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MENTAL HEALTH PLANS

Many States May Not Meet Deadlines for Plan Implementation

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The Honorable Edward M. Kennedy
Chairman, Committee on Labor and
Human Resources
United States Senate

The Honorable John D. Dingell
Chairman, Committee on Energy
and Commerce
House of Representatives

This report responds to a provision of Public Law 100-690 requiring the Comptroller General to evaluate states' implementation of the State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660) and report on it by September 30, 1990. This law requires states to plan and implement community-based care for their seriously mentally ill;[1] it also directs the Department of Health and Human Services (HHS) to provide planning assistance. We have concluded that it is too early to fairly and adequately assess implementation because states are not required to fully implement their plans until September 1991. During discussions with the Senate Committee staff, we agreed to examine state planning activities and assess the National Institute of Mental Health's (NIMH) role in helping states develop plans.

Toward this end, the objectives of this review were to assess the

- usefulness and timeliness of the assistance NIMH provided to help states develop plans,
- processes NIMH used to review plans and the outcomes of the reviews,
- benefits states derived from the act, and
- problems states may have in meeting the act's implementation time frames.

Scope and Methodology

To achieve our objectives, we carried out several activities:

- At NIMH, we interviewed officials for descriptions of the kinds of planning assistance they gave to states. We also observed NIMH's panel sessions, at which the plans were reviewed, and gathered information about the final outcomes of these reviews. (We did not attempt to make

[1] Although the legislation uses the term "chronically" mentally ill, subsequent legislative amendments use the preferred term "seriously" mentally ill.

services. (3) States complied with it by defining and identifying the seriously mentally ill. (4) It was also responsible, national mental health advocacy organizations said, for greater involvement of the mentally ill and their advocates in mental health planning at the state level.

Most of the 51 states we contacted said they would have difficulty meeting the act's deadlines. Forty-one states anticipated problems meeting the September 1990 deadline requiring substantial implementation, and 45 states, the September 1991 deadline requiring full implementation. Several problems will hamper timely implementation, such as the major changes states said they need to make in their mental health delivery systems, which will take longer than the 2 years provided in the act.

Background

Title V of the 1986 act requires each state to develop and submit to HHS a comprehensive mental health services plan that would be used to develop community-based care for the seriously mentally ill.[3] To develop the plans, the Congress appropriated $4.8 million for fiscal year 1988 and $4.7 million for fiscal year 1989. The first plans were originally due September 1988, but NIMH extended the deadline to January 1989 because planning funds were not provided until June 1988. The deadline for the second set of plans was September 30, 1989.

In their plans, states were to include evidence that they had responded to eight requirements set forth in the act. It directed the Secretary of HHS to assist the states, including giving them a model plan, which HHS did in October 1987. The Secretary was to evaluate state plans against the act's requirements and impose penalties on states if plans did not comply. Penalties could be as much as 10 percent or as little as 0.2 percent of a state's Alcohol, Drug Abuse, and Mental Health block grant allotment. The Secretary could not, however, require states to spend more money on mental health services than they would have spent without the act's planning requirement.

To avoid penalties, states must (1) develop acceptable plans by September 30, 1989, (2) substantially implement them by September 30,

[3]The act allows each state to define its own seriously mentally ill population. NIMH provided guidance in the form of model definitions for adults and children. According to the model, diagnostic factors should include the (1) type of illness, (2) level of disability, and (3) duration of illness.

March 1990, most states had revised their plans and HHS had approved them. Two plans were not approved and NIMH recommended that HHS impose the penalties called for by the act.

To evaluate submitted state plans, NIMH convened panels of mental health experts in November and December 1989. These panels consisted of medical practitioners, service providers, academicians, hospital personnel, representatives of state mental health organizations and private nonprofit organizations, and the mentally ill or their family members or both. The use of knowledgeable reviewers outside the agency to evaluate plans gave NIMH an independent perspective on the plans' efficacy.

Panel members reviewed and commented on (1) the responsiveness of each state's plan to the eight requirements outlined in the law and (2) other issues relating to mental health planning and community-based services. Some problems include these:

- Panelists raised questions about plan input from the seriously mentally ill in many states.
- Panelists expressed concern that many state plans did not provide adequate financial support. For example, panel members noted that state mental health planners in Alaska and New Jersey acknowledged that inadequate state financing could make service goals unattainable. Panel members thought Iowa's plan should have addressed the availability of county funds in addition to state mental health funds.
- Panel members found a lack of commitment by some states to move toward a community-based system of care. In one state's plan, for example, they found that the ratio of allocated resources between hospitals and community services was expected to remain constant at 80 percent for hospitals and 20 percent for community services.

NIMH's review was confined to the act's requirements. Its primary concern involved the information on numbers to be served—19 state plans did not have this information. Other concerns dealt with (1) inadequate descriptions of activities that would reduce the rate of hospitalization and (2) insufficient evidence of consultation with state institutions' and nursing homes' employee representatives.

In January 1990, NIMH approved 26 state plans as submitted and required the remaining states to revise their plans to bring them into compliance with act requirements. By March 1990, all plans but those of Guam and Puerto Rico had been revised and approved. Guam had not included information on numbers to be served, and Puerto Rico had not

seriously mentally ill in 1990 and 9, the same number as in 1989. State officials told us they would serve, collectively, about 5 percent more seriously mentally ill people in 1990 than in 1989. State officials also estimated they would serve, on average, almost 44 percent of their seriously mentally ill population, with estimates ranging widely from 15 to 89 percent. (See app. II.)

Many States May Not Meet Implementation Time Frames

Many states said, and NIMH officials agree, that states will have difficulty meeting the act's deadlines for full implementation. Of the 51 states we spoke with, 41 said the September 30, 1990, deadline allowed too little time to substantially implement the plans; 45 said the September 30, 1991, deadline allowed too little time to fully implement them. Problems delaying implementation include (1) differences between the federal and state cycles for planning, budget, plan approval, and program operation; (2) the uncertainty of funds for implementing the plans; and (3) the major changes many states have to make to their mental health systems to comply with the act.

The federal and state cycles for mental health planning, budgeting, and program operations differ. The plans submitted by the states were for the federal fiscal year, October 1, 1989, to September 30, 1990. Most state fiscal years, however, are July 1 to June 30. Twenty states sought mental health funding from their state legislatures to meet the objectives of their plans on or after January 1, 1990. The funding their legislatures approve will be for the states' fiscal years, starting July 1, 1990, leaving only 3 months for states to meet the act's September 30, 1990, deadline. Six states told us they are under biennial planning and budgeting cycles, making it difficult to quickly change their mental health plans.

Over half of the states mentioned funding and staffing problems as factors that may impede plan implementation. The act requires certain services, such as case management services, but does not provide additional federal funding. Some states said staffing problems, including the need to hire and train community mental health workers, would slow the pace of implementation.

In addition to resource problems, 15 states said the act requires major changes to their current systems, which will take longer than 2 years to completely implement, for example:

Please call me on (202) 275-1655 if you or your staffs have any questions about this report. Other major contributors to this report are listed in appendix III.

Linda G. Morra
Director, Intergovernmental
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Plan Content

The plans were to address the following eight requirements:

- Establish and implement an organized community-based system of care for the seriously mentally ill.
- Specify quantitative targets to be achieved in implementing such a system, including number of seriously mentally ill people residing in the areas to be served under such a system.
- Describe services to be provided for the seriously mentally ill that would enable them to gain access to mental health services, including access to treatment, prevention, and rehabilitation services.
- Describe rehabilitation services, employment services, housing services, medical and dental care, and other support services to be provided for the seriously mentally ill in order to enable them to function outside of inpatient institutions to the maximum extent of their capabilities.
- Provide "activities" (programs) that would reduce the rate of hospitalization for the seriously mentally ill.
- Provide case management services for the seriously mentally ill who receive substantial amounts of public funds or services.
- Provide for the establishment and implementation of a program of outreach to, and services for, the seriously mentally ill who are homeless.
- Consult with representatives of employees of state institutions and public and private nursing homes who care for the seriously mentally ill.

Penalties for Failure to Comply

The act provides that if the Secretary of HHS determines that a state has not developed the required plan by September 30, 1989, he must reduce the state's ADMS block grant allotment for fiscal year 1990. Furthermore, if the Secretary determines that a state has not (1) developed and substantially implemented its plan by September 30, 1990, and (2) developed and completely implemented its plan by September 30, 1991, he must reduce the state's ADMS block grant allotment for the affected fiscal years and succeeding years. This reduction is to continue until the state has developed and completely implemented the required plan.

Legislation (P.L. 100-690, section 2041) in November 1988 specified the amount and range of grant reductions. Grants to states may be reduced by the maximum amount the state is permitted to spend for administrative expenses (10 percent of the state's allotment) for fiscal year 1986. This legislation authorizes the Secretary, after determining that the state is making a good faith effort to comply, to reduce the penalty to as little as 2 percent of the amount the state was permitted to spend on administrative expenses (0.2 percent of the state's allotment).

Seriously Mentally Ill Population by State

State	Served (1989)	In 1990 To be served	In 1990 Estimated population	In 1990 To be served (in percent)[a]
AK	[b]	[b]	5,750	•
AL	24,378	29,000	43,000	67.4
AR	8,328	9,000	16,000	56.3
AZ	10,037	10,037	[b]	•
CA	150,000	150,000	300,000	50.0
CO	[b]	[b]	144,300	•
CT	35,000	36,000	245,000	14.7
DC	[b]	[b]	[b]	•
DE	2,780	3,200	5,200	61.5
FL	35,502	37,127	50,628	73.3
GA	82,489	82,489	129,951	63.5
HI	3,000	6,696	11,000	60.9
IA	[b]	[b]	25,000	•
ID	7,128	7,484	[b]	•
IL	[b]	51,850	61,589	84.2
IN	17,884	19,000	38,000	50.0
KS	6,000	8,000	10,360	77.2
KY	16,000	16,000	28,000	57.1
LA	23,000	25,530	52,026	49.1
MA	[b]	35,000	57,000	61.4
MD		[b]	137,000	•
ME	37,783	37,950	54,000	70.3
MI	18,500	26,000	92,000	28.3
MN	[b]	[b]	85,000	•
MO	20,218	20,218	42,139	48.0
MS	18,019	23,779	35,180	67.6
MT		[b]	5,836	•
NC	38,667	45,286	103,218	43.9
ND	5,550	5,912	12,083	48.9
NE	2,900	3,050	4,236	72.0
NH	5,088	5,700	7,036	81.0
NJ	67,030	67,680	108,685	62.3
NM	5,601	5,925	12,260	48.3
NV	5,615	7,351	11,957	61.5
NY	155,000	155,000	228,000	68.0
OH	27,973	28,000	60,000	46.7
OK	24,000	29,434	49,056	60.0
OR	27,383	28,615	67,086	42.7

(continued)

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State	Served (1989)	In 1990		
		To be served	Estimated population	To be served (in percent)[a]
PA	[b]	[b]	588,000	•
RI	5,305	5,305	9,000	58.9
SC	11 700	12,800	24,000	53.3
SD	[b]	[b]	5,069	•
TN	46 199	48,509	61,439	79.0
TX	136,000	136,000	628,000	21.7
UT	10 500	11,500	42,500	27 1
VA	18 500	22,000	60,000	36.7
VT	2,656	2,880	3,500	82 3
WA	27,650	28,341	32,000	88 6
WI	33,000	35,000	[b]	•
WV	18,132	18,132	24,605	73.7
WY	4,974	5,855	8,821	66.4
Total[c]	**1,145,304**	**1,203,264**	**2,709,966**	

[a]Average percent to be served during 1990 is 44 4

[b]State could not provide total population estimates for the seriously mentally ill that included institutionalized and noninstitutionalized adults, adolescents and children, and homeless

[c]Includes only the 37 states providing complete information for all three categories.

Federal Funds for Planning

For each of fiscal years 1988 and 1989, the 1986 act authorized $10 million to aid states in developing their plans. The Congress appropriated about $4.8 million for fiscal year 1988 and about $4.7 million for fiscal year 1989. HHS retained $101,600 of the fiscal year 1988 appropriation and $113,000 of the fiscal year 1989 appropriation to provide technical assistance to the states.

Each state received $82,200 in fiscal year 1988 and $81,000 in fiscal year 1989. The Congress did not authorize any funds for mental health planning for fiscal year 1990.

Use of Federal Funds

In 1989,[1] we reported that of 14 states surveyed, 13 (1) used their fiscal year 1988 funds to hire new staff within their mental health planning offices to do planning, coordination, and clerical activities or (2) contracted with mental health consultants to write their plans. The other state used its funds to support administrative expenses, such as printing and data processing costs. Ten states also used the funds for travel expenses incurred by their planning councils. Several states supplemented the federal funds with their own funds—for example, New Mexico and Puerto Rico each provided an additional $50,000 for developing their plans.

[1] Mental Health: Funds Needed for Future Planning Activities (GAO/HRD-89-94, Apr. 28, 1989).

Background

Millions of people in this country suffer from some serious—that is, persistent and severe—form of mental illness. Many reside in institutional settings, such as state mental hospitals and nursing homes. Others live in residential treatment centers, group homes, and sheltered apartments, as well as independently or with their families. Still others move between hospitals, homelessness, and jails due to inadequacies in state and local service systems.

The Congress and the federal government, for over 20 years, have been working to develop programs to assist in the treatment and rehabilitation of the seriously mentally ill; the goal of the programs has been to move these mentally ill from institutions to community-based systems. Primary among these programs was the Community Mental Health Centers Act of 1963 (P.L. 88-164), which provided federal funds to states for the construction of community-based mental health centers. This act was amended and extended several times between 1963 and 1981. In 1981, the Congress created the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant (P.L. 97-35), which consolidated several categorical programs, including the Community Mental Health Centers program, into a single block grant to the states.

Despite the federal support provided during the past 20 years, the Congress has continued to express concern about the frequency with which people with long-term mental illness fall through the cracks of mental health and social service systems. These people frequently have been unnecessarily rehospitalized, placed in the criminal justice system for minor infractions, or become homeless.

To help establish or further develop comprehensive systems of service—including Medicaid, vocational rehabilitation, psychosocial rehabilitation, housing, income support, education, and health and mental health services—the Congress, in November 1986, passed the State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660). Title V required each state to develop and submit to the Department of Health and Human Services (HHS) comprehensive mental health services plans that would establish and implement community-based systems of care for the seriously mentally ill. In developing their plans, states were to consult with employee representatives of (1) state mental institutions and (2) public and private nursing homes who care for the seriously mentally ill.

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Abbreviations

ADMS	Alcohol, Drug Abuse, and Mental Health Services
HHS	Department of Health and Human Services
NASMHPD	National Association State Mental Health Program Directors
NIMH	National Institute of Mental Health

- Four states said that they needed additional time to coordinate and integrate the efforts of various service providers.
- One state said it would have to significantly expand community-based services to reduce its hospitalization rate, explaining that it would take more than 2 years to set up local management systems and to redirect resources to meet local needs.

Because states realized that these changes would take a long time to implement, 18 plans covered periods ranging from 4 to 10 years. Full implementation, in these cases, within the 2 years provided by the act would not occur.

Conclusions

States and NIMH have complied with the act's planning requirements. In addition, the act has achieved beneficial results, including a greater role for the mentally ill, their families, and advocates in mental health planning, as well as, in many states, more money for community mental health services. However, it appears that many states will have difficulty meeting the act implementation deadlines and, as a result, will be subject to reductions in block grant allotments in fiscal years 1991 and 1992. States believe, and NIMH agrees, that it will take more time than provided in the act to implement their plans.

Agency Comments

HHS and the National Association of State Mental Health Program Directors (NASMHPD) provided comments on this report. HHS said the report (1) was helpful in understanding the act's initial effects on state mental health systems and (2) accurately reflected NIMH's role and responsibilities under the act. HHS also suggested some technical corrections that we have incorporated into the report as appropriate.

NASMHPD agreed that the act stimulated increased state planning and actions for the seriously mentally ill and that many states may not be in full compliance by the act's September 1991 deadline. NASMHPD pointed out that some states clearly chose longer time frames for their plans and frequently presented optimal sets of goals, many of which depend on additional funding.

Copies of this report will be sent to the Secretary of HHS and other appropriate congressional committees. Copies will also be made available to others on request.

provided information on consultation with employee representatives of nursing homes. In March, NIMH recommended that the Secretary of HHS impose the penalties provided for in the act.

Act Has Been Beneficial

The act's planning requirements achieved some beneficial results. States (1) involved state mental health planning councils, including the mentally ill and their family members, in the mental health planning process; (2) directed more funds toward community-based services; and (3) defined and identified their seriously mentally ill populations. States' estimates of the mentally ill to be served vary widely, ranging between 15 and 89 percent of the identified seriously mentally ill population. At least 31 states intend to serve more of this population in 1990 than in 1989.

NIMH encouraged states to develop their plans in consultation with service users and their advocates. Our survey of state mental health officials disclosed that this occurred frequently. States told us their planning councils, which included the seriously mentally ill and their advocates, (1) reviewed and commented on their plans and (2) wrote parts of 25 plans and formally approved 18. Officials of three major mental health organizations—the National Alliance for the Mentally Ill, the National Mental Health Association, and the National Association of State Mental Health Program Directors—also cited increased involvement by service users and advocates as one of the act's major accomplishments.

Many states attributed to the act increased funding for community-based mental health services in 1990. Eighteen states said the act was "definitely responsible" for funding increases, and another 18 states said it was "probably responsible" for the increases.

Most states also defined and identified their seriously mentally ill population. Although NIMH provided guidance in the form of a model definition, the act allowed each state to define its population. We reviewed 28 plans and found that 16 definitions were equal to, or broader than, the model definition and 8 were narrower. We were unable to characterize the definitions in 4 plans.

Forty-seven states were able to estimate the size of their seriously mentally ill populations; 40 states provided the number served in 1989 and 42, the number they expect to serve in 1990. Of the 40 states that provided both 1989 and 1990 data, 31 estimated they would serve more

1990, and (3) fully implement them by September 30, 1991.[4] As of June 1990, NIMH had not defined "substantially implement," but was studying different methods to be used to assess states' implementation of their plans. The legislative requirements, the nature of the penalties, and additional background information are in appendix I.

NIMH's Technical Assistance Was Timely and Useful

NIMH provided several types of planning assistance that were timely and useful. One type consisted of technical papers and a manual, including (1) a model plan provided early to states as a guide in developing their plans, (2) two technical papers addressing ways to finance a mental health system and methods of gathering data to support mental health planning, and (3) a handbook on how to evaluate a mental health system.

Another type consisted of NIMH's reviewing and commenting on state plans. NIMH asked states to submit initial plans by January 10, 1989, to strengthen state-planning capacity and establish baselines for future compliance reviews. NIMH provided timely written feedback to the states on how they could improve their plans for the submissions due September 30, 1989. A third type consisted of workshops and on-site visits conducted by the COSMOS Corporation, a research organization, under contract with NIMH. COSMOS also (1) disseminated a newsletter, Mental Health Planning News, and (2) developed planning case studies as well as key documents to assist in planning activities.

Most states found NIMH's technical assistance helpful. For example, 46 of the 51 states we contacted reported that the publications were "helpful"; only 5 said they were "of little or no help." Of the 43 states that asked for additional assistance, 28 rated the assistance as "very helpful"; 12 said "moderately helpful"; and only 3 said "little or no help."

Most Plans Approved

NIMH assembled panels of mental health experts to evaluate and comment on state plans and also used its own staff to review the plans. NIMH approved 26 plans in January 1990 as meeting the act's requirements and questioned the completeness of the rest, particularly the adequacy of the information on the number of people to be served. NIMH advised the states of its concerns and required them to revise their plans. By

[4] States are permitted an additional year, until September 30, 1992, to phase in case management services for all the seriously mentally ill who receive substantial amounts of public funds or services.

any independent judgments on plan adequacy, but, rather, relied on NIMH's and panel reviewers' judgments.)

- By telephone, we surveyed state mental health officials in all 50 states and the District of Columbia to obtain their views of the usefulness and timeliness of the assistance NIMH gave them in developing their plans. We also asked these officials to comment on the (1) benefits, if any, they derived from the act and (2) problems they might face in meeting the implementation deadlines. (We did not independently verify all the information provided by the states.)
- Finally, we interviewed officials of public interest groups for their opinions on the effects the legislation might have on state mental health programs.

We did our review from January to March 1990 in accordance with generally accepted government auditing standards.

Results in Brief

Fifty states, the District of Columbia, and seven territories submitted plans by the required date, September 30, 1989 (hereafter, the term "states" will include the District and the territories).[2] NIMH provided timely and useful technical assistance to help states prepare the plans, including a model plan, technical papers, and contract support. Many states told us this assistance was helpful in developing their plans.

In November and December 1989, NIMH convened panels of experts to review the state plans and reviewed the plans itself. In January 1990, NIMH approved the 26 plans that met the act's requirements. Reviewers noted that the remaining state plans did not meet one or more of the requirements. NIMH gave these states added time to revise their plans in response to reviewers' comments. By March 1990, most states had revised their plans so they would conform to the act's requirements and NIMH had approved all but two plans, for which it recommended penalties for noncompliance.

The act has achieved some beneficial results: (1) States and organizations told us it enhanced the participation of the mentally ill and their advocates in state mental health planning. (2) Many states also said it increased the funds directed toward community-based mental health

[2]The territories are American Samoa, Federated States of Micronesia, Guam, the Marshall Islands, the Northern Mariana Islands, Puerto Rico, and the Republic of Palau. The Virgin Islands were exempt from the submission deadline because their planning-related materials were destroyed by hurricane Hugo. The Virgin Islands' plan was submitted in April 1990