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**Developing a policy for the dually diagnosed: A policy  
management model for providing mental health services to the  
mentally ill-mentally retarded**

**Fletcher, Robert Jonathan, D.S.W.**

**City University of New York, 1993**

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A

**Developing a Policy  
for the Dually Diagnosed**

**A Policy Management Model  
for Providing  
Mental Health Services  
to the Mentally Ill–Mentally Retarded**

by

Robert J. Fletcher

A dissertation submitted to the Graduate Faculty in  
Social Welfare in partial fulfillment of the  
requirements for the degree of Doctor of Social  
Welfare, The City University of New York.

1993

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**This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.**

9/1/93  
Date

*Sauld J. Heman*  
Chair of Examining Committee

9/1/93  
Date

*Sauld J. Heman*  
Executive Officer

Eleanor Bromberg

Robert Salmon

Supervisory Committee

The City University of New York

# Abstract

## DEVELOPING A POLICY FOR THE DUALY DIAGNOSED:

### A POLICY MANAGEMENT MODEL FOR PROVIDING MENTAL HEALTH SERVICES TO THE MENTALLY ILL-MENTALLY RETARDED

by

Robert J. Fletcher

Adviser: Professor Harold Weissman, D.S.W.

Research reflects that 20% to 30% of the mentally retarded also show signs warranting a DSM III-R psychiatric diagnosis. Local mental health service systems are confronted with the need to provide services to such dually diagnosed persons, those who have mental illness and mental retardation in co-existence. There is a paucity of adequate and accessible community-based mental health services for this population.

This dissertation examines how one community mental health center assessed, planned, and developed comprehensive mental health services for the dually diagnosed through the development, articulation, and management of a cohesive policy. The dissertation centers on the activities of a policy manager (this writer). Policy management underlies the successful service planning and delivery for meeting the complex needs of this population.

The dissertation demonstrates how services for a local dually diagnosed population can be planned and delivered. Specifically, it provides a mental health service model for replication by other local-level service planners and providers.

## Acknowledgments

I wish to thank certain people without whose help this dissertation would not have been possible. The late Frank Menolascino, M.D., my friend and mentor for many years, was my inspiration; his mission of advocacy for the dually diagnosed, his compassionate values, and his professional posture set a constant example for me to follow. Professor Harold Weissman, D.S.W., chairman of my dissertation committee, helped me immeasurably with his thematic guidance and reflections. Allan Edmands, my editor, brought to this work not only his skill for organization and cohesion but also a fussiness for nice details that helped to correct infelicities, which, overlooked, might have detracted from the presentation. Winnie Palladino, my secretary, worked crazy hours into the night and over weekends, translating my wretched handwriting into one typed draft after another. Shirley Fletcher, Ph.D., my mother, instilled in me an appreciation for the value of education; without her vigorous encouragement I never would have begun the dissertation. Diane Fletcher, my wife, provided unfailing emotional support: She managed our household with aplomb and forbearance during my long and frequent absences, and I thank her for everything.

— Robert J. Fletcher

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# Chapter 1

## Introduction

Individuals who have both mental illness and mental retardation present unique challenges to both mental health professionals and mental retardation service structures. The group comprises a complex population whose needs are often poorly identified and who are often referred from agency to agency to agency in a fruitless effort to obtain services (*Menolascino, 1988*).

Mentally retarded people who also have emotional disorders may constitute one of the largest underserved populations in the United States (*Reiss, Levitan, and McNally, 1982*). Persons of normal intelligence who experience psychiatric problems can avail themselves of clinical services within the mental health delivery system. But mentally retarded persons who experience similar problems do not have easy access to psychiatric services. These persons, referred to as the *dually diagnosed*, characteristically fall through the cracks in the delivery service system, because neither the mental health system nor the mental retardation system wants to take responsibility for them (*Rowitz, 1980*). This failure to take responsibility can be attributed to the lack of a clearly articulated policy among providers for addressing the needs of the dually diagnosed.

Recent professional literature reveals that from 25 to 30 percent of the mentally retarded have associated symptoms of psychiatric disorders that would warrant a DSM-III-R diagnosis (*Menolascino and Stark, 1984*). It has also been found that psychiatric disorders in

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the mentally retarded are of the same kinds and types found in the nonretarded population (*Phillips, 1967*). Psychiatric disorders are reported to be twice as prevalent in the mentally retarded as in persons with normal intelligence. Clearly, the mentally retarded are a high-risk population for developing psychiatric disorders.

The social policy of deinstitutionalization has served to highlight the mental health treatment and service problems associated with this population. In the past two decades, there has been a dramatic shift in the structure of services to mentally ill persons. State and federal legislation, significant litigation, and advances in treatment technology have shaped social policy away from institutionalization and have directed the development of community-based programs to provide an array of treatment and support services to persons previously institutionalized with mental illness. Concurrently, the mentally retarded have been widely deinstitutionalized as well.

*Tropman (1984, p. 96)* discusses some of the inadequacies of this "policy":

All too often . . . policymakers had only the wisp of an idea, with no real concept of what "care" was to be, what community was, or how care should be based in the community. As a result, community-based policy has all too often resulted in "community institutions," row upon row of homes in which several retarded live, with none of the benefits of the institution and none of the benefits of the community.

Tropman asserts that a policy needs concrete implementation guidelines if it is to be anything more than an idea. In other words, a "policy" without such guidelines is not what this dissertation refers to as a *clearly articulated policy*.

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Associated with the change in social and treatment policy, however poorly articulated, has been a movement that began in the mid-1970s and has persisted to the present: separating the mental retardation service system from the mental health system (*Swanson and Menolascino, 1983*). Before 1978, for example, in the state under study, the State Department of Mental Hygiene regulated and licensed programs for both the mentally ill and the mentally retarded populations. Services for these two populations were delivered under one policy and administrative umbrella. In 1978, however, the Department of Mental Hygiene was disbanded, and two separate departments were established. The Bureau of Mental Hygiene (BMH) now plans, coordinates, and regulates services for the mentally ill in the state. The Bureau of Developmental Disabilities and Mental Retardation (BDDMR) does the same for the mentally retarded and others with developmental disabilities. Yet, as this dissertation will explore, the policy of separating services was unclear about how the BMH and the BDDMR should work with each other; only when a crisis developed in the delivery of services to a population neither agency was serving was an agreement hastily patched together.

Deinstitutionalization and the concomitant separation of mental health and mental retardation service structures have revealed the gaps in service delivery for the dually diagnosed. The changes have reflected a structural, philosophical, and treatment dilemma for this underserved population. The dually diagnosed are the most difficult to serve in community-based programs and serve as a specific challenge to the service delivery systems (*Menolascino, Gilson, and*

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*Levitas, 1986).*

The dually diagnosed who are returning to the community as a result of the policy of deinstitutionalization can be described as a population falling through the cracks. The reforms of the 1950s and 1960s focused on the inhuman conditions in mental institutions and developmental centers, but they have been unsuccessful in translating this concern into adequate resources for community care for the dually diagnosed.

The component probably most important and yet most often lacking is that of adequate mental health services. Although the passage of the Community Mental Health Centers (CMHC) Act in 1963 (amended in 1975 and 1977) has made community-based mental health services more available for some populations, it has not done so for the mentally retarded.

Research in the early 1960s demonstrated that mentally retarded individuals who receive outpatient psychiatric services were provided relatively brief service, characterized by shorter and less extensive interviews than those given other diagnostic groups (*Chandler, Norman, and Bahn, 1962*). Nearly ten years later, *Burton (1971)* concluded that mental health services to the retarded are essentially limited to evaluation and diagnosis without further treatment. *Swanson and Menolascino (1983)* made essentially the same assertion: "The mental health services that are available tend to be few in number and poorly coordinated" (*Swanson and Menolascino, 1983, p. 217*). Now, in the 1990s, little has changed with respect to the paucity of mental health services for the mentally retarded.

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The problem has long been recognized by the federal government through the President's Commission on Mental Health (PCMH), which identified major gaps in mental health services to the mentally retarded. The PCMH stated clearly the existence of such gaps: "Mental health delivery systems for mentally retarded persons are . . . unresponsive, woefully inadequate, and often nonexistent" (*President's Commission on Mental Health, 1978, p. 7*).

Ten years later, in *Mental Health and Mental Retardation: Identification, Diagnosis, Treatment Services*, a compilation of the presentations of the President's Committee on Mental Retardation Strategy Conference of 1985, *Behar and Taylor (1988, p. 381)* stated:

The President's Commission on Mental Health (1978) identified these problems of providing mental health services to mentally retarded persons; now, some ten years later, the problem, for the most part, remains unaddressed.

The plight of the dually diagnosed is only beginning to be recognized by the professional community. The dually diagnosed need more attention from policy makers, administrators, researchers, clinicians, parents, and the general public. The poor treatment of this underserved population reflects significant unmet needs in clinical, programmatic, training, and policy areas. The policy deficit is the most critical, for without a clearly articulated and consistent policy to overcome bureaucratic obstacles and improve the attitudes of professionals, the clinical, programmatic, and training needs are unlikely to be met.

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*Tropman (1984, p. 9) states:*

To survive in an increasingly complex environment, an organization needs, along with a supply of money and skilled personnel, a supply of concepts, views, and perspectives, which can become bases for policies that assist the organization in dealing with its environment.

According to Tropman, policy—an idea embodied in a written document, ratified by legitimate authority, and serving as a guide to action—is a concept of the way things should go, the way things should be. It is analogous to theory. Just thinking about shaping, fostering, and maneuvering these ideas within a human service organization improves the quality of the organization's activities.

Unfortunately, our society, with its ingenious "do-it-yourself" and experimental "seat-of-the-pants" traditions, places little emphasis on the planning ahead or thinking through alternatives implicit in the development of policy. According to Tropman, we should be more thoughtful about thought itself. Development of policy can enable professionals in the mental health and mental retardation services to effectively forecast potential problems with enough lead time to solve them before they seriously imperil operations. Developing a clearly articulated policy leads to a more helpful network of human service organizations and ultimately to higher-quality services.

For example, a policy could help service providers navigate through the bureaucratic maze. Services have been inaccessible to the dually diagnosed primarily because of bureaucratic systemic boundaries (*Fletcher et al., 1989*). Agencies serving the mentally disabled are usually licensed either by a state department of mental health or by a state department of mental retardation. Each of these

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departments issues licenses and regulates agencies according to its specific target population. Access to the delivery system, either in mental health or in mental retardation, is based on diagnostic criteria, and a person diagnosed as mentally retarded is generally found ineligible for the services of the mental health delivery system. The reverse is also true: Mentally ill persons, because of the psychiatric diagnosis, are usually barred from services available to the mentally retarded.

The resulting diffusion of responsibility means, at best, that services are fragmented. In large organizations such as the mental hygiene system, there is too often an inadequate sense of ownership for resolving problems (*Leismer, 1989*). Problems such as inadequacy of services are never resolved, because they do not appear to fall neatly into any single organization arena. It is all too easy for states to play the game of "exclusionary diplomacy" with regard to programs for the dually diagnosed by ignoring the dual diagnosis, by placing those they deem as primarily mentally ill in one discrete compartment and those they deem as primarily mentally retarded in another. Additionally, territoriality and professional egos of the care providers tend to encourage this bureaucratic stance, so the status quo is maintained (*Leismer, 1989*).

The result of the compartmentalized, exclusionary policy is the tendency to bounce a dually diagnosed person back and forth from one system to another (*President's Commission on Mental Health, 1978*), because neither system wants to take responsibility for someone who is perceived as "not belonging."

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Such a perception actually reveals the negative attitudes on the part of the treatment personnel, attitudes that have aggravated the bureaucratic structural barriers and further impeded mental health services for the dually diagnosed (*Walker, 1980*), attitudes that only a consistent, coherent policy is likely to ameliorate. Most mental health professionals do not perceive the mentally retarded as candidates for psychotherapy (*Levitas and Gilson, 1989; Fletcher [in press]*). These negative attitudes arise from ignorance due to a lack of training and to prejudice against the less articulate, less verbal, and less cognitively aware client population. A policy could provide a focus for training and could foster an atmosphere of tolerance.

### Policy Management

It is becoming increasingly recognized in the professional community that the existing service structures are grossly inadequate and insufficient for providing services to the dually diagnosed population. To enable that population to benefit from the technologies found in both service systems, there is a need to develop intersystem cooperative policy initiatives—to discover or generate ideas relevant to the dually diagnosed and to prioritize those ideas, to work with people and blend their skills into a unified effort, and to draft reports and other documents that lead to policy ratification (*Tropman, 1984*). Both the mental health and mental retardation service structures need to be willing to cross boundaries and transcend the issues of primary diagnosis and territoriality, which

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have long impeded the effective delivery of their services. A coherent policy is crucial if we, as a society, are to meet both the developmental and the psychiatric needs of the dually diagnosed. But perhaps such a policy must be developed and nurtured at the local level before it can guide the actions of the larger society.

This dissertation describes the activities of a *policy manager*, who has attempted to develop and nurture such a policy. According to *Tropman (1984, p. xiv)*, a policy manager is:

one who actively seeks to influence and shape the supplies of policy ideas within an organizational context much as the fiscal manager seeks to insure adequate supplies and developments of money and the personnel manager seeks to do the same for people.

Tropman elaborates on the role of the policy manager and the process of policy management. The policy manager has two basic missions: He must focus on the nature of an organization's policy, and he must seek to improve the quality of the ideas that make up the policy.

Policy management concerns the generation of ideas that, once ratified, become policy for an organization. A policy manager must be sensitive to key distinctions, which are explored in this dissertation: that between policy and planning, that between policy and practice, and that between policy and administration. The policy manager deals with the more difficult, more complex, and more troublesome arenas of organizational life.

The policy manager works with ideas—finds out which are appropriate to the problem at hand, digs out the relevant information, and synthesizes the ideas into coherent, prioritized

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options. He works with people, blending their skills toward generating policy options and fusing their input into a "single voice." He works with documents: writing drafts and proposals generated from the committee activity. This dissertation describes the policy manager's work with ideas, people, and documents that help shape a local-level policy concerning mental health services for the dually diagnosed.

The policy manager develops knowledge about policy issues, mobilizes people to develop the policy, and assumes political roles (advocate, coalition builder, and lobbyist). He assumes an extramural focus within a network of similar organizations to improve the standards of care for the dually diagnosed, illuminates the broader area of social policy, and works to make statewide policies more humane. Finally, he manages inevitable conflicts—differing points of view, opposing values, and contrasting political viewpoints—by providing solutions and through negotiation.

Policy development is a process. First, the problem to be addressed by the policy must be defined; here the policy manager must pull together a large number of ideas about the nature of the problem. Next, options must be generated into a coherent proposal; the policy manager has a crucial role here in shaping, reviewing, and trimming. Then, the proposal is ratified by a legitimate authority; here the policy manager must steer the proposal through bureaucratic obstacles and work to make it palatable. Then, the ratified policy is implemented with detailed plans and guidelines; here the policy manager helps administrators draft the guidelines. Finally, the policy

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is realized in actual programs; here the policy manager has an oversight role and remains alert to problems—problems that must be addressed in a new policy cycle.

### Purpose of the Study

This is a case study of how one county (a real county but with the fictional name of Bethany) set up a model service for the dually diagnosed. The intent is to describe how this was done in sufficient detail to enable other counties or entities to replicate the model if they so desire.

Conceptually, the study revolves around the activities of a policy manager. The study describes the role of the policy manager in influencing the planning and development of mental health services for mentally retarded persons at Bethany County Mental Hygiene Services (BCMHS).

The overarching research question is:

- ♦ How can a policy manager at a community mental health center (BCMHS) develop a clearly articulated policy and facilitate the planning and providing of mental health services for the dually diagnosed?

The following other questions are addressed:

- ♦ How is the population identified and its service needs determined?

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- ♦ What is the role of the policy manager in formulating local-level policy?
- ♦ What are the state-level policy initiatives, and how can the policy manager influence them?
- ♦ How can a policy manager utilize values, skills, knowledge, and resources to develop a responsive care network for the dually diagnosed?

The research strategy in this investigation for answering these research questions is a case study, an empirical inquiry that examines contemporary phenomena within its real-life context. The framework for the presentation of this study encompasses several interrelated components, including:

- ♦ **Research methodology:** a set of research questions and data collection methods used in the study.
- ♦ **Literature review,** including prevalence studies, structural barriers and service gaps, and training issues. A policy manager must be aware of the latest thinking in order to bring relevant ideas into the policy process.
- ♦ **Population and service needs identification,** derived from a study to determine the number of mentally ill-mentally retarded individuals and identify their needs. The results of the study provide the data necessary for planning services; without such data, policy management is very difficult.
- ♦ **Local-level environment**—the key players and influential forces.

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What are the distinctions between policy and practice, policy and planning, and policy and administration in the local policy environment? What is the role of the policy manager in influencing group decisions? How does he foster policy ideas thorough the policy process? What are the different settings for each phase of the process? How does the Office of Community Services act as a planning vehicle, and what role do the network of Bethany County agencies play? How did the policy manager make services for the dually diagnosed a higher priority? How did he shape the options generated by a task force into concrete proposals that were ratified into a coherent policy for the dually diagnosed?

- ♦ **State-level environment:** What is the impact of the state Bureau of Mental Hygiene and the state Bureau of Developmental Disabilities and Mental Retardation? How can a policy manager act as lobbyist? How can he influence social policy?
- ♦ **Recommendations for replicating the model.** How can policy management help with interorganizational planning and service development at the local level? What values must a policy manager bring to the policy development process? What information development, political and organizational, and interpersonal and conflict management skills are necessary? How can a policy manager apply knowledge, grounded in relevant research and organized according to a suitable paradigm, toward policy development? How can a policy manager apply the resources of information, feedback, position, and money? How can

## Chapter 1

a policy manager combine values, skills, knowledge, and resources in the actual planning and delivery of services at a community mental health center?

### Definition of Terms

This section defines the terms *mental retardation*, *mental illness*, and *dual diagnosis*.

#### ***Mental Retardation***

Mental retardation is a condition of low general intellectual functioning whose diagnostic criteria, according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM III, 1980, and DSM III-R, 1987)* of the American Psychiatric Association, determined through the Stanford Binet Intelligence Scale or the Wechsler Scale, are:

- ♦ Significant subaverage general intellectual functioning: an I.Q. of 70 or below.
- ♦ Concurrent deficits or impairments in adaptive functioning—i.e., the person's effectiveness in meeting the standards expected for his or her cultural group in such areas as social skills, responsibility, communication, daily living skills, personal independence, and self-sufficiency.
- ♦ Onset before the age of 18.

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There are four degrees of severity, reflecting the degree of intellectual impairment. Figure 1 illustrates these subtypes and the frequency of each.

---

Figure 1. Degree of Severity and Frequency of Mental Retardation.

<u>Degree of Severity</u>	<u>I.Q.</u>	<u>Frequency</u>
Mild	50-69	85% of MR persons
Moderate	35-49	10% of MR persons
Severe	20-34	3-4% of MR persons
Profound	Below 20	1-2% of MR persons

---

Mental retardation can further be defined as:

significantly subaverage intellectual functioning, existing concurrently with deficits in adaptive behavior; that is manifested during the developmental period prior to adulthood. The adaptive behavior refers to how well the individual is able to adjust to everyday needs for survival. It also refers to the extent to which [the individual meets] the expectations of society.

(Knopf, 1984, p. 424)

### ***Mental Illness***

The general term *mental illness* is used to cover a variety of disturbances affecting emotional, social, and cognitive functioning and

## Chapter 1

behavior. It is characterized by inappropriate emotional reactions in varying patterns and degrees of severity; by distortion, rather than deficiency of understanding and communication; and by socially misdirected, rather than merely inept, adaptive behavior. The *Diagnostic and Statistical Manual of Mental Disorders (DSM III, 1980, and DSM III-R, 1987)* of the American Psychiatric Association provides a formal classification system that distinguishes among the specific mental disorders—organic disorders, psychotic disorders, affective disorders, personality disorders, among others. For the purpose of this study, the labels *emotional disorders, mental disorders, mental illness, and psychiatric disorders* can all be considered synonymous.

### *Dual Diagnosis*

The term *dual diagnosis* refers to the complex dimensions of the co-existence of mental illness and mental retardation. Individuals who have dual diagnosis are commonly referred to as the dually diagnosed.

### Significance of the Study

State and local departments of mental hygiene and mental retardation are becoming increasingly aware of the issues and problems concerning the dually diagnosed population. This population presents unique service challenges to both levels of government, as well as to service structures and providers. The study explores

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facets of policy management, because the mental hygiene service system the study presents has policy implications at the state and local levels. Although the context of the study is at a county level, the mental health and mental retardation services involved are all licensed and regulated at the state level.

Bethany County Mental Hygiene Services is taking a leadership role in developing mental health services for dually diagnosed persons. It is hoped that this study will serve to stimulate local and state policy initiatives. Specifically, it is hoped this study can serve as a model for others to replicate. Additionally, it is hoped this study will stimulate professionals, particularly social workers, to be more active in treating and caring for the dually diagnosed.

### Limitations and Assumptions

The author of this study is playing a dual role. Not only is he the investigator, he is also the supervisor—and policy manager—of the mental health subunit that is the subject of the study. His dual role presents both advantages and disadvantages in the case-study research strategy.

A significant advantage is his “inside” perspective of the design and implementation. As an insider, the investigator can produce a perspective of the case study phenomenon likely to be closer to reality than what could be gleaned from a traditional case study. In particular, his awareness of the “politics” would not easily be matched by an outsider. Also, because of his dual role, the investigator has

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easy access to various sources of data—the documents, records, interviews, and participant observations that are necessary for conducting case studies.

A disadvantage is the potential for bias during the course of the case study. The investigator is a participant, directly or indirectly, in the events to be studied. Also, as *Tropman (1984)* explains, a policy manager may play a partisan role within an organization. Assessing these advantages and disadvantages of his unique dual role, the author believes that the case study can be conducted in a professional and objective manner.

The next chapter describes the research designs and methods used in this investigation.

## Chapter 2

### Research: Questions and Methods

This chapter proposes a set of research questions and data collection methods for this study. The study is designed to examine how a policy manager developed a local-level model of mental health services for persons who have both mental illness and mental retardation. The unit of analysis for the study is the Mental Health/Mental Retardation (MH/MR) Service subunit of Bethany County Mental Hygiene Services (BCMHS). Both the state and local environmental contexts for this population are investigated. The research strategy is the case study.

#### Research Questions

The overarching research question is:

*How can a policy manager at a local community mental health center (BCMHS) influence the provision of holistic mental health services for the dually diagnosed?* There are several related corollaries to this major research question. These include:

- ♦ How is this population identified and its service needs determined?
- ♦ What is the role of the policy manager in formulating local-level policy?
- ♦ What are the state-level policy initiatives, and how can the policy

## Chapter 2

manager influence them?

- ♦ How can a policy manager utilize values, skills, knowledge, and resources to develop a responsive care network for the dually diagnosed?

Fundamental assumptions, which form the basis of a well-articulated policy for delivering services to the dually diagnosed, include:

- ♦ Mentally retarded persons can develop psychiatric disorders.
- ♦ Dually diagnosed persons can clinically benefit from community-based mental health services.
- ♦ It is possible to transcend institutional structural barriers.
- ♦ Training and supervision can correct negative attitudes among professionals.
- ♦ Community mental health centers can deliver mental health services to the dually diagnosed.

The following categories of research questions are related to the overarching question as stated above:

- I. **Identification of the Population and Service Questions:** There are a number of questions related to the identification, service utilization, and service needs of dually diagnosed persons residing in Bethany County. These questions must be addressed before a coherent policy for dealing with the dually diagnosed can be developed. The data was solicited and analyzed in 1985. Therefore, the following questions are retroactive with regard to

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the time frame of the study:

- ♦ What is the number of dually diagnosed persons?
- ♦ What services are used by this population?
- ♦ What are the age brackets of the dually diagnosed?
- ♦ What are the major service barriers?
- ♦ What are the agency perceptions regarding planning and programs developed for this population?

### II. Local-Level Environment: Policy Development of Mental Health Services for the Dually Diagnosed: *How is policy established for mental health services for the dually diagnosed in Bethany County?*

- ♦ What role does the policy manager play in influencing group decisions?
- ♦ What are the distinctions in the local-level environment between policy and practice, policy and planning, and policy and administration?
- ♦ How does the policy manager foster policy ideas through the policy process?
- ♦ What are the different settings for each phase of the policy process?
- ♦ What role does the Office of Community Services play?
- ♦ What role does the administration of BCMHS play?

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- ♦ What role do other community agencies play?
- ♦ How did the policy manager, in a partisan political role, make services for the dually diagnosed a higher priority in Bethany County?
- ♦ How did the policy manager shape the options generated by a task force into concrete proposals that were ratified into a coherent policy for the dually diagnosed?

### III. State-Level Environment: Influencing Statewide Policy Initiatives:

*What constitutes the state-level external environment, and how is it related to the target population?*

- ♦ What is the responsibility of the State Bureau of Mental Hygiene (BMH) in its relationship to service provisions for the target population?
- ♦ What is the responsibility of the State Bureau of Developmental Disabilities and Mental Retardation (BDDMR) in its relationship to service provisions for the target population?
- ♦ What is the relationship between BCMHS and BMH?
- ♦ What is the relationship between BCMHS and BDDMR?
- ♦ How can a policy manager deal with the intricacies of organizational relationships?
- ♦ How can the policy manager act as a lobbyist to influence statewide policy initiatives?

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- ♦ How can the policy manager influence social policy?

### IV. Service Planning and Delivery: *How can another community mental health center replicate the Bethany County model in providing services to the dually diagnosed?*

- ♦ How can policy management help with interorganizational planning and service development at the local level?
- ♦ What values must a policy manager bring to the policy development process?
- ♦ What information development, political and organizational, and interpersonal and conflict management skills are necessary?
- ♦ How can a policy manager apply knowledge, grounded in relevant research and organized according to a suitable paradigm, toward policy development?
- ♦ How can a policy manager apply the resources of information, feedback, position, and money?
- ♦ How can a policy manager combine values, skills, knowledge, and resources in the actual planning and delivery of services at a community mental health center?

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### Research Methods

The research strategy to attempt to answer the aforementioned research questions is the case study. According to Yin (1984, p. 23), a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, where the boundaries between phenomena and context are not clearly evident, and where multiple sources of evidence are used.

Data has been collected from documentation, archival records, interviews, direct observation, and participant observation. The collection of evidence and sources, as listed in the following topics, represent an explicit data collection plan for this investigation.

#### *Documentation*

Documentary evidence for this investigation included:

- ◆ Letters, memoranda, and other communiqués
- ◆ Minutes of meetings related to key players and plans for the program
- ◆ Administrative documents, such as policy and procedure manuals, organizational charts, local governmental plans, agency proposals, and state governmental plans and proposals

#### *Archival Records*

The data collection source for obtaining information related to the client population under study was archival records. Some of this

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information was obtained from a computerized database at BCMHS.

This information included:

- ♦ Computer service records—i.e., demographic data about the clients who were served
- ♦ Survey data—i.e., information from previous surveys concerning the dually diagnosed population and their service needs
- ♦ Client records—i.e., individual medical charts to obtain specific clinical data

### *Interviews*

The investigator used the open-ended, as well as the formal, interview techniques. Key players in the planning as well as the implementation of the Mental Health/Mental Retardation (MH/MR) Service, the subunit of policy development that is the focus of this study, were interviewed. The investigator interviewed key players from other services in which interorganizational relationships concerning the dually diagnosed population had been developed. Additionally, key players at the state level were interviewed.

Interviews with these key players were useful in providing the investigator insight into the planning, implementation, and operation of the specialized mental health service. These interviews also provided a source for collaborative evidence.

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### ***Direct Observation***

The investigator had a unique advantage due to the nature of his position as supervisor (subunit leader) and policy manager of the MH/MR subunit at BCMHS. Direct observation of relevant behaviors and environmental conditions was easy and useful. The service delivery system is unique for the dually diagnosed with respect to the interorganizational relationships. Direct observation was valuable in examining the actual implementation of the relevant interorganizational relationships.

### ***Participant Observation***

Again, the investigator had the distinct advantage of using the data collection source of participant/observer because of the nature of his position with BCMHS. As a participant/observer, the investigator did not take a passive role; rather, he took a variety of roles within the case study and actually participated in the events under study.

Participant observation also provided some unusual opportunities in data collection. First, the investigator had access to sources of evidence that might have otherwise been inaccessible. He could perceive a phenomenon from the viewpoint of an insider, thereby perceiving more accurately. As subunit leader and policy manager, he could manipulate events or situations. *Yin (1984)* points out that though insider manipulations are not as precise as manipulations in rigidly objective experiments, they can produce a greater variety of situations for the purpose of collecting data for case studies.

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However, being a participant/observer presented a potential problem: *bias*. As a key player, this investigator was actively involved in the case being studied. He studied a phenomenon in which he had a role in the unit of analysis. Therefore, his "dual role" (both as policy manager and as investigator) needs to be taken into consideration. It may have biased the results, yet multiple checks on observations hopefully limited this potential bias.

### Study Analysis

The analytic strategy for organizing this investigation is case description and analysis. This strategy was selected because of its "fit" with the purpose of this case study—a descriptive analysis of a mental health service model. This dissertation describes and analyzes relevant events in a sequential order as a means to establish structure with respect to the collected data. Such description and analysis provide a logical organization for the case study (Yin, 1984).

Since the unit of analysis (the MH/MR outpatient services of BCMHS) is both innovative and has the potential for replication, many variables outside the unit of analysis are described—i.e., relevant social policy, history, local identification of need, state initiatives, and so on. The historical and environmental contexts were valuable to this case study, so analysis of data outside the unit of analysis is included. Each chapter is organized in a way that will have a bearing on the research questions. The chapters, in a logical and sequential order, describe and analyze the variables from the collection of

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relevant data about the dually diagnosed (beginning with a review of the literature), through conceptualization of a local-level policy for delivering treatment service to the dually diagnosed, through the implementation of that policy at the local level and the possibilities for influencing state policy, to recommendations for replication.

The next chapter is a review of the research literature concerning the dually diagnosed. Reviewing the relevant literature is necessary for identifying the problem that is to be addressed by a policy for delivering services to the dually diagnosed.

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### Problem Identification: A Review of the Literature

The first step in the policy development process is to clearly identify the problem to be addressed by the policy. The policy manager must pull together a large number of ideas about the nature of the problem. This chapter and chapter 4 concern problem identification—this chapter about the research concerning the dually diagnosed in general, and chapter 4 about the specific plight of the dually diagnosed in Bethany County.

As *Tropman (1984)* asserts, a policy manager must work with ideas: He determines which are appropriate to a particular problem, uncovers the relevant information, and synthesizes information from different sources. Ideas that guide action should be “correct,” at least as far as knowledge permits.

Policy, after all, is to practice what theory is to research: Policy embodies assumptions about cause and effect; it advocates remedies implicitly suggested by these assumptions. It behooves the policy manager to ensure that his assumptions are relevant, that they reflect the latest scientific research literature, and that they take into consideration the important conflicts in that literature. The policy manager in this study extensively reviewed the relevant literature to better understand the nature of the issues concerning the dually diagnosed population in Bethany County, and to prioritize these issues.

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The research literature has been increasingly concerned with the prevalence of mental illness in persons who have mental retardation. Recent studies have indicated that persons who have mental retardation are at risk for developing psychiatric disorders. Furthermore, the literature reflects that persons who have mental retardation are twice as likely to develop a mental illness than are those in the society at large. Because there is a lack of resources for the dually diagnosed, the high prevalence of dual diagnosis is related to social policy issues. This prevalence presents significant service delivery problems at the local and state levels. Not only are there service gaps, but professionals are ill equipped due to their lack of training to provide effective care and treatment for this underserved population.

In order for a policy manager to develop a policy for delivering appropriate and effective mental health services for the dually diagnosed, he must examine relevant issues found in the literature. This chapter cites three areas related to this investigation:

- ◆ Prevalence studies
- ◆ Structural barriers and service gaps
- ◆ Training issues

### Prevalence Studies

A growing number of studies have been conducted on the prevalence of dual diagnosis in the United States and Europe. The results of these studies vary widely, depending on the setting where the research was conducted, as well as on the methodologies employed. Until recent years, most studies on this topic focused on mentally retarded persons in institutions, where one may find both a high prevalence of psychiatric problems and more severe levels of retardation (*Menolascino, 1983*). The more recent studies have been conducted in community-based settings.

The following review of the literature begins with the older studies, conducted in institutional settings, through the most recent research, done in community settings. A critique of the research methodologies follows.

The literature reveals that psychopathology found in the general population can also be found in the mentally retarded (*Balthazar and Stevens, 1975; Fletcher and Menalascino, 1989; Menalascino and Stark, 1984; Szymanski and Tanquay, 1980*). The prevalence of psychopathology in the mentally retarded has been significantly higher than that found in persons of normal intelligence (*Balthazar and Stevens, 1975; Beier, 1964; Duncan, Penrose, and Turnbull, 1936; Jacobson, 1982; Lewis and MacLean, 1982; Menolascino, 1970; Menolascino, Gilson, and Levitas, 1986; Payne, 1968; Rutter et al., 1976*). According to *Menolascino and Stark (1984)*, the prevalent rate of mental illness in persons who have mental retardation is

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considered to be between 25% and 35%. Others have estimated the rate to be lower: *Jacobson and Ackerman (1988)* estimate that 15% to 25% of person with mental retardation may also have a psychiatric impairment. But all estimates are considerably higher than the prevalence of psychopathology in persons of normal intelligence. In reviewing many available studies, *Lewis and MacLean (1982, p. 76)* state: "The available studies lead to the inescapable conclusion that emotional disorders are much more common among mentally retarded persons than in the general population."

The research studies that have attempted to identify the prevalence of dual diagnosis generally fall into three categories: surveys of institutions for the mentally ill, surveys of institutions for the mentally retarded, and surveys of the noninstitutionalized retarded. The most important studies in these three categories are mentioned.

### *Mental Retardation in the Institutionalized Mentally Ill*

*Rosanoff, Handy, and Plesset (1935)*, after reviewing statistics for a New York State Hospital, reported 30% of the epileptic psychotics, 17% of the schizophrenics, and 10% of the manic-depressive psychoses occurred in patients who were considered mentally retarded. One year later, *Duncan, Penrose, and Turnbull (1936)* reported that 17.8% of 2,000 mental patients were found to be mentally retarded. *Pollack (1944)* suggested that the mentally retarded were found to be seven times more likely to be admitted to a mental institution than were individuals who were not retarded.

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### ***Mental Illness in the Institutionalized Mentally Retarded***

The reports of the incidence of mental illness found in the institutionalized population of retarded individuals vary greatly. For example, *Neuer (1947)* found that 28% of 300 admissions to the Lincoln State School had a history of either neurosis or psychosis. *Craft (1959)* found that 40% of 314 retarded individuals from an institution in England were found to have psychotic, neurotic, or personality disorders. Significantly, Craft found a high prevalence of personality disorders—33%—compared with only 7% having psychotic or neurotic disturbances. *Menolascino (1970)* found behavioral and emotional disturbance in 35% of 95 Down's syndrome sufferers under age 24 who were residing in developmental centers.

### ***Mental Illness in the Noninstitutionalized Mentally Retarded***

Surveys of the noninstitutionalized population also reported a high prevalence of emotional disorders among the mentally retarded. *Phillips (1967)* reported a study of 227 retarded children, which revealed that emotional maladjustment more often than not accompanied mental retardation. *Phillips and Williams (1975)* studied 100 mentally retarded children referred to a psychiatric clinic because of emotional problems. They found that 38% of the mentally retarded children were psychotically disturbed; 49% showed symptoms of characterologic, neurotic, behavioral, or situational disorders; and only 13% had no symptoms of a psychiatric disorder. *Webster (1963)* studied 150 preschool retarded children who were applying to a preschool retarded children's program in Boston and

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reported that 48% were rated as moderately emotionally disturbed and 18% were rated as severely disturbed. *Jakab (1980)* reported that among 595 referrals for evaluation, 194—or 33%—were found to be diagnosed as having a psychiatric disorder in addition to mental retardation.

*Benson (1985)* reported an approximate 85% rate of psychiatric problems in a sample of 130 adults and children referred to an outpatient mental health service.

*Eaton and Menolascino (1982)* found that 14.3% of a sample of 798 retarded individuals were found to be both mentally ill and mentally retarded. In a survey by *Jacobson (1982)* of 30,578 mentally retarded individuals in New York State, 12.4% of the adults and 7.8% of the children had emotional problems.

In the European literature, *Corbett (1979)* reported a rate of 46% for significant psychiatric disorders as part of an epidemiological survey in London. However, 25% of those received a diagnosis of "behavior problems." In Denmark, the prevalence of psychiatric morbidity was estimated to be 27.1% (*Lund, 1985*). *Rutter et al. (1976)*, on the Isle of Wight, found a 30% rate of psychiatric disorder in children with I.Q.'s less than 70. This compares with 7% of psychiatric disorders in the total population of nine-, ten-, and eleven-year-olds on the Isle of Wight.

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### *Methodological Issues*

It is becoming increasingly clear that most epidemiological research concerning the dual diagnoses of mental illness and mental retardation has suffered from major methodological problems. Most notable is the lack of uniform diagnostic definitions.

One major problem is how to define mental retardation (*Russell, 1988*); there is no international agreement on a definition. *Rutter and Graham (1970)* argue that using adaptive behavior criteria to select a retarded population produces high rates of psychiatric disorders, yet deficits in adaptive behavior is a criterion of mental retardation, according to the *Diagnostic and Statistical Manual of Mental Disorders (1987)*.

A second major methodological problem concerns the heterogeneity of the mentally retarded population. Many studies have not differentiated between the mildly and the severely retarded in conducting prevalence studies. This is a significant design flaw, since these two groups are dramatically different in almost every dimension (*Russell, 1988*).

The third major problem, perhaps the most critical, concerns the assessment of the psychiatric disorder. Diagnostic criteria among studies have varied greatly.

There have been various methods of data collection in reporting the prevalence of dual diagnosis. These include interviews, client records, case histories, standard surveys and standardized assessment, and testing. *Reiss (1988a)*, in a review of research, noted that when the method is simply to count the number of people

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with charts indicating a dual diagnosis, researchers have estimated prevalence rates of about 10%. However, when the method consisted of a caretaker survey, the prevalence ranges from 20% to 40%.

When employing the traditional method of the psychiatric interview, clinicians can be subjected to a phenomenon called *diagnostic overshadowing* (Reiss, Levitan, and Szyszko, 1986): The presence of mental retardation decreases the diagnostic significance of an accompanying psychiatric disorder.

Although it is clear that mentally retarded persons are vulnerable to psychiatric disorders, research methodologies lack consensus regarding the measurement and observation of mental retardation and mental illness.

### Structural Barriers and Service Gaps

The dually diagnosed require a multiplicity of service provisions to meet their complex psychiatric and developmental needs. These individuals are barred cross-boundary access to service. Unfortunately, the access is barred through protective regulations that spurn the very clients they are designed to help. This section reviews the recent literature on the problems of service fragmentation and gaps in service provisions.

The development of one separate service delivery system for the mentally ill and another for the mentally retarded has revealed the magnitude and importance of the service gaps. Deinstitutionalization has had a profound effect on services to both populations in the past

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30 years (*Menolascino, 1983*). In spite of the general support for a social policy of deinstitutionalization, the interpretation and implementation of that policy are substantially different in the field of mental retardation from what they are in the field of mental health (*Finch, 1985*). Many would strongly argue that the implementation of deinstitutionalization has been less successful for the mentally ill than for the mentally retarded. The dually diagnosed, however, have fared the worst.

The two parallel but separate service systems have been shaped by different influences. The field of mental retardation, over the last two decades, has been guided by a set of principles and concepts. The application of both the developmental model (*Nirje, 1969*) and the normalization principle (*Wolfensberger, 1971*) have had a profound effect on policy development and delivery of service models. The developmental model and the normalization principle, with their concepts of individual rights and mainstreaming, together with the advocacy of support organizations, have altered society's attitude toward the mentally retarded and led to their acceptance. For the mentally retarded, the deinstitutionalization process has been relatively successful.

By comparison, the deinstitutionalization process for the mentally ill has not been as successful. Clearly, the policy implementation emphasis for this population has been to dramatically reduce the number of mentally ill in our nation's institutions, but at the cost of insufficient provisions for after-care services.

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The policy has been driven by the medical, as opposed to a holistic, model. It was expected that individuals outside of hospitals would not need the same array of services in the community. But communities were not prepared to deal with their needs, so community-based services have been poorly developed, often fragmented, and inconsistent from community to community (*Pepper and Ryglewicz, 1982*).

The recent change in regulatory bodies, driven by the policy of deinstitutionalization, has highlighted the service gaps for the dually diagnosed population. The narrow diagnostic classification of dually diagnosed individuals following institutional release has added to the problem. The client is labeled as being either retarded or mentally ill and then placed into the "appropriate" agency for treatment.

*Fletcher et al. (1989, p. 225)* describe the diagnostic dilemmas as they related to these structural barriers:

During the last decade, many state governments moved to restructure the delivery of mental hygiene services, which resulted in a separation of mental health and mental retardation systems. Each system developed its own policies, procedures and funding mechanisms. Access into either system is based on diagnostic criteria. Simply stated, persons diagnosed as mentally retarded have access to services regulated by the state mental retardation and developmental disabilities system, while those diagnosed as having mental health problems have access to the state mental health system. The primary diagnosis is the leading—and usually the sole—criterion, determining which of the two systems a person has access to.

The same theme is reported by others in recent literature. *Pepper and Ryglewicz (1989)* report: "Instead of being supported by an interlocking continuous and closely woven mode of care and services, the person with dual or multiple disorders then ricochets

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like a slot-machine ball from one system to another.”

The absence of administrative ownership has resulted in inadequate levels of mental health services for mentally retarded persons (*Reiss, 1985*). Advocates for the mentally retarded during the 1950s through the 1970s demanded that there be a separation of services from the administration of services for mental health (*Menolascino, 1983*). Although this was a major benefit for the field of mental retardation in general, an unintended consequence is that it resulted in grossly inadequate mental health services for the mentally retarded individuals who needed them.

The separation of service structures occurred at the same time as the deinstitutionalization policy. Prior to deinstitutionalization, mentally retarded persons who exhibited severe maladaptive behaviors were hidden in the back wards of institutions. Furthermore, these maladaptive behaviors were generally viewed as manifestations of the condition of mental retardation.

Deinstitutionalization has not resulted in adequate services for the dually diagnosed. Several researchers have described the scarcity or absence of community-based services for this population (*Menolascino, 1991; Jacobson and Ackerman, 1988; Stark et al., 1988*). According to *Reiss (1988c, p. 45)*:

Very little has been done in the United States to provide outpatient mental health services for persons with mental retardation. Although the National Institute of Mental Health and the various state governments fund an extensive network of community mental health centers (CMHCs), many CMHCs refuse to serve people with mental retardation. Some CMHCs actually have formulated policies that preclude services to people with mental retardation, whereas others simply have not provided the needed service.

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The problem has been recognized by the federal government through its President's Committee on Mental Retardation (PCMR) and the President's Commission on Mental Health (PCMH). In a 1978 report of the Liaison Task Panel on Mental Retardation (*President's Commission on Mental Health, 1978, p. 7*), the PCMH acknowledged the gaps in the delivery-care system regarding mental health services for the mentally retarded:

Mental health delivery systems for mentally retarded persons are described as unresponsive, woefully inadequate, and often nonexistent. There appears to be a tendency for the mentally retarded client to be bounced back and forth between mental health and mental retardation professionals, with neither agency offering an adequate service delivery plan to meet the client's needs. Often, the individual is shuffled among mental health, mental retardation, and correctional institutions.

Eight years later, the same theme was echoed by many speakers at the National Strategy Conference on Mental Retardation and Mental Health, sponsored by the PCMR.

In a recent study, *Jacobson and Ackerman (1988)* reported a general concern that services for persons with mental retardation and psychiatric impairments were deficient in availability, accessibility, and adequacy. The data from this study also revealed that there was a need to improve coordination of services among service providers. Even though repeated studies have demonstrated that the mentally retarded suffer from the same range of mental health problems and psychiatric disorders as does the nonretarded population and at greater frequency,

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the mentally retarded citizen who is also mentally ill is still a comparative rarity in the community mental health system (indeed, in any mental health system), perhaps emblematic of the fact that the mentally retarded are in the community, but not yet of the community.

*(Menolascino, Gilson, and Levitas, 1986, p. 315)*

In 1983, the National Association for the Dually Diagnosed (NADD) was organized. NADD is a not-for-profit multidisciplinary and parent association that tries to focus national attention to the policy, program, and clinical issues concerning the dually diagnosed. NADD works to bridge the gulf between the two service structures of mental health and mental retardation by promoting and disseminating relevant information concerning the field of dual diagnosis. NADD combats the discriminatory practice of excluding the dually diagnosed from community mental health centers.

Over the last several years, there has been a burgeoning interest in the field of dual diagnosis. Presentations, national conferences, professional literature, and the founding of NADD have focused attention on this population. Model programs, conferences, and the recent proliferation of literature have served to bring about new technologies for its care and treatment.

Local-level providers and state-level government are becoming acutely aware of the gaps in service. We are now beginning to witness the emergence of services for this population. The technological capability for care and treatment is beginning to be recognized. What is needed now is a clearly articulated social policy to ensure that this new technology is implemented.

## Training Issues

Not only are there service gaps for dually diagnosed clients who fall through the cracks of separate health care systems, but professionals in both systems have serious gaps in their skills. According to the *President's Commission on Mental Health* (1978, p. 7):

Information gathered from many state coordinators indicates that the mental health field still responds to the myth that mentally retarded persons cannot and do not profit from psychotherapeutic intervention. Others report that mental health staff are unfamiliar with mental retardation and related their unwillingness to treat to lack of knowledge and training.

The paucity of training has contributed to the fact that few mental health professionals provide services to mentally retarded persons. The mere absence of training has contributed to ignorance and a set of assumptions that have influenced the service system:

Ignorance of what mentally retarded people are like, ignorance of how effective treatment may be in alleviating their mental health problems, and ignorance of what to expect from professionals. Stereotypes and prejudices feed upon such ignorance and further complicate the problem.

*(Cushna, Szymanski, and Tanquay, 1980, p. 4)*

*Phillips (1967)* challenged three myths:

- **Myth 1:** The maladaptive behavior of a retarded person is a function of his retardation rather than of his interpersonal relationships.
- **Myth 2:** Emotional disorders in the retarded are different in kind from those with normal intelligence.

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- **Myth 3:** Certain symptoms and specific maladaptive patterns in retarded people are a result of organic brain damage.

Another misconception has been the assumption that psychotherapy is ineffective with persons who have mental retardation. Data indicates, however, that dually diagnosed individuals can profit from all kinds of mental health treatment services on an outpatient basis (*Fletcher, 1988; Szymanski and Tanquay, 1980*). It is true that the psychotherapy treatment requires modification to accommodate the client's expressive and receptive language deficits: Clients must be helped to articulate their feelings, an articulation that goes a long way toward correcting behavioral difficulties. Moreover, intervention requires a more active, direct, and concrete clinical stance (*Menolascino, 1983*).

Almost all therapies, except the insight-oriented approaches, are appropriate for mildly mentally retarded adults (*Reiss, 1985*). Interventions include supportive psychotherapy (*Hurley and Hurley, 1988*), group therapy (*Fletcher, 1984*), and social skill training (*Matson, 1989*)—as well as treatment through medication (*Sovner, 1989*). Although these and other interventions have been successful with mentally retarded persons, most professionals cling to the belief that these people are unsuited for psychotherapy.

Again, as *Tropman (1984)* emphasizes, the policy manager must be aware of the latest thinking in order to bring ideas into the policy process; he must foster education where little (or nothing) was known before; and he must encourage reeducation, to disabuse myths and

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replace them with well-founded concepts consistent with appropriate values.

The need to increase training in clinical areas concerning the dually diagnosed has not gone unnoticed by researchers. *Lindenbaum (1989)* advocates the training and supervision of mental health professionals, whether in the field of mental retardation or mental health, in order to provide the most effective clinical treatment to the dually diagnosed client. Such training and supervision can correct negative attitudes among professionals. *Schramski (1989)* calls for staff training for paraprofessional staff who work with dually diagnosed clients through development of a repertoire of behavioral intervention methods to facilitate client success in community living. *McGee and Pearson (1983)* call upon the federally funded university-affiliated programs to take a more active role in providing increased professional training. These authors and others clearly recognize the need to increase our knowledge in the clinical dimensions of the dually diagnosed population. Misconceptions and ignorance have too long been obstacles in the supply side of mental health services.

### Summary

As *Tropman (1984)* asserts, policy ideas of quality should be simple (as opposed to simplistic or simple-minded). Simple ideas reduce a problem to its most fundamental features and embody suggestions for solutions to deal with those features. Simple ideas

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make compliance with policy easy, make noncompliance difficult. The simple ideas supported by the research literature cited in this chapter include:

- ♦ Mentally retarded persons can develop psychiatric disorders.
- ♦ Dually diagnosed persons can clinically benefit from community-based mental health services.
- ♦ It is possible to transcend institutional structural barriers.
- ♦ Training and supervision can correct negative attitudes among professionals.
- ♦ Community mental health centers can deliver mental health services to the dually diagnosed.

The next chapter continues the discussion of the policy development process of identifying the problem addressed by the policy. It examines a survey study conducted in Bethany County designed to identify the dually diagnosed population and its service needs. The survey also elicited proposed options from the respondents.

## Chapter 4

### Problem Identification and Option Generation: The Survey Study

The previous chapter discussed the research concerning the dually diagnosed in general. This chapter focuses on the problem of dual diagnosis in Bethany County specifically, by examining a survey study designed to identify the local dually diagnosed population and its service needs and to elicit some suggested options from the respondents. The results of the study provided the background data and option possibilities necessary for developing a coherent policy; without such data and options, policy management is very difficult.

Conversely, without some degree of policy management already in place, adequate quantitative information is not gathered. Workers in the human resources field tend to be suspicious of quantitative data. As *Tropman (1984)* asserts, they prefer to portray client needs in qualitative and affective terms, rather than in quantitative and empirical concreteness. The policy manager in this study had to overcome this resistance. Only with real data could the policy manager set policy priorities, taking into consideration the urgency of the problem, the importance of the problem, and resource allocation. The policy manager made it clear to the administrative staff of Bethany County Mental Hygiene Services (BCMHS) that program development had to be based upon other than mere staff or agency impressions. Future planning, in fact, needed to follow upon a coherent policy, based upon a clear identification of the dually

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diagnosed population and a careful assessment of their needs. It is during this problem identification phase of the policy development process that the policy manager has the "greatest leverage," as *Tropman (1984, p. 54)* calls it: His clearly defining the problem causes all else to follow. With real data that makes the problem concrete, the policy manager can pull together a broad range of ideas about the nature of the problem.

During the mid-1980s, community agencies in Bethany County were increasingly faced with referrals for persons who had mental illness and mental retardation. However, and even without specific lobbying from the policy manager, the community agencies recognized that adequate services for this population were not available. The policy manager was convinced that there was a need to assess the number of dually diagnosed persons and their service needs objectively. This was necessary in order to develop a policy that addressed their needs by fostering effective plans and services.

In light of this service dilemma, community agencies from the mental health and mental retardation systems, in conjunction with BCMHS (the local agency mandated by the state mental hygiene law for planning and coordination of service systems), developed a survey in 1985 to identify the population and its service needs. This chapter describes the survey and analyzes its results.

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### The Survey Tool

The needs assessment survey was broad in scope, because it was intended to assess, for the purpose of planning, the full range of service needs for the dually diagnosed in Bethany County. BCMHS mailed the survey in February 1985 to all the public and private providers of mental health or mental retardation services within the county. All the major service providers responded, including the following:

Bethany County Mental Health Services (BCMHS)  
Alpha Community Industries, Inc.  
Good Samaritan Hospital  
Tower Avenue Residence  
Bethany Association for Retarded Citizens (BARC)  
Community Rehabilitation Center (CRC)  
Clark Developmental Disabilities Services Board (DDSB)  
Clark Valley Psychiatric Center (CVPC)  
Extended Frontiers for the Retarded, Inc.

These providers are further discussed in chapter 5.

The organizations surveyed were asked to provide the following information:

1. The number of dually diagnosed clients seen during the previous year.

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2. The service provided to dually diagnosed clients and any referrals between mental health agencies, on the one hand, and mental retardation or developmental disabilities agencies, on the other hand.
3. The ages of dually diagnosed clients served.
4. Major barriers in providing adequate services to the dually diagnosed.
5. Agency opinions as to whether the dually diagnosed clients should be receiving particular emphasis in planning and program development, as well as opinions as to what the respective responsibilities of state, local, and private agencies should be.

For the purpose of this survey, a client was considered dually diagnosed if:

- ♦ He or she was identified as mentally retarded or developmentally disabled and had also been identified as suffering from mental illness;
- ♦ At the time of contact, was a resident of Bethany County;
- ♦ Was seen by an agency during the previous year for any reason; and
- ♦ Was not, at the time of the survey, a long-term-stay resident at either Clark Developmental Disabilities Services Board or Clark Valley Psychiatric Center.

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The definition for each category was:

- ◆ **Mental retardation:** The client had been tested 70 I.Q. or below on the Wechsler I.Q. Scale, 68 or below on the Stanford-Binet, and there were resultant or concurrent deficits or impairments in adaptive behavior, taking the person's age into consideration.
  
- ◆ **Mental illness:** During the previous year, the person had exhibited the symptoms of one or more psychiatric disabilities covered in the *Diagnostic and Statistical Manual of Mental Disorders (DSM III, 1980, and DSM III-R, 1987)*;, which would not be wholly attributable to either mental retardation or developmental disability.

### Survey Results

This section provides detailed results and analysis of the survey study. The categories that follow identify:

- ◆ The number of dually diagnosed clients
- ◆ The services received by the dually diagnosed
- ◆ Point-of-service and intersystem referrals
- ◆ Age brackets
- ◆ Barriers to effective service delivery

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### *The Number of Dually Diagnosed Clients*

Two hundred dually diagnosed clients were identified in the survey. The actual number is likely to be higher for two reasons:

1. The survey identified those dually diagnosed persons who were involved in the service delivery system during 1985. Those persons who were not in a program during that year were not counted. Since there existed a "diagnostic dilemma with respect to eligibility criteria," there were likely to have been some dually diagnosed persons who were not receiving services in 1985.
2. The phenomenon of diagnostic overshadowing (meaning that the presence of mental retardation decreases the likelihood that mental illness is diagnosed) was probably a factor. It is likely that some were not identified in the survey as a result of this phenomenon.

### *The Services Received by the Dually Diagnosed*

**Mental Health Outpatient Clinical Services:** Respondents reported that 51 clients had received mental health services during the period. These included services in the following locations:

	<u>Number</u>
Community Rehabilitation Center	1
BCMHS adult unit-Clarkston	32
BCMHS-Susanville clinic	2
BCMHS-Summit House day treatment	<u>16</u>
Total	51

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The data reflected that 25.5% of the 200 identified dually diagnosed persons had received outpatient mental health services. In other words, 74.5% of those identified had not received outpatient mental health services.

Clearly, this fact represented a major problem in the service delivery system. If the population was not identified with appropriate outpatient treatment, then community-based problems with these clients could only get worse.

This data was important for developing a policy for delivering mental health outpatient service for this population.

**Day Programming:** Respondents reported that 165 clients had received programming services through their agencies in 1984. This number comprised 82.5% of the identified dually diagnosed population in the county, with the bulk of clients served at Alpha and BARC. Since approximately 5% of dually diagnosed clients in Bethany County were under age 18 and would likely have been served by the school systems, there was a day programming gap of 12.5%, or 25 clients.

One caveat should be noted, however. Because of their disabilities, many dually diagnosed clients often have difficulty maintaining employment and tend to exhibit unstable performance in sheltered employment. This conclusion was supported by analysis of BCMHS computer data, which showed that 45.7% of all dually diagnosed clients who reported social performance disturbance did so with regard to job issues. The evidence was buttressed by anecdotal information received from BARC and Alpha, who reported consistent difficulty with dually diagnosed clients in the workplace.

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**Residential Services:** Respondents reported that 74 dually diagnosed clients had received residential services through their agencies in 1984. Placements were as follows:

	<u>Number</u>
Group homes for the mentally retarded	56
Group homes for the mentally ill	5
Residential school	9
Family care	<u>4</u>
Total	74

This comprised 37% of the projected dually diagnosed population of 200. An analysis of BCMHS clients showed that 22% of open-case clients lived with their families. This would suggest that between 41% and 47% of dually diagnosed clients currently live in unsupervised settings, either alone or in rooming houses or SROs (single-room-occupancy situations).

**Inpatient Psychiatric Services:** Respondents reported 20 cases of dually diagnosed clients who had received inpatient psychiatric services during the previous year. Services were provided at the following locations:

	<u>Number</u>
Clark Valley Psychiatric Center (CVPC)	8*
CVPC crisis residence	2
Good Samaritan Hospital	<u>10</u>
Total	20

\*4 were subsequently transferred to DDSB.

In general, inpatient psychiatric services were provided as a result of crises. In other words, approximately 10% of dually diagnosed clients had experienced crises severe enough to warrant inpatient care during the previous year. This was a rate substantially higher than that of the mentally ill population who did not have the

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co-existence of mental retardation. Data from the agency respondents indicated that accessibility for inpatient psychiatric care for this population had been a problem. The inpatient psychiatric facilities had often been quite reluctant to admit these patients, and the referral process was exceptionally difficult.

### *Point-of-Service and Intersystems Referrals*

Approximately 81% of the reported dually diagnosed clients served in Bethany County during the previous year had received most of their services in programs funded under the State Bureau of Developmental Disabilities and Mental Retardation (BDDMR). The remaining 19% had been served most of the time under the auspices of the State Bureau of Mental Hygiene (BMH). Referrals between the disability categories followed a similar pattern, with 41 clients receiving referrals from BDDMR facilities to BMH locations and 6 receiving referrals in the opposite direction. In other words, 76.5% of Bethany County's dually diagnosed clients had not received referrals for either primary or auxiliary services at a location funded to deal with a disability different from that dealt with by their primary provider. Even allowing for an additional 45 clients who received intensive day programming at certified day or continuing treatment programs under either BMH or BDDMR auspices, the number of dually diagnosed clients who had not received treatment across disability lines totaled 108, or 54% of the projected population.

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### *Age Brackets*

The age breakdown of the dually diagnosed population was as follows:

	<u>Number</u>	<u>Percentage</u>
Under 18	9	4.5
18-24	36	18
25-44	111	55.5
45-64	42	21
65 and over	2	1

The survey results indicate nearly three-fourths of those identified were between 18 and 44 years of age. The large concentration of clients in the 18-to-24 and 25-to-44 age groups could not be completely accounted for by the fact that they were "baby boomers"; the numbers were too much out of proportion and suggested one or another of the following additional explanations:

- ♦ The rapid growth in this population was partially caused by the policy of deinstitutionalization, wherein mentally retarded or developmentally disabled individuals were forced to exist within the community, relying on programs insufficient to provide the intensive support these clients need to survive; or
- ♦ The normal increase in mental health problems in this age group—due to the stress of entry into the adult world and its concomitant demands vis-à-vis work and social relationships—was exacerbated by the individual's mental retardation or developmental disabilities, which made the client more vulnerable to stress.

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These two explanations were certainly not mutually exclusive, but the relative validity of either proposition would have a significant impact on needs projections, since the first posits a need for institutional change, and projections based on the second would be primarily affected by changes in the population. Without more precise age information and knowledge of the causes for the increase in this population, any program development therefore had to focus on improving services to this population while keeping a close eye on the number and age of new cases to avoid overexpanding services to this population.

### *Barriers to Effective Service Delivery*

Following, listed in order to total responses, were the barriers to effective service delivery in the area of dual diagnosis, as identified by Bethany County providers of service:

- ◆ Lack of day programming places (8)
- ◆ Lack of interagency coordination (8)
- ◆ Not enough community residences (6)
- ◆ Lack of knowledge about the problems of dual disability (6)
- ◆ Lack of knowledge (6)
- ◆ Funding restraints (5)
- ◆ Inappropriateness of current treatment models (5)
- ◆ Regulatory restraints (4)
- ◆ Not enough case management (4)
- ◆ Staffing restraints (3)

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- ♦ Inadequate tracking (2)
- ♦ Transportation problems (1)

### Generating Options

All the agencies that responded to the survey saw improved services to the dually diagnosed population as a critical need, and in citing respective responsibilities of state government, local government, and private nonprofit agencies, they generated policy options.

#### *State Government Responsibilities*

According to the respondents, the state government should:

- ♦ Allocate adequate funding for dual diagnosis.
- ♦ Foster communication among state and community agencies.
- ♦ Foster easier access to both systems (BMH and BDDMR).
- ♦ Provide special education teachers for tutoring and counseling techniques.
- ♦ Provide technical assistance and training.

#### *Local Government Responsibilities*

According to the respondents, the county government should:

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- ◆ Facilitate interagency cooperation.
- ◆ Sponsor training.
- ◆ Press for legislation to address the needs of the dually diagnosed.
- ◆ Foster communication between BMH and proprietary agencies to ensure adequate clinical services at sites.
- ◆ Provide funding for drug treatment for the dually diagnosed.

### *Private Agency Responsibilities*

According to the respondents, private agencies should:

- ◆ Provide programs.
- ◆ Provide transportation, recreation, and vocational education.
- ◆ Develop residential programs founded on skill acquisition as well as therapeutic intervention.

### *The Need for Shaping the Options*

Now, though the survey provided much useful concrete data about the nature of the problem, the options suggested by the respondents resembled the output of a brainstorming session: lots of exciting, but vague, ideas. "Fostering communication," "sponsoring training," and "providing programs" are admirable goals, good policy ideas—but a policy idea is not itself policy. A policy must be articulated in the real world, and must take account of that world. As *Tropman (1984)* tells us, a policy must be a sufficient guide to action.

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The policy manager must shape the options generated; he must review them, nurture and improve them, and reduce their number to a reasonable few. And he must prioritize them. He needs to work with the options so that something can be done about them. The proposals that are finally produced by generated options should be suitable in terms of their reasonableness, their administrative efficiency, and their facility for expedient action.

Clearly, these options needed a great deal of shaping. But, fortified with the data about the problem of dual diagnosis (as well as the data about the problem generally, as cited in chapter 3), the options were sufficient to spur the BCMHS director to establish a subunit devoted to the problem of dual diagnosis: the Mental Health/Mental Retardation (MH/MR) Service, under the supervision of the policy manager. Although establishing the MH/MR Service does not itself constitute the development of a much-needed policy, it at least addressed the concerns raised by survey respondents as local government responsibilities, and the policy manager could use the subunit to further shape the options into concrete policy proposals, as chapter 5 will explore.

### Summary

The survey data provided BCMHS and other service providers with statistical information, as well as perceptions about the service needs of the dually diagnosed. The results of the survey provided the data necessary for further program development for this population.

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The survey identified the problem and generated some policy options.

A needs assessment survey of this type needs to have the cooperation of all the major mental health and mental retardation agencies within a given locale. Although the majority of the dually diagnosed are identified within the mental retardation system, approximately 20% were identified by the mental health system. Perhaps even more important is obtaining the cooperation from both systems with respect to the survey as a means to elicit and promote cooperation between key players at the local level from the two service systems.

The results of the survey provided objective data confirming agency perceptions that consumer demand was high while effective service utilization was low. The data demonstrated that the majority of the clients identified as dually diagnosed did not receive mental health services. The data certainly argued the need to develop adequate community-based mental health services for this population.

The data from this study provided valuable information about the number of dually diagnosed persons in Bethany County and their service needs. Combined with the options generated by the respondents, the data spurred the director of BCMHS to establish the MH/MR Service, a subunit that could focus on the needs of the dually diagnosed.

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The next chapter examines the local-level environment and discusses how the policy manager, from his base in the MH/MR Service, was able to help further identify the problem and generate policy options. It discusses how he shaped options generated by a task force into concrete proposals that were ratified into a coherent local-level policy for the dually diagnosed.

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### The Policy Development Process: The Local Environment

The previous chapter examined a survey study identifying the local dually diagnosed population and its service needs and eliciting from the respondents some suggested options. The survey results demonstrated the need for adequate community-based mental health services for this population, and the suggested options—though vague and not fully developed—spurred the director of Bethany County Mental Hygiene Services (BCMHS) to establish the Mental Health/Mental Retardation (MH/MR) Service, a subunit that, under the supervision of the policy manager, could focus on the needs of the dually diagnosed. Under the auspices of MH/MR, the policy manager could further shape the options into concrete policy proposals.

This chapter discusses how the policy manager developed not only the survey options but also the options generated by a countywide task force into a fully articulated local policy. The chapter examines the policy manager's role in influencing group decisions. It discusses the distinctions in the local environment between policy and practice, policy and planning, and policy and administration. It describes the roles played by government and other community agencies in policy development. But first, the chapter describes some salient characteristics of Bethany County, illustrating the geosociopolitical context of the plight of the locally dually diagnosed.

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### The Local Environment

Bethany County Mental Hygiene Services (BCMHS) is located in Clarkston, whose population of 25,000 makes it the largest community in Bethany County. The county itself has a population of 158,000. The population is heterogeneous, with the descendents of Dutch, Irish, English, and Italian immigrants predominant. African Americans and Puerto Ricans make up a small minority. Almost all the residents are native-born. Politically, the area is very conservative and strongly Republican.

Economically, the county does not fare badly. A computer manufacturing and development firm maintains an assembly plant in Clarkston and is the single largest employer, with 4,500 employees. Other jobs are available in the service industry (especially resort hotels) and in light industry. The unemployment rate hovers around 4%.

Additionally, the deinstitutionalization of the mentally disabled that was mandated as a social policy in the late 1970s did not result, as it did in larger communities, in an influx of handicapped, homeless individuals, incapable of coping in this area. The existing agencies, both public and private, rose to the occasion by expanding their services to meet the challenge. As a result, most individuals released from the institutions for the mentally ill or the mentally retarded were placed in appropriate community agencies and did not become "bag" or "street" people.

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The lone exceptions were the dually diagnosed. Only in recent years have the needs of this population been recognized and the local-level network taken steps to address their needs.

### The Local-Level Network

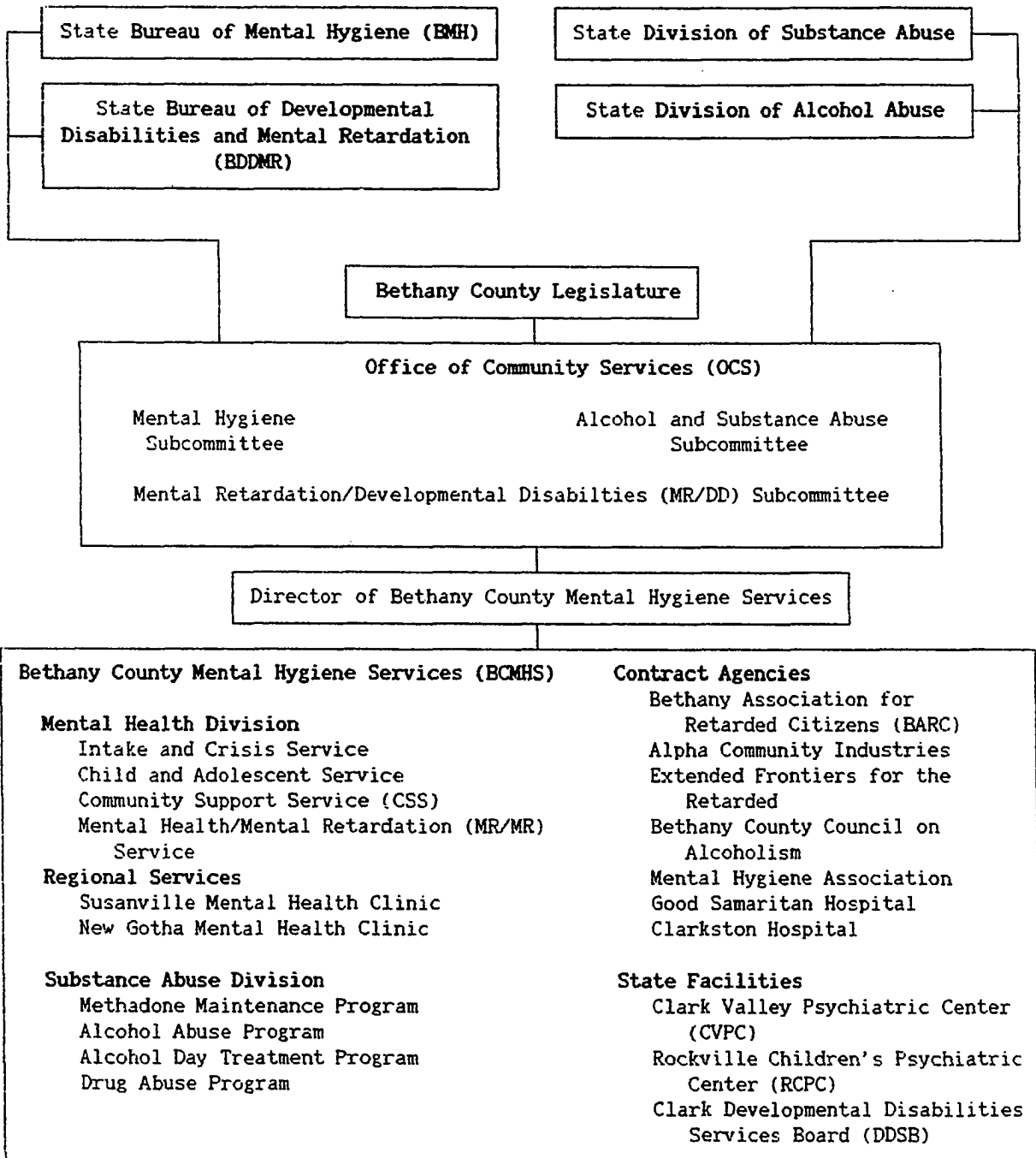
Public health agencies typically exist in an environment consisting of groups and organizations—i.e., legislative bodies, funding bodies, regulatory bodies, as well as other agencies (*Patti, 1982*). In this environment, BCMHS is in an interdependent relationship with various organizations for the exchange of resources, cooperation, and support. The interdependency phenomenon in organizations is reflected in the local-level network of the mental hygiene system. This system is profoundly complex, having many interrelated organizational components of an interdependent nature.

The simplest way to illustrate the complexity of the environment is through a diagram of the Bethany County network of mental hygiene services (see figure 2 on page 65). The top part of the diagram lists the Bureau of Mental Hygiene (BMH) and the Bureau of Developmental Disabilities and Mental Retardation (BDDMR), two state agencies that will be detailed in chapter 6.

The rest of figure 2 pertains to the local-level network and the relationships between the components. The following sections describe and analyze the various components of the local-level network that are relevant to planning and developing services for the dually diagnosed population in Bethany County.

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Figure 2. The Bethany County Network of Mental Hygiene Services.



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### *Office of Community Services (OCS)*

The current state law that authorizes and guides the activities of community service boards throughout the state had its beginnings in 1954, when the state legislature enacted the Community Mental Hygiene Law. This act preceded legislation on the national level to establish community mental health services. The law, which signaled the beginning of a shift in the state from hospital-based to community-based care, provided for community mental health boards in each county.

The Office of Community Services (OCS) of Bethany County is the policy-making group for BCMHS. By mandate of the Community Mental Hygiene Law, OCS is given responsibility of "overseeing mental health, mental retardation, developmental disabilities, and drug and alcohol abuse systems" within Bethany County. Specifically, this involves directing and administering a comprehensive planning process and developing and supervising a program of local services.

The activities of BCMHS are supervised by OCS, which consists of 15 county residents appointed by the county legislature. OCS supervises the delivery of services for mental health, mental retardation and developmental disabilities, and drug and alcohol abuse within the county; it also serves as the board of BCMHS. According to state law and regulations, OCS relies on three mandated subcommittees: the Mental Hygiene Subcommittee, the Mental Retardation/Developmental Disabilities (MR/DD) Subcommittee, and the Alcohol and Substance Abuse Subcommittee. These groups, each consisting of three board members and six nonboard members,

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appointed by the county legislature, make recommendations to OCS for action. The first two groups are further described in the following paragraphs. The Alcohol and Substance Abuse Subcommittee has no direct relevance to services for the dually diagnosed and has no further elaboration.

**Mental Hygiene Subcommittee:** The purpose of OCS's Mental Hygiene Subcommittee is to oversee the mental health service delivery system in Bethany County. It has oversight responsibility for the various necessary components, including residential, vocational, and mental health services.

The subcommittee has nine members. The meetings are also attended by related agencies' directors. There is a BCMHS administrator as well, who functions as a staff liaison to the subcommittee. The subcommittee's purpose is to assess needs and to make recommendations to OCS for needed policy revisions and program development initiatives.

One significant task of the subcommittee is to prepare the Local Governmental Plan, which is submitted to the State Bureau of Mental Hygiene (BMH) each year; the plan describes the goals for the forthcoming year. Though it is aware of the Mental Health/Mental Retardation Service within BCMHS, this subcommittee has not focused on the needs of the dually diagnosed population, because no one has acted as an advocate. None of the subcommittee members is a parent of a dually diagnosed individual, and the mental health agencies that are represented historically do not have this as their major point of interest.

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### **Mental Retardation/Developmental Disabilities (MR/DD)**

**Subcommittee:** The MR/DD Subcommittee consists of nine members. These individuals either are parents of developmentally disabled children or are otherwise knowledgeable in the field, as, for example, special education teachers. In addition to the committee members, representatives from all the MR/DD agencies in Bethany County attend the monthly meetings.

MR/DD is responsible for overseeing the service delivery system for the developmentally disabled population in Bethany County. This includes residential, vocational, respite, recreational, and—in more recent years—mental health services.

### ***Bethany County Mental Hygiene Services (BCMHS)***

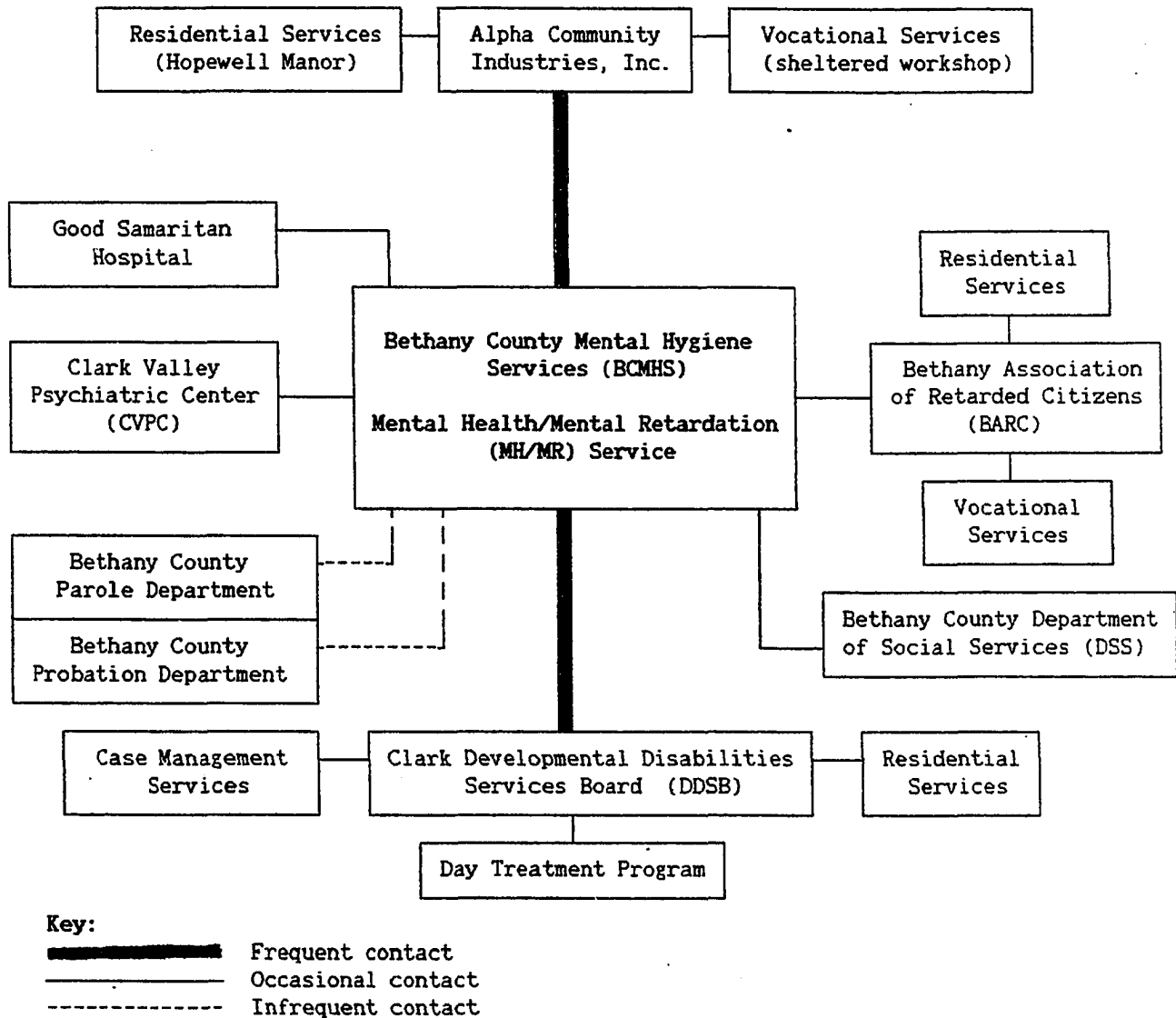
The day-to-day administration of mental health services within the county is the responsibility of BCMHS, under the oversight supervision of OCS. BCMHS consists of two divisions: the Mental Health Division and the Substance Abuse Division. The Mental Health Division is responsible for four service areas at the Clarkston Mental Health Clinic: Intake and Crisis Service, Child and Adolescent Services, Community Support Service (CSS), and the Mental Health/Mental Retardation (MH/MR) Service, the subunit that is the responsibility of the policy manager in this study. Additionally, the Mental Health Division operates two regional services in rural areas of the county: the Susanville Mental Health Clinic and the New Gotha Mental Health Clinic. The Substance Abuse Division is organized around four service subdivisions: the Methadone Maintenance

Program, the Alcohol Abuse Program, the Alcohol Day Treatment Program, and the Drug Abuse Program.

Figure 3 on page 70 shows the way the MH/MR unit interacts with other agencies in the county, agencies described in the following sections. It depicts the organizational set and interactional frequency at the community level.

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Figure 3. Interaction Frequency of the BCMHS MH/MR Service.



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### ***Alpha Community Industries, Inc.***

Alpha is a private, not-for-profit human service agency in Bethany County providing vocational and residential programs for mentally disabled persons. It is licensed by both the State Bureau of Mental Hygiene (BMH) and the State Bureau of Developmental Disabilities and Mental Retardation (BDDMR).

Alpha is a contract agency of BCMHS: BCMHS acts as a conduit through which Alpha receives its state funding monies. BCMHS also monitors Alpha's operations and budgets. Additionally, BCMHS provides financial resources to Alpha.

Of mutual interest between these two agencies are the clients served almost all the mentally ill clients served by Alpha are also clients of BCMHS.

Alpha accepts dually diagnosed persons into their vocational programs as long as each client's behavior is appropriate for a work environment. The programs are therefore a resource for only higher-functioning dually diagnosed clients.

### ***Clark Developmental Disabilities Services Board (DDSB)***

The Clark DDSB is one of 15 regional offices as part of the network of the state Bureau of Developmental Disabilities and Mental Retardation (BDDMR). The DDSB catchment area includes Bethany, Jones, and Whitman Counties. Each county has its own service delivery system.

Clark DDSB did not have a positive working relationship with BCMHS when the work of the policy manager described in this study

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began. As elsewhere, these two governmental agencies—one state (DDSB) and one county (BCMHS)—viewed their mission and services as very separate. Clark DDSB historically provides services for the developmentally disabled, and BCMHS provides services for the mentally ill. Service provision for the dually diagnosed had not been adequately dealt with by either agency.

### *Bethany Association for Retarded Citizens (BARC)*

BARC is a large human service agency, licensed by BDDMR, that provides a full spectrum of services for mentally retarded people. Several of the clients of the BCMHS MH/MR Service reside in a community-based residential program and/or attend a vocational program operated by BARC.

There is no agreement between BCMHS and BARC regarding services for dually diagnosed clients.

At MR/DD Subcommittee meetings, the assistant executive director of BARC has repeatedly said that BARC does not know how to deal with dually diagnosed clients and is therefore reluctant to accept them into their programs. Additionally, BARC tends to take a provincial approach to serving developmentally disabled individuals: Its executive director was vehemently opposed to the development of a centralized point of entry for services, which had been recommended by the MR/DD Subcommittee.

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### *Hospitals for Inpatient Psychiatric Care*

There are two inpatient psychiatric resources in the area: Good Samaritan Hospital and Clark Valley Psychiatric Center (CVPC). Good Samaritan is a private local hospital that has a 60-bed psychiatric unit. The State Community Mental Hygiene Law requires that referrals for psychiatric hospitalizations must first go to the local hospital. However, this hospital usually accepts only acute care cases (as opposed to those with chronic mental illness) and sometimes refuses to admit persons who carry a mental retardation diagnosis.

CVPC is a state-operated facility. It can be very difficult to get a mentally retarded person admitted there, too.

The lack of adequate inpatient psychiatric care in this community has been a major obstacle to providing services for dually diagnosed clients. The hospitals do not want to admit persons who have a diagnosis of mental retardation. Many of the admitting psychiatrists perceive maladaptive behavior as being associated only with the condition of mental retardation (see the discussion of diagnostic overshadowing in chapter 3), even though this maladaptive behavior could be associated with a co-existent psychopathology, even a clear DSM III-R diagnosis. The hospital's response is variable, depending on who the admitting psychiatrist is at that particular time. Some of the admitting psychiatrists, particularly at CVPC, state that they will not admit persons who have mental retardation. Sometimes, after such a refusal, the BCMHS director steps in to resolve the situation with the CVPV director.

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### ***Criminal Justice System***

Occasionally, the MH/MR subunit receives referrals from either the county probation department or the county parole department. Currently, for example, MH/MR has one client who is on parole and another who is serving a term on probation.

Although staff from MH/MR have had a good working relationship with the staff from the criminal justice system, there remains critical unresolved issues. *Starvis (1981, p. 3)* pointed out that:

The three phases of the criminal justice system—arrest, trial and punishment—all pose special problems for a person with a disability because the law presumes a person's competence to understand and exercise legal rights until it is shown that a person cannot do so by clear and convincing evidence.

### ***Bethany County Department of Social Services (DSS)***

DSS is the agency to which one applies for Medicaid, food stamps, and other entitlement programs. Additionally, this agency authorizes other programs, such as emergency grants and adult protective services. Since virtually all the 80 clients of the MH/MR Service are on Medicaid, contact with DSS by MH/MR staff occurs on an as-needed basis.

The relationship is good between MH/MR and DSS. The clients have already been determined and classified as mentally disabled, and DSS is not concerned whether the disability is mental retardation or mental illness. Therefore, there is no issue of territoriality with respect to primary versus secondary diagnosis, as there is with other agencies.

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### Policy Management in the Local-Level Network

American decision-making style is typically oriented toward crises. Fire fighting, of course, is more dramatic and exciting than fire prevention. *Tropman (1984)* points out that administrators often offer the excuse that their inability to plan is because they must deal with a current crisis, whereas the opposite is more likely the case: Their current crisis is the result of their inability to plan. Policy management deals with fire prevention, however, not on managing fires that are already blazing out of control.

To achieve this prevention, the policy manager must ensure the development of policy ideas long before they are needed. He ensures a supply of ideas and alternatives and then fosters them through ratification by an appropriate policy-making body. As regards a community policy, such as one focusing on the needs of the dually diagnosed in Bethany County, he must work within a network of overlapping organizations with conflicting interests and goals to develop a coherent policy that clearly benefits its focus population. Specifically, such a policy may lay the foundation for implementing procedures for community-based care: how discharges take place, what conditions are appropriate for intake, which agency is responsible for what.

The MH/MR Service is a subunit within the BCMHS policy arena; it deals with a complex and unstable environment. It must take into account the interests and goals of other agencies, and it must be proactive in its strategic response to those agencies—always with its

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focus on its own policy agenda: to improve the services for the dually diagnosed in Bethany County.

One clear advantage of a good working relationship with other groups in the local network is the exchange of ideas: The MH/MR subunit can determine how well a proposed policy idea meshes with current thinking by "bouncing it off" another group; this is a good way to check ideas with those who might be affected by them. Conversely, the other group can be a source of valuable alternative ideas. There is often an important advantage in involving the other group in the decision-making process.

### *What Policy Is Not*

As *Tropman (1984)* points out, successful policy management requires an awareness of the distinctions between policy and planning, policy and practice, and policy and administration.

**Policy versus Planning:** Far too often, planning takes place without a realistic policy backing it up. Policy is a general mission: It defines goals to be achieved, and it is formally ratified. In our local context, policy is ratified by the Bethany County Office of Community Services (OCS) and defines goals for providing mental health services to mentally retarded persons. Planning, on the other hand, is more specific; it accomplishes and implements goals defined by the policy.

**Policy versus Practice:** Policy is written and legally approved, whereas practice is what is actually done. For example, a policy in Bethany County could set forth how and by whom services for the

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dually diagnosed should be provided, whereas the practice at Clark Valley Psychiatric Center has been to reject clients with a diagnosis of mental retardation, even when these clients could undeniably be also diagnosed as mentally ill.

**Policy versus Administration:** This distinction is sometimes a bit trickier, since the policy manager is usually at the center of the policy-administration interface, and an administrator often acts with the authority of policy. An administrator interprets policy and "sets" it by committing an organization to a course of action. For example, the director of BCMHS is "on deck," in charge of day-to-day operations; he can interpret a policy mandated by OCS, can respond to OCS directives, and can present alternatives. On the other hand, the administrator is often so involved with day-to-day operations, that he cannot deal with nuances of policy development (finding it too theoretical and academic); he delegates the policy management role to a subordinate. For dual diagnosis issues, that subordinate is the director of the MH/MR subunit. Using MH/MR as a vehicle, the policy manager in this study has the time, unavailable to the director of BCMHS, to advocate for the interests of clients, to gather and to disseminate relevant information about their plight, and to attend committee meetings specifically authorized to generate policy options.

### *The Policy Process*

The policy manager moves ideas through a policy process, thoroughly described by *Tropman (1984)*. First, the problem to be

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addressed by the policy must be defined; here the policy manager must pull together a large number of ideas about the nature of the problem. It is in this problem phase that the policy manager has the greatest leverage: Defining the problem correctly causes all else to follow. In defining the problem, the policy manager must appreciate the problem's urgency and its importance; he needs to set some priorities.

The second phase of the policy process is option generation. Chapter 4 described some preliminary options generated by survey respondents. The policy manager reviewed these options, thinking of ways to elaborate them, consolidate them with other options from a task force, evaluate them in terms of their reasonableness and feasibility, and finally to reduce their number to the manageable few described later in this chapter. The next section describes how essential committees are in this phase, which is really a group effort. The policy manager himself, though, monitors the progress of this committee work, including the work on proposal drafts. He also obtains review and concurrence by other groups, both those who will need to authorize the policy and those who will be affected by it. He then adjusts the proposals based on the feedback he receives.

The third phase is ratification by a legitimate authority. Here the policy manager must steer the proposal through bureaucratic obstacles and work to make it palatable. In the example of this study, the authority is the Office of Community Services (OCS). The policy manager ensures, from the preceding phase of feedback gathering, that the views of key decision makers are taken into

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account in the final proposed recommendations. If necessary, the policy manager makes revisions until the ratifiers are satisfied.

During the fourth phase, the ratified policy is implemented with detailed plans and guidelines; here the policy maker helps administrators draft the guidelines. The policy manager might develop some sort of trial application. The implementing plans can be a group of supportive subpolicy regulations and definitions. This phase is the tactical follow-through.

The final phase is when the policy is realized in actual programs here the policy manager has an oversight role and remains alert to problems—problems that must be addressed in a new policy cycle. For the policy process is a cyclical, not a linear, process; it can be called a policy loop.

The policy manager primarily focuses on the movement of ideas through this process. He ensures that enough effort has been spent on problem definition, but not too much; that enough options have been proposed, but not too many. He enjoys a very powerful position because he can devote more time than others can on policy development, because he possesses vast amounts of information relevant to the policy, and because he is represented in many committees.

### *Working with Committees*

A major setting for policy management is the committee the policy manager must shepherd ideas through various stages and levels in the context of committees. As *Tropman (1984)* points out,

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committees made the policy manager's work easier: There are more people with whom to talk over issues. Committees are the arena for policy brainstorming and option generation, consensus building—and sometimes ratification.

The policy manager in this study is involved with many committees, which contributes to his powerful position. Not only is he in charge of the MH/MR subunit, but he represents BCMHS on several committees: He serves as a staffer on the MR/DD Subcommittee; he participates in mental retardation providers' meetings; he serves on a dispute resolution subcommittee; he represents BCMHS at the State Conference of Mental Hygiene Directors' Mental Retardation Committee; he participates in Clark DDSB's Community Residential Advisory Board; he participates in admission-discharge committees from several agencies in the local mental hygiene system.

With such wide involvement with such diverse groups of people, the policy manager is well situated to focus attention on and obtain support for his policy proposals. He can also better ensure that these proposals are brought to the appropriate policy setting.

### The Dual Diagnosis Task Force (DDTF)

Since 1987, the MR/DD Subcommittee has been very concerned about the plight of the dually diagnosed in Bethany County. In that year, its chairperson, who was also a member of OCS and a parent of a consumer of mental retardation services, joined the policy manager

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of this study to get OCS approval for the formation of the Dual Diagnosis Task Force (DDTF). The task force was composed of representatives from OCS, the MR/DD Subcommittee, and local organizations dealing with developmental disabilities. They were concerned with interagency policy; this was an opportunity for interface with professionals outside BCMHS to generate ideas leading to a policy encompassing proposals from both BCMHS and other agencies in the county. They could build a coalition advocating services for the dually diagnosed throughout the county.

The objectives of the task force were as follows:

1. To survey the needs of the dually diagnosed;
2. To view the existing programs and services for this population;
3. To identify the gaps; and
4. To generate options into a coherent proposal for a policy to address these deficiencies in the service system.

### *Problem Identification*

Over a series of meetings between February and September 1988, the task force studied the problem of provision of services to the dually diagnosed in Bethany County, with the object of making a series of recommendations for required action. The task force carefully considered recent needs studies done by both BCMHS and reviewed relevant literature provided by the policy manager (see chapter 3). They also reviewed the 1985 survey described in chapter

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4, outlining the needs of the county's dually diagnosed and identifying gaps in services. Input was also solicited from both providers and consumers of services to this population.

In the background section of their report, the task force identified the problems that would be addressed by an effective policy for delivering services to the dually diagnosed. It noted that not only were the dually diagnosed obliged to struggle through their lives with the two heavy burdens of their diagnoses, they also had few services open to them. In fact, many services were discriminating against them. Even supposedly accessible services were burdened with long waiting lists, involved considerable commuting, or both. Service providers typically had training and expertise in either mental health or mental retardation—but not both. In short, there were not enough available services, and there was too little training among professionals.

### *Option Generation*

Working on the task force, the policy manager helped to discover and generate relevant ideas dealing with the identified problems. He also helped to prioritize the options; he shaped them, reviewed them again and again, and trimmed them. He wrote and rewrote numerous drafts until six concrete proposals emerged:

- ♦ Support for an interagency cooperative agreement between the two state agencies (BMH and BDDMR) and its guidelines for services for the dually diagnosed.

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- ♦ The provision of services for the dually diagnosed by any existing program appropriate to their needs, and the provision of specialized services whenever needs cannot be met by existing programs. Decisions on services required should be made on a case-by-case basis.
  
- ♦ A complete continuum from more restrictive to less restrictive of specialized community services, both day and residential, for any dually diagnosed clients who require them.
  
- ♦ The development of the dually diagnosed psychiatric inpatient treatment programs, a community-based crisis residence, supervised apartments, and the expansion of day treatment and sheltered workshop programs.
  
- ♦ The development of cooperative joint training of mental health and mental retardation professionals and paraprofessionals. Since dually diagnosed clients may benefit from both mental health and mental retardation treatment models of care, a cross-fertilization of ideas, a sharing of skills, and a consistency of approach on a systemwide basis should be encouraged.
  
- ♦ Further study, possibly by another task force, to identify dually diagnosed school-age children, in order to increase school board awareness and to implement available testing.

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These proposals were far more concrete than the brainstorming options generated by the survey respondents of chapter 4. Some of those earlier options are not part of the task force recommendations, but quite a few are, in a much more developed form. For example, the "sponsor training" of chapter 4 is now the next-to-the-last item in the preceding list.

Now it was the task of the policy manager to steer the proposals through the bureaucratic obstacles and work to make the proposals palatable to the ratifying OCS board. Not all the proposals were ratified, as the following sections will reveal; but for those that were, the policy manager helped to implement them with detailed plans and guidelines, and is now helping to monitor actual programs. The following sections describe the further policy development of the task force proposals.

### Cooperation between the State Agencies

The task force recommended support for local interagency agreements between the mental health and mental retardation systems based on a 1988 Cooperative Agreement, developed at the state level and described in chapter 6. This agreement, endorsed by the respective commissioners of BMH and BDDMR, laid the framework and guidelines for local levels of agreement to articulate a service plan to address the mental health needs of the dually diagnosed.

The task force urged the director of BCMHS to implement a local-level plan to coordinate activities between the mental health and

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mental retardation systems in order to address the mental health needs of dually diagnosed persons. The director assigned this task to the policy manager, who then chaired a committee composed of representatives from the two systems. The committee drafted a local-level document articulating the conditions of accessibility to outpatient and inpatient mental health services. Over a period of eight months, the policy manager with his committee developed guidelines to enable dually diagnosed persons to be admitted into the mental health system if their diagnosis warranted.

One result of these guidelines, once implemented, was that inpatient psychiatric facilities at Clark Valley Psychiatric Center (CVPC) and Good Samaritan Hospital were mandated to assess the psychopathology of mentally retarded persons referred to them by BCMHS. Another result was that now a formal procedure was in place to allow referrals of mentally retarded individuals to BCMHS because of their behavioral and emotional problems to assess whether they had a psychopathology and needed treatment.

### Specialized Treatment on a Case-by-Case Basis

The task force recognized that some individuals require specialized services in one or more areas—such as residential programs, day programs, psychiatric services, and case management. They recognized that some clients may require such services for only a limited time before they could be integrated into existing programs. Therefore, the task force recommended that clients who

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need specialized services not available in existing programs be provided them, and that the decisions for such services be made on a case-by-case basis.

OCS approved this proposal, and BCMHS made agreements with various contract agencies and state facilities to implement the needed specialized programs. Sometimes disputes have arisen between BCMHS and Clark DDSB or between BCMHS and CVPC, as described in the next section, but generally, the programs are working well.

In the planning stage of the policy process, the policy manager had to solve a problem of duplication of waiting lists for services among service providers. Some clients were on waiting lists from more than one agency. The policy manager established a "clearinghouse" database, using each client's social security number, of vacancies and referrals to residential and vocational programs. Now providers and the county government (BCMHS) could plan services based on real numbers.

### A Continuum of Services

The task force recommended that there be a complete continuum of specialized community services—both day and residential—for any dually diagnosed clients who required them. Recognizing the potential for progress and growth in clients, the task force recommended that the continuum extend from more restrictive (inpatient psychiatric care, a dual diagnosis day treatment program) to less restrictive (supervised apartments, competitive employment).

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OCS approved this proposal. Over the last few years, the OCS Local Government Plan, embracing the language proposed by the policy manager, has addressed the needs of the dually diagnosed persons in Bethany County. Through the Local Governmental Plan, a number of services have emerged. A day treatment program has been established by the Developmental Disabilities Office of Bethany County, which is a local branch of BDDMR. The Local Government Plan documents the need for a continuum of services for dually diagnosed persons in the county. Additionally, OCS, as well as agency providers, have been planning services for this population and will implement a continuum of services as funding permits.

Three other developments resulted from or were furthered by this task force resolution: Hopewell Manor Community Residence, the DDSB day treatment program, and a better working relationship between BCMHS and Bethany Association for Retarded Citizens (BARC). These developments are described in the following sections.

### *Hopewell Manor Community Residence*

In 1988, Alpha Community Industries developed Hopewell Manor, a specialized community residence for dually diagnosed persons. It was designed to serve 12 young adults with primary psychiatric disorders and secondary diagnoses of mild mental retardation or borderline intellectual functioning. It is one of the three community residences for the dually diagnosed that is licensed by BMH.

The target population is characterized as having severe behavioral problems, often exhibiting aggressive behavior. The staff, who had

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little or no training, had a difficult time dealing with these situations. When a violent episode occurred, the staff initially responded in a negative or punitive fashion, which only reinforced the clients' maladaptive behaviors. As a result of the intense problems at Hopewell Manor, Alpha asked BCMHS to provide mental health services for the Hopewell Manor clients and consultation to its staff. BCMHS now provides weekly therapy sessions at Hopewell. The decision as to the types and kinds and frequency of mental health services was left to the discretion of the policy manager.

The policy manager also sits on Hopewell's admissions/discharge committee. All clients referred to Hopewell Manor are screened by the MH/MR subunit; MH/MR can assess if there is a DSM III-R psychiatric diagnosis. It is important to differentiate a behavioral problem versus the existence of psychopathology. This issue is important not only for treatment implications, but also to help ensure client accessibility into other mental health programs.

Hopewell Manor has helped fill a residential void in this community. As a community-based residential facility, it serves a challenging population that requires a great deal of mental health support and intervention.

### *The DDSB Day Treatment Program*

Clark DDSB decided to develop a dual diagnosis day treatment program because of the closure of a similar program run by the county. It was clear that there was a void in the community, and DDSB's deputy director for community services came forward and

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agreed that her agency would operate this needed day program. As a temporary measure, DDSB originally rented three small rooms from Alpha Industries as a facility for a pilot program. DDSB has since purchased a building for the provision of dual diagnosis day treatment and began operation of the 35-slot program in 1992.

The policy manager lobbied for and obtained a letter of agreement with state officials, and now BCMHS, through the MH/MR subunit, provides mental health services to the clients in DDSB's dually diagnosed day program. MH/MR provides individual counseling, group social skills training, and medication treatment services for the clients who attend the program. A social worker from the MH/MR team works on site at the program on a part-time basis. The clients are brought to the BCMHS clinic to see the psychiatrist on a monthly basis—or more often, if needed—because the program does not have its own psychiatrist on staff.

The program has been of value to the clients who use it because the persons in the program are a high-risk group for psychiatric hospitalization. These clients had not been able to be maintained in other community-based programs. They had been either terminated from vocational programs or not permitted entrance to either vocational services or other day programs due to their severe behavioral problems.

But the DDSB program does not fill all the county's needs. For example, the director of Alpha Industries had been expecting many of the Hopewell clients to attend the DDSB pilot program in the three small rooms DDSB was renting from Alpha. In fact, over the course

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of the last few years, several clients from Hopewell had been denied access into the project operated by DDSB; they did not meet the eligibility requirement as set forth by BDDMR, because their I.Q.'s were above 69. After the closure of the county program, many other clients had not found appropriate day program services, since they, too, had not been able to meet the state's eligibility criteria.

Nonetheless, the relationship between BCMHS and Clark DDSB has significantly improved over the last few years, due mostly to MH/MR's work with the DDSB clients. Also, monthly meetings are held between representatives from BCMHS and DDSB to discuss systemic issues and/or client-related concerns that are of interest to both agencies. The policy manager represents BCMHS at these meetings. When DDSB obtains a new client, the policy manager determines what mental health services may be appropriate.

### *The BCMHS-BARC Working Relationship*

Although there is no formal agreement between BCMHS and Bethany Association for Retarded Citizens (BARC) regarding services for dually diagnosed clients, the policy manager has developed informal agreements pursuant to the task force recommendation. Now line staff from both organizations have developed positive relationships, and there is contact on a regular basis regarding the treatment and care of mutual clients. A social worker from the MH/MR subunit provides individual therapy on site at the BARC sheltered workshop. A room is provided for this purpose.

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### Inpatient Treatment, Crisis Residence, Programs

The task force recommended that psychiatric inpatient treatment programs and a community-based crisis residence be established for the dually diagnosed. In line with their preceding recommendation, the task force recommended programs on the less-restrictive end of the continuum as well: supervised apartments, and the expansion of day treatment and sheltered workshops programs.

The BCMHS director assigned the policy manager to work with other agencies to develop a plan for accessibility to inpatient psychiatric services, pursuant to the BMH-BDDMR 1988 Joint Agency Cooperative Agreement (described in chapter 6). The policy manager worked with Clark Valley Psychiatric Center (CVPC), Good Samaritan Hospital, and Clark DDSB. The policy manager chaired the working committee.

This committee met approximately eight times, and in 1990, drafted a letter of agreement that was endorsed by high-level officials from BCMHS and the other agencies. The agreement articulates the detailed procedures for accessing mental health outpatient and inpatient services for mentally retarded persons who may need such services. The following is an example of the detailed procedures outlined in the agreement:

- ♦ A dually diagnosed client who, because of a mental illness episode, needed emergency service during work hours would be initially assessed by the BCMHS Intake and Crisis Service. If the episode

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occurred in the evening or on the weekend, Good Samaritan Hospital would perform the assessment.

- ◆ If the initial assessment determined that no further psychiatric services were needed, the client would be released to the custody of the residential program or other appropriate safe living environment (defined explicitly in the agreement).
- ◆ If further outpatient services were needed, the client would be referred to the MH/MR Service.
- ◆ If inpatient psychiatric hospitalization was needed, the client would be admitted to Good Samaritan Hospital.
  - The CVPC mobile outreach team would determine with Good Samaritan Hospital if the client warranted referral to CVPC.
  - BCMHS would arbitrate disputes over such referrals.
  - A treatment plan would be developed within 72 hours. BCMHS would assist with plans for clients known to it.

The letter of agreement improved the access of the dually diagnosed to inpatient mental health services at CVPC, a problem discussed earlier in this chapter.

The need for a free-standing crisis residence is mentioned in the local-level agreement. There was an acknowledgment by the parties of the agreement that there is a need for a crisis residence, but funding at the state level has not been available.

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### Joint Training

The task force recommended cooperative joint training of mental health and mental retardation professionals and paraprofessionals. Such training, the task force claimed, would encourage a cross-fertilization of ideas, the sharing of skills, and a consistency of approach on a systemwide basis.

Cross-fertilization is taking place between the MH/MR unit and contract agencies as well. The staff of MH/MR consults every other week with the staff of Alpha Industries' Hopewell House to share ideas.

Also, the MH/MR subunit and the DDSB Dual Diagnosis Day Program have developed a shared staffing arrangement. DDSB has provided a full-time case manager who works in the MH/MR subunit at BCMHS. Although he is actually employed by Clark DDSB, the supervision and assignments emanate from MH/MR under the direction of the policy manager. Conversely, an M.S.W.-level social worker from MH/MR provides individual counseling and group therapy on a part-time basis at the DDSB day program. This arrangement fosters interagency collaboration through an exchange of knowledge and skills.

The MR/DD Subcommittee suggested that an interagency conference be developed to address the needs of the dually diagnosed population. The policy manager chaired a conference planning committee, which included representatives from all the major mental health and mental retardation agencies. In September 1989, this

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committee sponsored a one-day conference that was attended by over 200 professionals. The conference was not only highly successful in training professionals and paraprofessionals in the care and treatment of the dually diagnosed, but it also facilitated interagency cooperation.

In 1992 the director of BCMHS requested that the two subcommittees MR/DD and Mental Hygiene collaborate on examining the issues related to the dually diagnosed population. The policy manager recommended that another full-day conference co-sponsored by all the mental health and mental retardation agencies in Bethany County. This recommendation was passed by the subcommittees, and the policy manager was assigned to chair a committee, composed of representatives from both systems, to organize the conference to be held in 1993. The fact that other agencies have committed time and money toward planning the conference ensures their seriousness about dealing with the dually diagnosed population. Without the vigorous involvement of both the mental health and the mental retardation systems, the problems of this population cannot be adequately addressed.

### Identification of School-Aged Dually Diagnosed

The task force recommended further study to identify dually diagnosed school-age children, in order to increase school board awareness and to implement available testing. Rather than another task force, however, a large forum was arranged to discuss this

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issue. It was attended by public school administrators and special education teachers, agencies serving children, and officials from the mental health and mental retardation agencies. Two salient conclusions were reached:

- ◆ There are developmentally disabled children in the school system, and some of these children also have concomitant mental health problems.
- ◆ Those mentally retarded children who have mental health problems were already receiving the appropriate services to meet their needs.

### Summary

This chapter described how the policy manager helped to develop a coherent local-level policy for delivering services to the dually diagnosed, especially through his work with the Dual Diagnosis Task Force and his shepherding their recommendations into ratified and implemented policy in Bethany County.

The policy manager was a powerful influence because he could devote far more time than others could to policy development, because he had access to a wealth of information relevant to the policy, and because he was active on many committees. His fostering of a network of information and contacts had gradually placed him in a very influential position. By establishing and nurturing

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relationships with other key players and, after diligent committee work, by earning their trust, he found himself steering policy toward the dually diagnosed in Bethany County.

The next chapter explores the statewide policy environment and describes how the policy manager lobbies to influence state policy toward the dually diagnosed.

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### Policy Lobbying: The State Environment

The dually diagnosed population presents unique service challenges to both state and local levels of government. Although the context of this study of policy development for the dually diagnosed is at a county level, the mental retardation and mental health services involved are all licensed and regulated at the state level. This chapter describes the state-level mental hygiene policy environment, in particular how it relates to the dually diagnosed. The chapter focuses on the two agencies responsible for statewide policy toward the mentally retarded and the mentally ill; describes policy initiatives by these agencies, examines a cooperative agreement between them, and analyzes the effectiveness of that agreement.

The chapter suggests ways that a policy manager might deal with the intricacies of the agencies' interorganizational relationship and act as lobbyist to influence social policy—acknowledging, however, that such lobbying has met with little success so far in this particular state policy environment. Lobbying efforts on the part of the policy manager must occur over a long period of time. Influencing the state-level environment is a struggle and a long-term activity.

Beginning in the mid-1970s and persisting to the present has been a nationwide movement to separate the mental retardation service system from the mental health system (*Swanson and Menolascino, 1983*). In the state under study, before 1978, the

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State Department of Mental Hygiene regulated and licensed programs for both the mentally retarded and the mentally ill populations; services for these two populations were delivered under one policy and administrative umbrella. But in that year, the Department of Mental Hygiene was disbanded, and two separate departments were established: the Bureau of Developmental Disabilities and Mental Retardation (BDDMR), which plans, coordinates, and regulates services for the state's mentally retarded and others with developmental disabilities; and the Bureau of Mental Hygiene (BMH), which does the same for the mentally ill. Each agency has its own commissioner, regulations, and procedures.

Separating the services is an example of statewide policy. A successful policy, as *Tropman (1984, p. 114)* asserts, needs a "strategic perspective" that systematically accounts for the policy context and external environment, and also accounts for how that context and environment change. Unfortunately, the policy of separating services was unclear about how the two agencies should work with each other: Only when a crisis developed in the delivery of services to a population neither agency was serving was an agreement hastily patched together.

### Bureau of Developmental Disabilities and Mental Retardation

The Bureau of Developmental Disabilities and Mental Retardation (BDDMR) operates within the state government in accordance with mandates derived from the state constitution and the State Mental

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Hygiene Law of 1954. That law requires that BDDMR plan for meeting the overall service needs of all developmentally disabled persons whether they reside in state-operated facilities, live at home, or reside in programs operated by the private sector.

Eligibility for BDDMR services is determined by definition, according to the State Mental Hygiene Law. *Developmental disability* is defined as a disability of a person that:

- ◆ Is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, or autism;
- ◆ Is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment to general intellectual functioning of adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such persons;
- ◆ Originates before the person attains 18 years of age;
- ◆ Has continued or can be expected to continue indefinitely; or
- ◆ Constitutes a substantial handicap to such person's ability to function normally in society.

In order to be eligible for a service licensed by BDDMR (i.e., day treatment, sheltered workshop, institutionalization), the person must meet the eligibility criteria as determined by the foregoing definition. If a person has a psychiatric disability co-existent with a developmental disability, eligibility for admission to a service licensed by BDDMR is at best difficult and, more often, impossible. The

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problem is the *primary diagnosis*: On the one hand, sometimes it is too easy for a licensed service to evade responsibility for adequately treating a client's maladaptive behavior by claiming that the client's disability is primarily mental retardation, not mental illness. In other words, as an effect of the diagnostic overshadowing discussed in chapter 3, the behavior is seen as just one more function of the mental retardation. On the other hand, sometimes the licensed service evades responsibility for treating a client at all by claiming that the disability is primarily mental illness and should be dealt with by the mental health system.

In a recent three-year plan, BDDMR acknowledged the systemic problems of providing services to the dually diagnosed:

- ♦ **Eligibility diagnosis:** This is the lack of a clear distinction between the primary and the secondary diagnosis, just mentioned.
- ♦ **Funding:** Under the Mental Hygiene Law, BDDMR can authorize payments for services only to local provider agencies that it certifies and licenses. Also, the conditions of reimbursement require that the primary diagnosis corresponds to the "primary diagnostic interest" of the certifying agency.
- ♦ **Coordination:** The dually diagnosed often need services from a variety of providers. BDDMR-licensed providers are focused on behavioral approaches, whereas historically the mental health system has been interested in the medical (system reduction) approach (see chapter 3). Although in recent years the mental health system has taken a broader approach toward the diagnosis

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and treatment of mental illness, a fully integrated, holistic approach has not yet been realized. Typically there is little interaction between these groups of providers, so that the expertise of one system is unavailable to clients who are being served by the other system.

But even with this acknowledgment of the problem, BDDMR made no policy initiatives to deal with it, not in that three-year plan nor in the plan that followed it. Again, without a clearly articulated, ratified, and monitored policy, even obvious, acknowledged problems remain unsolved.

### Bureau of Mental Hygiene

The Bureau of Mental Hygiene (BMH) is a large and complex organization responsible for the public mental health system in the state. BMH plans, regulates, provides, and finances mental health services in this system. These services include inpatient hospitalization and a wide variety of outpatient and residential programs operated by the state and local government facilities, voluntary organizations, or proprietary agencies. The system is administered on the state level by the BMH Central Office, on regional levels by the BMH regional offices (of which there are five), and on the county level by local governmental units.

In recent years, BMH has significantly expanded support for persons with the most severe mental illness. Patients discharged to

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home and community now have an opportunity for continuing treatment and support. BMH considers its mission to provide emergency access, treatment, and rehabilitation within a comprehensive, coordinated system to anyone who needs them. Its current five-year plan refers to the human dignity of each client and resolves to foster an environment that offers hope to client and family.

In 1978, as part of its systems approach, BMH developed the Community Support Service (CSS) program, whereby the severely mentally ill are connected to needed services in the community setting. Local government agencies, such as Bethany County Mental Hygiene Services (BCMHS), administer these CSS programs at the local level. Communities are encouraged to assess the totality of needed services and supports available for clients who suffer from persistent and serious mental illness. The services and supports include not only mental health programs but also other health care, housing, and employment. The statewide CSS program assumes 100% of net operating costs for local agencies providing services. However, though most severely mentally ill people now reside in communities (usually with their families), the vast proportion of state and federal resources continue to support inpatient treatment in institutions.

BMH, like BDDMR, acknowledges the need to serve the dually diagnosed. But also like BDDMR, BMH has no comprehensive policy in place to ensure that the dually diagnosed are actually served. Its current five-year plan refers to the need to serve dually diagnosed clients by combining the resources of both BMH and BDDMR, but it

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restricts such services to clients who have an I.Q. of 50 or greater. What about the mentally ill client who has an I.Q. below 50? The literature clearly shows that the full range of psychopathology exists at all levels of mental retardation—mild, moderate, severe, and profound (*Dosen et al., 1990; Menolascino and McCann, 1983; Szymanski and Tanquay, 1980*).

The BMH five-year plan's acknowledgment of the need of the dually diagnosed, even of those whose mental retardation is mild (i.e., those whose I.Q. is greater than 50), can hardly be considered as a policy, since it doesn't clearly identify the problem, which is the first step of the policy process. It asserts that no estimate for the size of this dually diagnosed population is available. Yet the prevalence of dual diagnosis has been researched in a number of studies, which show that emotional disorders are much more common among the mentally retarded than among persons of normal intelligence (see "Prevalence Studies" on page 31). One possible interpretation of BMH's "ignorance" of any estimate is a reluctance to accept a considerably larger caseload.

In any event, the BMH five-year plan, though acknowledging the existence of the dually diagnosed as a special population, makes no mention of any policy initiatives or program development with regard to their care and treatment. The dually diagnosed are a special population who need service from both service systems, but BMH is not willing to take the next logical step to develop a statewide policy to deal with their service needs, even by just coordinating whatever local service initiatives that already exist.

## Multidisabled Discrete Units (MDUs)

BDDMR and BMH were a single agency before 1978, and they still operate by mandates from the same state government. Thus, even with the chronic barriers between the two service systems of mental retardation and mental health, there is some cooperation and coordination between the two agencies. We have seen in the previous section how each agency recognized that the dually diagnosed need services (without making arrangements to ensure that the services were actually delivered). This section and the next examine ways that the two agencies deal with each other. This section discusses how dually diagnosed clients have been transferred from facilities licensed by BMH to facilities licensed by BDDMR. The next section discusses a cooperative agreement between the agencies for dealing with the dually diagnosed and analyzes the effectiveness of that agreement.

Over the last several years, BDDMR and BMH agreed to transfer retarded clients who were in BMH state psychiatric hospitals and place them in specialized *multidisabled discrete units (MDUs)* operated by facilities licensed by BDDMR. (The agencies use the term *multidisabled* for the dually diagnosed.) These units are large and are institutionally based. For example, Clark Developmental Disabilities Services Board (DDSB) has a 100-bed MDU.

Funding considerations are at least partly behind the transfer. In a BMH facility, costs for hospitalization are solely borne out of state taxes. But placement in a BDDMR facility is funded by Medicaid: Half the burden is paid with federal rather than state dollars.

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Another possible reason for the transfer is litigation in the form of court action suits against psychiatric hospitals for not providing appropriate services for the dually diagnosed. Specifically, three central state psychiatric centers have been named in allegations for failure to provide appropriate care and treatment in a lawsuit filed in federal district court by advocates on behalf of dually diagnosed patients who reside in these facilities.

We have already seen how BMH does not want to take any responsibility for mentally ill persons who have an I.Q. under 50. Perhaps this is another reason for the transfer of dually diagnosed clients to, and often initial placement of these clients in, MDUs operated by BDDMR. With the MDUs as an option, BMH does not need to provide mental health treatment services, day program services, and residential services for community-based mentally ill persons who have I.Q.'s below 50.

A BDDMR official has acknowledged that this was only "transinstitutionalization" and that there are no plans at this time to move these individuals into community-based settings. This official did at least acknowledge that there *should* be movement into the community.

In an evaluation of one of these MDUs, *Galligan (1990, p. 357)* points out the need to develop appropriate community-based service models for dually diagnosed clients:

Basic research on the etiology and manifestation of mental illness in people with mental retardation must continue while appropriate service models for dually diagnosed individuals are developed. Otherwise, these individuals will most likely remain in institutions or return from "failed" community placements.

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The lack of residential alternatives and community supports were significant obstacles to the further growth of the dually diagnosed clients in the MDU under study.

There are some important questions about MDUs yet to be answered. Is the care and treatment really better in MDUs as opposed to psychiatric hospitals operated by BMH? Will dually diagnosed clients ever have an opportunity to successfully return to their communities? Unless BDDMR, BMH, and other state regulatory and funding agencies change their policies, these clients will continue to enter an institution initially or to return to an institution after moving to the community (*Fidura, Lindsey, and Walker, 1987*).

### The 1988 Cooperative Agreement

We have seen how BDDMR in its three-year plan and BMH in its five-year plan fail to take policy initiatives to deal with the acknowledged dually diagnosed population. Nonetheless, perhaps in response to litigation, there has in recent years been a positive policy initiative toward cooperation between these two state systems on behalf of the dually diagnosed. Significantly, however, these initiatives are not referred to in the two agencies' own operating plans.

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The 1988 Joint Agency Cooperative Agreement for the Multidisabled is the third joint effort in the agencies' attempts to improve service delivery for the dually diagnosed who reside in community settings. The focus of the agreement is to build upon the relationships that already exist between state and local providers. The agreement attempts to provide an opportunity for programs to work together more effectively; that is, it provides a framework for *local agreements* and continued dialog among *local providers* for the provision of services to the dually diagnosed.

Specifically, the agreement requires BDDMR and BMH to work with county governments to develop county service plans for the dually diagnosed. These plans must include:

- ♦ Short-term crisis residential capacity
- ♦ Joint screening and consultation
- ♦ Case management to link clients with appropriate service providers
- ♦ A process for accessing inpatient psychiatric care for short-term stabilization
- ♦ Procedures for returning a patient to his or her original residential setting following hospitalization
- ♦ Dispute resolution procedures for resolving agency differences concerning responsibility for patients and compliance with the terms of the 1988 Cooperative Agreement

In the agreement, BDDMR and BMH apportion the dually diagnosed according to degree of severity of mental retardation:

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- ♦ Those whose I.Q. is below 50 (those with moderate, severe, and profound retardation) are to receive services coordinated by BDDMR alone;
- ♦ Those whose I.Q. is between 50 and 69 (the mildly retarded) are to receive services coordinated by either BDDMR or BMH, depending on the presenting primary diagnosis; and
- ♦ Those whose I.Q. is 70 or above (the borderline retarded) are to receive services coordinated by BMH alone.

In addition, BMH agreed to be responsible for treating and stabilizing any dually diagnosed individual, regardless of which agency had the primary responsibility for the individual. That is, even if a client were in a residence sponsored by BDDMR, BMH would ensure immediate admission to BMH-sponsored placement if the client had a serious episode of overt mental illness.

The agreement recognized that local psychiatric centers, Developmental Disabilities Services Boards (DDSBs), and county and municipal governmental units throughout the state had each developed a unique service system based on the particular characteristics of its catchment area. The agreement called for BDDMR- and BMH-licensed facilities to work with local governmental units to develop a cooperative agreement for crisis intervention in each area. As we saw in chapter 5, the Dual Diagnosis Task Force of Bethany County proposed local support for the statewide agreement.

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### *Statewide Evaluation of the Agreement*

The 1988 Joint Agency Cooperative Agreement for the Multidisabled was the third agreement between BDDMR and BMH for dealing with the dually diagnosed; the two previous agreements—1978 and 1983—were never fully implemented, however. The 1988 agreement included a requirement for a comprehensive evaluation of its effectiveness a year after its being ratified, with a proviso for revision if necessary. In November 1989, the two agencies mailed a jointly developed questionnaire to each BDDMR Developmental Disabilities Services Board (DDSB), BMH regional office, and psychiatric center in the state. Participants were instructed to work cooperatively with the local county liaisons responsible for development of local service plans, in completing the survey. Figure 4 on page 110 shows the results of the survey.

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Figure 4. The Results of Evaluating the 1988 Statewide Agreement.

<u>Summary of Results</u>		
Total # of completed agreements statewide:		55
Total # outstanding		7
Total # required:		62
Total # of counties represented by survey:		45
Completed by agency auspice:		
	BDDMR	25
	BMH	34
	County	20
Total # of clients served by Cooperative Agreement through local service plans:		263
Types of services provided:		
	Crisis Intervention	74
	Screening/evaluation	109
	Case management	39
	Residential services	22
	Other	10
	Inpatient psychiatric care:	98
	— # returned to original placement	49
	— # admitted to long-term psychiatric care	9
	— No destination given	40
Total # of disputes	Local level	26
	Regional level	2
# of dispute cases that could not be resolved:		2
# of dispute resolutions that can be attributable to the completion of the local service plan:		20

### *Assessing the Agreement's Effectiveness*

The 1988 Cooperative Agreement between BDDMR and BMH was certainly a positive policy initiative, meaning that it represented the first step of policy development: identifying the problem. First, it acknowledged the existence of the dually diagnosed. Second, it recognized that the dually diagnosed are an underserved population; otherwise, there would have been no need to construct such an

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agreement. Third, it advanced the idea that the two distinct service systems work in a cooperative fashion. But, as the response to the evaluation survey indicates, the effectiveness of this policy initiative in actually addressing the service needs of the dually diagnosed has been limited.

The agreement has been effective in assisting localities to resolve disputes over which agency had responsibility for a mildly retarded client or over compliance with the agreement. Out of 28 disputes in the state, only 2 were reported unresolved. In both cases, the agencies actually reached agreement, but appropriate resources for adequate resolution were lacking. Most respondents, in fact—after acknowledging that the Cooperative Agreement had assisted the local service system to improve the process of service planning for community-based dually diagnosed clients—lamented that no plan, no matter what its quality, can ultimately succeed if the appropriate resources or services are not available.

The “missing” services most commonly cited by respondents were residential options and improved access to psychiatric services for persons who have a primary diagnosis of mental retardation and whose behavioral problems require psychiatric intervention. In chapter 4, we examined the results of a local survey taken in Bethany County in 1985, where 54% of dually diagnosed clients did not receive referrals from a BDDMR facility to a BMH facility or vice versa. Apparently, this lack of cross-referrals is still a problem throughout the state.

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The agreement cited the need for procedural arrangements for short-term inpatient care for stabilization for dually diagnosed clients, regardless of which agency had primary responsibility for those clients. Evaluation respondents indicated that crisis intervention and screening services were utilized, but they mentioned no ongoing treatment services. The inference is that crisis screening and evaluation is available in some areas, but ongoing outpatient treatment services are unavailable.

The agreement called for BDDMR and BMH to work with counties to develop county service plans for the dually diagnosed. There was no mandate, however, that the local service plans *must* be developed or implemented. Moreover, the agreement did not set forth a procedure to follow up or ensure that these plans would, in fact, be developed. Finally, the agreement did not establish incentives for local communities to develop such plans or otherwise initiate appropriate services. As of January 1991, there were still many local-level plans that had not been developed or submitted.

Even though the agreement represented an important policy initiative in the state, it has failed to resolve the problem of service delivery, which it so ably identified, because it was not comprehensive in its scope. A policy *initiative* is not the fully articulated policy that is needed if the state's dually diagnosed are going to be adequately served. The fact that neither BDDMR nor BMH adequately addresses the problem of dual diagnosis in its own operating plan, even to the extent of referring to the 1988 agreement, demonstrates that the agreement does not constitute a

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fully developed policy. A true policy is not merely a statement of philosophy of care and treatment; it is a ratified idea that can be a guide to action through careful guidance and management. *Tropman (1984, p. 103)* attributes:

much of the faulty and flawed administration of human service organizations . . . to deficiencies of policy guidance and management. . . . [M]any of the so-called crises, real enough when they occur, give evidence through their repeated occurrence, one might say, of the fact that they could have been prevented. . . . Policy management . . . is simply a method, a set of ideas and approaches, to shape and structure the development of events as they unfold.

Nonetheless, the 1988 Joint Agency Cooperative Agreement laid the groundwork for Bethany County and other counties in the state to capitalize on it. Though only a few of the state's 62 counties have done this, the groundwork is available for other policy managers.

### The Policy Manager as Lobbyist

Policy management must deal with the most difficult, complex, and troublesome areas of organizational life. *Rittel and Webber (1973)* refer to such problems as "wicked problems": They cannot be formulated definitively, there is no immediate solution, their solutions are either good or bad (as opposed to true or false), and they do not go away on their own accord.

Providing services to the dually diagnosed poses just such a wicked problem, especially since it cannot be solved completely at the local level but requires coordination between various local and state agencies. The policy manager of an organization, as *Tropman (1984)*

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notes, should have an extramural focus within a network of similar organizations; he must act as a lobbyist to influence decision-making groups at the county, state, regional, and national levels. As a lobbyist, he can seek to shape or structure the decisions of the larger policy-making collective; he can seek to make state policies less restrictive and more forward-looking and humane.

A national organization is an ideal vehicle for influencing social policy. It can mobilize people, using the strength of groups (the local affiliates of the organization). It can launch studies, promulgate rational standards, and generate publicity. Most important, it can lobby.

To deal with the intricacies of the interorganizational snarls that inhibit a coordinated policy, the policy manager worked through lobbying organizations, including the National Association for the Dually Diagnosed (NADD), whose purpose is to focus national attention on the policy, program, and clinical issues concerning the dually diagnosed. NADD provided a platform for the policy manager to lobby government agencies beyond the local-level environment in Bethany County—in particular, to lobby BDDMR and BMH.

In 1990, at a conference co-sponsored by NADD, the policy manager interviewed the official of BDDMR who is considered the dual diagnosis expert at the agency. This official was quite aware of the various systemic (diagnostic, funding, and coordinating) issues concerning the dually diagnosed, but he noted that BDDMR was not planning to develop specific community-based services for that population. He insisted that services should emanate from the local

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level, using existing resources.

At the same conference, the policy manager interviewed the BDDMR's director of multidisabled discrete units (MDUs). This director agreed with the other BDDMR official about the need for communities to have appropriate services for dually diagnosed clients; otherwise, these clients would have to remain in the MDUs. He was very interested in hearing about the Bethany County model of service delivery.

In October 1991, the executive director of NADD, at the instigation of the policy manager, wrote to the state commissioner of BMH, expressing NADD's concern regarding accessibility of community-based mental health centers for the dually diagnosed. The commissioner replied that though BMH continues to provide services to all persons no matter their primary diagnosis when acute symptoms of mental illness occur, such a full range of services as community-based mental health centers is the responsibility of BDDMR. The policy manager then contacted the senior attorney for the State Mental Hygiene Legal Services, who informed him that responsibility for the development of a full range of community-based services for the dually diagnosed is actually shared by *both* BMH and BDDMR.

The attorney made it clear that the commissioners of both agencies have statutory powers and duties to eliminate gaps in services to the dually diagnosed to the extent that no persons should be denied treatment and services because he or she suffers from more than one disability. The State Mental Hygiene Law further

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mandates the commissioners to develop procedures for the regulation of programs to offer care and treatment.

Criteria for eligibility for services is used as a systemic barrier to deny services for individuals who have a dual diagnosis. Systemic problems need not exist, because the State Mental Hygiene Law authorizes the commissioners to ensure that the dually diagnosed are not denied services.

BDDMR expresses interest in providing service for the dually diagnosed population, but regulations such as eligibility criteria serve as structural barriers. BMH does not want to take responsibility for treatment that state law clearly assigns to both it and BDDMR.

It is reasonable to assume that both state commissioners are not interested in providing necessary services to assist a person with a dual diagnosis in order to maximize their potential. The difficulties with lack of resources and turf problems make it difficult for BDDMR and BMH to bridge the gaps that exist between the two service systems. Perhaps further successful class action suits will act as a catalyst to force BDDMR and BMH to develop policies that will enable community-based services to provide appropriate care and treatment services for the dually diagnosed.

### Summary

This chapter provided information about the policy, or lack thereof, of BDDMR and BMH toward the dually diagnosed population. These two state agencies are aware of the existence of the dually

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diagnosed population as well as the structural problems associated with service delivery. However, there has been no real effort at the state level to provide adequate community-based services for this population. The state prefers the local level to address the critical issues, without providing the local level with adequate supports, resources, or incentives. The dearth of a true state-level policy is apparent.

The Cooperative Agreement of 1988, however, is an important step forward in the right direction, a major policy initiative. It is a blueprint for the long-term solution, as Bethany County's implementation of it illustrates (see chapter 5). It laid the groundwork for any of the state's counties to capitalize on it, as Bethany County has. Suggestions for policy managers in these other counties are provided in chapter 7.

This chapter also described a few of the policy manager's attempts to lobby the state agencies. Lobbying to influence the state-level environment is a continuing struggle, and it takes time. Professional organizations can be a useful vehicle for these lobbying efforts.

The next chapter describes the values, skills, knowledge, and resources a policy manager needs in developing a coherent dual diagnosis policy. It provides strategies and recommendations that a policy manager in another organization can use to develop local-level services for the dually diagnosed.

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# A Local-Level Policy Management Model for Replication

The dually diagnosed comprise a complex population whose needs are often poorly identified and who are often referred from one agency to another. Service planners and the professional community are increasingly confronted with the problem of meeting the needs of this population in the community environment. The specific challenge confronting the mental hygiene system is to develop effective service delivery that is responsive to the mental health needs of dually diagnosed individuals.

The purpose of this chapter is to serve as a guide to a policy manager who is planning a responsive mental health service system for the local dually diagnosed population. The chapter illustrates how policy management can help with interorganizational planning and service development at the local level. It is intended to aid others in planning and developing such services through the utilization of existing community mental health centers (CMHCs).

The most effective vehicle for addressing the multifaceted problems associated with the dually diagnosed population is the local level of service planning and delivery. The policy manager at the local level need not wait for national or state initiatives. With the help of the policy manager, the existing CMHC can take the lead in developing a local responsive care network for the dually diagnosed (*Landsberg, Fletcher, and Maxwell, 1987*).

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This chapter describes how a policy manager can utilize the four pillars of effective policy management—values, skills, knowledge, and resources—to bring this about. The policy manager probably arrives at the policy process with his or her values, but the other pillars take time to evolve; they don't simply happen. This is a long-term process; the policy manager must demonstrate skills and knowledge through painstaking work. Such work is also necessary for the policy manager to marshal the required resources. Without such work, developing an effective policy toward the dually diagnosed is next to impossible, and this underserved population will continue to fall through the cracks.

### Values

Any organization, or network of organizations, such as the local CMHC and the organizations it works with, share a common culture: norms, beliefs, values, symbols, rituals, slogans, and myths. The values embedded in an organization's culture legitimize the organization's goals and the power within the processes needed to attain these goals (*Parsons, 1970*). To be effective, the policy manager must be sensitive to the organization's values and perspectives, and manipulate them to further the development of policy. As *Tropman (1984, p. 237)* states:

The role of the policy manager, existing as it does in the realm of ideas and the relationship of ideas to the solution of agency, community, and national problems, is centrally affected by the values system—his or her own set of values

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and those dominant within the agency, the community, and society.

According to *Tropman (1984, p. 110)*, the context of policy is "the broad set of values and ideas within which policy agendas are drawn."

Tropman describes the competing set of values that bedevil social policy. Policy ideas are linked to values, but values are diverse: There are core values central to American culture, a local variation of the prevailing values as regards the client population, the values of the staff, and the values of the policy ratifiers. Values typically come in pairs. For example, the values of independence (self-reliance, privacy, competition) are contrasted with those of interdependence (family connectedness, socialization, cooperation). The same people can hold multiple, and conflicting, sets of values; different situations will give rise to different values. In American society, reciprocity is stressed; therefore, handicapped clients, who receive more than they give, are pitied, scorned, barely tolerated—sometimes even by the staff who are supposed to serve them.

The policy manager should have a somewhat open mind about value pairs: Raising issues of one value automatically raises issues of its opposite. The policy manager should strive to find a balance between them. Rather than rallying against a conflicting value, the policy manager needs to work with it, to develop techniques to accommodate it, in order to develop a social policy that can be widely accepted.

On the other hand, the effective policy manager needs to bring to the work of policy development a fundamental set of personally held

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values, values stemming from his or her strong *interest* in the plight of the dually diagnosed, values that can be summarized by what *Menolascino (1989)* refers to as *professional posture*—a gentleness, a hopefulness, a warmth, a belief that individuals with mental retardation can grow and develop. Professional posture should underlie the performance of the CMHC, and the policy manager should take every opportunity to promote it, by including it in every policy preamble and otherwise reinforcing it.

### Skills

*Shapira (1971, p. 65)* suggests that the person responsible for policy should have

the risk-taking qualities, the daring and the initiative usually associated with the entrepreneur. . . . The task obviously also requires a great deal of intellectual agility where the ability to think in an imaginative way and to cope with novel situations must be coupled with great rigor of analytic and systematic thought.

According to *Tropman (1984, p. 115)*, policy management needs a “strategic perspective” that takes into account the policy context (values) and the external environment; such a perspective requires some considerable skill. The second pillar of the policy manager’s effectiveness is his or her skills—in particular, information development skills, political and organizational skills, and interpersonal and conflict management skills.

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### ***Information Development Skills***

Information development, according to *Tropman (1984, p. 123)*, is the "pulling together information from extant sources, crystallizing, and then compiling it, anticipating the kinds of information and evidence that might be needed and then trying to bring them together." The policy manager should spark ideas, compile them into a useful set, and synthesize "many facets of a solution into one with the potential for success." After several points of view have been expressed, the policy manager needs to offer a view that encapsulates the salient kernel of the problem. A cursory study of the agenda before a meeting, a little thinking, and the taking of premeeting notes are activities associated with this skill.

The policy manager in this study instigated relevant ideas concerning the issues of Bethany County's dually diagnosed, prioritized them, and provided synopses for the Dually Diagnosed Task Force. He wrote drafts generated from committee activity and synthesized the principal points for ratifying officials.

### ***Political and Organizational Skills***

A policy manager needs political and organizational skills, too. He or she should continually act as an advocate for the dually diagnosed, always putting their interest foremost. Of course, as *Tropman (1984, p. 127)* points out, advocacy promotes the interest of the organization as well: "Arguing for the support of the disadvantaged can also mean support for the agency as an instrument for serving the disadvantaged." In Bethany County, service for the dually

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diagnosed was not a high priority before the Office of Community Services (OSC) approved the recommendations of the Dual Diagnosis Task Force, largely as a result of the advocacy (through information dissemination) of the policy manager in this study. As a result, OCS increased its support for the policy manager's subunit: MH/MR Services.

The policy manager must be adept at working with organizations, and should probably be a participant in as many committees as possible that have responsibility for the dually diagnosed. In committee work, the policy manager sets up the links and provides the constancy needed for policy ratification. The policy manager in this study was not only in charge of the MH/MR subunit; he represented Bethany County Mental Health Services (BCMHS) on the county's MR/DD Subcommittee, the mental retardation providers' meetings, the MRDD subcommittee of the State Conference of Mental Hygiene Directors, a committee for resolving disputes among mental health and mental retardation providers, and several other local committees. Diverse committees are inevitably comprised of people with various levels of understanding and commitment to the issues concerning the dually diagnosed; in his role as a constant voice, the policy manager continually focused committee work toward his policy objectives. With his involvement in so many committees in this complex network of human service providers, the policy manager could ensure that ideas he had helped develop were brought forward to the appropriate policy setting for ratification and implementation.

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The policy manager should be a coalition builder, bringing together different interest groups, even "strange bedfellows," for the purpose of pursuing a particular goal. In Bethany County, the Dual Diagnosis Task Force provided an opportunity for BCMHS personnel to interface with other organizations in the county: Some of the coalition's proposals emanated from the mental health system, others from the mental retardation system. The policy manager ensured that the two systems spoke with a single voice.

The policy manager, according to *Tropman (1984)*, should be a mobilizer, too: assembling people and money to further political ends. The policy manager in our study, for example, organized a conference of professionals, co-sponsored by all the mental health and mental retardation agencies in Bethany County, to address the training needs of staff dealing with the dually diagnosed.

The policy manager should be a lobbyist, continually seeking to influence decision-making groups. Chapter 6 described some of the policy manager's lobbying at the state level, but lobbying takes place locally as well. For example, a recent state regulation that agencies could spend no more than 5 percent of client service time in off-site visits threatened to change the basic nature of the MH/MR Service: Dually diagnosed clients typically do not commute to the agency clinic for services; agency staff visit them at their contract-agency residential units.. But the policy manager lobbied to get the contract agencies designated as satellite clinics.

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### ***Interpersonal and Conflict Management Skills***

The policy manager should be able to work with people, not just as a group but as individuals. According to *Tropman (1984)*, the policy manager should be an enabler (encouraging and supporting ideas springing from others), a motivator of the group, a challenger of myths, and especially a manager of conflict. The policy manager must try to resolve the inevitable conflicts within and among organizations and, after reviewing all the positives and negatives of opposing approaches, provide solutions.

Conflict arises when the press of time limits the availability of options. Therefore, effective, proactive policy management that anticipates crises and devises strategies to deal with them before they strike is the best way to prevent conflict. The policy manager needs to take a proactive stance and identify the issues that currently are *not* being dealt with and put them on the policy agenda.

Committees are an important arena of policy formulation, and the policy manager should be able to run a good meeting. This requires a formalized agenda, with completely but concisely phrased and appropriate items, distributed to attendees well beforehand. After all, most policy decisions are actually made outside of the committee room; the committee typically function as a forum for brainstorming, option generation, and consensus building. But even if the committee has the authority for ratification, its effectiveness is diminished if the items it must deal with are too complex. During the committee's discussion of difficult items, the effective policy manager understands how to work with people, accounting for their personal dynamics.

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After several points of view are expressed, the policy manager can offer a view that captures the essence of the problem, that synthesizes the views already presented, and that leads inevitably to a conclusion of the committee spoken as though with a single voice. Such a view is not difficult to reach if the policy manager has adequately prepared for the meeting with a carefully crafted agenda.

But sometimes a well-run meeting is not enough to prevent or defuse conflict. The policy manager may need to step back from the daily round of contentions in order to get some perspective on the structure of the chronic conflicts. Sometimes just recognizing the types and dimensions of conflict helps to relieve the pressures. The policy manager needs to be self-aware: Is there a conflict of interest or of role? Are the solutions he offers encountering the staff's resistance because those solutions are somehow threatening? Perhaps the best strategy here is to enable others, to let the ideas spring out of the mouths of others in the committee.

Sometimes the policy manager must be a challenger, diplomatically but penetratingly questioning an adversary to the proposed policy. Maybe he needs to play the devil's advocate, and this is likely to generate some interpersonal stress.

At other times, when no one else has any idea how to resolve a conflict reminiscent of the arguments of children, the policy manager can simply provide a solution. The solution must be offered from a philosophical or ideological point of view; rarely should the policy manager advance an option as a personal view. For example, in the local mental retardation providers' meetings, a conflict arose over

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whether the dually diagnosed should receive integrated or specialized services. The policy manager brought out the positives and negatives of each approach and then elicited the solution: The two approaches were not mutually exclusive. Some dually diagnosed individuals warranted specialized services, but not all of them and not for an indefinite period of time.

Most of the time, the policy manager deals with conflict as a negotiator or mediator, trying to build consensus. He brings the disputing parties together to see if they can resolve disputes. For example, as we saw in chapter 5, the policy manager in this study brought disputing agencies from the mental health and mental retardation systems together and succeeded in getting a letter of agreement among them for the provision of inpatient mental health treatment for dually diagnosed clients who needed it.

Although the policy manager's ultimate aim is interagency collaboration at the service level, he or she must first secure the commitment of top administrators to the concept. Of course, top management of both the mental health and the mental retardation systems first must be convinced of the value of providing services for the dually diagnosed, which only interagency collaboration can make possible. The impetus rests with the director of the community mental health center, since that organization has the responsibility, under a State Mental Hygiene Law, for coordination and oversight of services in a county.

The policy manager must convince administrators of the concept that there are mentally retarded people who need and can benefit

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from mental health services. The policy manager should promote the principle that all individuals have a right to receive appropriate services according to individual needs; he or she should tirelessly promote the principle until top administrators embrace it. The policy manager should assert the value that the local community has a responsibility to meet the mental health needs of this population.

### Knowledge

According to *Tropman (1984)*, a policy manager works with ideas, ascertaining which are appropriate to a particular problem, digging up the relevant information, and synthesizing information from different sources. The third pillar of the policy manager's effectiveness is his or her knowledge: knowledge grounded in the relevant research and organized according to a suitable paradigm, or theory.

Of course, the policy manager should also know both the mental health system and the mental retardation system. The policy manager in this study, for example, worked solely in the mental retardation system from 1977 to 1979, whereas he has worked primarily within the mental health system since 1979. Knowing both systems well—the mental retardation system with its developmental model and normalization principle, and the mental health system with its medical model—including the key players and resources of each, the policy manager can effectively bridge between them to develop a policy for the dually diagnosed.

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### ***Research Literature***

Policy embodies assumptions about cause and effect; it proposes solutions derived from such assumptions. The policy manager needs relevant policy assumptions, taking into account the latest scientific research literature, including critical conflicts in that literature. An effective policy manager must study the relevant research dealing with the issues of dual diagnosis. Chapter 3 reviews this research literature in detail, concentrating on the following three topics:

- ♦ **Prevalence studies.** The literature reflects that persons who have mental retardation are twice as likely to develop a mental illness than are those in the society at large.
- ♦ **Structural barriers and service gaps.** There is a serious lack of resources for the dually diagnosed, the high prevalence of dual diagnosis is related to social policy issues. The literature reveals serious service delivery problems at the local and state levels.
- ♦ **Training issues.** The literature demonstrates that professionals are ill equipped due to their lack of training to provide effective care and treatment for the dually diagnosed.

The policy ideas supported by the research literature include:

1. Mentally retarded persons can develop psychiatric disorders.
2. Dually diagnosed persons can clinically benefit from community-based mental health services.
3. It is possible to transcend institutional structural barriers.

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4. Training and supervision can correct negative attitudes among professionals.
5. Community mental health centers can deliver mental health services to the dually diagnosed.

### *Open Systems Theory*

After assembling ideas from the research literature, the policy manager needs a suitable paradigm, or theory, to prioritize them and to put them into perspective. The paradigm needs to take into account the complexity and instability of the dual diagnosis policy environment. A community mental health center (CMHC) must consider the interests and goals of other agencies, and it must be proactive in its strategic and tactical responses to these agencies within both the mental health and the mental retardation systems—always with its focus on its own policy agenda: to improve the services for the local dually diagnosed. The two systems have each concentrated on services in their respective environments, but the dually diagnosed need the services of both systems. A policy manager needs to promote intersystem collaboration and cooperation at the local level.

This section discusses a theoretical and conceptual framework for analyzing the organizational structure underlying policy management: *open systems theory*. The open systems theory provides a lens through which we can focus upon interorganizational relations. According to this perspective, organizations are engaged in

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interchanges with the environment that are essential to the system's viability (*Buckley, 1967*).

Open systems theory focuses less on the formal structure of an organization—its administrative units, its managerial reporting scheme—than on the actual behavior of people within the organization interacting with its environment (*Ulrich and Wieland, 1980*). We cannot separate an organization's structure from its functioning (*Kahn, 1974*). In fact, since an organization is more a structuring of events than of physical parts (*Allport, 1962*), its structure is its functioning (*Katz and Kahn, 1978*).

Open systems theory is a theoretical underpinning for effective policy management. After all, according to *Shapira (1971, p. 65)*, a policy manager is "primarily concerned with putting theoretical insights to use in system decisions." Open systems theory sheds light upon the structure of an organization; it is a paradigm for understanding how a system functions at an automatic and unconscious level. Policy management, in contrast, acts at a conscious and purposeful level to manipulate the system's automatic behavior toward deliberate policy objectives; it is a deliberate and conscious articulation about how a system *should* work. Policy management provides guidance to the interplay of forces described by open systems theory. To manipulate the system successfully, however, the policy manager needs an understanding of a system's dynamic behavior, an understanding provided by open systems theory.

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**The System and Its Environment.** A *system* is a complex adaptive organization of interacting components or parts related to one another in a more or less stable way at any given moment (*Buckley, 1967*). In order to grow and develop, the system is *open*; that is, it is engaged in a continual interchange with its environment. It receives input from the environment, and it converts the input into output to the environment. The system must achieve certain goals with this production of output, goals that the environment considers valuable, goals that a policy mission statement aims to achieve. A system is constantly influencing, and being influenced by, the environment. What occurs internally within the system is "largely determined by external forces—ideas, values, people, and social conditions—that inevitably penetrate the system's boundaries" (*Patti, 1982, p. 145*). The policy manager must ensure that these influences foster the development of policy.

The environment surrounds the system. It includes the overlapping agencies that provide parallel or complementary services. The system exchanges resources, cooperation, support, and even clients with other agencies and is interdependent with them (*Patti, 1982*). Often, the other agencies have divergent, even conflicting, expectations about the system's proper function: Who gets served, how, and to what ends? As we saw in chapter 5, policy management ensures that these questions are adequately and effectively addressed.

The environment also includes economic conditions, the current state of scientific and technological knowledge, laws, politics, and

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demographics. The successful policy manager must be aware of these conditions as they have a bearing on policy. The general environment is roughly equivalent to society as a whole, and a mental health organization must continually deal with society's ambivalence toward it, especially when a suffering economy necessitates cutbacks in funding (*Patti, 1982*). According to *Tropman (1984)*, society may claim to want to provide necessary and useful services to segments of the population, but at the same time may suspect that the services are unnecessary or that they are likely to be abused. The environment faced by human service organizations is

more turbulent, the values which support them are less secure than is the case with other organizations. They can be subject to rapid swirls and eddies of support, something that . . . stresses the need for a savings account of ideas and approaches that can be called upon in time of need.

(*Tropman, 1984, p. 23*)

A policy manager can help an organization here by anticipating problems arising out of this ambivalence.

According to *Tropman (1984)*, environmental changes can occur rapidly, dramatically and adversely affecting a human service organization whose personnel aren't on the lookout for them. On the other hand, an organization with a clearly articulated policy can influence the environment to the benefit of both organization and environment. An interorganizational coordinating committee, such as the Dual Diagnosis Task Force described in chapter 5, represents an attempt on the part of an organization to influence, if not control, the external environment—and certainly to the benefit of the dually diagnosed.

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**Conversion of Inputs to Outputs.** Any system involves a flow and transformation of energy: an intake of energy from the environment (*input*), a transformation of the energy through itself (*throughput*), and a discharge of the energy back to the environment (*output*) (*Katz and Kahn, 1971*). Input, throughput, and output form a recurrent cycle.

The pressures at input are quite different from the evaluations at output—especially in the human service organization. For example, society's purported values are for changing people (the desired output), but often the resources in funding and personnel (the actual input) are adequate only for processing people. This is a disjunction with tremendous relevance to policy management. Those who control crucial input may have unrealistic expectations of output and may seek simplistic formulas to tie input and output together. The policy manager, according to *Tropman (1984)*, aware of the entire system and its relationship to the environment, can be in a position to interpret output problems to input controllers and vice versa. A definitive policy can provide articulation between external systems to control input to better influence the desired output—for example, to secure agreements on who is seen by which agency for how long and under what conditions, who gets discharged, when the discharge should happen, and where the client should be discharged to. Chapters 5 and 6 describe a few such policy agreements.

**Open Systems Theory and Interagency Collaboration.** The open systems framework moves our focus from the intrinsic facets of discrete component parts to the interaction and relatedness of the

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components. It lets us appreciate “the entire range of elements that bear on social problems, including the social units involved, their interrelationships, and the implications of change in one as it affects all” (*Compton and Galaway, 1979, p. 82*). It gives us analytical tools to accommodate knowledge from all the disciplines that social work must draw from, to view massive, disparate data with perspective, and to organize that data into a holistic synthesis (*Janchill, 1969*). Open systems theory frees social scientists from linear approaches with cause-and-effect explanations, and instead offers them an interactive focus with which to analyze the effects of one system or another.

The policy manager can apply the open systems perspective to promote what *Woodward and Pederson (1991)* refer to as interagency collaboration in developing a responsive service network that spans two service delivery systems. Coordination not only is a means for increasing the quality of public service delivery systems, but also improves the efficiency of government itself (*Whetten, 1982*). This is especially true of coordination in a time of shrinking resources. The importance and value of interagency collaboration in addressing the needs of the dually diagnosed reflects the experience of Bethany County Mental Hygiene Services (BCMHS) and is illustrated by the following concepts, adapted from *Lynch and Harrison (1986)*:

- ♦ The needs of individuals with dual diagnosis are complex.
- ♦ No single agency or discipline has all the knowledge, skills and resources.

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- ♦ Interagency collaboration reduces duplication, fills gaps, and makes the system more understandable and accessible.
- ♦ Collaborative services, when properly coordinated by a policy manager, can be well planned, cost-effective, and high-quality.
- ♦ Collaborative services are more likely to be truly interdisciplinary.
- ♦ Communication among systems is enhanced.
- ♦ Interagency collaboration promotes trust and respect, as well as effective services.
- ♦ Only interagency collaboration can effectively promote the community integration, independence, and productivity of dually diagnosed individuals.

### Resources

The fourth and final pillar of the policy manager's effectiveness is resources—including information, feedback, position, and money.

#### *Information*

An effective policy manager must possess more than the background knowledge from research literature organized by a theoretical paradigm. He or she needs current information germane and immediately applicable to the local context—including facts about the local policy environment, an assessment of local service needs, and issues appropriate for staff training.

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**Facts about the Local Policy Environment.** The demand for greater interorganizational coordination, an application of the open systems theory, stems not only from the frustration of clients, but also from the frustration of local human service administrators. Community public mental health agencies are charged with the responsibility of administering services and programs that are often highly fragmented. *Levine (1974, p. 374)* discusses the "political pluralism" among service providers in America, a hodgepodge of agencies. Service providers may often have incompatible jurisdictional boundaries, unclear patterns of hierarchical authority, conflicting eligibility criteria, and contradictory program standards—making it difficult to develop a comprehensive service system for people who have a dual diagnosis.

*Woodward and Peterson (1991, p. 9)* pointed out that "knowing the value and challenge of interagency collaboration assists local groups in assessing their community's ability to replicate this model." In building up an information resource, a policy manager needs to answer the following questions about the local policy environment, adapted from Woodward and Peterson:

- ♦ How does the local data compare with published research literature?
- ♦ Is there a lead agency like the BCMHS to secure the support of the other major agencies serving the population? Such an agency can lend legitimacy to the activities of the policy manager. The policy manager in this study had access to OCS and the MR/DD

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Subcommittee as a result of being attached to BCMHS.

- ◆ Which are the key agencies that must recognize the critical service needs of the dually diagnosed? Essentially all service agencies in the mental health and mental retardation systems need to realize that the dually diagnosed need services from both systems (for example, medication and crisis intervention from the mental health system, and vocational and residential services from the mental retardation system).
- ◆ How ready are the key planners to focus their attention on these service needs? The policy manager, after gauging the interest of the key planners, should instigate such focus as needed.
- ◆ What policy ideas are available for development into a policy toward the dually diagnosed? Here are a couple:
  - A dually diagnosed client can clinically benefit from community-based mental health services.
  - A client can be adequately served by both the mental health and the mental retardation systems if administrators can overcome bureaucratic barriers and their sense of territoriality.
- ◆ What existing services are available as part of the service delivery system? The policy manager needs to introduce some fluidity into the rules for service delivery.
- ◆ What new services should be developed to complement existing service delivery? The policy manager may need to form a task force like the Dual Diagnosis Task Force described in chapter 5.
- ◆ Which key players in the various community settings can lobby for

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these programs? The policy manager should consider parents of consumers, consumer groups, and advocacy organizations.

- ◆ How can the policy manager increase the awareness, interest in, and advocacy for the dually diagnosed? The policy manager should seize every opportunity and lobby in every arena. The policy manager of this study promotes services to the dually diagnosed in each of the several committees he is a member of, at regional and national conferences, and in the relevant college courses he teaches.
- ◆ What data is available on the dually diagnosed in the community? The policy manager can conduct a needs assessment survey, which is described in the following paragraphs.

**Assessment of Local Service Needs.** In the context of interagency agreement, the policy manager should organize a local task force to analyze the service needs and issues related to the dually diagnosed and to recommend specific actions toward ameliorating unmet needs. The task force must be sanctioned by a policy-making body in order for it to have legitimacy; the Bethany County model was sanctioned by OCS, which is responsible for planning and coordinating mental hygiene services in the county. The task force should be composed of representatives from the administrative and clinical levels of both the mental retardation and the mental health systems. The task force should also include consumer/family representation.

A task force provides the policy manager with a staging area for formal fact finding and for planning services to meet the needs of the

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dually diagnosed. The task force model provides an arena where agencies and individuals from mental retardation and mental health disabilities service systems can together explore relevant issues, share ideas, and exchange information regarding each other's capacity for serving this population. A task force can stimulate working relations between local mental health and mental retardation agencies on an ongoing basis that can help to coordinate services for this population. The Bethany County Dual Diagnosis Task Force was successful in developing a heightened awareness of dual diagnosis among local service planners, providers, government officials, and consumer advocates.

The task force can develop a survey tool to assess the size and scope of the problems at the local level. The needs assessment survey (a model of which is described in chapter 4) should probe for the following:

- ♦ **Identification of the dually diagnosed in the community.** The survey can include language that assists in identifying the dually diagnosed population, those who have symptoms of both mental retardation and mental illness. The survey should include clear and unified definitions of mental retardation and mental illness; for that see chapter 1. One screening instrument to assess psychopathology in mentally retarded persons is the Reiss Screen for Maladaptive Behavior, developed by *Reiss (1988b)*. It consists of 40 items that are rated as either no problem, problem, or major problem by the mentally retarded persons being evaluated.

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The items include aggressiveness, eating problems, loneliness, impulsivity, hyperactivity, sadness, stealing, suicidal ideation, paranoia, low energy, and social inadequacies. The evaluation is completed by teachers, supervisors, caretakers, or persons who know the individual well enough to report on his or her suspected maladaptive behavior. The scores are then compared with norms to determine whether a mental health disorder is suspected; if so, the individual is referred to a professional mental health practitioner for a standard mental health evaluation.

- ◆ **Demographic data.** This part of the survey should elicit demographics to identify age ranges, types of living environments, and other vital statistics.
- ◆ **Current utilization of services.** This part of the survey should identify which services are currently being utilized—services from both the mental health system and the mental retardation system.
- ◆ **Service gaps.** This part of the survey should elicit perceptions about the service delivery system, including such areas as residential options, mental health services, vocational alternatives, coordination, and so on.
- ◆ **Barriers to effective service delivery.** This part of the survey should elicit responses about such problem areas as funding, structure, training, attitude, skills, resources, and so on.
- ◆ **Training needs.** The survey should elicit data related to the training needs of the personnel within the agency. These needs will probably vary, depending on the type of service provided by the agency that is responding to the survey.

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- ◆ **Problems of systems coordination.** This is an important area to identify, since the lack of coordination can be the source of some, if not all, of the system problems. The survey could identify the current, as well as the recommended, system coordination issues confronting the dually diagnosed at the local level.

The policy manager should ensure that drafts of the survey are reviewed, revised as necessary, and approved. At the same time, he or she should secure an agreement to participate from the executive directors of each of the mental health and mental retardation agencies in the community task environment. By the time the survey instrument is finished, it can be sent to the agencies.

**Issues Appropriate for Staff Training.** The policy manager should promote staff training appropriate to the differentiation and complexity associated with serving the dually diagnosed population. He or she needs to explode myths about the dually diagnosed—that the maladaptive behavior of a retarded person is a function of his retardation, that emotional disorders in the retarded are different in kind from those with normal intelligence, that symptoms and maladaptive patterns in retarded people are a result of organic brain damage, and that psychotherapy is ineffective with the mentally retarded. Of course, psychotherapy must accommodate the client's expressive and receptive language deficits; intervention, according to *Menolascino (1983)*, requires a more active, direct, and concrete clinical stance. It is important not to rely exclusively on any single technique or therapeutic school because of the complexity of the

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dually diagnosed clients; a flexible and eclectic approach is often indicated.

The policy manager of this study, following the suggestions of *Tropman (1984)*, brought all these ideas into the policy process: He fostered his staff's education in areas where little or nothing was known before, and he encouraged reeducation to disabuse myths and replace them with well-founded concepts consistent with appropriate values.

### ***Feedback***

Another important resource the policy manager needs is feedback: He or she must ensure that the policy machinery adequately alerts planners and implementers to problems that must be addressed by policy changes. The sensing of information from the environment about the suitability of a policy is called feedback, a capability thoroughly explored in open systems theory to explain the adaptability of a system. Information revealing that the results of a policy are not meeting the goals of the policy is *negative feedback*, which works like a thermostat: The system responds to negative feedback by correcting its processes (*Compton and Galaway, 1979*).

The policy process, described in chapter 5, incorporates feedback: After the policy is ratified, the fourth phase of the policy process begins, where the policy manager sees that the policy is actually implemented with detailed plans and guidelines to ameliorate difficulties brought on by the new policy and actually to execute the policy. During the final policy phase, the policy manager oversees the

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implementing programs and remains alert to new problems that must be addressed in a new policy development cycle.

In fact, policy management, by bringing the workings of open systems theory into deliberate conscious attention, improves upon feedback: As *Michael (1980)* suggests, development of policy can enable professionals in the mental health and mental retardation services to effectively forecast potential problems with enough lead time to project solutions before the problems can seriously imperil operations. According to *Tropman (1984)*, human service organizations are well served by a strategic policy and planning committee devoted to thinking about the future and assessing alternatives, to charting likely courses of significant environmental changes and dealing with them in advance.

The policy manager can ensure adequate feedback by incorporating an eclecticism in the policy: The staff at a CMHC should have an identity with both the mental health and the mental retardation systems. They should provide treatment services as part of a larger interorganizational team, consisting of residential, vocational, and mental health services. Treatment is interorganizational: A treatment plan involves not only the therapist and client, but also staff from workshops and group homes or family. The client is also part of the team. In this way, when an aspect of the policy is working or not working, the staff will more likely be aware of it.

For example, when one of the MH/MR staff sees a client, a direct-care provider from the group home is present and shares

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information in a "consultation book" on the client's progress or problems since the previous visit. The MH/MR staff member contributes observations from the session into the consultation book, which is later reviewed by the entire group home staff. This process embodies a continuous communication, or feedback loop.

### *Position*

Another important resource of the policy manager is his or her position in the overall service provision system. According to *Tropman (1984)*, the policy manager needs to know who is working where and what he or she can do, know who is in power and what policy the powerful will support. The policy manager needs a sufficient level of authority to be privy to where the policy action is being taken. He or she accumulates this authority largely from devoting far more time and effort than others do toward the issues of the dually diagnosed.

The policy manager in this study was attached to BCMHS, the county's lead agency, which provided his activities legitimacy by giving him access to OCS, the MR/DD Subcommittee, and to other working committees with contract agencies. BCMHS, as the leading planning organization for the county's mental health services described in chapter 5, has spearheaded the development of a comprehensive service system to meet the holistic needs of the dually diagnosed, utilizing both the mental health and mental retardation systems. The establishment of interdependent relations between BCMHS and other organizations (the contract agencies) is key to the

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comprehensive service system. The exchange of clients, staff, and other resources with organizations in the environment has enabled BCMHS to provide mental health services to dually diagnosed clients while enabling the other organizations to pursue their respective goals. Under the auspices of BCMHS, the policy manager developed and managed a policy involving interorganizational cooperation and coordination.

The policy manager needs access to top management, as well as to public relations, advisory, and research groups. As *Patti (1982)* points out, such mental health administrators are continually looking for reliable and feasible ways to evaluate the effectiveness of programs—that is, feedback. Such administrators span the system boundary and act as an intermediary between the environment and the agency. The policy manager can work with them to identify priorities for what is important for an agency's survival.

The boundary-spanning responsibility is very important in providing services to the dually diagnosed. The policy manager has the responsibility to recognize (or anticipate) alternatives, opportunities, and negative forces in the external environment that may affect BCMHS. He must then take appropriate action so that the role and functions of the agency are maintained or extended.

The policy manager, working within a mental health agency, is further legitimized by his knowledge and interest in mental retardation. With such legitimacy, the policy manager was able to meet once a month with the executive directors of all the mental retardation services in Bethany County to evaluate the present

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system, review the programs, and plan for future service. Both private and public agencies are represented at these meetings, which provide an opportunity to establish trusting relationships among the provider agencies.

The policy manager, by sitting on various committees in the local policy environment, informs other agencies of the existence of the service. Mental health administrators, as *Patti (1982)* points out, spend much time and effort justifying existing programs or lobbying for new ones. The policy manager nurtures the concept of "interorganizational treatment planning" as part of a comprehensive policy. He meets with middle managers from other agencies to discuss interorganizational treatment planning (generating policy options) and elicits their cooperation. Securing administrative support (policy ratification), they implement an interorganizational team approach to care and treatment. By representing BCMHS at all internal and external meetings and forums dealing with mental retardation, the policy manager monitors the programs administered by these groups and is alert to problems that may need to be addressed by another cycle of policy development.

The BCMHS program supervisor meets regularly with the subunit leaders, including the policy manager, to process information and make decisions about internal activities related to mental health services provided by BCMHS. The subunit leaders, positioned at a middle-management level between the top management and the subunit staff who personally deliver service, translate the executive level goals and directives into specific program objectives.

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Finally, the policy manager sets up conditions conducive to staff morale. He facilitates communication both vertically to the director of BCMHS and to OCS, and horizontally within the service itself as well as with cooperating departments and agencies. (The premise underlying the need for dual diagnosis services in the first place, after all, was the lack of communication and cooperation between service providers for the mentally ill and those for the mentally retarded.)

### *Money*

A very important resource of the policy manager is, of course, money. As *Tropman (1984)* asserts, an effective policy manager must understand and be able to influence the funding arrangements in the policy environment. What are funding organizations likely to support, for example?

All MH/MR clients are funded through the Community Support System (CSS), which itself is funded by the State Bureau of Mental Hygiene (BMH) to maintain the severely and persistently mentally ill in a community setting. In a departure from the previous forms of governmental efforts, CSS accepts as a fact the large number of federal, state, and local agencies providing services to the mentally ill. BMH plans to continue to stress the importance of an open systems approach to the development of community support programs. Communities are encouraged, under the CSS plan, to assess the totality of needed services and supports available for severely disabled persons. The rationale for the total funding is to

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ease the financial burden at the local level and to maximize services for those eligible for CSS-funded services. The funding mechanism is an incentive for local communities to develop services that were previously neglected.

In order to be eligible for CSS funds, the MH/MR subunit must use certain eligibility criteria for clients. The subunit accepts only clients with severe and persistent mental illness as a primary diagnosis, not those with only alcohol abuse problems or only mental retardation (who are served by other agencies). The following are the formal MH/MR eligibility criteria, as established by the state, for accepting CSS clients:

- ♦ The individual must be at least 18 years of age and have a primary DSM-III-R psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, or developmental disabilities.
- ♦ The individual must be severely functionally disabled due to mental illness for at least the past 12 months on a continuous or intermittent basis in at least three of the following areas:
  - Self-care
  - Activities of daily living
  - Self-direction
  - Social functioning
  - Economic self-sufficiency
  - Ability to concentrate
- ♦ The individual must meet at least one of the following characteristics:
  - He or she is currently enrolled in the state CSS program and has been served in a BMH-certified or -funded program during the last two years.

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- He or she must have been admitted repeatedly to BMH-certified programs (three or more times in the last 18 months).
- He or she has undergone two or more psychiatric hospitalizations in the last two years.
- He or she has had one consecutive stay of six months or more in a psychiatric hospital, a BMH-certified residence, or a BMH-designated adult home or single-room-occupancy hotel.
- He or she receives SSI or SSDI due to mental illness.

The MH/MR eligibility for client intake, as seen in the first bullet in the foregoing list, excludes any assessment for developmental disabilities (mental retardation). Under the State Mental Hygiene Law, payment for services tailored to the mentally retarded are authorized by the Bureau of Developmental Disabilities and Mental Retardation (BDDMR) only to local provider agencies that it certifies and licenses, and MH/MR is certainly not one of those agencies. Moreover, the conditions of reimbursement require that the primary diagnosis corresponds to the "primary diagnostic interest" of the certifying agency—in other words, mental retardation explicitly, not "dual diagnosis." As an augmentation of the MH/MR subpolicy definitions, however, the policy manager secured an agreement with contract service agencies licensed by BDDMR to serve the mentally retarded that they assess clients only for developmental disabilities, not for psychopathology. Then the clients who are both mentally ill and mentally retarded receive services from the MH/MR subunit,

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from other services of BCMHS, and from these other contract agencies.

Also, MH/MR generates revenue by billing Medicaid for client visits. Nearly all its clients are eligible for Medicaid.

The policy manager should marshal funding resources for dual diagnosis from many sources, including grants. For example, in Bethany County, the policy manager represented BCMHS on a grant review committee and evaluated an array of grant proposals earmarked for specific programs.

The policy manager must remain alert to every funding opportunity, which might arise as a consequence of an arrangement ostensibly irrelevant to funding. For example, the case manager on the staff of the MH/MR subunit is actually employed by the state. His work assignments, supervision, and even performance evaluation, are done by the policy manager; his salary, however, is paid by the state. This interagency staffing arrangement, an outgrowth of the policy development efforts described in chapter 5, has worked extraordinarily well. It is multifaceted and benefits both agencies. More important from the perspective of policy management, the arrangement has promoted a sense of interagency cooperation between BCMHS and the state. Historically, there has been a sense of mistrust and misunderstanding between the two agencies. Furthermore, from a political perspective, this staffing arrangement helps to maintain the MH/MR subunit; it would be doubtful that BCMHS would consider eliminating MH/MR. Finally, sharing the staffing has saved BCMHS money. The clients he sees and the case

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management functions he performs are billable services through Medicaid and CSS funding sources, and these are revenues to BCMHS. (On the other hand, the state benefits by having its clients seen and treated at BCMHS.)

### Putting It All Together

The policy manager builds an effective policy upon the the four pillars of effective policy management: values, skills, knowledge, and resources. Then he or she is ready for applying a developed policy in the actual planning and delivery of CMHC services.

#### *Service Planning*

The needs assessment survey, part of the information resources of policy development, supplies the policy manager and task force with a substantial amount of data regarding service issues and numbers of persons who have a dual diagnosis. The Bethany County Dual Diagnosis Task Force developed a comprehensive report with its specific recommendations, which it submitted to the Office of Community Services (OCS) for review. OCS adopted most of the recommendations and charged the director of BCMHS to take action on them (see chapter 5).

The adopted recommendations in Bethany County provided the impetus for planning and developing services. Actual planning for services at the local level is officially through OCS and its subcommittee structure. Additionally, the executive directors of the

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major agencies meet each month to discuss planning, program development, and systemic issues. Here is another forum for interagency coordination.

It is important for participating agencies and key players to understand the following four basic principles employed in the service planning process, adapted from *Taylor (1988)*:

- ◆ Instead of trying to develop a separate system dedicated to the dually diagnosed, services should emanate from the current, established service delivery structures: that of the mental health system and the mental retardation system. Clients already stigmatized do not need another label. When these clients are integrated into the current systems, they can interact with peers who might serve as positive role models. Also, revenues can be directed toward the needs of individual clients if they aren't needed for building an entirely new structure.
- ◆ Individual clients should be placed in core programs because of their specific needs, not because of a formal diagnosis. With staff from both delivery systems on hand, the professionals who make placement decisions are the same ones who will be delivering services.
- ◆ Staff should augment or enhance core programs with needed services on a case-by-case basis. In other words, a client whose primary diagnosis is mental illness and is therefore in a mental

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health program can receive specific developmental services from mental retardation professionals.

- ♦ The last programs to be developed should be the intensive, restrictive ones—and then only after their need has been clearly demonstrated. During the first year, for example, the emphasis should be on residential and vocational services, with mobile crisis intervention teams and intensive case management available only as needed.

The foregoing principles embrace the concept of the *functional* role of service delivery. Service planners need not become preoccupied with designing an entirely new service delivery system to complement the mental health and the mental retardation systems. With the help of the policy manager, they can instead focus on how best to utilize the existing systems, to determine how those system can be strengthened through service enhancement in an integrated interagency network. Careful planning under the guidance of policy management—especially if informed with an organizing paradigm such as open systems theory—can achieve service integration between the two systems, exploiting the strengths of each for the best clinical, programmatic, and cost-effective perspective. The mental retardation system can best provide services that meet the developmental needs of the mentally retarded. The mental health system can best provide the mental health needs of the same population.

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As demonstrated by the principles of Taylor just described, there is a need to ensure a service network that is integrated, comprehensive, and responsive to individual needs. Planning for dually diagnosed must integrate not only developmental and mental health services, but also other health services, social services, and other local community services. Additionally, the service network must ensure accessibility and availability of programs and services according to individual needs and desires. The policy manager and service planners should take into account individual choice, so that the client will participate in his or her own care and treatment.

In planning services for this population, the policy manager should maintain systems coordination by bringing together high-level administrators of the provider agencies on an ongoing basis. The policy manager in this study sits on the MR/DD Subcommittee, which makes recommendations to OCS; OCS legitimizes the overall policy.

### *Service Delivery*

The community mental health center (CMHC) movement began in the early 1960s with the Community Mental Health Centers Act of 1963, legislation that embodied some of the most progressive ideologies and models of care through the provision of mental health services at the local level. This new initiative was established so that all persons who needed mental health services could be served within a short distance from where they resided. The intent of the law was to provide services to all citizens in need of such service, including those who have mental retardation. However, after nearly two

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decades, *Swanson and Menolascino (1983)* noted that CMHCs were not adequately providing for the mental health needs of retarded individuals. The policy manager should work to persuade the local CMHC to take an active role in providing comprehensive mental health services for the dually diagnosed, including psychiatric assessment, individual and group psychotherapy, medication treatment, consultation, day hospital programs, social skills training, crisis intervention, and case management services.

There are two models for providing clinical services to the dually diagnosed, which the policy manager should take into account: the generalist model and the specialist model.

In the **generalist model**, the mental health clinician provides services to dually diagnosed individuals as well as to other client populations. The generalist provides mental health services to a number of client populations—children, substance abusers, the chronically mentally ill, and so on. This staffing model works best in less populated areas, where there is a relatively smaller CMHC.

In the **specialist model**, staff members have specific training in mental retardation. Mental health personnel can understand the treatment techniques and philosophies found in the field of mental retardation. The specialist can negotiate for client services with both the mental retardation and the mental health systems. This model is ideal for larger, populated areas, where systems are more complex. The larger a community, the more complex the system.

There are also two models for the location of service delivery for the dually diagnosed: the facility-based model and the client-centered

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model.

In the facility-based model, the traditional model of service delivery in the mental health system, the client goes to the CMHC for services. The model is predicated on the ability of an individual to travel independently to the CMHC. In the Mental Health/Mental Retardation (MH/MR) subunit at BCMHS, the facility-based model applies to about 30% of the clients, either those who can use public transportation or those who are driven to the clinic by care providers.

In the service-based model, mental health services are delivered to individuals in their natural environments, such as their homes, sheltered workshops, or any other place where the client could profit from mental health services. It is not rare, for example, for an individual session with the client to take place at a local coffee shop; although nontraditional, such a session provides an "in vivo" experience, where the client can feel safe and unthreatened and where the clinician can observe how the client interacts with the environment in a more natural setting. Another advantage of the service-based model is when mental health services are provided in group homes or rehabilitation facilities; here the mental health clinician can interact directly with care providers from the mental retardation system. Mental health services should be integrated with ongoing habilitative activities, and they should interface with and closely take into account all aspects of a mentally retarded person's life (*Chanteau, 1988*).

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### Summary

Over the last several years, the service delivery system at the local level is beginning to recognize the psychiatric disorders in many of the mentally retarded. The gaps in the service delivery system are causing acute problems for the community, problems that only a clearly articulated policy can adequately address.

The state level of government may not directly provide the impetus to plan and develop mental health services for the dually diagnosed. In the absence of state impetus, these services can emanate from the local level by means of an interagency, coordinated, and collaborative approach under the guidance of a policy manager. Local-level policy can then influence state government, which will, or should, eventually initiate its own dual diagnosis policy.

This chapter has provided a perspective that a policy manager can employ at the local level in planning and developing a responsive service delivery system for the dually diagnosed. In order to do this, the policy manager must promote a set of values that make such a service delivery system important; he must possess and bring to bear considerable skill in developing information, operating in a political arena, and dealing with people; he must exploit extensive background knowledge of mental health and mental retardation that can be focused through an operating paradigm such as open systems theory; and he must be able to capitalize on such resources as current information, feedback, position, and money.

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All this takes considerable effort and time; it is a long-term process. The policy manager in this study brought his own values to the policy process, but he had to build the other pillars of effective policy management—skills, knowledge, and resources—over a long period of time. He honed his policy skills and knowledge, and he assembled his policy resources, gradually, through careful, thoughtful, hard work. For example, he did not assume his policy development function on committees all at once, simply through a series of fortuitous appointments from a powerful administrator. He asserted himself by suggesting his placement on one committee after another, suggesting that the placement was in the agency's interest. Once on a committee, he worked diligently on the issues the agency had sent him there to deal with, thereby building trust and gaining respect from other committee members at the same time he was nurturing skills and acquiring knowledge. After this trust and respect had been secured, and while he was pursuing the business of his agency, he was able to influence others toward the policy issues of dual diagnosis.

From the position of the local CMHC, the policy manager needs to seek interagency collaboration in developing a local-level policy. Without a fully developed policy mandating the CMHC to take an active role in interagency service delivery—a policy developed over substantial time and with tireless fostering and application of values, skills, knowledge, and resources—the dually diagnosed are likely to continue receiving inadequate and often nonexistent mental health services.

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Local communities are beginning to explore ways to respond to the mental health needs of persons who have mental retardation. Communities are at various stages of service planning and implementation of services with respect to interagency collaboration and cooperation. Under the guidance of a policy manager, other communities can replicate the planning and service delivery described in this dissertation. This dissertation was written to provide another policy manager with the opportunity to replicate the efforts made in one community—Bethany County. It is hoped that the dissertation can assist other communities in developing a clearly articulated policy that will serve as a guide for planning and developing interorganizational mental health services for the dually diagnosed.

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