facilities Plan that achieving "appropriate quality of care levels" in the state hospitals is the major prerequisite for the transfer of state hospital funds to community services. This goal has been department policy for the past three years and has been part of the Commissioner's attempt to gain consensus and plan for change. The Commissioner, however, has not specified what would constitute appropriate quality of care levels.

In view of the strategic importance of this prerequisite for change, the LPR&IC finds that an explanation by DMH of what constitutes "appropriate quality of care levels" in the state hospitals is now needed.

The LPR&IC recommends that DMH specifically identify in its comprehensive statewide mental health plan, estimated requirements for "appropriate quality of care levels" in the state hospitals and include specific measurement definitions and data on necessary supportive and program staff.

Special Problems Facing State Facilities

According to the Facilities Plan, by 1985 state hospitals will serve long-term care patients exclusively. Acute care patients, now treated at state hospitals as well as in the community, will be hospitalized only in community settings. This service redistribution will be accompanied by a reduction in the number and type of staff needed as well as the closure of some buildings on hospital grounds.

Despite the reduction in population anticipated at each hospital, DMH does not forecast absolute closure of any facility or discontinuance of direct service delivery. While the three large state hospitals are scheduled for reduction in size and use, the Plan envisions the expansion of Cedarcrest Regional Hospital and the Bridgeport Mental Health Center. Thus, the Department's reduction in staffing needs at the state hospitals will be partially offset by expanded staffing at state-owned community facilities. At the same time, increases in staffing at non-state owned mental health service providers will be necessary if the

Commissioner executes his stated intention to utilize grants to non-profit agencies as the means to establish the network of services.¹

Staffing needs. Establishment of patient characteristic profile criteria (see p. 84) is intended to transform the state mental hospitals from primarily acute to long-term treatment facilities. DMH envisions that the state hospital will become the direct provider of services for the most seriously disturbed, chronically ill patients for whom community-based service alternatives do not exist or who cannot readjust to community life.

Staffing needs will alter with this reorientation of patient care, with a greater emphasis placed on non-medical personnel. Redeployment of staff to other state mental health facilities is possible only to the extent that vacancies exist. However, in view of the Commissioner's proposed shift to increased indirect service delivery, opportunities for state employment will be constrained. Therefore, the LPR&IC recommends that the DMH plan and adopt programs for the redeployment and retraining of state hospital staff for more efficient and effective use within and outside of the state hospitals.

Building conversions. Establishment of transitional living programs received DMH's highest priority for new community grants during the past two years. As a result, grants to non-profit agencies have been awarded for transitional living facilities in more than ten catchment areas. Most of the operating grants were awarded prior to establishment of the facility and were conditional upon successfully obtaining all necessary permits. But, delays have been widespread due to the difficulty in accumulating funds for capital improvements and especially in receiving local zoning approval. As a result, no new facility became operational during 1978.

Recognizing the obstacles in securing site approval from local authorities, the LPR&IC recommends that the Commissioner make available small buildings at state hospitals to community agencies for the purpose of establishing transitional living facilities.² Suitable buildings would include residences and small

¹ Commissioner Plaut has said that while the state will never be completely out of direct service provision, he is committed to a major shift in the current 4:1 ratio favoring direct delivery. (Interview, 9/11/78.)

² Authority to do this is specified in C.G.S. 17-210a(m)(i).

buildings situated at the edge of the hospital ground in proximity to public transportation.¹ These facilities would be in addition to Norwich Hospital's Gateway Reentry Program and Connecticut Valley Hospital's Dutton Transitional Living Center housed in large institution-like facilities.

DMH's Future Provider Role

Although historically Department budgets have overwhelmingly favored state-owned and operated facilities (see Table II-1), the Commissioner has clearly chosen a combined public and private service delivery for the future.² Thus, rather than taking an "either/or" approach, DMH plans to increase its subsidies to non-profit agencies while also maintaining state-owned community-based services.

The Department's present policies have fostered budget increases to community services in excess of those for state hospitals. At the same time, the Department's direct-service delivery at state-owned community facilities has outpaced grants to non-profit agencies (see Table II-1).

In order to clarify DMH's service provider role in the future, the LPR&IC recommends that the Department include in the Facilities Plan five year projections for direct and indirect service delivery at each existing and planned facility.

Although the LPR&IC supports expansion of indirect services at community facilities through grants and contracts, the Committee is cognizant of the difficulties encountered with the Commission on Hospitals and Health Care (CHHC) when new services at general hospitals are proposed. As a member of the CHHC, the Commissioner should emphasize that redirection of services from state hospitals to general hospitals is not contingent upon new program funding. Rather, a shift in service delivery setting is a redistribution of existing programs previously housed at the state hospitals. In effect, the Commissioner must make certain that CHHC decisions do not inhibit his Department's goals to provide indirect services.

¹ Connecticut Valley Hospital is probably the most appropriate site since it abuts an urban area and small buildings are located on the perimeter of the grounds.

² See footnote 2, p. 88.

Preadmission Screening

In the past, the lack of mental health service alternatives often resulted in hospitalization of persons whose "level of functioning"¹ did not require such intense care. Though the establishment of the community-based services network presents options to this procedure, the insufficient quantity of alternative services continues to preclude the most appropriate service in the least restrictive setting. The Department has stated its intention, however, to reduce further utilization of the state hospitals when the regional system of services is adequately realized.

This can be accomplished by (1) preventing inappropriate admissions and (2) narrowing the criteria for patient eligibility. By developing patient characteristic profile criteria, DMH will be able to reduce hospital populations and transform the hospitals from primarily acute to long-term treatment facilities. To this end, the Department has established a long-term patient profile made of six groups of patients considered appropriate for a state psychiatric hospital level of care.² The application of these criteria will enable the Department to reduce the rate of admissions and thus, more effectively reduce state hospital utilization.

Specifically, the Department plans to remove alcohol and drug services from the three large hospitals. In addition, DMH plans to establish admission criteria based on a prospective patient's:

- level of functioning;
- severity of disturbance;
- anticipated minimum length of treatment; and
- scope of care not available or not feasible within the community.

In addition, by 1985 the Department plans to establish a designated preadmission screening capability within each catchment area by grant, contract or other arrangement with community-based providers for screening potential admissions to geriatric

¹ See footnote 1, p. 85.

² In terms of length of stay, a "long-term" patient is one requiring 30 or more days of hospitalization.

services. A similar preadmission screening capability is planned by 1985 for all potential admissions to general psychiatric services in the state hospitals.

The LPR&IC recognizes the importance of improving prescreening for mental health clients to (1) achieve the Department's goal of delivery service in the least restrictive setting and (2) improve cost-effectiveness of service delivery. Therefore, the LPR&IC recommends that DMH outline its plans for establishing preadmission screening in each catchment area by 1985. In particular, DMH should specify the funding and other program arrangements to be offered community-based providers. Furthermore, DMH should describe the means by which the state hospitals will be incorporated into this network of community-based prescreening services and how prescreening services will reduce inappropriate admissions.

Conclusion--And Future Considerations

During the past two decades, community settings for mental health service delivery have become recognized as preferable to the traditionally large inpatient state institutions. This is due in part to the successful use of psychotropic drugs which allows many persons with mental disorders to function in the community. Ideally, a community mental health setting provides medical services (e.g., inpatient and outpatient clinics) and support services (e.g., counseling structured living facilities, rehabilitation programs and social clubs) which vary in treatment intensity according to consumer need.

In Connecticut, community mental health services originated in the early 1960s with the construction of the Connecticut Mental Health Center and the initiation of a small grants program to general hospitals for outpatient clinics. Today, DMH owns five community mental health facilities, operates six alcohol and drug facilities and provides grants to non-profit agencies for community mental health programs. Supplemented by federal funding for designated community mental health centers, these services have formed the basis for the network of regionalized services statutorily mandated in 1974. The framework remains skeletal, however, with gaps in the variety and quantity of community services. Furthermore, the system is unbalanced with state hospitals continuing to dominate DMH's program budget despite the decrease in patient populations.

In the course of this study, the LPR&IC identified three major problem areas which have limited the Department's ability to achieve its goals. These include:

- the inability of the Department to reduce successfully the admissions and readmissions to state hospitals. As a result, while many persons with mental disorders spend an increasing amount of time in the community, rather than at a state hospital, the Department's funding of state hospital facilities remains predominant;
- the difficulty in developing an equitable method of distributing program funds on a regional basis has created disparities in community service availability between and within the five regions. This is intensified by the limited resources available for community programs;
- the frustration encountered by the citizen participants in the decision-making process has the potential for weakening the complex, statutorily mandated regional structure. In order to avoid engendering antagonism, the Commissioner must not ignore or deflect citizen participation. On the other hand, he must make available to the public participants sufficient training and direction to avert inappropriate recommendations.

At the time the LPR&IC conducted this study DMH was in the initial stage of transition, attempting to redirect its role from a direct service provider primarily at large state hospitals to both an indirect and a direct service provider in a variety of settings. The focus of this study, therefore, has been on DMH's implementation of its existing statutory mandates, policies and goals which set this course.

The LPR&IC did not question the validity of these directives. Instead, the LPR&IC proceeded on the basis that it is both realistic and feasible to expect that a variety of mental health services should be available and accessible to all state residents. Furthermore, the LPR&IC assumed that the interlocking boards and councils, required for citizen participation, are

both necessary and positive to achieve the network of services. In time, the efficiency of both the regionalized service network and the citizen participation structure will reveal itself as effective and manageable or unwieldy and impractical.

The next several years will be decisive for DMH as the success or failure in establishing the community services network evolves. When this occurs, possibly by 1982, it will become necessary for the General Assembly to assess the statutory mandates which have given shape to departmental goals and policies. Review at this time will determine if community mental health services are, in fact, available and effective. Depending upon the outcome, substantive policy changes and statutory revisions may be in order.

APPENDICES

- I-1. Glossary
 - I-2. Agency Response
 - IV-1. Description of State-Owned Facilities
-

Appendix I-1

Glossary

acute care facility (hospital) - an establishment that provides, through an organized medical staff, permanent facilities that include inpatient beds, medical services, continuous nursing services, and diagnosis and treatment for patients suffering from acute conditions.

advisory boards for state hospitals and facilities - program and policy boards for each state-operated facility appointed by the Commissioner and usually comprised of 15 members. Catchment Area Council representation is statutorily mandated.

Advisory Council to the Board of Mental Health - broad based 30-60 member body to meet federal statewide citizen participation requirement under P.L. 93-641. Council has spawned many task forces and subcommittees.

alcohol treatment - inpatient or outpatient service which includes therapy, counseling and education.

alcoholic - a person who "habitually or periodically lacks self-control as to the use of alcoholic beverages, or who habitually or periodically uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted" (C.G.S. 17-1551(1)).

Board of Mental Health - Twelve member advisory board to the Commissioner consisting of each of the five Regional Mental Health Board Chairmen and seven Governor appointees according to C.G.S. 17-207.

catchment area - a defined geographical area and its population toward which a delivery system is responsible for provision of services (NIMH criteria). Connecticut, conforming to federal criteria, has identified 23 catchment areas each of which serves a population of 75,000 - 250,000.

Catchment Area Council (CAC) - the grassroots organizational level of the citizen advisory structure comprised of "consumers" appointed by the chief executive officer in each municipality and "consumers" and "providers" elected by the appointed representatives.

clinic - a term which has a broad meaning, usually referring to observation and treatment of an individual patient, upon which the knowledge and experience of the clinician are brought to bear.

Commission on Hospitals and Health Care (CHHC) - seventeen members, appointed by the Governor and legislative leaders, according to specific criteria and including three commissioners (one from mental health). Major responsibility is to approve proposed rate increases for all hospitals and home health care agencies (C.G.S. 19-73).

community - the people, groups, agencies and other facilities in one locality whose mental health needs are served by the psychiatric facility. By specific program implications, this may define a large geographical area from which selected admissions are arranged for diagnosis and treatment of particular or distinctive psychiatric disorders.

community mental health center (cmhc) - public or private general hospitals, agencies and/or consortiums which (a) provide a comprehensive level of services according to federal criteria and (b) receive federal funds for planning, construction, research or operation.

Community Mental Health Centers Act of 1963 (P.L. 94-63) - introduced federal funding for comprehensive community mental health programs. Originally provided construction grants only; operating grants initiated in mid 1960s. 1975 amendments expanded scope of services, from five to twelve, required for all new applicants.

Connecticut Alcohol and Drug Abuse Council (CADAC) - effective July, 1978 CADAC became the single state agency for alcohol and drug abuse. CADAC plans and allocates state grants and administers and supervises all related federal grants. Membership consists of specified commissioners and appointees by the Governor and designated legislative leaders (C.G.S. 17-155ff).

consumer - anyone who is not a "provider."

continuum of care - the range of programs and services which must be available to an individual. This includes both generic (needed by most clients) and specific (needed by few clients) programs and services.

counseling - professional guidance programs provided by many different agencies, especially family service organizations. Programs range from general counseling services for persons at varying levels of stress to specialized programs for special needs or population groups.

crisis intervention - an immediately available service to meet the critical needs of individuals who present themselves for help during an emotional crisis. Different from emergency service, which is related to more severe danger or behavioral breakdown. The service may be on a residential or outpatient basis.

custodial care - the 24-hour supervision of a person usually provided by an institution with the purpose of maintaining the person's present condition rather than providing treatment or therapy.

deinstitutionalization - reorientation of mental health service delivery from institutional to community settings.

detoxification - a medical process by which substances harmful to the body, are changed to compounds to be harmlessly assimilated or excreted.

discharge planning - activity geared toward release of hospital inpatients. Planning usually begins when the patient enters the hospital and may ultimately lead to placement in a nursing home, transitional or structured living facility, or return to patient's residence or other living unit.

drug dependent person - with specific exceptions, one who has developed a "psychic or physical dependence, or both, upon a controlled substance following administration of that substance upon a repeated periodic or continuous basis" (C.G.S. 19-443 (19)).

drug treatment - inpatient or outpatient therapy and supportive counseling and education for detoxified drug dependent person (see methadone maintenance).

emergency admission - a measure for achieving the personal safety and eventual care and treatment of a mentally ill person, may be voluntary or involuntary: essential characteristic is that it provides immediate placement in a hospital.

encumbrance - the commitment and reservation of all or part of an appropriation in anticipation of a planned expenditure. Those portions of any appropriation which are encumbered are not available for expenditure for any purpose other than that indicated on the encumbered document.

executive directors - staff to each Regional Mental Health Board funded by DMH.

extended care facility - a hospital or institution organized and operated to provide long-term care to those suffering from chronic illness.

follow-up care - continuing treatment and rehabilitation provided in the community, to help the patient maintain and continue to improve his adjustment following a period of treatment in a psychiatric facility. Synonymous with aftercare.

formula funding - regional allocations of mental health funds developed by the Commissioner based on regional "population, need for and utilization of existing mental health services and any other factors which the Commissioner considers important and relevant" (C.G.S. 17-226i).

HEW - U.S. Department of Health, Education and Welfare.

half-way house - a psychiatric facility, community based, offering residential services to individuals in aftercare status emphasizing social rehabilitation with support and guidance toward the goal of independent living.

Health Systems Agency (HSA) P.L. 93-641 - federally mandated agencies which plan and review all health services within the boundaries designated. In Connecticut, the geographic area is congruent with the five mental health regions.

homecare service - housekeeping services provided to hospital inpatients, discharged patients or non-hospitalized mentally ill persons and their families.

inpatient - a patient or pertaining to a patient who stays in an institution in excess of twenty-four hours.

intermediate care facilities (ICF) - federal designation of a state certified rest home with nursing supervision.

intoxicated person - one whose "mental or physical functioning is substantially impaired as a result of the use of alcohol" (C.G.S. 17-1551(12)).

involuntary patient - any patient hospitalized "pursuant to an order of a judge of the probate court after an appropriate hearing, or a patient hospitalized for emergency diagnosis, observation or treatment upon certification of a qualified physician" (C.G.S. 17-206a(e)).

Joint Commission on Accreditation of Hospitals (JCAH) - an affiliation of organizations whose purposes are: (1) to establish standards for the operation of hospitals and other health related facilities and services and (2) to conduct survey and accreditation programs that will encourage the maintenance of these standards.

levels of functioning - a scale developed by NIMH which equates one's ability to function with the level of care needed.

Medicaid (Title XIX, Social Security Act) - provides federal financial assistance for medical assistance payments on behalf of cash assistance recipients and, in Connecticut, on behalf of other medically needy, who except for income and resources, would be eligible for cash assistance.

Medicare (Title XVIII, Social Security Act) - hospital insurance benefits paid to participating hospitals, skilled nursing facilities, and related providers of health care to cover the reasonable cost of medically necessary services furnished to eligible individuals.

medication service - prescription service for discharged patients and other clients. Medication supplied at no charge at state owned facilities only. Frequently accompanied by outpatient therapy.

mental health - an emotional/mental state of adjustment to other people and to the environment which allows for realization of potential, personal effectiveness and gratification with some degree of awareness and understanding of one's self and other people, and without serious emotional/mental disruptions.

mental health clinic or center - an establishment that provides through an organized medical or professional staff and facilities, diagnostic and treatment services for patients who are usually ambulatory.

mental health service regions - statutorily mandated and designated by the Commissioner for the purpose of establishing a system of regionalized services. Present boundaries of the five regions are coterminous with the Health Systems Agency regions.

mentally ill person - one with a "mental or emotional condition which has substantial adverse effects on his or her ability to function and who requires care and treatment, and specifically excludes a person whose psychiatric disorder is drug dependence..." (C.G.S. 17-176).

methadone maintenance program - a structured program of administering daily dosages of methadone, used as a substitute for heroin in withdrawing a person from that drug. Methadone is given under supervision and with proper controls, allowing the person to continue to function adequately in society.

National Institute of Mental Health (NIMH) - now part of the federal Department of Health, Education and Welfare (HEW) but formerly an independent federally funded research institute.

outpatient service - the provision of regularly scheduled therapy visits, and non-scheduled visits in case of crisis for persons who require low intensity treatment. Services may be available at more than one location to increase accessibility for clients and may also include walk-in clinics and diagnostic services.

partial hospitalization - services which provide a planned program of milieu therapy and other treatment modalities. The service is designed for persons who spend only a part of a twenty-four hour period in the facility.

Patient's Bill of Rights - in Connecticut, the rights to: due process, humane and dignified treatment, an habilitation program, communication, visitation, and right to confidentiality of records (see C.G.S. 17-206b-17-2-6k).

preadmission screening - capability to screen potential patients or clients to assure that intensity of treatment recommended coincides with a person's "level of functioning."

prevention and education - a wide range of activities other than direct clinical services designed to develop effective mental health programs in the catchment or service area, increase the awareness of the residents of the nature of mental health problems and treatment services available, and promote coordination of mental health services with other health and social services.

provider - in Connecticut the term includes any person who "receives income from private practice or any public or private agency which delivers mental health service" (C.G.S. 17-226j(c)). Federal definition is more stringent.

psychiatry - that branch of medical science which specializes in the field of mental/emotional illness. A psychiatrist is always an M.D. and must become a medical doctor before he specializes in psychiatry, obtaining special training and doing a residency in that field.

psychology - the scientific study of behavior, of development and functioning. Psychologists may specialize in several different areas, such as clinical, social, experimental, in teaching, etc.

Public Health Code - regulations established and amended by the Commissioner of Health Services to preserve and improve the public health (C.G.S. 19-13 and 19-607).

regional budgeting - in Connecticut, a non-implemented concept for determining mental health programs on a regional basis.

regional director (rd) - DMH staff appointed by the Commissioner, with the consent of the Regional Mental Health Board, who is a liaison between the RMHBS and the Central Office.

Regional Mental Health Board (RMHB) - a non-profit corporation whose consumer-provider members are selected by and from sub-regional Catchment Area Councils according to statutory mandate.

regionalization - refers to the Mental Health Services Act (P.A. 74-224) which sets forth as its purpose the establishment of a system of regionalized services and specified the structural framework for implementation.

service delivery area - a catchment area or other designated geographical area for which services are exclusively provided.

skilled nursing facilities (SNF) - federal designation of a state-licensed facility providing 24-hour skilled nursing care.

social club - recreational activities which reinforce and supplement other rehabilitation and resocialization programs.

third party payments - reimbursement or direct payment for medical services provided through private health insurance plans, Medicare or Medicaid.

Title XX, Social Security Act - a section of the Social Security Act, which outlines rules and provides per capita funding to states for the provision of community-based social services. Since services are defined by each state, the number of services and the definition of the service vary widely. Categories may include day care, counseling, employment training, developmental services, homemaker care and home health aid.

transitional living - residential services for mentally ill patients not requiring care in a mental hospital, but unable to function fully in the community and therefore requiring some level of intermediate intensity care including quarter-way, half-way, three-quarter way houses, supervised apartments, foster care, boarding home care, and qualified nursing homes.

treatment - any measure designed to ease or cure an abnormal or undesirable condition.

voluntary patient - any patient "...who applies in writing for and is admitted to a hospital for observation, diagnosis or treatment of a mental disorder" (C.G.S. 17-206(d)).

vocational rehabilitation - activities involving the evaluation of patients or clients to determine their vocational problems, aptitude and ability, collaboration with community resources and agency staff for the appropriate course of treatment or work training/placement of patients or clients.

Appendix I-2

Agency Response

It is the policy of the Legislative Program Review and Investigations Committee to submit a late draft of each report to the appropriate agency for critical comment prior to publication. Written comments from the Commissioner of Mental Health were solicited for this report.



STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH

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ELLA GRASSO
GOVERNOR

ERIC A. PLAUT, M.D.
COMMISSIONER

August 30, 1979

The Honorable William E. Curry, Jr.
The Honorable Astrid T. Hanzalek
Co-Chairmen, Legislative Program Review
and Investigations Committee
18 Trinity Street
Hartford, Connecticut 06115

Dear Chairmen:

Thank you for the opportunity to respond to the Legislative Program Review and Investigations Committee's draft report to the Department of Mental Health. The report is a commendable study of the Department. It is comprehensive in scope, well-written, well-organized, and gives an essentially accurate picture of the current status of the Department and its future plans and directions.

I am particularly pleased that the report so clearly articulates the difficulties the Department of Mental Health faces in implementing the development of regional community-based systems of mental health care, while upgrading the quality of care in our institutions in a period of fiscal constraint. As the report indicates, the advocates of giving highest priority to improving the quality of care in our institutions and the advocates of community alternatives have been moving towards greater understanding, rather than towards polarization. I believe that this report will further that process.

There are numerous recommendations in the report, mostly of a technical nature. I am responding to these in detail in an appendix to this letter. Many of the recommendations are very useful. Only a few seem inappropriate to me. I do, however, regret that the Committee did not attach any fiscal notes to their recommendations, as implementation will depend upon the availability of adequate resources. I also regret that the Committee did not make any recommendations for legislative change. Fortunately, the need for legislative change has been recognized by both the Public Health Committee and the State Board of Mental Health. I am sure that, as they develop proposed legislation, they will find the Committee's report very helpful.

August 30, 1979

-2-

I would like to express my personal appreciation to the Committee and its staff for this report. Special thanks are due Ms. Betty Cochran and Dr. Judy Shapiro, who did the primary staff work. Their dedication to their task, their objectivity, and their open-mindedness were appreciated by the many hundreds of people whom they had contact with in the course of the study.

Sincerely,



Eric A. Plaut, M.D.
Commissioner

EAP/acf
Att. (Appendix)

APPENDIX
to
Letter of Eric A. Plaut, M.D.

August 30, 1979

RECOMMENDATION NO.

1. "The Legislative Program Review and Investigations Committee recommends that the joint rules of the General Assembly be amended to place responsibility for the Department of Mental Health and for state mental institutions with the Public Health Committee."

DMH - Strongly concurs.

2. "Therefore, the LPR&IC finds that while all three state mental hospitals currently are accredited by both JCAH and HEW, the reality of daily care and treatment often falls short of external and statutory standards."

DMH - Concurs. The issue is one of fiscal constraints.

3. "In light of this issue, the LPR&IC recommends that the Department of Mental Health prepare for the General Assembly a FY 1980-85 realistic projection of patient care staffing levels needed to upgrade the quality of care and treatment in the state mental hospitals."

DMH - Data are already available in the current five-year plan and the Bayes Report. An updating should be done for the 1981-86 five-year plan.

4. "The LPR&IC recommends that the DMH set guidelines for implementing and evaluating the compliance of C.G.S. 17-206e (b) with the state mental hospitals. These guidelines should include the definition of 'habilitation program,' particularly with respect to how such a program differs from a medication program."

DMH - It is not correct to assume that the use of medication is always distinct from a treatment program. Particularly in acute cases, it may be the primary form of treatment. The Department already has guidelines to assure that the chronic use of medication is adequately monitored.

RECOMMENDATION NO.

5. "The LPR&IC recommends that C.G.S. 17-178 be amended to include payment of an independent physician selected by the patient or his or her attorney. In addition, the Committee recommends that the Probate Court be allowed to appoint only one independent physician to assist the court in the evaluation of the respondent's mental condition."

DMH - No objection. Fiscal note needed.

6. "LPR&IC recommends that C.G.S. 17-178(g) be amended to require a yearly state initiated recommitment hearing that includes the procedural safeguards of the initial commitment hearing."

DMH - No objection. Fiscal note needed.

7. "In order to determine the availability of mental health services in Connecticut, the LPR&IC recommends that each CAC develop an inventory of all public and private mental health services according to Departmental definition of mental health services."

DMH - Already exists in some areas. Fiscal note needed to do statewide.

8. "LPR&IC recommends that DMH rank the twenty-three catchment areas by service need and provide technical assistance to the neediest catchment areas for developing federal community mental center applications."

DMH - DMH is required by DHEW to use the federal criteria for priority in applications for federal funds. We concur that the federal criteria are not very reflective of actual need. DMH does already provide technical assistance to those neediest CACs that are ready to apply for federal funds. DMH would be happy to have additional resources to provide more technical assistance. Fiscal note needed.

9. "In order to measure more effectively the amount and type of service delivered by each community mental health grantee, the LPR&IC recommends that the DMH develop alternatives to the existing grant mechanism. Alternatives now being considered by DMH include the following: (a) substituting the present general terms of community grants with specific conditions under which grant money is to be spent; (b) supplementing the community grant mechanism"

with contracts for units of service delivered; (c) implementing a system of co-insurance in which DMH pays all or part of the service cost depending upon third-party coverage."

DMH - As noted, DMH is exploring these alternatives.

10. "The LPR&IC recommends that the Commissioner of Mental Health distribute the FY1980 community grants appropriation more equitably (see Chapter V, Formula Funding) and require the Regional Mental Health Boards to demonstrate reduction in any disparities at the catchment area level."

DMH - A more "equitable" system is desirable, but the definition of "equity" is elusive. Hopefully, a better formula will be agreed upon for FY 81. The Commissioner appreciates the support of the LPR&IC in his efforts to encourage the Regional Boards to reduce disparities.

11. "In order to facilitate the coordination of mental health services, the LPR&IC recommends that DMH establish regional information and direction centers to match individual client needs with available services and assist the interaction between service consumers and providers. Further, it is recommended that these centers be located in the offices of the Regional Mental Health Boards (RMHBs), and that responsibility for information coordination and client direction rest with Board staff and/or community volunteers."

DMH - DMH had such a program in place. Unfortunately, it was funded with CETA dollars, and they are no longer available. It would be inappropriate to place such a program administratively under the RMHBs. Such a responsibility would undermine their primary functions of program planning and evaluation. Fiscal note needed.

12. "The Commissioner of Mental Health establish procedural guidelines for state hospital discharge planning and follow-up activities. These guidelines should include minimum fulltime staffing requirements, staff training programs and community referral and liaison arrangements."

DMH - Procedural guidelines are developed where useful (see, for example, existing guidelines for discharge to SNF's). Minimum program requirements are established under the licensing procedures. Upgrading these will involve

higher rates in community settings. Fiscal note needed (primarily in increased Title XVIII, XIX, and XX and SSI costs).

13. "The Department develop minimal care settings in the community including but not limited to foster care, sheltered homes, and boarding homes."

DMH - See 12 above.

14. "DMH pursue federal funding of community housing for the chronically mentally ill."

DMH - DMH will assign a person to this full time.

15. "DMH together with the Departments of Income Maintenance and Health Services develop ways of maximizing third-party payments and other support payments and services for deinstitutionalization patients."

DMH - DMH has been actively working to establish a format to study the whole issue of insurance coverage for psychiatric patients. We expect this to be done this coming year.

16. "DMH and community nursing agencies formally describe their discharge planning and follow-up activities as medically necessary, and, therefore, reimbursable."

DMH - Same as 15 above.

17. "The LPR&IC recommends that the following actions be taken to provide the service needs of the psychiatric patients in nursing homes."

1. The Connecticut Public Health Code be revised to (a) specify the types and minimal levels of mental health recreation and physical therapy services and/or staff in licensed nursing homes authorized to care for persons with manageable psychiatric conditions;¹
(b) provide minimum requirements for in-home staff or consulting psychiatric or other mental health professional services (for example, psychological, psychiatric nursing or social work services); (c) specify the minimum number of monthly, quarterly or yearly visits, as well as minimum levels of treatment intensity of required psychiatric and other mental health professional nursing home services.

2. DMH together with the Department of Health Services monitor the number, frequency and level of treatment intensity of psychiatric visits to mental health patients in nursing homes.

3. The Department of Income Maintenance increase the level of reimbursement for follow-up visits by a psychiatrist.

4. The Department of Income Maintenance classify other mental health professional nursing home visits as Medicaid reimbursable services."

DMH - DMH concurs with the thrust of these recommendations. We hope that they are considered by the Governor's Committee on Nursing Homes. Fiscal note needed.

18. "The LPR&IC finds that the absence of clarification by the Commissioner has resulted in confusion and misinterpretation concerning the regionalized mental health delivery system and the roles of the various participants. Therefore, the LPR&IC recommends that the Commissioner define, describe and interpret the experience to date of regional budgeting, formula funding and citizen participation. This information should be incorporated into a memorandum sent to all participants whose roles were established under the regionalization legislation."

DMH - DMH finds that the ambiguity noted by the LPR&IC results not from the absence of clarification by the Commissioner, but from the ambiguity of the existing statute. Hopefully the study of this issue by the Public Health Committee and the Board of Mental Health will result in corrective legislation."

19. "The LPR&IC recommends that prior to July 1, 1980, the Commissioner establish the statutorily mandated regional per capita formula. So that this formula is more reflective of service need than the present trial formula, greater weight should be given these variables as represented by per capita income and the extent of state-owned community facilities.

Furthermore, the LPR&IC recommends that formal application of the established formula be limited to new community grant account funds until FY 1984 budgeting. At that time, the formula's application should be extended to DMH's entire service budget."

DMH - DMH would like to establish formula funding as soon as possible. Further experience with trial formulas is essential before attempting to establish one by regulation. Full regional formula budgeting (including state institutions) will require a change in the way the Legislature appropriates money to the DMH. This issue needs to be addressed legislatively, if full formula budgeting is to be implemented by 1984.

20. "The LPR&IC finds that the differing goals of the Commissioner and the regional citizen participants are mutually exclusive and this increase the potential for conflict!"

DMH - As noted in the covering letter, this polarization is diminishing. The work of the Public Health Committee and the Board of Mental Health in the coming months should further help to reconcile the different perspectives.

21. "Findings. The LPR&IC finds that the Mental Health Services Act intended the following:

1. Inclusion of state facilities in the system of regionalized services and, therefore, in regional budgets.

2. Regional Mental Health Boards advisory input in the regional budget preparation.

3. Final determination of regional budgets left to the Commissioner.

Therefore it is necessary and appropriate to (1) initiate regional budgets which include state facilities budgets and (2) extend RMHB's specific budgetary recommendations to all state-owned facilities. At the same time, while LPR&IC is critical of the delay in implementing the regionalization legislation, the Committee finds that immediate implementation of regional budgeting could create disruptions in service delivery and in the development of meaningful citizen participation. Therefore, the LPR&IC finds that actual regional budgeting by formula cannot be implemented realistically by FY 1981.

Recommendation. In order to eliminate the potential for disruptions in service at both state hospitals and community-based services, the LPR&IC recommends that the Department include in the aforementioned recommended memorandum the following information: an implementation timetable, projected impact of regional budgeting and formula budgeting, and an analysis of the future role of regional citizen participants.

Furthermore, the LPR&IC recommends that the timetable adopted reflect informal use of both regional budgets and formal budgets from FY 1981 through FY 1983. Regional budgets would be derived from the consolidated budget including (1) regional utilization costs for the previous year, unless modified by the Commissioner at the suggestion of the RMHBs and (2) all proposed grants and

contracts as recommended by the RMHBs including new funding allocated by formula. Prior to FY 1984, formula budgets would be developed for the sole purpose of providing guidelines for eliminating disparities between regions. While the RMHB input will be limited by the "hold-harmless" provision for state hospital funding, the formula budget will provide documentation if the RMHBs press recommendations advocating increased community services.

Finally, the LPR&IC recommends that beginning with the FY 1984 budget, formula budgets become the actual regional budgets with the previous "hold-harmless" provision for state hospitals no longer applicable.

DMH - DMH concurs with the LPR&IC findings. As noted in the responses to the Committee's 18 and 19 (above), a detailed plan for implementation of full regional budgeting is premature at the present time. Both the data from FMIS and clarification of the legislative ambiguity are needed before such a plan can be realistically developed.

22. The LPR&IC recommends that DMH regulations include a provision whereby a CAC must notify the RMHB and the Regional Director if a municipality fails to fill a vacancy within 60 days. The Regional Director, in turn, would be required to contact the chief municipal officer.

DMH - Concurs. Will discuss with RMHBs and CACs.

23. The LPR&IC finds that despite the statutory mandate (C.G.S. 17-226k(b) to adopt regulations concerning the "study and (evaluation) of mental health services," no regulations have been promulgated. Therefore, the LPR&IC recommends that DMH promulgate the regulations specified in C.G.S. 17-226k(b), but heretofore not adopted, regarding evaluation procedures to be followed.

DMH - Adequate experience with evaluation procedures may have been accrued to adopt such regulations now. DMH will explore.

24. "The LPR& IC recommends that the RMHBs immediately undertake development of regional comprehensive plans to be utilized by the Commissioner as advisory documents for the comprehensive State Plan. Furthermore, the LPR&IC recommends that references to a comprehensive plan be deleted from Departmental regulations (C.G.S. 17-2261-8) since (1) recommendations for regional comprehensive plans are statutorily mandated and (2) the time frame for submission in the regulations may place unrealistic parameters on the regional plan given the need to synchronize regional and state planning.

DMH - DMH concurs with the recommendation the RMHB's undertake the development of comprehensive referral plans. It disagrees with the recommendation that references to a plan be deleted from DMH regulations. Regional and State plans need to be integrated despite the time constraints or both become meaningless.

25. "While the LPR&IC supports establishment of the Legislative Task Force to review the existing regional structure and to propose modifications or changes, it recommends that the following priority issues be addressed:

1. The need to tailor the citizen participation structure so that the efforts of the RMHBs and Facilities Advisory Boards are channeled effectively in the pursuit of a regionalized service delivery system.
2. The need to balance the accountability of the Department with meaningful citizen participation.
3. The need to refocus the Department's service priorities from state hospitals to community services in the coming years.

DMH- DMH concurs with the areas recommended for study, but hopes that many other areas requiring legislature change will also be considered (see comments above).

26. "Therefore, the LPR&IC recommends that the Commissioner provide data to the General Assembly which will facilitate policy development and rational decision-making. These data should include but not be limited to, the effect of closing at least one state hospital and transferring funds to community programs, the cost of direct service-delivery as compared to state subsidies for non-profit agencies, the cost of maintaining deinstitutionalized patients in nursing homes and the cost and feasibility of relying on general hospitals to provide service for involuntary patients.

DMH- DMH is not planning to close any state hospitals. Should the legislature wish to consider closing any given hospital, DMH would assist the Office of Fiscal Analysis in any cost analyses it might wish to make. Comparing direct service-delivery costs with indirect service delivery costs is a highly complex task. DMH has discussed the usefulness of such an undertaking with DIM. An adequate study would require fiscal support. Such a study would include the cost of patients in nursing homes. DMH is in the process of negotiating a contract with the Connecticut Hospital Association to explore the issues regarding cost and feasibility of general hospital care.

27. "The LPR&IC finds that the critical nature of these assumptions makes further clarification necessary. Therefore, the LPR&IC recommends that DMH reassess these assumptions and include in FY 1980 Facilities Plan the following information:

an elucidation of the Department's responsibility for helping to develop the additional 250 community psychiatric beds and other needed community services with specific and detailed steps to be accomplished within an explicit timetable;

an outline of the Department's plans for developing transitional living support and other needed community services;
and

an explanation of what actions the Department will be taking to cooperate and coordinate with CADAC in developing the 125 additional community alcohol beds.

DMH: As noted above, DMH is working with the Connecticut Hospital Association on developing additional community psychiatric beds. As noted above, DMH will have a full time person assigned to the development of housing for discharged patients. DMH stands ready to work with CADAC in developing additional community alcohol beds.

"THE LPR&IC further recommends that DMH actively involve the Advisory Council of the Board of Mental Health and the RMHBs in developing departmental policy on these points.

DMH: Concur

28. "The LPR&IC finds that an explanation by DMH of what constitutes "appropriate quality of care levels" in the state hospitals is now needed.

"The LPR&IC recommends that DMH specifically identify in its comprehensive statewide mental health plan, estimated requirements for "appropriate quality of care levels" in the state hospitals and include specific measurement definitions and data on necessary supportive and program staff.

DMH: The Beyes Report contains preliminary projections of what DMH would consider necessary levels of staffing for appropriate quality of care. A more detailed study should be done when resources are available. Fiscal note needed.

29. "The LPR&IC recommends that the DMH Plan and adopt programs for the redeployment and retraining of state hospital staff for more efficient and effective use within and outside of the state hospitals.

DMH: In-service training programs for more efficient and effective use of staff within the hospitals are in place. Since DMH does not project any decrease in direct-care personnel until 1984 a program for retraining of staff for these purposes would be premature.

30. "The LPR&IC recommends that the Commissioner make available small buildings at state hospitals to community agencies for the purpose of establishing transitional living facilities.

DMH: OPM has initiated a study of the utilization of buildings on all state campuses. DMH has already requested that the question of making some buildings available for use by community agencies be included in that study.

31. " The LPR&IC recommends that the Department include in the Facilities Plan five year projections for direct and indirect service delivery at each existing and planned facility.

DMH: Concur

32. "The LPR&IC recommends that DMH outline its plans for establishing preadmission screening in each catchment area by 1985. In particular, DMH should specify the funding and other program arrangements to be offered community-based providers. Furthermore, DMH should describe the means by which the state hospitals will be incorporated into this network of community-based pre-screening services and how prescreening services will reduce inappropriate admissions.

DMH: Concur

Appendix IV-1

State-Owned Mental Health Facilities

The Department of Mental Health owns ten mental health facilities and six alcohol and drug facilities. All but two of the mental health facilities are operated solely by the Department. The exceptions are the Connecticut Mental Health Center which is operated jointly with Yale University and the Capitol Region Mental Health Center which contracts for services with the University of Connecticut. All DMH facilities exclusively for alcoholic and drug-dependent persons are state operated.

In addition to DMH owned and/or operated facilities, the state owns facilities which provide mental health services not under the jurisdiction of DMH. Most notable are the John Dempsey Hospital at the University of Connecticut Health Center and facilities operated by DCYS for persons under 16 years of age.

DMH owned mental health facilities include three large state hospitals (primarily for inpatients), two comprehensive community mental health centers (primarily for outpatients), one regional inpatient hospital, one day treatment facility, one clinic (primarily outpatient), one forensic facility and one research facility. In addition, DMH owns one hospital for the treatment of alcoholics and operates five additional facilities for alcoholics and/or drug-dependent persons.

A description of the DMH mental health facilities reviewed in this report follows.¹ It should be noted that the Ribicoff Research Center at Norwich Hospital and Whiting Forensic Institute for the criminally insane are omitted because of the specialized service provided. In addition, Blue Hills Hospital and the five smaller alcohol and drug facilities are not described since they are beyond the scope of this report.

¹ Data sources for all descriptions were the 1977-1978 Connecticut Administrative Reports Vol. XXXII and DMH.

State Hospitals

Connecticut Valley Hospital (CVH)

Year Established: 1867, Oldest Connecticut state mental hospital

Area Served: Approximate central third of state including the cities of New Haven, Middletown, New Britain and Bristol

Average Daily Resident Population: 666

Average Daily Outpatient Population: 489

Permanent Full-time Positions: 1,058

Fairfield Hills Hospital (FHH)

Year Established: 1929

Area Served: Western geographic third of state (total of 50 cities and towns in Litchfield, Fairfield, New Haven Counties)

Average Daily Resident Population: 932

Permanent Full-time Positions: 1,138 (largest number)

Norwich Hospital

Year Established: 1904

Area Served: Entire eastern portion of state and Hartford city area

Average Daily Resident Population (FY 1978): 840

Permanent Full-time Positions (FY 1978): 1,077

Three large state hospitals serve Connecticut; Norwich Hospital in Norwich (NH), Connecticut Valley Hospital (CVH) in Middletown and Fairfield Hills Hospital (FHH) in Newtown. DMH provides inpatient service for the care of mentally ill adults and aged. Also provided are detoxification and treatment programs for alcohol dependent persons at each hospital. Inpatient drug treatment and outpatient methadone maintenance programs are available in both CVH and FHH. Norwich Hospital operates an outpatient clinic for alcoholics in the City of Norwich.

Each hospital also provides discharge planning and vocational rehabilitation programs for inpatients. In addition, CVH and NH operate transitional living and partial hospitalization programs. Since July 1, 1979 outpatient services are funded only at CVH's outpatient clinic. Prior to this date, Norwich Hospital funded staff positions at several general hospital outpatient clinics; this funding has now been transferred to community services programs.

Comprehensive Community Mental Health Centers

Connecticut Mental Health Center

Year Established: 1964
Area Served: New Haven and 12 surrounding towns
Average Daily Resident Population (FY 1978): 36
Average Daily Outpatient Population (FY 1978): 2,785
Permanent Full-time Positions (FY 1978): 242

Greater Bridgeport Community Mental Health Center

Year Established: 1965
Area Served: Six towns of Bridgeport, Easton, Fairfield, Monroe, Stratford, Trumbull
Average Daily Resident Population (FY 1978): 32
Average Daily Outpatient Population (FY 1978): 3,594
Permanent Full-time Positions (FY 1978): 172

DMH own two comprehensive facilities--the Greater Bridgeport Community Mental Health Center (BMHC) and the Connecticut Mental Health Center (CtMHC) in New Haven. The CtMHC, a major research and training facility, is operated jointly with Yale University. An important division of CtMHC is the Hill West Haven Center which provides community-based services to a targeted portion of one catchment area.

Both the BMHC and Hill West Haven Division of the CtMHC have received federal community mental health centers funding; the BMHC received a \$2.3 million construction grant and the Hill West Haven Division more than \$2.7 million for staffing grants. As federally designated community mental health centers, each provides the five basic services originally required--inpatient, outpatient, partial hospitalization, alcohol treatment, and prevention and education.

The CtMHC also provides a comprehensive drug treatment program; special services for Spanish-Americans; and consulting services to community groups and agencies, particularly those of the inner city. Nevertheless, the emphasis of the total operating budget of the CtMHC (especially the portion funded by Yale) remains in research and training at the central facility.

In addition to the federally required services, the BMHC provides an occupational therapy program for mental health patients residing in the community. However, the primary service remains the outpatient program which is the largest in the state.

Community Facilities

Cedarcrest Regional Hospital

Year Established: 1977

Areas Served: 38 towns in north central part of Connecticut

Average Daily Resident Population (FY 1978): 42

Permanent Full-time Positions (FY 1978): 144

Recurring operating expenditures: \$1,861,209

Value of Real Property: \$9,399,960

Capitol Region Mental Health Center

Year Established: 1974

Area Served: Hartford and 28 surrounding towns

Average Daily Outpatient Population (FY 1978): 50

Average Daily Partial-hospitalization Pop. (FY 1978): 40

Permanent Full-time Positions (FY 1978): 50

Recurring Operating Expenditures: \$1,200,000 (approximate)

Value of Real Property: \$6,000,000 (approximate)

Franklin S. DuBois Day Treatment Center

Year Established: 1963

Areas Served: Eight municipalities in Catchment Areas 1 and 2

Average Daily Outpatient Population (FY 1978): 48

Permanent Full-time Employees (FY 1978): 12

Recurring Operating Expenditures: \$273,700

Value of Real Property: \$180,349

Cedarcrest Regional Hospital in Newington, the most recently opened DMH facility, was established to provide inpatient services in a community setting for Hartford area residents. Although the resident population has increased, funding limitations have slowed expansion of services.

The Capitol Region Mental Health Center in Hartford, presently undergoing renovation, offers short term (up to six weeks) and long term (more than six weeks) outpatient services. Short term outpatient care, usually aftercare for discharged state hospital patients, includes medication maintenance, screening and therapy. Long term care also includes rehabilitation programs.

The DuBois Day Treatment Center in Stamford provides a community day treatment program in a non-institutional setting. Also provided are a consultation and referral service, an outpatient therapy program, a medication clinic and a liaison program with Fairfield Hills Hospital.

Summary

Through its three state hospitals DMH provides most of the inpatient beds for mentally ill persons in Connecticut. Three smaller DMH community facilities supplement inpatient care.

While inpatient beds are distributed throughout the state, most of DMH's outpatient service is concentrated in Regions I and II. Together, the two state-owned mental health centers in Bridgeport and New Haven serve more than 6,000 persons daily. In contrast, the state does not provide direct outpatient service in Region V. In Region IV service is limited to an average of 50 persons daily while in Region III service is limited to the area adjacent to CVH.

Finally, other mental health services are available selectively in various facilities. However, because a full range of services is not delivered in every region, it is DMH's intention to increase availability by subsidizing indirect service delivery through grants to non-profit general hospitals and agencies.