Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVITALIZING THE COMMUNITY SUPPORT PROGRAM

JUNE 1993

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVITALIZING THE COMMUNITY SUPPORT PROGRAM

JUNE 1993 OEI-05-92-00120

EXECUTIVE SUMMARY

PURPOSE

To assist the planning efforts of the Center for Mental Health Services by gathering the perspectives of key stakeholders about the Community Support Program.

BACKGROUND

On October 1, 1992, the Alcohol, Drug Abuse, and Mental Health Administration, within the Public Health Service (PHS), was reorganized into a new agency called the Substance Abuse and Mental Health Services Administration (SAMHSA). Within SAMHSA, the new Center for Mental Health Services (the Center) is charged with coordinating the Federal role in the prevention and treatment of mental illnesses and promotion of mental health. It also administers several grant programs, including the Community Support Program (CSP).

Created in 1977 by the National Institute of Mental Health (NIMH), CSP was designed to assist States and communities in improving opportunities and services for adults with seriously disabling mental illnesses. Funded at about $12 million for Fiscal Year (FY) 1993, CSP provides grants to State mental health authorities for services research demonstrations, and projects involving primary consumers[1] and families in the development of services. It also provides grants to technical assistance resource centers.

We were requested by the Center to assist them in identifying future directions for the Community Support Program, given the new mission and mandate of the Center. We spoke with 124 persons nationwide for this study: Federal and congressional staff, researchers, professionals, and providers; State commissioners and CSP directors; consumer and family groups; CSP grantees; and others.

FINDINGS

While the questions in this study were about CSP, most of the findings and recommendations relate more broadly to the Center. This is because most respondents quickly went beyond CSP to talk about the Center, or talked interchangeably about the both. They believe that CSP has laid a strong conceptual foundation for the Center's activities. They have many notions of how the Center should apply the philosophy and principles of CSP to its other activities in the future.

The greatest impact of CSP has been in changing attitudes and perceptions about serving adults with severe mental illnesses, rather than bringing about the widespread development of comprehensive community-based services.

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[1] Defined as ex-patients, or as current and former users of mental health services.

Respondents say that to provide strong Federal leadership on behalf of persons with severe mental illnesses, the Center should adopt the principles of CSP - rehabilitation, recovery, and integration into the community - as its cornerstone.

People want to see the Center's agenda focused on the implementation of comprehensive community-based services. They seek strong linkages between CSP and other Center programs, and between the Center and other organizations.

Respondents believe that a major thrust of the Center should be technical assistance to help States implement comprehensive community-based services.

The call is overwhelming for technical assistance that focuses more on consultation and less on written information.

Respondents call for the Center to redefine and revitalize CSP demonstrations.

People agree that evaluation for future demonstrations should be strengthened, combining rigor with pragmatism.

Consumer and family involvement is seen as valuable, but most respondents say a more strategic focus for this part of CSP is now needed.

The majority view is that the Center should refocus this part of CSP, and that they should evaluate consumer and family involvement. People want to know more about how these groups can help improve the accessibility and quality of comprehensive community-based services.

RECOMMENDATIONS

In implementing the concepts of CSP on behalf of persons with severe mental illnesses, we recommend that the Center take the following steps.

Develop a strategic plan for the next 3 years.

The plan should focus on the implementation of comprehensive community-based mental health services. It should include a national policy agenda and strategies for the Center's most important program activities. It should contain objectives, timetables, and criteria to measure the impact of the Center's activities on improving the accessibility and quality of comprehensive community-based services for persons with severe mental illnesses.

Broaden its constituency and maintain strong linkages with agencies and organizations within and outside government.

Many respondents believe that CSP has become overly focused on certain constituents to the exclusion of others. We recommend that the Center broaden its base. It should involve a wide variety of constituents in developing and carrying out the strategic plan. It

should also maintain on-going relationships with a host of organizations and constituents at Federal, State and local levels.

Develop a strategy to provide more practical technical assistance to the field, in addition to the dissemination of written information.

The Center should ensure that technical assistance is provided by individuals with expert knowledge of programs and experience in implementing comprehensive community-based services.

Incorporate practical yet reliable evaluation methodologies into CSP demonstrations of services.

Respondents need reliable information on effective community-based services. The Center should conduct CSP demonstrations which evaluate the cost, process, and outcome of such services on the lives of clients, and employ the most rigorous designs applicable to address the questions being asked.

COMMENTS

The PHS commented on this report; the full text of their comments is in Appendix A. They concurred with our recommendations and described steps taken to implement them. We thank them for their comments.

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INTRODUCTION

PURPOSE

To assist the planning efforts of the Center for Mental Health Services by gathering the perspectives of key stakeholders about the Community Support Program.

BACKGROUND

On October 1, 1992, pursuant to Public Law 102-321, the Alcohol, Drug Abuse, and Mental Health Administration within the Public Health Service was reorganized into a new agency called the Substance Abuse and Mental Health Services Administration (SAMHSA). Two centers in SAMHSA target substance abuse services. The new Center for Mental Health Services (the Center) is charged with coordinating the Federal role in the prevention and treatment of mental illnesses and promotion of mental health. It also administers several grant programs, including the Community Support Program (CSP), child and adolescent mental health grants, grants for the benefit of homeless individuals, for State protection and advocacy and human resource development programs, and mental health services block grants. The Center also coordinates evaluations, assessments, and policy studies relevant to mental health services. The National Institute of Mental Health (NIMH) retains responsibility for mental health research, including services research.

The Community Support Program

Created in 1977 by NIMH, CSP was designed as a pilot program to stimulate and assist States and communities in improving opportunities and services for adults with seriously disabling mental illnesses. Initially CSP was funded through contracts with State mental health agencies. Funding was converted in 1980 to grants, with a focus on State systems change. Today CSP is funded at about $12 million for FY 1993.

The CSP followed on the heels of the deinstitutionalization movement and was the first Federal initiative devoted exclusively to improving care of persons with severe mental illnesses in the community. Its fundamental premise is that such individuals can be helped to live productive lives in the community. Prior to CSP, the focus was on mental health treatment alone. A new concept, or model, called the "community support system" was developed within CSP as a basis for planning and organizing services for this population. It reflects an integrated, comprehensive system of care, including not only mental health services but an array of rehabilitation and social services as well: client identification and outreach; crisis response services; housing; income support and benefits; health care; rehabilitation, vocational training and employment assistance; alcohol and/or other drug abuse treatment; consumer, family, and peer support; and protection and advocacy.

Currently, CSP promotes the development of community service systems primarily through grants to State mental health authorities. The two major thrusts are

demonstrations, and statewide service system improvement projects to involve primary consumers and families in the planning, provision, and assessment of services. A third, smaller, CSP emphasis is grants to resource centers that provide technical assistance on housing, consumer self-help, and rehabilitation research and training. All States have been CSP grantees at some time during the life of the program.

The population of concern for CSP is adults with severe mental illnesses: "individuals 18 years and older with a severe and persistent mental disorder that seriously impairs functioning in the primary aspects of daily living such as interpersonal relations, living arrangements, or employment." According to the 1989 National Health Interview Survey, as many as 4 to 5 million adults in the U.S. suffer from severe mental illnesses.

From 1955 to 1985, large State institutions reduced their patient population by 80 percent. Now, according to projections in the 1989 National Health Interview Survey, about two-thirds of the severely mentally ill population reside in the community. A report by the Federal Task Force on Homelessness and Mental Illness notes that as a group, this population is younger, more heterogeneous - including more minorities - and more troubled than in the past. It includes many people in their 20's and 30's who have spent little or no time in an institution. Their incidence of homelessness, and contact with the criminal justice system, have been on the rise.

Nationally, about 60 percent of State mental health funding still goes for in-patient care rather than community-based services, even though the majority of this population resides in the community. The Federal share of funding for services remains small compared to the State and local shares. For example, in 1985, States supplied over 78 percent of the funding to support State mental health agencies; the remainder was provided by Federal sources including block grants, Medicare, and Medicaid.

One of the most important national issues which could affect health and mental health services for this population is national health care reform. The extent to which mental health services are a part of this reform is not yet known, but it could have a significant impact on the Center's programs.

Related Programs

The Mental Health Services block grant, formerly part of the Alcohol, Drug Abuse, and Mental Health Services block grant, is the largest program at the Center providing funds for services for this population, with an appropriation of some $280 million for FY 1993. Comprehensive State mental health planning requirements, which stem from Public Law 99-660, are now an integral part of the block grant. States are required to submit both annual plans and implementation reports.

The Center also funds two programs for homeless persons. Projects for Assistance in Transition from Homelessness, a formula grant program funded at about $30 million in FY 1993, serves homeless persons with mental illnesses, including those with substance abuse disorders. Access to Community Care and Effective Services and Supports grants,

funded for the first time in FY 1993 at approximately $22 million, require States to implement an integrated set of services to meet the needs of homeless severely mentally ill and/or substance abusing persons. The program resulted from a recommendation by the Federal Task Force on Homelessness and Severe Mental Illness; the Task Force was created by the Secretaries of the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS), and chaired by NIMH.

Another related program in the Center is the State Human Resources Development Program, which provides grants to States to develop and disseminate knowledge and technology related to human resource development issues and problems.

Other Federal programs outside the Center provide significant funding for this population. In HHS, Supplemental Security Income and Social Security Disability Insurance in the Social Security Administration (SSA) provide income. Medicaid, in the Health Care Financing Administration (HCFA), funds health care, case management, and other community-based services. Housing programs in HUD, and vocational rehabilitation programs in the Department of Education (E.D.), are two other examples.

SCOPE AND METHODOLOGY

To help guide planning efforts, the Center requested our assistance in gathering the perspectives of a variety of stakeholders on the accomplishments, weaknesses, and future direction of CSP. We did not conduct a formal evaluation of the program.

Following a review of literature, we spoke with 124 persons nationwide between October and December 1992: persons from the Office of the Assistant Secretary for Health, the Center and NIMH: congressional staff; researchers; mental health professionals and providers; State mental health commissioners ("commissioners" in this report) and CSP directors; consumer and family groups; present and former CSP grantees; persons from foundations and other national organizations; and others. Some responded to our questions in writing, but we talked to the majority by telephone or in person.

We spoke with consumers and family members at a conference of CSP service system improvement grantees in October. We visited Dane County (Madison, Wisconsin) in December to observe programs, not funded by CSP, which are nationally renowned for their approach to serving this population; we talked to providers and consumers there.

We asked the following questions: (1) What have been the major accomplishments of CSP, and have there been problems associated with it?; (2) In the future, what one problem relative to community services for people with severe mental illnesses is it most important for CSP to address, and why?; (3) Would you change the way CSP is structured, administered or funded (assuming the level of funding remains unchanged)?; and (4) What role should CSP play relative to other Center programs?

This inspection was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

The findings in this report are based on the opinions of 124 persons with a wide range of experience relative to adults with severe mental illnesses.

Readers will note that while the questions in this study were about CSP, most of the findings and recommendations relate more broadly to the Center. This is because most respondents quickly went beyond CSP to talk about the Center, or talked interchangeably about both. They believe that CSP has laid a strong conceptual foundation for the Center's activities. They have many notions of how the Center should apply the philosophy and principles of CSP to its other activities in the future.

The greatest impact of CSP has been in changing attitudes and perceptions about serving adults with severe mental illnesses, rather than bringing about the widespread development of comprehensive community-based services.

Respondents identified a number of strengths and weaknesses associated with CSP. In general, comments reflect the view that the program had its greatest impact before the mid-1980's, when they say that support from NIMH waned in favor of biomedical research.

Respondents credit CSP with creating a new conceptual framework for serving adults with severe mental illnesses, which has taken root across the country.

We found strong agreement that a great accomplishment of CSP was that it articulated a philosophy of comprehensive community-based care for adults with severe mental illnesses. People praise CSP for providing Federal leadership on behalf of this population and say it "stirred things around" by emphasizing new thinking and creativity. One of the most important results of the collaboration between Federal staff and others outside government was the development of the Community Support System (CSS) concept, which conveyed the importance of providing social welfare supports along with mental health treatment.

The consensus view is that because of Federal leadership via CSP, there is now broad recognition of the value of comprehensive community-based services for persons with severe mental illnesses, and the CSP philosophy and the CSS have been accepted across the country.

However, it appears that CSP accomplished less in leading to the widespread implementation of the comprehensive community-based services it envisioned.

The question of how much CSP has contributed to widespread implementation of community-based services is more difficult to answer.

Many people believe that CSP has helped implement new services. State CSP directors credit the program with driving the development of new services with its emphasis on networking, information dissemination on models, demonstrations, and consumer involvement. Commissioners, many of whom have been involved with CSP for years and whose States have been CSP grantees, praised the program, especially in the early years, for its "vision," "moral leadership," and "extraordinarily effective use of a small amount of money to catalyze and accelerate a formative movement."

Others were more restrained but also credited CSP with helping establish new services. The program "singlemindedly promoted the development of community service systems." Funds were targeted at strategic, change-oriented activities and represented the only Federal dollars with the flexibility to respond to emerging issues and needs in the field. People say that "CSP has become synonymous with innovation," providing funds for commissioners to try new services that their States would otherwise not have funded. Staff spread the word about new services by highlighting grantees and their activities at national conferences, in speeches, and in reports disseminated to the field.

Praise notwithstanding, however, people described a number of factors that weakened the impact of CSP, particularly after the mid-1980's: inadequate funding to accomplish widespread change; inadequate technical assistance; an excessive focus on consumers and families to the exclusion of the treatment community; and turnover of State and local leadership (commissioners, especially) who could implement change. Another weakness - poor evaluation of the demonstrations - is discussed separately in this report.

In summary, it seems plausible that CSP has been a catalyst in introducing new ideas about serving severely mentally ill adults, and in some States where key people were receptive to these ideas, introducing new services. However, since the vast majority of State funding nationally still goes to hospital rather than community care, it is difficult to conclude that States have wholeheartedly endorsed community-based services, whether in response to CSP or not. We suspect that some respondents, by virtue of their long and close relationship with CSP, may believe that it has had greater impact nationwide than is actually the case.

Respondents say that to provide strong Federal leadership on behalf of persons with severe mental illnesses, the Center should adopt the principles of CSP - rehabilitation, recovery, and integration into the community - as its cornerstone.

For the respondents in this study, the most important role the Center can play is to widely promote the CSP concepts of rehabilitation and recovery for persons with severe mental illnesses, and push for the greatest possible integration of this population in the community.

People want to see the Center's agenda based on CSP principles and focused on the implementation of comprehensive community-based services.

Respondents say unequivocally that the Center should adopt CSP principles as its guiding

principles. In addition to the philosophy of rehabilitation and recovery, the principles respondents mentioned most were: an unrelenting focus on the severely mentally ill population, emphasis on creativity and new, innovative services, a flexible approach to adapting to State and local needs, and involvement of consumers and families.

People expect the Center to be in the forefront of the debate on national issues affecting persons with severe mental illnesses. In "riding the wave of newness," as one person put it, respondents want the Center to develop a strategic agenda setting forth the policies and priorities around which all of its programs will revolve. The most important priority, they say, is the widespread implementation of services, for which CSP has set the stage.

They want CSP and other Center programs to be more closely integrated.

People see close collaboration and teamwork between CSP, homeless programs, the block grant, and the Human Resource Development Program as important to creating comprehensive community-based services for people with severe mental illnesses. They say the Center should seek to model the kind of coordination and linkage among its programs that the Federal Government requires of States.

Short of actually combining programs, which a number of respondents advocate, the Center could use joint planning, and task forces or work groups, for these programs to address cross-cutting issues and otherwise coordinate their activities. Comments show that respondents think of CSP as the framework or "moral compass" of these other programs. This was especially true of those, particularly the commissioners, who called for a complete overhaul of the Human Resource Development Program, to better fit the CSP mission and link the programs more closely.

Many people favor joining the block grant and CSP in some way, so the programs can be used more strategically, together, to foster the development of new services. Besides the general notion that the State plans should embody CSP principles, the most frequent suggestion was that CSP dollars be used as an incentive, or "carrot," for States to fund new initiatives directly related to State plan priorities. Respondents urged the Center to find ways such as this to provide incentives rather than penalties for States to develop new services.

Other ideas about CSP and the block grant were that: they be used together to promote a "national policy agenda" designed to "revitalize" the mental health system; CSP demonstrations should test and prove services which then could be implemented through the block grant; and, the results of CSP demonstrations be used as the basis for establishing priorities, guidelines, or requirements attached to the block grant.

They want the Center to establish strong, strategic linkages, using the inclusive, collaborative approach of CSP's early years.

In talking about CSP's accomplishments, we noticed a tone approaching nostalgia in the comments of people who have been involved with the program since its inception. They

applaud the highly collaborative approach that CSP staff took with people outside government, especially in its early years. They urge the Center to use the same approach in establishing a wide variety of linkages both within and outside government to carry out its mission.

In the Federal arena, respondents call for the Center to collaborate with a host of agencies to represent the severely mentally ill population on key national policy and funding issues, to promote the CSP philosophy of rehabilitation, and to disseminate the results of demonstrations on services to them. Center staff should have special expertise in the programs most affecting the population, and linkages with HCFA, SSA, HUD, and E.D. are particularly important. Some people view the Federal Task Force on Homelessness and Severe Mental Illness as a model for Federal interaction, with the caveat that what really matters is whether the recommendations of the Task Force are implemented.

The issue of greatest urgency to respondents is clearly national health care reform. There is great concern that the needs of this population will be overlooked unless the Center is actively involved in the national debate on their behalf. On a positive note, some see CSP concepts as compatible with the concept of managed care, which is being discussed today in connection with health care reform.

In addition, respondents ask the Center to collaborate with many other organizations and constituents, to bring about significant, lasting systemic changes in the balance between institutional and community care for persons with severe mental illnesses. This includes Congress; State legislators, governors, and heads of State Medicaid agencies; commissioners and the National Association of State Mental Health Program Directors (NASMHPD); county governments; mental health treatment providers, including community mental health centers (CMHC) and hospitals; human service providers; academia; foundations; and national organizations representing various constituents.

Respondents believe that a major thrust of the Center should be technical assistance to help States implement comprehensive community-based services.

Of all the issues in this study, technical assistance engendered the greatest agreement. Two-thirds of all respondents say that technical assistance - in short, "getting good models out to a broader constituency" - should be a major priority for the Center. They also see human resource development as a key issue related to technical assistance.

The call is overwhelming for a technical assistance effort going beyond the dissemination of written information.

People commented very favorably about CSP technical assistance before the mid-1980's. They say that the program funded people getting together in a number of ways to stimulate cross-fertilization across the country about new ideas. Staff reached out to States, asking how they could help. Respondents found learning conferences interesting, stimulating, and inspiring. The program sent people to other States to observe new services first hand, giving them new ideas they went on to implement in their own States.

It brought experts in to work with States, or held "common concerns" meetings where a small group from several States could grapple with one particular issue.

The impact of technical assistance may have waned in recent years. We heard that resource centers, while a good concept, reach relatively few people and over-emphasize written information. Some people said that conferences too often "preach to the converted" by including the same participants and consultants, over and over. State CSP directors object that they do not meet separately to discuss issues germane only to them.

People want many things from technical assistance, but the bottom line is that the Center should create a "do tank rather than a think tank," with more hands-on consultation and less emphasis on writing and publishing, "teaching and preaching." Following are some specific suggestions.

- Bring more, and different, constituents together on a national, regional, or State-to-State basis.
- Help commissioners and CSP directors strategize ways to bring governors, legislators, or State Medicaid agencies into the process of developing community services, since financing is such a key issue.
- Broaden the circle of national experts drawn upon to provide technical assistance, to include more State and local players who have successfully implemented services in the field.
- Use technology (teleconferencing and interactive video were two examples) more, and more creatively.
- Set up regional centers; or, examine the Centers for Disease Control or Agricultural Extension Service as models of effective approaches to technical assistance.
- Provide more written information in summary form. State and local programs can not afford journal subscriptions, and few staff in the field read journals.

Respondents also advocate an expanded human resource development effort to train staff in the delivery of comprehensive community-based services.

Respondents say that local implementation of new services is severely hampered by the lack of staff adequately trained in providing community-based services. There is a strong call for the Center to strengthen the Human Resource Development Program and otherwise step up its efforts to address this problem, focusing on certification, re-training, and skill-building. Training is needed not only for mental health professionals such as psychiatrists, nurses and social workers, but also vocational rehabilitation workers, employment counselors and others who work with persons with severe mental illnesses in the community.

Respondents call for the Center to redefine and revitalize CSP demonstrations.

The CSP demonstration program has changed over the years. The earlier demonstrations were pure services demonstrations, with little attention to the importance of evaluation. Over the past 5 years, increasing efforts have been placed on improving the rigor of these demonstrations. More recent studies therefore employ rigorous experimental designs with control or comparison groups.

Respondents do not view demonstrations as a major accomplishment of CSP. They say that well-designed demonstrations are still needed.

Opinion is mixed about the usefulness of past CSP demonstrations. However, many respondents agree that, notwithstanding NIMH efforts to strengthen it, evaluation has been weak.

Some people praise early CSP demonstrations as the first, and only, source of information about new services or as a "carrot" for States to try new services they would not otherwise have funded. They have found some of the information useful but also acknowledge that evaluation was far too weak. Others criticize them for yielding too little empirical data, largely due to poor evaluation. This made it difficult, they say, for CSP staff to respond to challenges about the validity or effectiveness of community-based services, which in turn weakened the credibility of the program as a whole. In fact, a few respondents went so far as to criticize CSP for promoting, as "panaceas," specific services or models which were essentially unproven; case management was mentioned here. One said further that the lack of reliable data on service effectiveness has meant that the "replication and spread of new services has been remarkably slow."

Respondents are hungry for demonstrations that identify "real solutions for real problems" and "efficient, effective models of service at a time of budget cuts." Most advocate a broad, systems change focus, although there is some sentiment to continue to study specific services (self-help and psychosocial rehabilitation were two examples) or services for subpopulations, especially those suffering from both mental illnesses and substance abuse.

There is a wealth of ideas on how future demonstrations should be focused and structured. One suggestion is that the Center conduct a short term evaluation to document the accomplishments and national impact of CSP on the development of services. The Center would publicize the results, giving CSP public credit for the change it has brought about.

Following are a few of the many other suggestions we heard:

- Focus demonstrations on one or more "centerpiece" priorities or themes;
- study new or cutting edge services, policies or ideas of national significance, looking for the next subjects of scientific research years down the road;

- replicate proven or promising services, to learn about implementing services in "real life" situations, and what outcomes they produce in the lives of clients;
- study services integration or linkage; and,
- involve consumers for real, then validate how they help; look at their participation in policy development, planning, and service delivery, including self-help and other consumer-run services.

As for how demonstrations might be structured, respondents also had many ideas. Fund them for up to 5 years, with "built-in self correction allowed" and the option to end them at various intervals if grantees fail to meet interim goals. Include a staff training component and evaluate this also. Test the same service in several sites in one State, several States in a region, or several regions in the country. Require States to include several counties, or to reconfigure their spending by putting more dollars into community-based services.

Most respondents say that State mental health authorities should continue to be the primary grantees. As the major players in State mental health policy and services, they must be involved for systems change to occur. On the other hand, some favor working from the bottom up in States where mental health services are greatly decentralized or State mental health authorities are slow to embrace change. In such cases, they say, the Center should fund local grantees directly, with some sort of State sign-off. They think this might promote increased interest in community-based services at the State level.

Respondents urge collaboration between the Center and NIMH on planning demonstrations. One view is that the Center should pick up where NIMH leaves off, that is, conducting "effectiveness testing" of services researched by NIMH, focusing on how to implement them. Another is that NIMH should research promising service models emerging from Center demonstrations. The intent of such collaboration would be to foster the implementation of services which have been proven effective, and to promote studies which meet State and local needs.

People say that evaluation for future demonstrations should combine rigor with pragmatism.

Respondents agree that evaluation should document three things: client outcome (i.e. the effectiveness of services in producing positive changes in the lives of clients), the cost of services, and how services actually work. Some added that consumer input is especially valuable in designing demonstrations.

On the subject of what constitutes "good" evaluation, people favor some sort of middle ground, "the most rigorous design possible yet practical and applied." It should be built in up front by providers and researchers together and based on what services are needed rather than what research question is to be answered. Given widespread praise for CSP's historical emphasis on creativity and innovation, we were not surprised to hear comments

such as: "Replication isn't always 'scientific.' Combine rigor with pragmatism and creativity," and, "CSP should loosen its tie but keep it on, and focus on the cutting edge." Commissioners were particularly eloquent about striking a balance between the need for new services, now, and the need for empirical data.

People are concerned that many States lack the technical ability to conduct good evaluation and propose several ways to address this lack. One is to conduct evaluation centrally with a group of experts established by the Center. Another is to provide technical assistance on evaluation to prospective grantees, rather than after-the-fact which is now the case. A third is to mandate strong linkages between State mental health authorities and universities; this would increase State buy-in to the need for evaluation, ensure that the services studied are the ones States value, and increase the chances for replication by the State once the demonstration is over.

Consumer and family involvement is seen as valuable, but most respondents say a more strategic focus for this part of CSP is now needed.

Respondents, including two-thirds of the State CSP directors and half of the commissioners, credit CSP to a great extent with creating and nurturing the consumer and family movements. They also say CSP provided valuable policy guidance and technical assistance relative to these groups. Their view is that the activities of these groups have led States, and those in the mental health field generally, to gradually adopt a community support philosophy. People tend to see consumers as particularly important since, as one put it, "they know what works and what doesn't. This is what causes change."

People also believe that CSP has become "overidentified" with - that is, favors consumers and families over others involved with CSP, or consumers over families, or even certain consumers over others. This meant, they say, that CSP excluded and ultimately alienated many in the treatment community, professionals such as psychiatrists, and providers such as CMHCs and hospitals. The sense of many of the criticisms about overidentification was that "no one group should define CSP."

Some people, especially State CSP directors, favor continuing this part of CSP for fear that many incipient organizations - consumer organizations, especially - will die without Federal funding. The majority view, however, is that the Center should refocus this part of CSP to bring about collaboration that produces "positive life outcomes" for persons with severe mental illnesses. People suggested: a national "theme" for this part of CSP related to strategic State issues; grants to develop the capacity of these groups to participate in State policy development and planning, specifically; and funding a national consumer center or hiring consumers as Center staff. Many suggested focusing demonstrations on consumer and family involvement.

A secondary theme is that no matter how consumers and families are involved, the Center should "evaluate these efforts to find out if what they are doing works, and how." Respondents want to know more about how these groups can help improve the accessibility and quality of services.

RECOMMENDATIONS

This study shows that CSP stakeholders have strong expectations for the Center beyond how it might alter CSP. Their fear is that without strong Federal leadership, the incipient community support network developed during the last 15 years will weaken, placing impossible demands on State and local governments and potentially leading to the rehospitalization of millions of people. They request information and assistance from the Center to expand and strengthen that network. And they are eager to be included in developing the Center's mission and strategy.

In response to the findings in this report, we recommend that the Center take the steps outlined below. The first recommendation is broad; the others provide more specifics about how the Center should maintain a broad base, and implement technical assistance and CSP demonstrations.

The Center should develop a strategic plan for the next 3 years.

The Center should develop a strategic plan focused on the implementation of comprehensive community-based services. The plan should first include a national policy agenda addressing legislative, regulatory, funding, and other issues affecting services to persons with severe mental illnesses. In addition, it should include strategies to: provide technical assistance; conduct demonstrations of services; involve consumers and families; more closely integrate Center programs; and expand human resource development efforts.

The Center should establish objectives and timetables for each of the plan's components, and criteria to measure their impact on improving the accessibility and quality of services for persons with severe mental illnesses. It is important for the Center to focus its activities on improving client outcomes.

The Center should broaden its constituency and maintain strong linkages with agencies and organizations within and outside government.

This study points out that many respondents believe that CSP has become overly focused on certain constituents to the exclusion of others. They are asking the Center to broaden its base, and to revive the inclusive, collaborative approach of CSP's early years.

We agree. First, we recommend that the Center involve a wide variety of constituents in developing - and carrying out - its strategic plan. We recommend further that they give particular attention to refocusing - and broadening - the participation of consumers and families, and the mental health treatment community. Secondly, the Center should establish strong on-going relationships with Federal agencies, State and local governments, NASHMPD, universities, foundations, and national organizations serving this population.

The Center should develop a strategy to provide more practical technical assistance to the field, in addition to the dissemination of written information.

This recommendation responds to the call from respondents for technical assistance. The Center is charged with establishing an information clearinghouse. To complement the clearinghouse, we recommend that the Center identify an office charged with providing technical assistance to persons in the field. If placed at a high level in the Center, this office would promote program integration by serving as the focal point for technical assistance for all Center programs. Just as important, it would convey the message that Center leadership considers technical assistance focused on implementation to be a priority.

The Center should staff this technical assistance effort with individuals with expert knowledge of Federal programs most affecting persons with severe mental illnesses, and first-hand experience implementing comprehensive community-based services in the field.

In addition, we think that a summary of the information from past CSP demonstrations would be helpful, not only summarizing what has been learned but identifying important knowledge gaps which the Center could address in its strategic plan.

Demonstrations in CSP should incorporate practical yet reliable evaluation methodologies.

As noted in this report, respondents are eager for reliable information on effective services. We recommend that the Center base CSP demonstrations on a strategic theme or themes. They should develop a methodology, or methodologies, to evaluate the cost, process, and client outcomes of services, methodologies including consumer feedback on outcome, and designs should be the most rigorous applicable to address the questions being asked. Demonstrations should be for a period of up to 5 years, with the option to discontinue at 2, 3 or 4 year intervals if grantees do not meet interim goals. We also suggest that the Center consider requiring States to include a number of counties in their demonstrations, to encourage local implementation of new services.

We agree with respondents that the Center and NIMH should collaborate with respect to services demonstrations and services research.

COMMENTS

The PHS commented on this report; the full text of their comments is in Appendix A. They concurred with our recommendations and described steps taken to implement them. We thank them for their comments.

APPENDIX A

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Memorandum

Date JUN 1 1993

From Acting Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "Revitalizing the Community Support Program," OEI-05-92-00120

To Acting Inspector General, OS

Attached are the Public Health Service comments on the subject report. We concur with the report's recommendations and our comments delineate the actions taken or planned to implement them.

Audrey F. Manley, M.D., M.P.H.

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE (PHS) ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT "REVITALIZING THE COMMUNITY SUPPORT PROGRAM," OEI-05-92-00120

General Comments

The Center for Mental Health Services (CMHS), which is a component of PHS' Substance Abuse and Mental Health Services Administration, requested that OIG review the Community Support Program (CSP) to assist CMHS in identifying future directions for the CSP, given the new mission and mandate of CMHS. We appreciate the effort that OIG made, and particularly wish to acknowledge OIG's willingness to assist us on such short notice. It is apparent that a tremendous amount of work was involved in contacting over 100 key persons knowledgeable of the CSP.

The OIG report identifies changing attitudes and perceptions about serving individuals with severe mental illness. Also, it discusses the actual development of a comprehensive community-based service system as the intended by-product of a significant change in attitudes resulting from Federal and State leadership and efforts by family and consumer advocates. It would have been helpful to have information on which components of the CSP were most influential in altering attitudes: the demonstration grants, conferences, interagency work, or system change efforts.

OIG Recommendation

1. The CMHS should develop a strategic plan for the next 3 years.

PHS Comment

We concur. We agree with the importance of developing a national policy agenda focused on issues affecting service to persons with severe mental illness and acknowledge that CMHS has lead responsibility for developing objectives and timetables for plan components. This strategic planning process is currently underway. Information and ideas gleaned from several past and future meetings with a broad array of constituents will ultimately shape CMHS goals and priorities.

OIG Recommendation

2. The CMHS should broaden its constituency and maintain strong linkages with agencies and organizations within and outside the government.

PHS Comment

We concur. The CMHS will, in collaboration with several State and local mental health directors, hold a series of public fora across the nation in an effort to broaden its base. We agree with the report that the CMHS agenda should be based on CSP principles and focused on the implementation of community-based services. We also agree that CMHS should be in the forefront of the debate on national issues affecting persons with severe mental illness.

It should be noted that increasingly significant linkages among Federal agencies have become the cornerstone of CMHS programs. For example, the ACCESS (Access to Community Care and Effective Supports and Services) program in CMHS' Division of Demonstration Programs (organizationally the same division with responsibility for the CSP) is an inter-agency grant program with significant affiliations with the Departments of Housing and Urban Development, Agriculture, Labor, and Veteran's Affairs, as well as with the Health Care Financing Administration and the Social Security Administration. In addition, the administration of the Community Mental Health Service Block Grant, and the Projects for Assistance in Transition from Homelessness Formula Grant allow for the development of strong Federal/State relationships.

OIG Recommendation

3. The CMHS should develop a strategy to provide more practical technical assistance to the field, in addition to the dissemination of written information.

PHS Comment

We concur that "hands on" technical assistance (on the part of experts) is often helpful in the effort to create a changed system of care for individuals with severe mental illness. We also agree with the report that this assistance should be appropriately coupled with the dissemination of written information. CMHS continues to analyze ways to provide technical assistance in a more effective manner. Additionally, when permitted within its resource level, CMHS has made modest efforts to augment the type and amount of technical assistance provided.

OIG Recommendation

4. Demonstrations in CSP should incorporate practical yet reliable evaluation methodologies.

PHS Comment

We concur. This recommendation has particular relevance and specificity to the future of CSP. One CSP critical objective is the generation of knowledge derived from well-designed and implemented demonstrations. Program staff are currently identifying specific themes for demonstrations. The suggestion to develop interim goals for funding continuation is welcome.

Technical Comments

- Data Analysis. It would have been helpful to separate out the responses of different constituencies and draw implications from them. In reading the specifics that underlie some of the recommendations, it is clear that the various constituencies have different, often conflicting goals for the CSP. It would be beneficial for the report to acknowledge and differentiate these differences.

- Site Visit. It is unclear why Dane County in Wisconsin was selected as the sole location for a site visit. Dane County has never received any CSP funding and was not recommended as an example of a locality that has used CSP principles in developing a community support system. There are many other sites that would have appropriately and usefully demonstrated the impact of the Federal CSP effort.

- Page 11, Paragraph 4. Statements in two sentences seem to be contradictory. The first sentence states that CSP has become "overidentified" with...consumers over families. The next sentence states that CSP is "overidentifying" with consumers and families.