Community Support Services In Treating Individuals With Schizophrenia

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Community Support Services In Treating Individuals With Schizophrenia

by

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Abstract

The effectiveness of Community Support Services for adults with schizophrenia is substantiated by evidence from both research and experience. When comprehensive, coordinated services are provided, the use of long-term hospital services (institutionalization) for adults with schizophrenia is dramatically reduced. This thesis reviews studies pertaining to community care for individuals with schizophrenia, including modifiable risk factors for rehospitalization, which can be dealt with in the community. The transition in Montana's mental health system, which includes altering resource allocation and meeting the challenge of providing community support in a rural state, will be discussed. Recommendations for improvement are provided based on experience as an intensive case manager for individuals with severe mental illness. A synthesis of the literature concludes that individuals can be deinstitutionalized and treated in the community, and that community treatment is often more effective than long-term hospitalization. Not only is community treatment often more effective than hospitalization, but it is usually less than the cost of institutionalization.
Community Support Services in Treating Individuals with Schizophrenia

The debate concerning where people with severe mental illness thrive best has been a heated issue since the early 1900s. At their zenith in the 1950s, state hospitals housed almost 500,000 patients (Rydman, 1990). Deinstitutionalization began to take place, as it promised both economic savings and greater respect for the rights of patients in mental hospitals. Today, fewer than 100,000 patients remain in state hospitals, and the population will continue to be downsized so that only those with the most debilitating mental illnesses remain institutionalized. Those who are deinstitutionalized will need a higher continuum of care. Therefore, Community Support Services will need to be extended and improved. A wide range of services for both acute and chronic patients is necessary for successful integration into the community. According to Robert L. Okin, MD (1987), a clinical assistant professor at the Harvard Medical School and clinical associate in psychiatry at Massachusetts General Hospital, services included should be "outpatient care, crisis intervention, day treatment, and psychosocial and vocational rehabilitation" (p.27). A graduated series of residential settings should provide active treatment at one end of the continuum and asylum at the other. Okin (1987) further states that "specific patients should be assigned to a case manager, and psychiatric units in general hospitals should be established and/or maintained" (p.23). As this full range of services is developed, the role of state hospitals can be reduced until they are being used only for the most critical patients. As the population of the state hospitals declines, money will be saved.
Community support systems versus the state hospital system is not an either/or issue, but resource limitations force states to choose where to spend the bulk of their funds. Historically, the most expensive course of action has been to provide a more money to state hospitals and to community care, and this course of action has offered little hope for significant improvement in either system. According to Okin (1987), "it would not even be advisable to enlarge state hospitals as a transitional measure while waiting for community services to improve" (p.24). That would divert from community care the very resources needed to correct its deficiencies, and even more state hospital beds would be needed.

Effectiveness of the Community Support Program

Support for long-term community treatment of schizophrenia

Dr. Madianos (1992), an associate professor and Chief of the Community Mental Health Center at the Department of Psychiatry, University of Athens, studied the effects of a particular type of community based psychiatric aftercare on the adjustment level in chronic schizophrenic patients over a five-year period. The questions Madianos and Madianou (1992) asked in the study were as follows:

1. Does a community based aftercare program have any effect on the adjustment of participants over the long term?

2. Does the program have an impact on relapse and readmissions to the hospital?

3. Is there a relationship between social adjustment levels and relapses? (p.38)

The subjects in this study were 106 chronic schizophrenic patients residing in Greater Athens (Madianos & Madianou, 1992). Group A of the study was 34 patients
receiving care from the community mental health center. The center follow-up services included: medication maintenance, problem-solving and supportive psychotherapy, group social and recreational activities, and social-work intervention with key members of the patient's families. These services are consistent with the National Institute of Mental Health's definition of a Community Support Program (CSP). "Group B included 72 patients with the same diagnostic, sociodemographic, economic, and clinical characteristics who were receiving outpatient care, focused mainly on prescription of medication" (Madianos & Madianou, 1992, p.38).

The average follow-up period in this study was 54 months. One initial assessment was made in 1979, and two subsequent assessments followed in 1982 and 1984. The outcome variable of social adjustment was assessed by the Community Adjustment Scale (C.A.S.). This is a comprehensive rating instrument devised by M. Madianos. According to Madianos (1992), "the instrument records quantitative, scaled judgments of the patient's community life and functioning" (p.39). Madianos (1992) further explains that "the scale is based on information reported by the patient and family members, on the rater's home visits and observations, or on other sources of information" (p.39).

There was a significant difference (p<.01) between group A and group B on C.A.S. scores reported in 1982 and 1984. (Madianos & Madianou, 1992). During the period between the first and second assessments, 45.4% of group A and 87.5% of group B relapsed. Madianos and Madianou (1992) defined a relapse "as a change from a residual state of the illness and reemergence of prominent psychotic symptoms" (p.40).
At the third assessment, relapse rates for group A were much lower (38%) than those for group B (85.3%). In both assessments, a much higher proportion of patients in group B than in group A relapsed and were readmitted to mental hospitals.

This study supports the hypothesis that for social adjustment, a Community Mental Health Center (CMHC) aftercare program, which contains most of the essential components of the United States' Community Support Programs, is more successful than a routine outpatient service in maintaining chronic mental patients in the community (Madianos & Madianou, 1992). Madianos and Madianou (1992) found that "patients who received aftercare by the CMHC were better re-integrated into the community and functioned more effectively than those who were treated by non-sectorized outpatient services that were orientated primarily toward medication maintenance" (p.40). It should be noted, however, that the positive effects of the CMHCs broad-spectrum program were first noticed after a 24-month follow-up period (May 1982-May 1984). The Community Adjustment Scale (C.A.S.) scores of the two study groups did not differ at the time of their initial assessment (1979-1980). Another important finding was that the fewer the number of previous relapses and readmissions or the shorter the hospital stay, the better was the community adjustment of the patient. In conclusion, Madianos and Madianou (1992) discovered "that in Greece, as elsewhere, effective deinstitutionalization of the chronic patient population will depend on the availability of adequate community-based social support and rehabilitation services" (p.42).

In the United States, Community Support Programs (CSPs) will have a great impact on deinstitutionalization. Rydman (1990) examined the amount, cost and impact
of community based services received by a group of chronic mental patients. Sixty-nine percent were schizophrenic, and were tracked over three consecutive intervals of community tenure following discharge from state hospitals in west Chicago. Community care focusing primarily on medication monitoring, versus case management combined with community mental health services after hospital discharge, was tracked. According to Rydman (1990), "routine services provided by the CMHCs services included the following: outpatient, e.g., sustaining care, medication maintenance, individual and group psychotherapy; community day treatment, e.g., day hospital, and life skills education; and crises and emergency services" (p.223). The subjects selected for the CMHC-CSP demonstration were all those incurring a third admission to the designated state hospital within a current 12-month period.

Dependent variable data on the study population were provided by the Illinois Department of Mental Health INFONET system (Rydman, 1990). "The contents of this data system include the historical variables of total number of state hospitalizations, type of state hospital experience (as defined by number and type of patient movements, e.g., unauthorized absences, home visits, etc.), duration of hospitalization, date of admission and discharge, and time in community between date of discharge and rehospitalization in any state hospital" (Rydman, 1990, p.224). The variable time in community is expressed in days in community (DIC). It is defined as the number of days from hospital discharge forward to the patient's next admission in any state hospital. While in the community, patients were tracked for voluntary admissions independent of case management placement to private hospitals, nursing homes, intermediate care facilities and/or other
Effectiveness of CSP

long term care shelters. Rydman designed a system to gather independent variable data on the amount, type, and times of CSP exposures.

Rydman (1990) concluded that the addition of case management to routine community-based services increases the time a patient spends in the community following hospital discharge. "By doing this, patients are given the chance to break a cycle of hospital dependency, establish community supports, and remain connected to the community based system of care" (Rydman, 1990, p.224). As a result, the "window" of community based life is prolonged for those who decide to become involved in case management following state hospital discharge. According to Rydman, (1990) "the use of case management as an interorganizational device to improve access to care will increase consumption of care hours, and therefore the cost of community based services to the severely mentally ill" (p.233). Rydman (1990) pointed out that "these additional costs are offset by savings accrued through decreased hospital inpatient days" (p.224).

For this study, lack of case management services led to less time spent in the community due to more rapid hospital readmissions. This, in turn, leads to more frequent hospital admissions and more days of hospital care, which costs more than community care.

Husted, Wentler, and Bursell (1994) determined the effectiveness of a rural CSP comparing the number of days hospitalized for an equal amount of time before and after participation in the program. The number of days hospitalized for schizophrenic subjects before CSP had a mean of 80.5 compared to a mean of 19.0 hospitalizations after CSP (p=.0208). Participation in the program resulted in a significant reduction in the number of days hospitalized.
Dickstein, Hanig, and Grosskopf (1988) examined the effectiveness of Community Support Programs in reducing hospitalizations. They conducted a retrospective study with the records of the intensive community support and treatment program (ICSTP) of the Highline West Seattle Mental Health Center. The researchers compared the hospitalization rates for 91 clients, of whom eighty-five percent had a diagnosis of schizophrenia, in the two years before entering the CSP and during enrollment. Average annual admissions declined by 60%, and the average days spent annually in hospitals declined by 70%. Before enrollment in the program, the 10% of the clients who were the highest users of hospitalization accounted for 30% of all hospital days, and the next 10% who were the next highest utilizers accounted for another 22%. During their enrollment in the program, 52% of the clients (N=47) had no hospital days.

Cost effectiveness of the Community Support Program

Galster, Champney, and Williams (1994) conducted a study in two suburban and rural Ohio counties. They compared the costs for severely mentally disabled individuals receiving treatment in a Community Support Program to those who are treated in a state hospital. Galster et al. estimated the operating costs at the Central Ohio Psychiatric Hospital (COPH) to be from approximately $4,200 to $5,300 more expensive per client per month. Galster et al. (1994) explains, “even the most difficult (and expensive) to treat clients (who were quite comparable to those clients served by the Central Ohio Psychiatric Hospital) were treated in the community (including their cost of subsequent visits to the COPH) at less than a third of what it would cost for full-time institutionalization” (p.241). In comparison, direct operating costs among community-
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Based options were modest, at most $1,067 per client per month.

Dickstein, Hanig, and Grosskopf (1988) examined the cost effectiveness of the CSP at Highline West Seattle Mental Health Center. They found that the estimated annual costs of the ICSTP decreased after enrollment in the CSP. Before enrollment in the program, a subject's major measurable cost was for psychiatric hospitalization, which accounted for $11,984 of the average annual cost of $12,554 per client. Hospital costs declined during the client’s participation in this program, with average savings in this area alone of $8,006 per client. During enrollment, the cost of the program itself was $5,494 per client, or $500,000 annually. This figure is nearly 60% of all costs measured during enrollment in the program. The savings resulting from decreased hospitalizations were nearly $3,000 per client, even when the cost of the CSP was included.

Modifiable Risk Factors that can be Dealt with in a CSP

Since the 1960s, U.S. public policy regarding treatment of the mentally ill has emphasized community-based care in place of hospitalization (Rydman, 1990). Since 1978, Community Support Programs have been a vital component of the nation's mental health care system for the seriously mentally ill. “CSPs are targeted to serve patients post hospital discharge under a policy of tertiary prevention or non-institutionalization” (Rydman, 1990, p.216). They are designed to provide a wide range of rehabilitative, social, economic, and psychological services. Since the focus of care for this population has switched from the state hospital to community care, the length of inpatient stay decreased and state hospitals have begun to function as acute care facilities. Concomitant with institutional population decreases have been increasing hospital admissions. A large
portion of these are readmissions of former patients. Such former patients are often referred to as chronic, or seriously mentally ill (SMI). According to the National Institute of Mental Health (NIMH) estimates, there are between 1.7 to 2.4 million chronic mentally ill persons in the United States (Goldman, Gattozi, and Taube, 1981), or roughly 9 per 1,000. Health service researchers have further estimated half of these, or 4.5 per 1,000, use the public mental health sector (Shapiro et al., 1984). "Some hospital readmissions may be unavoidable for persons with chronic, exacerbating illness, but the challenge for public mental health systems has been to maintain seriously mentally ill individuals in the community whenever possible, especially since hospitalization represents the category of care with the greatest direct cost" (Sullivan, Wells, Morgensteni, & Leake, 1995, p.1749). Given this fact, data are needed on factors that increase the risk of rehospitalization, especially those that are potentially modifiable by community-based interventions. For purposes of developing programs to reduce the risk of rehospitalization, it is necessary for service providers and policy makers to focus on patient and program characteristics that they can change. While demographic factors, such as gender and ethnicity, may predict rehospitalization, these are not factors that can be modified by clinical or policy interventions.

Effects of Family Atmosphere

Family atmosphere, particularly the factor termed "expressed emotion," is an important contribution to how well an individual with schizophrenia adapts in the community after institutionalization. "Expressed emotion" was coined by Brown and his colleagues in the sixties (1985). Brown (1959, 1972) found that emotional attitudes of
key relatives towards schizophrenic patients are linked with relapse into florid schizophrenia. Brown's group measured attitudes, elicited by means of a lengthy semi-structured interview called the Camberwell Family Interview (CFI). A number of dimensions were involved (Brown, 1985). They combined the scales of critical comments, hostility and emotional overinvolvement into an overall index of expressed emotion (EE). According to Brown (1972), "subsequent results have shown that patients with schizophrenia living with high EE relatives have a significantly higher relapse rate nine months after discharge than patients from low EE families" (p.54). These results were later confirmed by other researchers throughout the world. In England (Leff and Vaughn, 1976), California (Vaughn et al., 1984), India (Wig et al., 1987) and Yugoslavia (Ivanovic and Vuletic, 1990), all found similar results.

P Mozny and P. Votypkova (1992) investigated whether the link between emotional atmosphere in the family and relapse of schizophrenia could be confirmed in the Czechoslovakian population. The mental status of the schizophrenic patients was assessed by means of the Present State Examination (PSE) and Psychiatric Assessment Scale (PAS) within a week of admission. The key relatives of patients (the spouse of married patients and both parents of patients living in parental households) were then invited to the hospital for the CFI. Mozny and Votypkova rated relatives as "high EE if they made six or more critical comments about the patient, showed hostility in the form of generalization or rejection, or were rated at 3 or more on the Emotional Over-Involvement scale " (p. 176). In cases where both parents were interviewed, the family was rated as high EE overall if one parent was rated as high EE.
The mental state of the patient was reassessed by means of the Present State Emotion and Psychiatric Assessment Scale within a week prior to discharge (Mozny & Votypkova, 1992). All patients were then followed for 12 months after the index discharge. When a patient was rehospitalized, the PSE and PAS examinations were repeated to establish whether there was a recurrence of florid symptoms. The criteria defining relapse relied on the PSE scores at discharge and at readmission. Mozny and Votypkova (1992) defined a patient to "have relapsed when there was a total increase of three points on one or more of the three scales of hallucinations, delusions, and incoherent speech, with the caveat that a single point change from 0 to 1 on any scale was discounted" (p. 177). According to these criteria, the sample was divided into two categories: "relapse" and "no relapse."

In accordance with the studies by Leff and Vaughn (1976) and Vaughn et al. (1984), Mozny and Votypkova (1992) tried to establish the impact of the amount of face-to-face contact between patients and their relatives and of the regular taking of antipsychotic medication on the relapse rate. The amount of face-to-face contact was established as part of the CFI; like Leff and Vaughn (1976), Mozny and Votypkova (1992) used the threshold of 35 hours per week to distinguish the low and high contact groups. As to the regular taking of medication, they had to rely on the testimony of the patients, or their relatives, or the evidence of the outpatient case records.

A total of 165 relatives from 125 families were interviewed by means of the CFI, (Mozny & Votypkova, 1992). Of these 125 families, Mozny and Votypkova rated "69 as high EE (55.2%) and 56 as low EE (44.8%)" (p.178). Parents were more often rated as
high EE than spouses (parental high EE 69.2%, marital high EE 40%, p< 0.01). Mozny and Votypkova concluded that "this was due mostly to their over-involved attitudes (42.2%), albeit often combined with criticism (31.1%)" (p.178).

The results of Mozny and Votypkova's (1992) research demonstrate a relationship between expressed emotion and relapse at the (p<0.01) level. The relapse rate in high EE patients was 59.4% versus 23.3% in the low EE patients. This study confirmed the protective value of reduced face-to-face contact with high EE relatives and of regular antipsychotic medication. The benefit of regular medication was significant in low EE as well as in high EE patients. However, Mozny and Votypkova (1992) note that "medication did not significantly reduce the relapse rate of patients living in high face-to-face contact with high EE relatives" (p. 178). Patients from low EE families benefited just as much from regular medication. It is safe to conclude that patients who admitted not taking their pills regularly were significantly more prone to rehospitalization, regardless of their EE status.

Mozny and Votypkova (1992) statistically analyzed the link between relapse rate and other potential predictors. The comparison of the Expressed Emotion index with other predictors showed that only the EE had significant predictive power in the 12-month follow-up period. Other variables failed to predict the course of schizophrenia significantly. Mozny and Votypkova found one exception in this regard: "patients whose total length of previous hospitalizations exceeded 12 months were more likely to relapse in the subsequent follow-up period (p<0.05)" (p.178). In Mozny and Votypkova's (1992) sample, "the longer the previous hospitalization, the more likely the patient was to relapse
after index discharge" (p.178). This finding is consistent with the results obtained by Madianos and Madianou (1992). Patients living in high EE families spent three times as long in the hospital as patients from low EE families (p<0.01). This was partly due to the fact that high EE patients were rehospitalized much more often than low EE patients. Even when low EE patients were rehospitalized, they spent less time in the hospital than high EE patients (p<0.05).

Mozny and Votypkova (1992) concluded that the emotional atmosphere in the household of schizophrenics and the attitudes of relatives towards patients significantly influenced the course of the illness. It is thus obviously unreasonable to focus treatment efforts solely on the patient, omitting the rest of the family. Unfortunately, this is likely to happen when patients are hospitalized in large psychiatric facilities far from their homes. The patients are isolated from their everyday social milieu, and their contact with relatives is restricted to a few hours per week. CSPs could reduce this problem, as relatives' attitudes could be changed towards their mentally ill family members. Falloon, (1984), Goldstein, (1984), and Leff (1985) have demonstrated that the attitudes of relatives can be changed by means of a comprehensive therapeutic program. This results in a reduced relapse rate in patients, which increases cost effectiveness (Mozny & Votypkova, 1992,).

Medication noncompliance, criticism/rejection of the patient, and alcohol abuse

Sullivan et al. (1995) conducted a study to identify risk factors for rehospitalization in a seriously mentally ill population, focusing on factors that have the potential to be modified through community-based interventions. Sullivan et al. (1995)
states, "that while many previous reports have examined hospital recidivism among seriously mentally ill patients, most have not focused specifically on modifiable risk factors" (p.1750). For example, research has consistently noted that previous hospitalizations are a strong predictor of future hospitalizations (Thomson 1985) and that various demographic characteristics predict rehospitalization (Buell & Anthony, 1975). While these studies have been helpful in delineating groups at risk for readmissions, they do not explain why readmissions occur (Sullivan et al. 1995).

Sullivan et al. (1995) found that rehospitalization was associated with higher levels of rejection of subjects by family members. Most striking in this study's findings concerning the families was that at least one-half of the family members reported not knowing the subject's diagnosis or prognosis. According to Sullivan et al. (1995), "aside from the difficulty presented by the disruptive behavior or positive symptoms, caregivers who do not understand the nature of chronic mental illness could mistake the anergia of negative symptoms as laziness, or fail to help maintain treatment compliance because they do not attribute difficult behavior to an underlying illness" (p.1756). Thus, interventions to help family members better understand and cope with their relatives' mental illness could be very helpful in this mental health system. A number of previous studies have found that family interventions can significantly lower the risk of relapse, and several formal intervention programs have been tested. However, these programs may require modification for this population in resource-poor areas where family members may be needed to serve as part of an extended treatment team.
Sullivan et al. (1995) studied the population and catchment area of the larger of Mississippi's two state hospitals, Mississippi State Hospital at Whitfield, to identify risk factors for hospital readmissions. All subjects in the study were required "1) to have previously been an inpatient at Mississippi State Hospital at least once between January 1, 1985 and December 31, 1987, 2) to have a chart diagnosis of schizophrenia, and 3) to be between the ages of 18 and 55 years at the time of the index hospitalization (January to March 1988)" (Sullivan et al., 1995, p. 1752). It was also required that subjects be current residents of Mississippi and that they not have been hospitalized elsewhere for psychiatric problems since their last Mississippi State Hospital discharge.

Sullivan et al. (1995) "used an epidemiological paradigm to conceptualize hospital readmission, treating hospital readmission as the outcome event" (p.1753). During the data collection period, each subject who was readmitted to Mississippi State Hospital was considered a "case" subject. As each "case" was entered into the study, Sullivan et al. (1995) located a matched "control" or nonrecidivist comparison subject who was hospitalized at the same time as the case subject, but was not readmitted at the time of the case subject's readmission. Therefore, subjects were matched on length of time at risk for readmission, yielding 101 matched pairs.

Potentially modifiable risk factors were grouped into five domains: "1) health beliefs and behaviors (including substance abuse and medication compliance), 2) utilization of health care services (including usual types and numbers of outpatient visits), 3) aspects of home environment (family criticism of the subject), 4) barriers to care related to finances or transportation, and 5) satisfaction with life" (Sullivan et al. 1995,
Patients may underreport substance abuse and overreport the degree to which they comply with medication regimens (Babiker, 1988, as cited in Sullivan et al., 1995). Sullivan et al. (1995) derived measures of alcohol abuse and medication compliance from both subjects and informants. Specifically, "data from the subject was used except when the subject denied alcohol abuse or noncompliance but the informant reported this problem" (Sullivan et al., p.1754). In that case, the informant's rating was utilized.

The results indicated that the "risk factors with the highest adjusted odds ratios were medication noncompliance, criticism/rejection of the patient, and alcohol abuse" (Sullivan et al., 1995, p.1755). Adjusting for the other risk factors in the comparison group, the rate of noncompliance was 8.18 times greater among the case subjects than among the comparison group. The rate of patient rejection was 3.62 times higher for the case subjects than for the comparison group, and the rate of alcohol abuse was 3.33 times higher for the case subjects than for the comparison groups. In addition, "transportation-related barriers to care also had a relatively high odds ratio, but neither it nor satisfaction with CMHC service, financial barriers to care, or lack of use of the CMHC as a regular source of care were significant at the p<0.05" (Sullivan et al., 1995). According to Sullivan et al., (1995):

Since the great majority of the subjects (82%) use the CMHCs as their primary source of mental health care, CMHCs would clearly be the best sites for broad community-based interventions directed at these risk factors. Previous studies have noted the prognostic importance of all three of these factors to clinical outcomes (Sullivan et al., 1995, p.1756).
Medication noncompliance, long known as a pervasive problem among the seriously mentally ill, has been linked to lack of insight into illness, medication side effects, use of oral rather than injectable medication, cost of medication, missed outpatient appointments, negative patient and/or family attitudes towards medication, and various demographic characteristics (Bartko, Herczeg, & Zador, 1986). Sullivan et al. (1995) previously reported that noncompliance in their study group was associated with lack of insight (i.e., subjects' denial of mental illness), a history of fewer outpatient appointments, and being single. According to Sullivan et al. (1995), screening programs to identify patients at highest risk for noncompliance should include these factors.

Although a review of the literature reveals few reports of formal intervention programs to improve the medication compliance of patients with schizophrenia, Kelly and Scott (1990) reported success with the use of brief health education programs for schizophrenic patients in the Veteran Affairs system. "Compared with a control group, patients in their program had improved medication compliance, increased positive attitudes about care providers, and reduced rehospitalization rates which resulted in reduced mental health costs" (Kelly & Scott, 1990, p. 1196). Further, a review of the compliance literature suggested that programs that succeed in improving adherence to treatment regimens share four components: "provision of information about the illness and its treatment, prompts of reminders, positive reinforcements (rewards), and social support for treatment" (Sullivan et al., 1995, p.1756).
Montana's Mental Health System

Montana's mental health system has been experiencing organizational and financial changes with regard to the state hospital-community support system debate. Montana's residential services component of the Mental Health Division consists of two state institutions: Montana State Hospital and the Montana Center for the Aged. Montana State Hospital (MSH) consists of campuses at Warm Springs and Galen, which are approximately four miles apart. The Warm Springs campus is designated as the adult state mental health facility and provides inpatient psychiatric treatment for mentally ill adult Montanans who cannot effectively be served in existing community based alternatives. The Galen campus provides residential treatment for individuals with chemical dependencies, acute hospital care for patients from both Montana State campuses, and nursing care.

Community Mental Health Services

Montana's community mental health services are provided by a variety of local agencies as well as independent private practitioners and short term psychiatric inpatient units. The state of Montana has five regional multi-county mental health centers, which are established by state law (Title 53, Chapter 21, Part 2, MCA) as private nonprofit organizations. According to state law, a community mental health facility must provide at least certain services. Each center must provide outpatient services for children, the elderly, individuals who have serious mental illness, and residents of its service area who have been discharged from inpatient treatment at a mental health facility. Other services
include twenty-four-hour-a-day emergency care, day treatment, consultation and education in mental health, and screening for patients being considered for admission to state mental health facilities.

In 1989, the staff from Consultants for Community Change, Inc., conducted a site visit to review Montana's mental health services. This report included recommendations for further development of a Community Support System (CSS) for adults with psychiatric disabilities in Montana (McCabe, 1989). Another purpose of the site visit was to review current utilization and functions of MSH, and to make recommendations regarding how to develop more effective communication and continuity of service between the hospital and the community mental health system. One of the suggestions made by the reviewer, Sinikka McCabe, from Consultants for Community Change, was to examine the feasibility of phasing down the state hospital through improved community treatment. The average daily population for fiscal year 1988 was 288.5 at the Warm Springs campus and 178.4 at the Galen campus. McCabe (1989) suggests that the phase down of the capacity at MSH should be undertaken over several years. This process should involve the transfer of funds from the state hospital to community services which would strengthen and expand the capacity of community mental health services.

According to McCabe (1989), "the size of the state of Montana makes hospital admission disruptive in a person's life, as the distances hamper necessary and adequate discharge planning and often lengthen the person's stay at the hospital" (p.62). As hospitalization is more expensive than community based care, this is unnecessary utilization of mental health dollars. McCabe (1989) also discussed funding and resource
allocation in Montana, noting that MSH has received the majority of new state mental health dollars. More than half of the current mental health funds are spent on inpatient services, rather than on CSPs. "State funding," according to McCabe (1989), "should be targeted to the development of high quality community services that will in turn reduce the overall system's reliance on the state hospital" (p.64). Resource allocation is more cost-effective when more of the dollars allocated for mental health services are delegated to Community Support Systems.

Resource Allocation in Montana

In fiscal year 1992, MSH was allocated $23,050,492, while Community Mental Health programs were allocated only $6,302,714 (Montana Department of Corrections and Human Services, Mental Health Division, 1994). This was three years after the site visit and the recommendation to divert funding from the hospital to community programs. In fiscal year 1991, the average daily population at the Warm Springs campus was 286, compared with 288.5 in 1988. In fiscal year 1995, the average daily population at the MSH (Warm Springs campus) was 205 patients. This represents a reduction of 83.5 patients from 1988 to 1995. Many of these patients are now being effectively treated in CSPs, which have expanded their services to deal with a population that often has higher needs. Services have been expanded under the Mental Health Division of the Department of Corrections and Human Services' (1994) proposal for a Comprehensive Treatment and Support System (CTSS) for adults with severe and disabling mental illness. The CTSS consists of the ten Community Support System components as defined by the National Institute of Mental Health. The ten components are client
Identification and outreach, mental health treatment, crisis response services, health and
dental care, housing, income support and entitlements, peer support, family and
community support, rehabilitation services, and protection and advocacy. These ten
components are coordinated by case managers and made available throughout Montana in
larger communities. A fully developed CTSS in all or even most Montana communities
is unrealistic, as thirty-five of Montana's counties contain fewer than 10,000 people, and
are defined as rural according to the Mental Health Division. Twenty-one counties in
Montana contain more than 10,000 people, and these non-rural counties contain 82% of
the State's population and account for 88% of the admissions to MSH. Given this fact,
the Department has proposed that the CTSS be developed in Montana's non-rural
counties, utilizing case management to provide the services to the estimated 6,000 adults
with severe mental illness in Montana.

New state hospital

Montana State Hospital at Warm Springs was constructed in the 1920's. A new
hospital will be completed in 1999 and is expected to have an average daily population of
135 patients, with a maximum capacity of 166 patients. When the full consolidation of
the campus and the reduction of patients is achieved in 1999, there will be 150 fewer
employees at MSH and an annual savings to the state of $7.5 million per year. These
savings may then be allocated to community programs.

Experience Working in a Community Support Program

I have had the experience of working in a Community Support Program (CSP) for
adults with severe mental illness in Helena, Montana. I completed a practicum at Helena
Community Support Services (HCSS) and did relief work as an intensive case manager. HCSS serves individuals living in southwestern Montana and provides comprehensive, effective, quality mental health services in a community setting. All of the services which are offered by this organization are designed for individuals with a history of hospitalizations and/or mental disabilities that require long-term community care. HCSS provides consumers with the support necessary to maintain independent living. This provides a cost-effective alternative to hospitalization.

As an intensive case manager, I worked with individuals who had just been discharged from MSH at Warm Springs. I facilitated their transition from the hospital to community care. This consisted, among other things, of completing a needs assessment with the individual and helping him or her meet these needs. This involved assisting the consumer with budgeting, medication monitoring, transportation, housing, and appointments. Finding some method to link the consumer with his or her residential community was also one of my goals. Successful approaches to this included motivating the individual to establish relationships, encouraging the individual to become involved in the evening recreation program, and encouraging adult education, vocational rehabilitation, or supportive employment. These tasks are not easy for recently discharged individuals, as they have often become accustomed to the security and isolation of the hospital. Trying to empower a consumer to participate in a program or activity that is new is both challenging and very rewarding.
Suggestions and Insights

Through my experience in working with individuals who have been recently discharged from the state hospital, I have developed some suggestions for improvement with regards to community support services and the mental health system in Montana. I was working in a program at Community Support Services in Helena, which does an outstanding job of serving individuals with severe mental illness, considering its understaffed and underfunded state. While I was working at HCSS (January 1996 to August 1996), budget cuts forced the elimination of many positions: two of the four therapists, three of the seven intensive case managers, the program manager for the case management office, the program manager of the day treatment program, and both of the employment specialists. Case loads for case management services doubled, increasing from approximately 10 consumers to 20 or more. Ultimately, there was less time to devote to consumers. Therefore, it was increasingly difficult to provide the quality of care necessary. If the program received more adequate funding, the staff of HCSS could be expanded to have the number of employees necessary to treat a growing population with high needs. Many of the new consumers require a higher continuum of care, as they have recently been discharged from the state hospital. It is imperative that the consumers' needs be effectively met in the community so that adjustment and integration occur. This will prevent the cost of rehospitalization. If the individual starts to decompensate (i.e., goes off medication), HCSS has no method of intervening. The Community Commitment Law states that HCSS can file for commitment only when an individual has
decompensated to the point that he or she is a danger to self or society at large. A commitment law change is necessary so that community support services in Montana have some mechanism for intervening before costly hospitalization is required. The cost of hospitalization for an individual for one year at Warm Springs is approximately $100,000, according to Jeff Sturm (Personal Communication, 1996), the Community Director of Mental Health Services, Inc., Region Four. The most expensive individual in the Helena Community Support Services program costs $32,000 per year. This represents a significant difference in treatment costs.

The effectiveness of the Community Support Program in treating individuals with schizophrenia, and the cost-effectiveness of these programs, has been clearly demonstrated. Montana's mental health system is in the process of transitioning its focus of care from the state hospital to community support programs (CSPs). However, this transition will only be successful if CSPs are given the funding necessary. More staff will be necessary to provide services for an increased population with a higher level of need in the community. It is imperative that lawmakers are aware of the research supporting the efficacy of the Community Support Program as a cost-effective alternative to hospitalization. The consensus of research demonstrating the overall effectiveness of treating individuals with schizophrenia in the community must be communicated to our lawmakers. This will insure that the funds necessary to run a treatment effective CSP are available.
References


