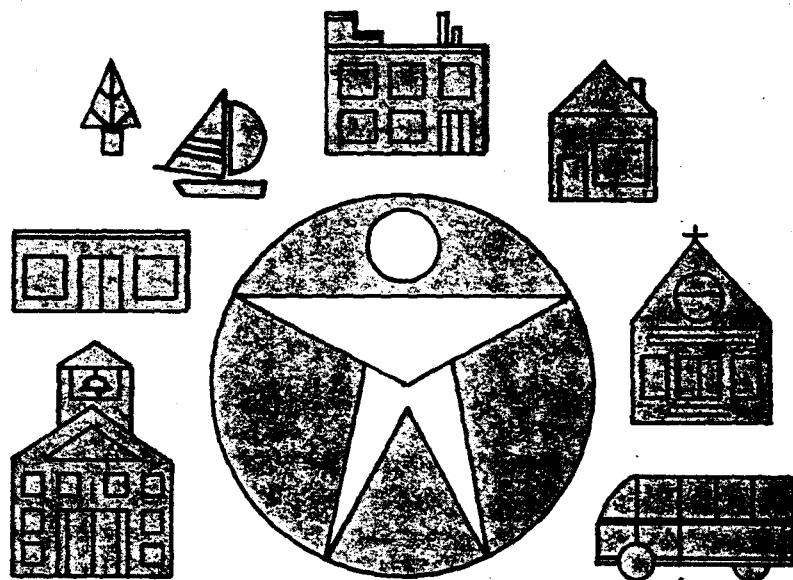


Brewster v. Commw. of Mass.



MH-MA-001-002



NORTHAMPTON CONSENT DECREE

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

DAVID BREWSTER
HECTOR SANTIAGO
RICHARD SCHNEIDER
DONALD GABOURY
MARTIN WEINBERG
ALBERT POTTER
ELLA BAILEY
THONNIE ROWELL, by his next friend
STEPHEN FERRARONE
MARY MCGUILLICUDDY, by her next friend
CAROL BOOTH

in behalf of themselves and
all other similarly situated
Plaintiffs

MASSACHUSETTS ASSOCIATION FOR MENTAL
HEALTH, INC.
MASSACHUSETTS ASSOCIATION FOR RETARDED
CITIZENS, INC.

Plaintiffs-Intervenors

v.

MICHAEL S. DUKAKIS
Governor, Commonwealth of
Massachusetts

DR. ROBERT L. OKIN
Commissioner, Department of
Mental Health

DR. MARY JANE ENGLAND
Associate Commissioner for
Programs, Department of Mental
Health

CIVIL ACTION
NO. 76-4423-F

LINDA GLENN

Assistant Commissioner for Mental
Retardation Services, Department
of Mental Health

ROBERT W. MURPHY

Assistant Commissioner for Mental
Health Services, Department of
Mental Health

* RAYMOND BRIEN

Regional Administrator of Region
I, Department of Mental Health

EVELYN MCLEAN

Acting Area director of the
Franklin-Hampshire Area,
Department of Mental Health

ANDREW PHILLIPS

Area Director of the Holyoke Area
Department of Mental Health

FRANK ROBINSON

Acting Area Director of the
Springfield Area, Department of
Mental Health

KERRY HOLLAND

Area Director of the Westfield
Area, Department of Mental Health

JOSEPH VAN HOENACKER

Area Director of the Berkshire
Area, Department of Mental Health

IRVING A. JACOBS

Superintendent, Northampton State
Hospital

DR. JONATHAN FIELDING

Commissioner, Department of
Public Health

JOHN R. BUCKLEY

Commissioner, Executive Office for
Administration and Finance

All individually and in their
official capacities,
Defendants

FINAL CONSENT DECREE

A. General

1. Plaintiffs are all mentally disabled persons who were as of December 15, 1976, are, or may be hospitalized at the Northampton State Hospital. They bring this action pursuant to, inter alia, 42 U.S.C. §1983, claiming violations of their constitutional and statutory rights to be treated in appropriate, less restrictive alternatives suitable to their needs.

2. This Court has jurisdiction of the subject matter, pursuant to, inter alia, 28 U.S.C. §1343 and 42 U.S.C. §1983. On October 27, 1977, this Court certified this matter as a class action.

3. Based upon the record and consideration of submissions filed by all the parties in conjunction with the case, this Decree is entered by the Court and consented to by the parties for the purpose of establishing a comprehensive system of appropriate, less restrictive treatment, training, and support services for each member of the plaintiff class which will meet, without necessarily defining, federal and state constitutional and statutory standards.

4. This Decree, including the attachments hereto subject to the provisions of paragraphs 9 through 11, shall be as binding on the defendants' successors, officers, agents, employees, and attorneys as on the defendants themselves. Defendants and their successors will take actions necessary to

secure full implementation of this Decree, including coordinating with other agencies and officials of the Commonwealth of Massachusetts and delegating among themselves and their subordinates the appropriate responsibilities.

5. In order to address the issues the parties and the Court deem pertinent for final settlement of the case, this Decree, including the attachments hereto subject to the provisions of paragraphs 9 through 11, sets forth the defendants' commitments towards the plaintiff class. This Decree includes a final, substantive resolution of most of the issues raised by this litigation. To the extent that current information renders final, substantive settlement of an issue impracticable, the parties have agreed upon a schedule and process for collaboration and/or negotiation, supervised by the Court, which the parties believe can lead to a final resolution of the issue in a fair and reasonable manner.

6. Jurisdiction is retained by the Court until further order, to enable any party to apply at any time for such further orders as may be necessary or appropriate for the interpretation, implementation, enforcement, or modification of the terms of this Decree and for supervision and approval of the resolution of issues left for further planning and negotiation.

B. Definitions

7. As used in this Decree, the following terms shall have the following meanings:

"Department" means the Department of Mental Health of Massachusetts.

"Commissioner" means the Commissioner of the Department of Mental Health.

"Region I" means the geographical area designated in Section 3.2 of the Code of Human Services Regulations, Title 4 - Mental Health and Mental Retardation, in force as of the date of this Decree, including the four counties of Franklin, Hampshire, Berkshire, and Hampden.

"Regional Office" means the principal administrative office for Region I or its successor.

"Regional Services Administrator" means the director and chief administrator of Region I or its successor.

"Areas" means the geographical divisions designated in Section 3.2 of the Department Regulations, in force as of the date of this Decree.

"Area Office" means the principal administrative office for each of the five Areas, or their successors, in Region I.

"Hospital" means the Northampton State Hospital, Northampton, Massachusetts.

"Resident" means a member of the class who resides at the Northampton State Hospital or is not otherwise discharged

from the Hospital while residing in another facility or environment.

"Client" means a member of the plaintiff class who does not presently reside at the Northampton State Hospital.

"The plaintiff class" means all persons who were, as of December 15, 1976, are, or may be hospitalized at the Northampton State Hospital, including those persons on indefinite visit or conditional discharge during that period.

"Community residence or residential alternative" means any mental health or retardation program providing residential services, other than a state hospital or state school for the retarded, including, but not limited to, a supervised residence or apartment, transitional residence or apartment, specialized residence or apartment for persons with behavior or physical problems, group home, halfway house, foster home, specialized home care, rest home, nursing home, or any other type of environment providing care or treatment for mentally disabled persons.

"Nonresidential program" means any mental health or retardation service provided in other than a residential setting, including, but not limited to, individual needs assessment and service planning, case management, counseling and psychotherapy, respite care, family therapy, medication clinic, crisis intervention, day treatment, day activity, prevocational training and sheltered workshop, transitional

employment and job placement, supervised recreation, or any other type of nonresidential service providing care or treatment for mentally disabled persons.

"Individual Service Plan or ISP" means an individualized written plan describing the individual's capabilities and needs for treatment, training, and support services, including the methods to be utilized and the person(s) responsible for providing such services.

C. Principles for Creating and Maintaining Community Programs

8. The following principles form the basis for creating and maintaining the comprehensive system of community mental health and retardation services suitable to meet the needs of all members of the plaintiff class:

a. A comprehensive community mental health and retardation system consists of three distinct components: (1) residential environments which are the least restrictive and most normal settings appropriate for each resident or client; (2) nonresidential treatment, training, and support programs which are geographically separate from community residences and which provide the major daily activity for those clients whose residential environment does not provide the total treatment program, as well as for other members of the plaintiff class who live independently in the community; and (3) management services to adequately develop, coordinate, administer, monitor, and evaluate this network of environments and programs.

b. Residents and clients are entitled to live in the least restrictive, most normal residential alternative and to receive appropriate treatment, training, and support suited to their individual needs.

c. There are approximately 2135 mentally disabled plaintiffs in Region I who have been, since the initiation of the lawsuit, are, or will be

hospitalized within any two year period at the Northampton State Hospital. The lack of appropriate treatment in less restrictive community alternatives can result in their unnecessary institutionalization. These plaintiffs constitute the population to be served by the development of new and the expansion of existing programs and services, as is more fully described in Attachment A.

d. There are approximately 3588 other mentally disabled plaintiffs, as described in Attachment A, who are presently receiving community residential and nonresidential services, but who may be hospitalized if such services are eliminated, reduced or otherwise diluted. To the extent these existing services remain adequate, these clients are not part of the population to be served by the development of new programs and services.

e. The provision of appropriate treatment, training, and support services to residents and clients will not deprive other persons currently receiving mental health or retardation services from the defendants from continuing to receive such services for as long as they are determined to be necessary, according to professionally accepted standards.

f. The determination of client service needs will occur through an individualized screening, evaluation, and service planning process, including annual reviews of Individual Service Plans.

g. The determination of the appropriate residential and nonresidential placement for each resident and client will be made so as to guarantee that all persons are placed in the least restrictive alternative which will provide them with appropriate treatment, training, and support.

h. In light of the profound effects of the long term institutionalization of many of the plaintiffs, and the practical problems in making available the most suitable setting, some residents and clients may be placed initially in the more structured alternatives; however, they will be provided with the necessary treatment, training, and support to enable them to move, as quickly as possible and in accordance with their capabilities, into less restrictive, more open settings and programs.

i. Since the residential models are designed to be the most normal and least restrictive environments appropriate for the residents and clients, smaller apartment units are preferred to larger group homes, although either may be appropriate depending on the particular circumstances.

j. Community residential and nonresidential services will be offered, to the maximum extent feasible and entirely if possible, on a voluntary basis and with due regard for the client's dignity and personal autonomy.

k. All residential and nonresidential services will be offered by providers of services on a nondiscriminatory basis, without regard to a resident's or client's degree of handicap or ability to pay, subject to the provisions of G.L. c. 123, §§32 and 37.

l. Community residential alternatives and nonresidential programs will be integrated in the community and operated in the most normal manner appropriate to the needs of their clients.

m. Standards for all residential alternatives and nonresidential program models are necessary to insure the health, welfare, and dignity of all clients of such programs. Licensing procedures are necessary to enforce these standards and serve as the primary monitoring device to insure program adequacy.

n. An evaluation process is required to assess a program's quality and effectiveness in meeting the needs of its clients.

o. Adequate residential and nonresidential services will be provided in appropriate, less restrictive alternatives to all residents and clients for as long as determined necessary to meet their individual needs, according to professionally acceptable standards.

D. Development of Community Programs

9. The community residential alternatives and nonresidential programs, set forth in Attachments B and C respectively, represent appropriate program models designed to meet the needs of all residents and clients. These models are based on current information and experience and may be modified, to the extent that new knowledge discloses more appropriate alternatives, provided that the plaintiffs' attorneys are given notice and an opportunity to object reasonably in advance of any budgetary or programmatic action to implement any modification.

10. The number of residential and nonresidential placements in each program model, set forth in Attachments D and E respectively, represent the number of placements which the parties deem appropriate to meet the needs of all residents and clients. The number of placements in each program model which will be created may be modified to the extent necessary to meet the individual needs of all residents and clients as determined by their Individual Service Plans.

11. The parties recognize that administrative and management services are necessary and appropriate to develop, coordinate, manage, monitor, and evaluate the diverse system of community programs. A proposed design for such administrative and management services is set forth in Attachment F. This design is subject to further review and modification by the

*budgetary
issues*

defendants' normal budgetary and programmatic processes, provided that plaintiffs are informed of and allowed to participate in and have the opportunity to object to any budgetary or programmatic decision. The design set forth in Attachment F does not imply any conclusion as to whether the proposed positions are to be newly created or reallocated from the Hospital. Such management services insure that all residents and clients receive appropriate treatment, training, and support in the least restrictive alternative suitable to their individual needs.

*beginning
of obligations*

12. The defendants will create and maintain appropriate community residential alternatives and nonresidential programs, including necessary management services, for all members of the plaintiff class adequate to meet their individual needs as recommended in their Individual Service Plans.

13. The defendants will create and fund appropriate community residential alternatives and nonresidential programs and will maintain and continue to fund all new and existing programs unless the needs of the residents and clients, as determined by their Individual Service Plans, no longer require such programs.

14. The defendants will not place residents or clients in residential alternatives or nonresidential programs which fail to meet the environmental, care, and programming standards included in this Decree and the attachments hereto, subject to the provisions of paragraphs 9 through 11.

15. With respect to residents at the Northampton State Hospital, the defendants will create and maintain residential and nonresidential programs which will reduce the census of the Hospital to 250 residents by June 30, 1979, to 150 residents by June 30, 1980, and to no more than 50 residents by June 30, 1981. As to this remaining population, the defendants will, by June 30, 1981, create and maintain appropriate community residential and non residential programs suitable to the individual needs of those residents for whom the community program models set forth in Attachments B-E are appropriate, and will place those residents in such alternatives.

hospital
census
reduction
timeline

16. To the extent that the community program models set forth in Attachments B-E do not adequately meet the needs of a portion of this remaining population, the defendants agree, during the formulation of the budget for fiscal year 1981, to seek a resolution of outstanding issues relevant to the need for a secure treatment setting at an appropriate location. If the parties cannot agree on a resolution of these issues, they will report to the Court by November 15, 1979.

17. The defendants will use their best efforts to insure the development of an inpatient capacity of additional acute psychiatric beds in community general hospitals in Region I, as deemed necessary to meet the needs of members of the plaintiff class described in Attachments C, D and E. To the extent that factors outside the defendants' control inhibit or

prevent the creation of this inpatient capacity in community hospitals, the parties recognize the need to modify the projected number, type, and timing of community residential alternatives necessary to meet the needs of these members of the plaintiff class.

18. The defendants will take all necessary action to maximize the reallocation of funds from the Hospital to the community. Reallocation will proceed so that by June 30, 1981, the unit cost will not exceed \$40,000 per resident at the Hospital.

19. With respect to clients who have been or may be institutionalized at the Hospital and who are presently receiving some but not all of the residential and nonresidential services appropriate to their needs, the defendants will upgrade existing community programs and create new programs and services to meet their individual needs. The defendants agree that sixty percent of the deficiency in existing services, as described in Attachment G, will be eliminated by June 30, 1980, and the remainder will be eliminated by June 30, 1981.

20. By June 30, 1979 the defendants will place forty mentally retarded residents currently at the Hospital in appropriate, less restrictive residential alternatives and provide them with treatment, training, and support services suitable to their individual needs. The projected cost of these placements for six months is \$412,000, of which \$260,000

MR
funding
commitments

will be allocated from the Commonwealth's 5022-0100 account and the remaining \$152,000 will be reallocated from the Hospital budget for the 1979 fiscal year.

21. By June 30, 1980 the defendants will place all remaining mentally retarded residents at the Hospital in appropriate, less restrictive residential alternatives and provide them with treatment, training, and support services suitable to their individual needs.

22. The defendants will insure that Department personnel experienced in mental retardation will assume predischarge planning and community placement responsibility for all mentally retarded residents and clients in order that there is no distinction in Department aftercare responsibilities for any mentally retarded client based on prior residency in the Northampton State Hospital as opposed to state schools for the retarded. All mentally retarded clients will be considered within the scope, and will receive the protections of, all mental retardation regulations, standards, and procedures.

23. The defendants will make their best efforts to insure that residents and clients of community residential alternatives and nonresidential programs are provided equal access to all generic services, such as education, transportation, recreation, and medical care, and will develop appropriate links between the community mental health delivery system and such services.

24. The defendants will use their best efforts to overcome all obstacles and barriers to the creation of community residential and nonresidential programs, as required by this Decree, including, but not limited to, the actions set forth in Attachment H.

25. As soon as it is practicable and to the extent not inconsistent with existing contracts, the defendants will reach a written agreement with the operator of the community residence or nonresidential program to include the following:

a. require the residence or program to comply with the applicable terms of this Decree and with all applicable statutes, rules, and regulations promulgated by the United States, the Commonwealth of Massachusetts, and the Department;

b. reserve the right of employees and contractees of the Department to have reasonable access to the residence or program and to audit its records, to supervise services to its clients, and to operate, or make appropriate provision for the operation of, the residence until clients are appropriately placed elsewhere in the event the provider substantially fails to fulfill the terms of its contract;

c. specify all charges and the sources of payment of a client's program, room and board, and any other expenses;

d. require the participation of the residence or program director, or appropriate representative, in the Individual Service Plan process for each of their clients;

e. require substantial fulfillment of the applicable portions of each client's Individual Service Plan.

Sanctions for failure to comply with the provisions of the agreement will be included in the agreement and will include, but will not be limited to, the termination of the agreement and the removal of the client from the placement. Prior to the renewal of an agreement, the defendants will monitor the service provider's compliance with the terms of the agreement.

E. Individual Service Plan

26. The defendants will furnish or continue to furnish all residents and clients with a written Individual Service Plan which specifies in detail the individual's capabilities and needs for services, including the methods to be utilized to provide such services. The Individual Service Plan will address the individual's residential and nonresidential program needs, with particular emphasis on the determination of the least restrictive residential environment and suitable nonresidential treatment, training, and support services appropriate to meet those needs. Such residential alternatives and nonresidential services will include, but not be limited to, those programs set forth in Attachments B and C. The Individual Service Plan will describe short-term and long-term program goals and timetables for the attainment of these goals. The Individual Service Plan will identify by name the person or persons who are primarily responsible for implementing, and overseeing implementation of, service goals.

27. The Individual Service Plan will be developed under the direction of a qualified professional and will be reviewed at least annually by an interdisciplinary team which is appropriately constituted in accordance with professionally acceptable standards and which includes the person or persons primarily responsible for the daily care and support of the resident or client, as well as the community service coordinator responsible for the client. Each resident or

client, and the individual's guardian, advocate or other representative will be notified of and invited to participate in the interdisciplinary team meeting, unless the resident or client objects to such attendance. Notification of team meetings will be provided as far in advance as practicable, and in no event less than two weeks prior to the meeting. As of September 1, 1979, a resident or client, either individually or with the assistance of a representative, may challenge the Individual Service Plan pursuant to procedures to be agreed upon by the parties by June 1, 1979, which will be substantially similar to those to be promulgated in Department regulations.

28. The resident's or client's community service coordinator will be responsible for reviewing and supervising the client's progress, for ascertaining that appropriate services are being delivered, and for coordinating the input of other professionals and staff in the Individual Service Plan process.

29. Recommendations as to residential and nonresidential program placements will be based on an evaluation of the actual needs of the resident or client rather than on what programs are currently available. In cases where the services needed by a client are unavailable, the Individual Service Plan will recommend an interim program based on available services which meet, as nearly as possible, the actual needs of the client. The number of clients in need of a service or program which is not currently available and the

type of residential alternatives or nonresidential programs which they need will be compiled in order to plan for the further development of programs.

30. For all residents who do not presently have an Individual Service Plan in conformity with the provisions of paragraph 26 of this Decree, an ISP will be developed by January 1, 1980.

31. A uniform system of records will be established by the Department for Area offices and residential and nonresidential programs to the extent necessary to insure the proper delivery of services and in accordance with Department regulations. A complete copy of the resident's or client's record will be kept at a single, appropriate location and updated regularly.

F. Standards

32. In order to protect the legal and civil rights of all residents and clients, including their rights to personal dignity, individual autonomy, adequate treatment, and freedom from abuse, the Department will draft and promulgate regulations, to be incorporated by reference in this Decree, governing residential alternatives, nonresidential programs, Individual Service Plans, and due process procedures for residents moving from the Hospital to a community setting. These regulations will substantially parallel similar regulations promulgated or drafted by the Department of Mental Health for mentally retarded persons and will be promulgated pursuant to the following schedule, unless an extension is agreed upon by the parties:

- a. Community residential regulations by June 1, 1979;
- b. Nonresidential program regulations, including provisions for all relevant program models described in Attachment C, by March 1, 1980; and
- c. Individual Service Plan and Due Process regulations by April 1, 1980.

33. The Department will include the plaintiffs in reviewing and revising drafts of these regulations and all other standards affecting clients' rights and the quality of life in community programs. If the standards as promulgated differ substantially from those regulations applicable to mentally retarded persons, separate standards for community

residential and nonresidential programs serving members of the plaintiff class will be jointly drafted through a negotiation process between the plaintiffs and the Department and subsequently included in this Decree.

G. Personnel and Training

34. The defendants will either directly or indirectly recruit qualified personnel to staff community residential alternatives and nonresidential programs. Such recruitment efforts and hiring practices will be designed to insure that personnel working in community programs are sensitive to clients' needs and their right to be treated in the least restrictive, most normal setting possible. Every effort will be made to screen out those applicants for employment who might pose a danger to clients or who fail to work in their best interests.

35. The defendants will provide all new employees with appropriate orientation and training programs to increase their skills and interest in achieving service goals for clients. The defendants agree to provide staff persons employed in new residential and nonresidential programs with training appropriate to their tasks as set forth in Attachments B and C. Those Hospital employees for whom employment in community settings is both desired and suitable will be offered retraining to permit them to serve appropriately the needs of clients in these community programs. The parties will prepare by October 1, 1979, a plan for orientation, retraining, and ongoing development of Hospital staff and employees of community programs. This plan will be incorporated by reference in this Decree after review and approval by all parties.

personnel
plan

36. Personnel policies will be designed to maximize use of individual employee skills and to enhance effective services for clients and working conditions for employees. Personnel policies will include provisions, consistent with state law, for suspending or terminating employees whose job performance is determined, after appropriate review, to be substantially unsatisfactory or to violate the rights of clients as set forth in relevant statutes, regulations or the provisions of this Decree.

37. The defendants agree to use their best efforts to secure federal funds, through Title XX of the Social Security Act, 42 U.S.C. §1397a(2) (A), and other sources, to train and retrain individuals working in community programs. To the extent federal funds are inadequate for this purpose, the defendants agree to provide by other means or to seek adequate funding for training personnel.

H. Monitoring and Evaluation

38. The defendants will, through the Department's Area and Regional offices, monitor compliance with contract requirements and the provisions of this Decree by local vendors, agencies, and other providers of service to residents and clients. To fulfill this responsibility, the defendants will use the licensing procedures for residential and nonresidential programs included in the Department regulations described in paragraph 32.

39. The defendants will, through program standards and evaluation mechanisms to be established by the Department, seek to insure that residential alternatives and nonresidential programs provide appropriate services which provide a high quality of life for their clients and which are effective in promoting their clients' early movement to less restrictive, more independent living environments. *planned*

40. The defendants will develop and maintain a management information system to better understand clients' use of residential and nonresidential programs and to generate data for planning and evaluation purposes.

I. Hospital and Placement Procedures

41. The defendants will make all reasonable efforts to substantially reduce new admissions to the Hospital through the creation of residential alternatives and nonresidential programs designed to prevent the unnecessary hospitalization of clients. No mentally retarded client will be admitted to the Hospital except upon criteria developed by and with the express approval of the Regional Services Administrator. No resident will be transferred to another state hospital or school unless and until the Regional Services Administrator or the Commissioner determines that such transfer will offer the resident more appropriate services and a more suitable, less restrictive environment than the Hospital.

42. The defendants will provide all residents of the Hospital with appropriate planning and preparation for discharge from the Hospital through the Individual Service Plan process. The Department will seek to insure, through the assignment of a community service coordinator to each resident, appropriate links between Hospital based and community services

43. The parties will review all issues relevant to the phasing down of the Hospital, including administrative, personnel, programmatic, and fiscal considerations, and will produce, through a negotiation process, a reorganization and phase-down plan by November 15, 1979 which will be included by reference in this Decree. The plan will include specific timetables for reallocation of Hospital funds and may include a

reorg &
phase
down
plan

proposal for the use of the Hospital grounds and buildings, which plan shall keep at an absolute minimum maintenance costs for the Hospital grounds and buildings not used by residents. The plan will be designed to insure that no resident is provided with less treatment or a more restrictive environment during this transition period than presently exists at the Hospital.

44. The procedures for the reallocation of Hospital funds, which will be set forth in detail in the reorganization plan, will be done in such a manner as to insure a staff-patient ratio appropriate to meet the basic needs of the residents. No funds will be reallocated from existing community programs serving members of the plaintiff class, except to the extent that the parties agree that such programs are inappropriate to or inefficient in meeting the needs of their clients.

45. After a placement in an appropriate residential alternative and/or nonresidential program has been located, the Area Director will inform the resident or client of the proposed placement. Notification will also be given to the plaintiffs' attorneys, pursuant to an agreement between the parties set forth in Attachment I. If the resident or client finds acceptable and consents to the proposed placement, it will be accomplished without undue delay. If the resident or client rejects the proposed placement, the Department will make an effort to locate an alternative residential and/or

nonresidential program more suitable to the wishes of the resident or client and appropriate to his/her needs. The Department will draft, in consultation with the plaintiffs, detailed regulations governing placement and transfer procedures and will issue such regulations, pursuant to paragraph 32(c).

46. The resident or client may at any time initiate a request for transfer to a more appropriate, less restrictive setting. The Area director will respond within 30 days, either accepting or rejecting the request and stating the reasons for any rejection. A request for such a transfer will be rejected only because continuation in the current residence offers the individual a better opportunity for personal development in a more suitable, less restrictive environment, because of statutory restrictions on the resident's or client's freedom of movement, or because a placement is not currently available elsewhere. In this third situation the resident or client will be transferred as soon as an appropriate placement can be found or developed.

J. Implementation and Monitoring

47. The defendants will use their best efforts to insure the full and timely financing of this Decree, *best efforts in financing decree*
including: submission of appropriate budget requests to the
Massachusetts General Court; allocation of sufficient funds to
insure that all existing and new programs meet the minimum standards herein; full allocation of funds appropriated for services during the fiscal year; allotments of appropriated funds as needed; prompt release of scheduled positions and processing of conversion and transfer requests; use of an appropriate voucher system by the comptroller's office to insure the prompt availability of necessary funds; use of a timely payment system to insure adequate cash flow to providers of services, so long as the providers have in place an auditing system and comply with reasonable auditing procedures to be established by the defendants which do not restrict the appropriate provision of services to clients. In order to finance the obligations of this Decree, the defendants agree not to transfer funds among accounts in such a way as to reduce the level of services presently being provided to mentally disabled persons at the Hospital or elsewhere in Region I of the Department of Mental Health.

48. The defendants will include in every future contract requiring an agent or independent contractor to perform duties, standards, and procedures which would otherwise

be performed by the defendants or their employees, a clause requiring the agent or contractor to meet the relevant obligations of this Decree and the attachments hereto.

49. The parties agree that Regional and Area administrative personnel should have reasonable flexibility to implement residential and nonresidential programs.

50. The defendants agree to take all necessary action to insure full and timely compliance with the provisions of this Decree. The parties recognize that there may arise, during the implementation of this Decree, difficulties beyond the control of the defendants which may inhibit timely accomplishment of certain of its terms. Whenever the parties or the Monitor determine that such difficulties have arisen and significantly threaten implementation, the problem may be brought to the Court for its attention.

51. By January 1, 1979, an independent Monitor will be appointed by the Court from a list of proposed candidates jointly prepared by the plaintiffs and defendants. The Monitor will be responsible solely to the Court and will serve the Court and the interests of justice for as long as necessary. The Monitor will review and report to the Court and the parties on the progress towards implementation of this Decree, in accordance with procedures and schedules to be agreed upon by the parties. The Monitor's first term of appointment will be for eighteen months, which may be extended by agreement of the parties and the Court. The parties' attorneys will consult

with each other prior to the reappointment or replacement of the Monitor, and exchange proposals regarding the Monitor's position at least three weeks prior to submittal to the Court for approval. The defendants will pay the salary and expenses of the Monitor and will provide necessary clerical support. The defendants will pay the costs and expenses of those consultants which the Monitor finds necessary to fulfill its responsibilities as set forth in this Decree, provided that either the parties agree or the Court, after a hearing, finds that such consultation is appropriate.

52. The Monitor will be allowed access to all information, records, residential environments, and program areas, and will be permitted to interview any person affected by or involved in the implementation of this Decree to the extent necessary to discharge the Monitor's duties under this Decree.

53. The Monitor will evaluate residential, nonresidential, and management services in the community, including their costs and effectiveness, as well as services at the Northampton State Hospital which relate to placement in community programs, pursuant to the standards set forth in this Decree and the attachments hereto.

54. The Monitor may make informal suggestions to the defendants in whatever form the Monitor deems appropriate in order to facilitate compliance with the Decree.

55. If an individual complaint or problem is not or cannot be resolved through existing procedures of the Department, any employee or agent of the defendants, any resident or client, or any guardian, advocate, or other representative of a resident or client, may bring a situation or disagreement related to the provisions of this Decree to the attention of the Monitor for appropriate action. The Monitor will provide written notice of such matter to the parties' attorneys. The Monitor may make a recommendation to the defendants to promptly address or resolve such problem. The Monitor's action on individual complaints or problems will be considered final, and inappropriate for review by this Court, except to the extent provided in paragraph 61.

56. The Monitor will have the authority to make recommendations with regard to implementation of the Decree if: (1) the Monitor believes that the defendants are not in compliance with the Decree; (2) this judgment is accompanied by written findings of fact which indicate the source of the evidence upon which each finding is based; and (3) the recommendations are consistent with and can be implemented within the framework of the Decree. Such recommendations will include, where necessary, timetables for implementation of steps or measures necessary to bring the defendants into compliance.

a. Copies of each recommendation accompanied by the findings of fact required by this paragraph will

be filed with the Court and sent to counsel for the parties. All parties shall be bound by the recommendation unless, within fifteen business days, any party files an objection with the Court and requests a hearing. Objections may be made on the basis that (1) the findings of fact relied upon by the Monitor are erroneous, (2) the Monitor's judgment of noncompliance is erroneous, or (3) the Monitor's recommendations are beyond the provisions of or inconsistent with the Decree.

b. The hearing on the objections will be held at the earliest convenient time after notice to all parties.

57. The Monitor will submit written reports to the Court and the parties every six months on the progress achieved in complying with the provisions of this Decree, including a description of all problems and disputes which have arisen and suggestions for appropriate action to remedy such problems. The reports will also make recommendations on unresolved issues and propose modifications or revisions in the Decree to facilitate compliance with its fundamental purposes. Before filing its report the Monitor will submit a draft thereof to the parties for comment. The Monitor may submit special reports to the Court and the parties at any time.

58. Any party may submit a written request to the Monitor for a specific action or recommendation. A copy of such request will be filed with the Court and served upon the parties' attorneys. The Monitor will prepare and file a

response with the Court in 30 days, a copy of which will be sent to all parties. Any party objecting to the Monitor's response may request a hearing before the Court.

*advocacy
program*

59. The Monitor will investigate and determine the necessity for trained, independent advocates to assist clients in the protection of their rights as set forth in relevant statutes, regulations, and the provisions of this Decree, including the attachments hereto. The Monitor will submit its recommendation to the parties and the Court by January 1, 1980, on the appropriate role of and funding for such independent advocacy. The plaintiffs and defendants agree to cooperate in investigating sources of funding and in seeking federal funds to establish and maintain an advocacy system, to the extent such is determined to be appropriate.

60. The plaintiffs and the defendants will cooperate with the Monitor in his/her efforts to facilitate compliance with this Decree. For this purpose, the Governor's office, the Secretary of Administration and Finance, the Executive Office of Human Services, the Department of Public Health, and the Department of Mental Health will designate staff persons responsible for coordinating implementation of this Decree and will furnish the names of such persons to the Court, the Monitor, and the plaintiffs' attorneys.

61. Plaintiffs' counsel may apply to the Court for appropriate relief on matters of significant concern to the class. Nothing herein shall be construed to prevent a resident

or client or his/her legal representative from bringing an independent enforcement action in the event that the individual's grievances have not been remedied through the procedures specified in this Decree or other procedures existing within the Department.

62. Defendants will post in each building at the Northampton State Hospital, and will either post in or send to each community program where members of the plaintiff class receive services, a notice that the Court has issued a judgment setting forth standards and procedures to be applicable to all the plaintiffs. The defendants will insure that a copy of that judgment is available for inspection at Area and Regional offices of the Department of Mental Health during regular business hours by employees and agents of defendants, vendors and service providers, residents, clients and their parents, relatives, and legal guardians, and all other interested members of the public. Defendants are committed to providing copies of this Decree to all providers of mental health services in Region I. Defendants agree to make available to concerned individuals, local agencies, and consumer organizations copies of the Decree and the attachments hereto at a reasonable cost.

Assented to this 6th day of December, 1978:

For the Plaintiffs:



Steven J. Schwartz
Attorney for the Plaintiffs
and the Massachusetts
Association for Mental Health



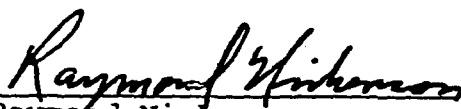
William C. Newman
Attorney for the Plaintiffs



Boisfeuillet Jones, Jr.
Attorney for the
Massachusetts Association
for Retarded Citizens



Elizabeth B. Rawlins
President, Massachusetts
Association for Mental
Health, Inc.



Raymond Nickerson
President, Massachusetts
Association for Mental
Retardation, Inc.

For the Defendants:



Michael S. Dukakis
Governor



Francis X. Bellotti
Attorney General



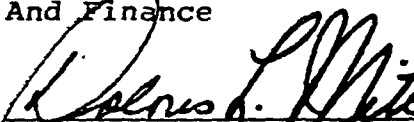
S. Stephen Rosenfeld
Assistant Attorney General



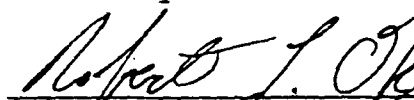
Catherine A. White
Assistant Attorney General



John R. Buckley
Secretary of Administration
And Finance



Dolores L. Mitchell
Secretary of Human Services



Robert L. Okin
Commissioner of the Department
of Mental Health

Jonathan E. Fielding ms
Jonathan E. Fielding
Commissioner of Department
of Public Health

Raymond P. Brien
Raymond P. Brien
Regional Services
Administrator

Approved at Springfield, Massachusetts, this seventh day of
December, 1978.

Frank H. Freedman
Frank H. Freedman
United States District
Court Judge

SCHEDULE OF ATTACHMENTS

- A Population Analysis
- B Residential Alternative Models
- C Nonresidential Program Models
- D Residential Placement Recommendations
- E Nonresidential Placement Recommendations
- F Management Component
- G Deficit in Existing Programs
- H Defendants' Obligations to Overcome
Obstacles to Implementation
- I Notification of Discharge Agreement

ATTACHMENT A

FINAL DRAFT

Analysis of the Mentally Disabled Population
Presently Hospitalized and at Risk
of Hospitalization in Region I

I. Introduction

In order to plan a system of community treatment programs and residences for mentally disabled persons, it is necessary to identify the population within the parameters of the planning process and then to subdivide this population into relatively homogeneous groups or clusters according to individual characteristics and corresponding mental health needs. The total population, defined as all persons who have been, are now, or will be hospitalized in the Northampton State Hospital (the Hospital), can be viewed as composed of five distinct subpopulations: (1) Acute patients admitted for the first time and who remain in the Hospital for a brief period; (2) Recidivist patients who have been admitted more than once and who remain in the Hospital for varying lengths of time; (3) Long-term patients who have been hospitalized for more than three months and usually for more than a year; (4) Non-acute patients who were hospitalized on or after December 15, 1976, who have been discharged as of a given planning date, and who are not likely to return to the Hospital; and (5) Persons never admitted to the Hospital but at substantial risk of being hospitalized unless alternative services are available. For planning purposes, the grouping of each of these subpopulations was

undertaken on the basis of the Final Draft of the Index Construction jointly prepared by the plaintiffs and defendants. This document identifies the number of persons in each subpopulation and analyzes that subpopulation according to relevant clusters. The data set forth within will form the basis for determining the appropriate number and type of community programs and residences necessary to meet the needs of the mentally disabled population subject to this planning process.

II. Methodology for Identifying Subpopulations

Although no formula or statistical design has been created to precisely identify the number of persons who have been or may be hospitalized, there is remarkable similarity in the results produced by several different approaches that have been devised after an exhaustive review of hospital data and results of the assessment survey. It is recognized that all of these approaches attempt essentially to approximate a dynamic model of client "flow" into and out of the hospital, without actually relying upon a dynamic--simulation methodology. The development of a fully dynamic model of patient flow would have required the retrieval of a substantial amount of additional data, and requires considerable delays in the planning process. As noted, the distinctive methodologies employed here do show a remarkable convergence, results of which are described below:

A. Acute Subpopulation - 525

There are an average of more than five hundred and twenty-five new admissions to the Hospital each year who have never been previously admitted to a mental hospital. Alternatively, a total of 32 persons in the Hospital on September 17, 1977 were identified on the assessment survey as either acute or adolescent with not more than one previous admission, and hospitalized for less than three months. Similarly, there were 29 persons with no previous admissions. Given the average length of stay at the Hospital for this subpopulation of approximately 20 days, these persons represent an acute population of approximately 550 ($29 \times 18 = 532$; $32 \times 18 = 576$).

B. Recidivist Subpopulation - 1076

In order to determine the unduplicated count of persons admitted to the Hospital over a two year period who had previously been hospitalized, an extensive review of Hospital records was undertaken. This review included examining the admission history of every person admitted during the six month period from October 1, 1977 - March 31, 1978. This individual analysis allows for an exact determination of the number and frequency of persons entering the Hospital in a given time period, in addition to precisely identifying who those persons are and the source of their referral.

On the basis of this data (see especially Appendix C, Tables 1 to 3), a total of 1300 annual admissions to the

Hospital were identified, 736 of which were readmissions. When this figure was adjusted for repeated readmissions of the same client, there were 680 unduplicated individuals identified for a single year. In order to determine for a 2 year planning period how many unduplicated recidivist clients would re-enter the Hospital, a number of data-based assumptions were made (see Appendix C, Table 4). Basically, four separate recidivist subgroups were identified:

- Group A: Consisting of 46 persons, each of whom are readmitted two to three times each year, and 4 to 6 times over a two year planning period;
- Group B: Consisting of 318 persons, each of whom are readmitted once each year, and twice over a two year planning period;
- Group C: Consisting of 121 persons, each of whom are readmitted about every 18 months, 80 of whom could be expected to show up within a single year, and all of whom could be expected to show up at least once during the two year planning period, and;
- Group D: Consisting of 590 persons, each of whom are readmitted about every 30 months, 236 of whom could be expected to show up within a single year, and 472 of whom could be expected

to show up at least once during the two year planning period.

Thus, for a one year planning period we would expect 680 unduplicated clients $(46 + 318 + 80 + 236)$ in the recidivist subpopulation. For a two year planning period there would be 957 unduplicated recidivist clients $(46 + 318 + 121 + 472^*)$ admitted to the Hospital.

In addition to this total, there are 119 other clients released from the Hospital on an indefinite visit status, who returned to the Hospital one or more times during the year (See Appendix C, Table 3). Although pursuant to Department procedures these persons are not formally re-admitted, they clearly must be considered as part of the recidivist subpopulation for planning purposes. Thus this methodology suggests the total unduplicated recidivist subpopulation that will be admitted to the Hospital in a two year period is 1076 persons $(957 + 119)$.

C. Long-Term Subpopulation - 362

A total of 362 persons at the Hospital on September 17, 1977 had been there longer than three months. Of this group more than three hundred had been hospitalized for more than a year.

*While Group D (the infrequent readmit group) consists of an estimated 590 individuals at risk of readmission, only 472 could be expected to show up during the two year planning period.

D. Nursing Home Discharged Subpopulation - 172

As of June 30, 1977 there were 178 persons on convalescent leave status. These people, although not residing in the Hospital, are still considered clients of the Department. Alternatively a total of 172 persons were discharged from the Hospital to either a nursing home, rest home, or boarding home during FY 1977. Given the exceedingly low readmission rate from nursing and rest homes, there is little likelihood this subpopulation is included in the recidivist subpopulation above. Finally, 1980 former Hospital patients were discharged to nursing or rest homes between 1969 and 1977; of this number 1240 left between 1969 and 1974. Thus in years 1975 to 1977, slightly more than 200 persons per year were discharged to these type of facilities, with only a slight risk of their returning to the Hospital (1980 - 1240).

E. At Risk Subpopulation - 3588

Based on an October 1977 Department inventory of all community facilities in Region I, there are 3588 persons presently being served that were identified as being at risk of hospitalization in the absence of these programs. Although it is difficult to determine with precision the size of this group, it is clear that existing community mental health services presently being used by this subpopulation should be maintained at their current levels and not be considered available to other persons not presently

receiving such services. Any decrease or dilution of these services for this subpopulation would create a substantial risk that members of this group would be hospitalized. However, Department staff should retain the discretion to decide whether a given program is operating below capacity and is therefore able to serve additional clients without decreasing existing services to, or creating a risk of hospitalization for, this subpopulation. Given these programmatic principles, the calculation of this subpopulation represents the best available figure and is supported by recently collected information in the Region.

Combining these subpopulations, the community mental health system should be designed to serve 2135 persons through a variety of programs and residences. While some portion of this population, particularly the long-term and discharged subpopulation (C and D), may require continuous residential services and programming, a substantial percent of this group, especially the acute subpopulation (A), will require intensive services for only limited time. Moreover, the subpopulation of persons never hospitalized but at risk of institutionalization (E) should be considered to be receiving appropriate services at the present time, provided none of these services are reduced or otherwise altered. By grouping each subpopulation into homogeneous clusters, it is possible to determine the number of persons needing each type of program or residence.

III. Clustering of Subpopulations

Using the Final Revision of the Index Construction, a total of 47 clusters were created. The assessment survey of all (47)

persons in the Hospital on September 17, 1977 generated data indicating that much of the resident population fell within a relatively small number of clusters. Almost half of the clusters were void. The frequency distribution of all the clusters for that population, which includes the entire long-term subpopulation and a portion (approximately 1/12) of the acute and recidivist subpopulations is attached as Appendix A followed by a summary list of all the clusters that were not void (Appendix B).

Each relevant cluster was then cross-tabulated with the number of prior admissions and length of stay in the Hospital order to determine which clusters related to the acute, recidivist and long-term subpopulations. Appendix D sets forth the results of that cross tabulation, including the percentage of each subpopulation in each cluster. That table also describes the percentage of each cluster that, on the basis of clinical and practical experience, would be expected to fall within each subpopulation. Thus, although three persons in poor health were admitted for the first time and were at the Hospital less than three months, thereby falling in the acute subpopulation, it is highly likely that they will remain at the Hospital indefinitely and thereby soon become part of the long-term subpopulation. Appendix E sets forth the results of the cross-tabulation adjusted for these clinical considerations, including the percentage of each adjusted subpopulation in each

cluster. It should be noted that the adjustments were only made in obvious cases and technically resulted in an insignificant net change in each subpopulation.

On the basis of this adjusted cross-tabulation, the following projections emerge for each subpopulation:

A. Acute Subpopulation -

Total Number - 525 per year or 31 for a 20-day period

Frequency Distribution in Relevant Clusters:

<u>Cluster</u>	<u>Percent</u>	<u>Number</u>
N (27,29)	28	9
O (34)	9	3
P (35)	63	20

B. Recidivist Subpopulation

Total Number - 1076 per year

Frequency Distribution in Relevant Clusters:

<u>Cluster</u>	<u>Percent</u>	<u>Number</u>
B (4)	5	54
C (5)	10	108
F (11)	16	172
M (21)	10	108
N (27,29)	7	75
T (41)	10	108
V (45)	37	398
W (47)	5	54

C. Long-Term Subpopulation

Total Number - 362

Frequency Distribution in Relevant Clusters:

<u>Cluster</u>	<u>Percent</u>	<u>Number</u>
A (1,2)	9	33
B (4)	4	15
C (5)	2	8
D (9)	2.6	9
E (10)	2	8
F (11)	13	49
G (14,15)	1	4
H (17)	5	17
J,L (18,20)	2	8
K (19)	5	20
M (21)	12	45
Q (36,37)	1.4	5
R (39)	1	4
S (40)	1.6	6
T (41)	10	37
U (44)	1.4	5
V (45)	27	94

D. Discharged Subpopulation

Total Number - 172

Although it is not possible to determine the distribution of these persons amongst the clusters, it is clear that psychiatric supportive services for the entire subpopulation should be provided in the nursing and rest homes in which they reside.

E. At Risk Subpopulation

Total Number - 3588

An analysis of this population and the current services they are now receiving is set forth in Appendix F. This data, drawn from the Region I Inventory Survey conducted in October - November 1977, represents the best information available on this subpopulation, and appears generally reliable for the limited purpose of an assessment and planning tool. Assuming a continuation of existing treatment programs serving this subpopulation, no planning of additional services is required.

APPENDIX A

IV. Clusters

NOTE: Clusters 6 - 47 not designated as high on ADL include only persons who score low on the ADL index.

1. High on Hlth., high on Beh.
2. High on Hlth., medium on Beh.
3. High on Hlth., low on Beh.
4. High on Hlth., Chronic Brain Syndrome.
5. High on Assaultive Behavior.
6. Mentally Retarded, high on Beh., medium or high on Psych.
7. Mentally Retarded, high on Beh., low on Psych., medium or high on CAP.
8. Mentally Retarded, high on Beh., low on Psych., low on CAP.
9. Mentally Retarded, high on ADL.
10. Mentally Retarded, medium on Beh., medium or high on CAP.
11. Mentally Retarded, low on Beh., medium or high on CAP.
12. Mentally Retarded, medium on Beh., low on CAP.
13. Mentally Retarded, low on Beh., low on CAP.
14. Over 60, high on Beh., medium or high on Psych., medium or high on CAP.
15. Over 60, high on Beh., medium or high on Psych., low on CAP: OR Over 60, high on Beh., low on Psych., medium or high on CAP.
16. Over 60, high on Beh., low on Psych., low on CAP.
17. Over 60, high on ADL.
18. Over 60, medium on Beh., medium or high on Psych., medium or high on CAP.
19. Over 60, low on Beh., medium or high on Psych., medium or high on CAP.
20. Over 60, medium on Beh., medium or high on Psych., low on CAP: OR Over 60, medium on Beh., low on Psych., medium or high on CAP.

21.	Over 60, low on Beh., medium or high on Psych., low on CAP: OR Over 60, low on Beh., low on Psych., medium or high on CAP.	52
22.	Over 60, medium on Beh., low on Psych., low on CAP.	0
23.	Over 60, low on Beh., low on Psych., low on CAP.	0
24.	Adolescent, high on Beh., medium or high on Psych.	0
25.	Adolescent, high on Beh., low on Psych.	0
26.	Adolescent, medium on Beh., medium or high on Psych.	0
27.	Adolescent, low on Beh., medium or high on Psych.	2
28.	Adolescent, medium on Beh., low on Psych.	0
29.	Adolescent, low on Beh., low on Psych.	12
30.	Acute, high on Beh., medium or high on Psych.	0
31.	Acute, high on Beh., low on Psych.	0
32.	Acute, medium on Beh., medium or high on Psych.	0
33.	Acute, medium on Beh., low on Psych.	0
34.	Acute, low on Beh., medium or high on Psych.	3
35.	Acute, low on Beh., low on Psych.	20
36.	Chronic, high on Beh., medium or high on Psych., medium or high on CAP.	2
37.	Chronic, high on Beh., medium or high on Psych., low on CAP: OR Chronic, high on Beh., low on Psych., medium or high on CAP.	3
38.	Chronic, high on Beh., low on Psych., low on CAP.	0
39.	Chronic, high on ADL.	4
40.	Chronic, medium on Beh., medium or high on Psych., medium or high on CAP.	6
41.	Chronic, low on Beh., medium or high on Psych., medium or high on CAP.	44
42.	Chronic, medium on Beh., medium or high on Psych., low on CAP.	0
43.	Chronic, low on Beh., medium or high on Psych., low on CAP.	0

- 44. Chronic, medium on Beh., low on Psych., medium or high on CAP.
- 45. Chronic, low on Beh., low on Psych., medium or high on CAP.
- 46. Chronic, medium on Beh., low on Psych., low on CAP.
- 47. Chronic, low on Beh., low on Psych., low on CAP.

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APPENDIX B

SUMMARY OF CLUSTERS FOR NORTHAMPTON STATE HOSPITAL

An asterisk (*) indicates that the index was not considered in determining the cluster.)

Cluster	Composed of Cluster No.	Characteristic	Beh.	Psych.	CAP	ADL	NO.
A	2,3	High Hlth.	Low Med.	*	*	*	33
B	4	Chronic Brain Synd.	*	*	*	*	19
C	5	Assaultive Behavior	*	*	*	*	15
D	9	MR	*	*	*	High	9
E	10	MR	Med.	*	High-Med.	Low	8
F	11	MR	Low	*	High-Med.	Low	61
G	14,15	Elderly	High	High-Med. Low	High-Med. Low	Low	4
H	17	Elderly	*	*	*	High	17
J	18	Elderly	Med.	High-Med.	High-Med.	Low	6
K	19	Elderly	Low	High-Med.	High-Med.	Low	20
L	20	Elderly	Med.	Low	High-Med. Low	Low	2
M	21	Elderly	Low	Low	High-Med. Low	Low	52
N	27,29	Adoles.	Low	High-Med. Low	*	Low	14
O	34	Acute	Low	High-Med.	*	Low	3
P	35	Acute	Low	Low	*	Low	20
Q	36,37	Chronic	High	High-Med. Low	High-Med. Low	Low	5
R	39	Chronic	*	*	*	High	4
S	40	Chronic	Med.	High-Med.	High-Med.	Low	6
T	41	Chronic	Low	High-Med.	High-Med.	Low	44
U	44	Chronic	Med.	Low	High-Med.	Low	5
V	45	Chronic	Low	Low	High-Med.	Low	121
W	47	Chronic	Low	Low	Low	Low	4

Clusters 1,6,7,8,12,13,16,22,23,24,25,26,28,30,31,32,33,38,42,43,46 had no members (N = 0)

APPENDIX C

TABLE 1

RECIDIVIST PATIENTS WHO HAVE RETURNED TO
NORTHAMPTON STATE HOSPITAL WITHIN ONE YEAR SINCE LAST ADMISSION
OCTOBER 1, 1977 - MARCH 31, 1978*

Number of Readmissions	<u>Unit</u>					<u>Northampton State Hospital</u>	
	I	II	III	IV	V	Six-Month Total	One-Ye Total
One	16	40	29	55	19	159	318
Two	3	3	5	4	3	18	36
Three	1	2	1	1	0	5	10
More	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total	20	45	35	60	22	182	364

*These figures do not include readmissions of persons on indefinite visit status. See Table 3, following.

APPENDIX C

TABLE 2

ANALYSIS OF RECIDIVISM FOR
NORTHAMPTON STATE HOSPITAL PATIENTS
OCTOBER 1, 1977 - MARCH 31, 1978*

	<u>Six Month Total</u>	<u>One Year Total</u>
Total admissions to Northampton State Hospital	650	1300
Number of first admissions	283	566
Readmissions within 12 months since previous admission (unduplicated patient count)	182	364
Readmissions 12 to 24 months since previous admission (unduplicated patient count)	40	80
Readmissions after more than 2 years since previous admission (unduplicated count)	118	236
Total readmission episodes during 6 month period	368	736
Unduplicated count of all persons readmitted	340	680

*These figures do not include readmissions of persons on indefinite visit status. See Table 3, following.

APPENDIX C

TABLE 3

ANALYSIS OF RECIDIVISM FOR
 NORTHAMPTON STATE HOSPITAL PATIENTS
 PLACED ON INDEFINITE VISIT STATUS
 OCTOBER 1, 1977 - MARCH 31, 1978

	<u>Number of Persons</u>
Placed on Visit	270
Discharged (at end of 6 months)	151
Returned from Visit (within 6 months)	119

RATE OF RETURN FROM VISIT

<u>Number of Returns Within 6 Months</u>	<u>Number of Persons</u>
1	97
2	10
3	7
4	4
5	1

APPENDIX C

TABLE 4

RECIDIVIST POPULATION: A 2 - YEAR PLANNING PERIOD ESTIMATE

	# Clients at Risk of Readmission	Average Annual Readmissions for This Group	# of Clients at Risk Who Will Be Readmitted During		# of Readmission Episodes that Are Attributed to Group During	
			1 Yr. Period	2 Yr. Period	1 Yr. Period	2 Yr. Period
A.	46	2.21	46	46	102	204
B.	318	1.00	318	318	318	632
C.	121	.66 (every 18 months)	80	121	80	121
D.	590	.4 (every 30 months)	236	472	236	472
TOTAL	1075		680	957	736	1,429

Assumptions:

Group A: The n of 46 is based on TABLE 1, Appendix C; the average readmit rate is a weighted average based on 36 clients having 2 readmissions 1 year and 10 having 3 readmissions 1 year.

Group B: The n of 318 is based on TABLE 1, Appendix C.

Group C: The n of 121 is derived from TABLE 2, Appendix C; 80 unduplicated clients with an average readmit rate of .66 (or once every 18 months) were identified in this group. It is assumed that this group of 80 derives from a larger subpopulation, given an average admit rate of .66 which characterizes this group, the total population at risk would have to be 121 in order for 80 individuals to show up within a one year period.

Group D: The n of 590 individuals at risk is derived from TABLE 2, Appendix C; 236 unduplicated clients in that table are identified with a risk of readmission somewhat less than once every 2 years. Assuming that the average readmit rate for this group is about once every 30 months (or .4 readmits 1 year), then the total class at risk would have to be 590, in order to find 236 individuals showing up in a single year. Note however, that for a two year planning period, only 472 of these 590 individuals will show up at the Hospital.

APPENDIX D

Clusters	Acute			Recidivist			Long Term		
	No.	Under 3 Mos. No Prior Adm. Projected % of Cluster	Actual % of Sub-Pop.	No.	Under 3 Mos. & 1 Prior Adm. & Projected % of Cluster	Under 3 Mos. 2 or More Prior Adms. Actual % of Sub-Pop.	No.	Over 3 Mos. Projected % of Cluster	Actual % of Sub-Pop.
A 1,2 High Health	3		10	0			30	100	12
B 4 Chronic Brain	1		3	3	25	4	15	75	4
C 5 Assaultive	2		7	5	40	6	8	60	2
D 9 MR - ADL	0			0			9	100	2.2
E 10 MR	1		3	0			7	100	1.8
F 11 MR	1		3	11	20	14	49	80	15
G 14,15 Elderly	0			0			4	100	1
H 17 Elderly-ADL	0			1		1	16	100	4
J } 18,20 Elderly	0			1		1	7	100	1.8
L }									
K 19 Elderly	0			0			20	100	6
M 21 Elderly	1		3	6	13	7	45	87	11
N 27,29 Adolescent	5	75	18	6	25	7	3		.8
O 34 Acute	3	100	10	0			0		
P 35 Acute	11	100	40	9		11	0		
Q 36,37 Chronic	0			0			5	100	1.2
R 39 Chronic-ADL	1		3	0			3	100	.8
S 40 Chronic	0			2		2	4	100	1
T 41 Chronic	0			7	20	9	37	80	9
U 44 Chronic	0			0			5	100	1.2
V 45 Chronic	0			27	20	34	94	80	25
W 47 Chronic	0			3	100	4	1		.2
TOTALS	29		100%						

Clusters	Acute			Recidivist			Long Term		
	No.	Under 3 Mos. No Prior Adm.		No.	Under 3 Mos. 1 Prior Adm. & 2 or More Prior Adms.		No.	Over 3 Mos.	
		Projected % of Cluster	Actual % of Sub-Pop.		Projected % of Cluster	Actual % of Sub-Pop.		Projected % of Cluster	Actual % of Sub-Pop.
A 1,2 High Health	0			0			33	100	9
B 4 Chronic Brain	0			4	25	5	15	75	4
C 5 Assaultive	0			7	40	10	8	60	2
D 9 MR - ADL	0			0			9	100	2.6
E 10 MR	0			0			8	100	2
F 11 MR	0			12	20	16	49	80	13
G 14,15 Elderly	0			0			4	100	1
H 17 Elderly-ADL	0			0			17	100	5
J } 18,20 Elderly	0			0			8	100	2
L }									
K 19 Elderly	0			0			20	100	5
M 21 Elderly	0			7	13	10	45	87	12
N 27,29 Adolescent	9	75	28	5	25	7	0		
O 34 Acute	3	100	9	0			0		
P 35 Acute	20	100	63	0			0		
Q 36,37 Chronic	0			0			5	100	1.4
R 39 Chronic-ADL	0			0			4	100	1
S 40 Chronic	0			0			6	100	1.6
T 41 Chronic	0			7	20	10	37	80	10
U 44 Chronic	0			0			5	100	1.4
V 45 Chronic	0			27	20	37	94	80	27
W 47 Chronic	0			4	100	5	0		
TOTALS	32		100%	73		100%	367		100%

APPENDIX F

ANALYSIS OF REGION I INVENTORY DATA

Code:	A - Emergency/Prevention Service	Average Length of A - 3 days
	B - Outpatient Therapy	B - 7 months
	C - Day Treatment/Activities	C - 10 months

Program	Code	# of Clients Per 2 Wks.	Multiplication Factor	# of Per
<u>Hampshire Franklin</u>				
East Spoke F.C.P.H.	B	7	1.7	11
"	A	17	26	442
"	C	1	1.2	1
Outreach (N'ton)	A	2	26	52
Outreach (Gfld)	A	1	26	26
Frank. Cty. M.H.C.	A	4	26	104
"	B	29	1.7	49.
"	C	10	1.2	12
Hampshire Day House	B	26	1.7	44.
"	C	3	1.2	3.
<u>Westfield</u>				
Westfield A.M.H.C.	A	4	26	104
"	B	6	1.7	10.
Northampton St. Hosp.	C	1	1.2	1.
<u>Berkshire</u>				
Main St. Human Res.	A	5	26	130
"	B	13	1.7	22.1
B.M.H.C.	A	2	26	52
"	B	14	1.7	23.8
"	C	22	1.2	26.4
No. Berk. M.H.C.	B	4	1.7	6.8
"	C	16	1.2	19.2

APPENDIX F (Cont.)

Program	Code	# of Clients Per 2 Wks.	Multiplication Factor	# of Clients Per Year
<u>Springfield</u>				
Baystate	A	57	26	1482
"	B	84	1.7	142.8
C.C.C.	B	98	1.7	166.6
"	C	6	1.2	9.2
<u>Holyoke-Chicopee</u>				
Maple House	A	1	26	26
H.C.M.H.C.	A	1	26	26
"	B	23	1.7	39.1
Crossroads	B	36	1.7	61.2
Wing Mem. Hosp.	A	11	26	286
"	B	<u>123</u>	1.7	<u>209.1</u>
TOTALS		627		3588

ATTACHMENT B

COMMUNITY RESIDENTIAL ALTERNATIVES
FOR MENTAL HEALTH CLIENTS
PROGRAM MODELS

Prepared for the Massachusetts
Department of Mental Health

Region I Planning Process

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COMMUNITY-BASED RESIDENTIAL SERVICES FOR MENTAL HEALTH CLIENTS

I. INTRODUCTION

The following program descriptions, compositions and cost breakdowns are meant to serve as a guideline for regional and area planning in the development of community residential alternative programs. The matching of client and residential alternatives as described for each program is based on the Region I Client Evaluation Survey. Approaches to staffing and start up program costs will require modification depending on such factors as the support services provided, client level of functioning, location of the facility and condition of the building.

Program Considerations

An underlying principle in the development of program models should be the maximizing of individual client growth and the development of individualized service plans to assist and teach clients to live as normal a life as possible in the mainstream of the community. This can be facilitated by incorporating the developmental model when designing Individual Service Plans, recognizing the capability of each person to learn, grow and develop, no matter how severely disabled.

Many clients in need of a community residential placement require assistance in gaining self-help skills, socialization skills, and use of community resources. For some clients training may be quite basic; for others, more sophisticated, depending on the individual level of functioning upon entry into the community program. In addition, some clients may require an individualized program to eliminate problematic behaviors and/or supervision of basic physical care needs.

The following programs describe staffing and cost figures for either eight bed residences or 4 bed apartments. Although each apartment is described for a maximum of four persons, two separate apartments might be clustered together in one large building or adjacent buildings. In no event, however, should programs be located in such geographical proximity as to create an undue concentration of clients in one area or neighborhood.

Many of the attached program descriptions include the alternative of operating programs in either houses or apartments. As many programs can be implemented in either type of housing, facility decisions should be based on the programmatic flexibility as well as on the barriers to implementation and operation presented by each type of facility. These may include the relative social advantages of a small apartment for four persons over a larger home for eight residents; the ability to design and implement service plans on a more individualized basis in smaller settings; the reality that small apartments are more normative than larger homes; considerations of the types of housing available in an area; the availability of start-up monies (minimal for an apartment program which requires no mortgage); cost of alternative staffing requirements (often higher in apartments than in homes); renovation or time delays caused by the need to meet the State Building Code for Group Residences; and issues related to community acceptance and integration and local zoning ordinances.

Finally, some of the residential alternatives are described as specialized programs for persons with severe behavioral problems and/or physical care needs. Staffing in these programs has been designed to provide the additional coverage required by the added program responsibilities. Programmatically, however, it is important for any one facility to have a mixed population with regard to level of severity of disability, as an important aspect of residential programming is peer role modeling, interaction and support. It is recommended that no more than half the residents in any specialized program require intensive behavioral intervention or physical care. Special subpopulations, such as programs for adolescents, may require alternative staffing configurations. With some modifications, however, the range of specialized programming needs should fit within the alternative residential programs described herein.

Satellite Model of Organizing Network of Community Residential Services

When planning an area network of community residential programs one concept to consider is the Satellite Model of Organizational structure. This consists of a core residential unit which, in addition to providing services and training to clients who live there, also provides managerial support and program coordination for each program in the area's network of residential services. Professional staff as needed by the residential network are maintained by the unit and are responsible for providing programmatic coordination and management for clients within the network. Some clients receiving services in the satellite network may never live in the core unit itself but may move into a satellite setting directly. Others may live in the core unit during an evaluation period, so that an individual service plan may be developed and appropriate satellite program identified. Some clients may come to the core unit intermittently for respite or emergency care. Satellite programs may consist of specialized group home or apartment programs, specialized home care and support services to clients residing in non-DMH provided or funded housing (see following descriptions). Utilization of this model would necessitate modification of the enclosed program and staffing descriptions to accommodate a centralized and consolidated administrative and program coordination.

Staffing Considerations

Full time staff positions are based on a non-residential forty hour week rather than a live-in staff approach. Programs utilizing live-in staff will require modification of the staffing pattern described here. The annual salary for mental health workers is estimated at \$9500 with the recommendation that each program establish two levels of salary, with entry level workers without experience in community mental health work (MHW I) beginning at \$3500 and those with greater expertise and/or experience (MHW II) beginning at \$10,500.

In addition, it is important that new staff participate in a comprehensive training program designed to orient them to the larger community mental health system, other generic community services, the goals, objectives and behavioral techniques of the particular residential program and a range of skills necessary to meet client needs.

On the enclosed charts the number of positions indicated in the "Direct Care Personnel" column reflect the number of persons on duty on a particular shift. The Full Time Equivalent (F.T.E.) column indicates the number of forty hour week positions necessary to provide the coverage. The "Cover Factor" column reflects staff necessary to cover vacation and sick leave time. Recommended staffing patterns should be viewed from the standpoint of overall need rather than rigid adherence to shift. For example, if a director is at a residence at scheduled times during the day shift she/he may be able to provide the minimal coverage required when the majority of clients are engaging in day activities outside the home. It might then be advantageous for some of the day shift mental health workers' hours to be reassigned to the evening shift when more clients are in the residence. Additionally, it may be important to staff understanding of client functioning, inter-staff communication and program implementation for staff to rotate shifts so that all staff have the opportunity to be with clients engaging in a variety of daily living and social experiences. Actual staff scheduling should also include time for all staff to meet weekly to discuss general concerns of the program and individual client progress, as well as a time for house meetings with all staff and residents present.

Staffing for each program with a minimum of eight clients includes a half time Director/Administrator. Responsibilities of this position should include hiring and supervising direct care staff, coordinating and managing the residential aspect of the Individual Service Plans (ISP), arranging for support services as needed, facilitating the use of generic community services, representing the program in community relation efforts, providing or arranging for pre-service and in-service training of direct care staff, managing the fiscal aspects of the operation and maintaining data as required. Organizational structure and staff composition of the residential program will affect the responsibilities and time needed for "Director/Administrator" duties. For example, an agency operating more than one residential program may require a full time director with funding partially provided by each program. A small agency operating a single program may want to combine the half-time director and float time into one position to include both direct care and administrative duties and/or may require night staff to handle a portion of the paper administrative duties such as completion of statistical reports, etc.

The duties of mental health workers include assisting and teaching clients in learning to live independently, providing counselling and support to clients as necessary, implementing the program's goals and responsibilities and sharing with the director and other staff the daily operational tasks of the residence. Weekday staff are expected to facilitate clients' involvement in non-residential programs, activities and employment, but must be available to clients who, for whatever reason, do not participate in such activities.

Budget Considerations

When calculating the amount of DMH resources needed for operating expenses, client income should be deducted from the total cost. Many clients are eligible for Supplementary Security Income (S.S.I.) which is presently \$216.93 per month. Subtract the amount the client keeps for personal needs. Multiply the remainder by 12 (months). Reduce this figure by 5% as most facilities average a 5% vacancy rate over a year's time. This will provide you with an estimated non-DMH house income.

Provider Considerations

It is generally beneficial for providers of these programs to be private, non-profit organizations experienced in operating residences for mentally disabled clients. Such providers should have the professional skills necessary to design, establish and coordinate quality programs, including the ability to recruit and train dedicated staff. They should also possess the administrative capability and flexibility to manage such programs and integrate their goals with the larger community alternative system. To the extent that small, inexperienced private corporations or public agencies are used as providers, some modification of these program models may be necessary to account for the lack of flexibility or other resultant constraints.

Providers also have the flexibility to rent or purchase homes or apartments as well as the discretion to combine rent, maintenance and some insurance costs to cover variable rental prices.

PROGRAM DEFINITIONS

II. PROGRAM DEFINITIONS

- A. Support Services to Clients Residing in Non-DMH Provided or Funded Housing - Staff support and consultation consisting of regular visits to clients to assist in their adjustment to their living environment and the community at large, as well as assisting facility providers, when appropriate, in their work with clients.
- B. Specialized Home Care Program - Supervised living of one to three adults in a private home in the community. Home care providers supervise and assist in activities of daily living, home management skills, utilization of community resources, etc. Each home may serve 1-3 clients.
- C. Supervised Apartment Program - A community-based residential program providing structure and supervision to adults living in apartments. Supervision and teaching of daily living skills are provided to assist clients to move to less restrictive settings.
- D. Supervised Group Home - A small community based group living facility providing room, board and supervision in daily living skills for persons in need of long term maintenance.
- E. Transitional Apartment Program - A community based transitional apartment program with a maximum of four persons per apartment, operating 24 hours a day providing room, board, and supportive services including supervision and intensive training in daily living skills. Residents are usually expected to move to a more independent and/or less intensive living situation within one year.
- E. 1 Transitional Community Residence - A community based living facility operating 24 hours a day providing room, board and supportive services including supervision and intensive training in daily living skills. Residents are usually expected to move to a more independent and/or less intensive living situation within one year.
- F. Apartment Program with Physical Care Component - A community based apartment program with a maximum of four persons per apartment that provides daily assistance and training in basic activities of daily living and physical care for clients with high A.D.L. needs.
- F. 1 Group Home with Physical Care Component - A community based living facility providing room, board and daily assistance and training in basic activities of daily living and physical care for clients with minimal behavioral problems and high A.D.L. needs.
- G. Apartment Program with Behavioral Emphasis* - A community based apartment program with a maximum of four persons per apartment providing room, board and intensive services within the apartment for persons with serious behavioral problems. The program is designed to replace problematic behaviors with appropriate living skills so the individual may move to a less restrictive, more normalized environment. Residents will have low physical care needs.

- G. 1 Group Home with Behavioral Emphasis* - A community based living facility providing room, board and intensive services within the home for persons with serious behavior problems. The programs are designed to replace problematic behaviors with appropriate living skills so the individual may move to a less restrictive, more normalized environment. Residents will have low physical care needs.
- H. Apartment Program with Physical Care Component and Behavioral Emphasis - A community based apartment program with a maximum of four persons per apartment that provides both intensive behavioral program intervention as well as physical care and help with activities of daily living.
- H. 1 Group Home with Physical Care Component and Behavioral Emphasis - A small community based group living facility that provides both intensive behavioral program intervention as well as physical care and help with activities of daily living.

* A Group Home and Apartment Program with Intensive Behavioral Emphasis to meet the needs of persons with severe self-destructive or other destructive behaviors is included by increasing the staffing in this model. In all other regards, including the purpose and programming of these residences, the models are the same.

START-UP COSTS

III. START-UP COSTS

Start-Up Costs will vary considerably depending on such factors as location and condition of facility; whether facility is to be purchased or rented; whether there are legal complications; the particular building code specifications to be met, etc.

- a. House Purchase/Down Payment: Conventional mortgages from banks usually require a 20% down payment. Thus a \$15,000 down payment would be sufficient to obtain a \$75,000 conventional mortgage. With liberal bank and/or employment of a state/federal mortgage assistance/guarantee program this amount could vary.
- b. Legal Services: Generally such services might include title transfer, zoning advice and legal counseling. In some instances, these services might be obtained on a pro bona basis, in which case there would be no cost.
- c. Real Estate Taxes: This varies depending on the time of year the property is purchased. If the sale is closed in January, taxes for the entire year must be paid before an exception is granted. Conversely, if the closing occurs in December, little or no taxes need be paid. To date no way has been found to obtain an exemption on the first year's taxes short of a legislative act.
- d. Meeting Building Code Specifications: These requirements include total smoke and heat detector systems (approximately \$5000) and special fire resistant paint. Depending on the structure, other expenses could include widening stairs, adding rear fire escapes, changing the direction for opening doors, adding fire doors, installing emergency lighting, etc.
- e. Staff: Prior to beginning program operation staff must be available to write proposals, perform need studies, make referral contacts, hire and train staff, purchase supplies and equipment, deal with banks, lawyers, contractors, etc.
- f. Contingency Fund: Clients generally move into a new residence a few at a time over the first few months of operation. During this time the majority of expenses are fixed costs that have to be met, in spite of a lower income from client fees.
- g. Staff Training: New staff should participate in a comprehensive training program prior to beginning to work with clients. Ongoing training should be provided through consultation funds.

ESTIMATED START-UP COSTS

I. Residence or Home

	<u>Minumum</u>	<u>Average</u>	<u>Maximum</u>
a. Down Payment	0	7,500	15,000
b. Legal Services	0	400	800
c. Real Estate Taxes	0	400	800
d. Building Code Specifications	5,000	6,500	8,000
e. Staff	2,000	3,000	4,000
f. Furnishings	8,000	11,000	14,000
g. Vehicle	4,500	5,000	5,500
h. Insurance (Car and House)	700	800	1,000
i. Miscellaneous	300	400	500
j. Contingencies	1,000	1,200	1,400
k. Delay of Payments	4,500	8,000	8,000
l. Staff Training	<u>1,000</u>	<u>2,000</u>	<u>3,000</u>
	<u>27,000</u>	<u>46,200</u>	<u>62,000</u>

II. Apartment

Items (a-d) would not likely be applicable to apartment programs. The other costs (e-l) would be the same.

STAFF AND OTHER OPERATING COSTS

- A. Support Services to Clients Residing in Non-DMH Provided or Funded Housing - Staff support and consultation consisting of regular visits to clients to assist in their adjustment to their living environment and the community at large, as well as assisting facility providers, when appropriate, in their work with clients. This service may be provided to persons residing in varied residential settings, including nursing/rest homes, boarding houses, cooperative apartments and private homes. Clients include: A small number of elderly and chronically handicapped clients (54) presently at the hospital with minimal needs other than assistance in adjusting to their new living environment; an additional large group of clients (528) with a history of recurring hospitalizations who require these support services to live in their own home or apartment and the (198) clients presently residing in nursing/rest homes where their mental health needs are minimally met.

Alternative approaches to providing this service include: ¹

- a. The provision of consultation and follow-up to Facility Staff and Clients in Nursing/Rest/Boarding Homes

STAFFING/COST SCHEDULE

- i. Program providing minimum support service (4 hours per week).

<u>Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	N.A.	N.A.	9,500	950	171	95	1,216	N.A.	1,216

- ii. Program providing maximum support service (12 hours per week).

<u>Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	N.A.	N.A.	9,500	2,850	513	285	3,648	N.A.	3,648

Support Services to Clients Residing in Non-DMH Provided or Funded Housing (Continued)

b. The provision of mental health staff to supplement staff of nursing/rest homes for the purpose of providing specialized services required by mentally disabled population.

STAFFING/COST SCHEDULE
(to supplement a facility for 16 mental health clients)

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS	1.0	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S&S DAYS	.4	9,500	3,800	684	380	4,864	486.4	5,350
1 MENTAL HEALTH WORKER	M-F EVE's	1.0	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S&S EVE's	.4	9,500	3,800	684	380	4,864	486.4	5,350
<u>Sub-Totals:</u>		<u>2.8</u>	<u>38,000</u>	<u>26,600</u>	<u>4,788</u>	<u>2,660</u>	<u>34,048</u>	<u>3,404.8</u>	<u>37,452.8</u>
<u>II. Administrative Personnel</u>									
1 MH SUPERVISOR	N.A.	.25	12,000	3,000	540	300	3,840	384	4,224
<u>III. TOTALS:</u>		<u>3.05</u>	<u>50,000</u>	<u>29,600</u>	<u>5,328</u>	<u>2,960</u>	<u>37,888</u>	<u>3,788.8</u>	<u>41,676.8</u>

Support Services to Clients Residing in Non-DMH Provided or Funded Housing (Continued)

c. The provision of consultation and follow-up to clients residing in cooperative apartments or homes to assist with obtaining and maintaining apartments, employment, budgeting, etc.

			STAFFING/COST SCHEDULE						
			Equivalent	Actual	Fringe	G&A	Staff	Cover	
I. <u>Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Full/Time</u> <u>Salary</u>	<u>Salary</u>	<u>18%</u>	<u>10%</u>	<u>Costs</u> <u>Subtotal</u>	<u>Factor</u> <u>(x.10)</u>	<u>TOTAL</u>
(Program providing 4 hours per week of support service.) ²									
1 MENTAL HEALTH WORKER	N.A.	.10	9,500	950	171	95	1,216	121	1,337.6
(Program providing 12 hours per week of support service.) ³									
1 MENTAL HEALTH WORKER	N.A.	.3	9,500	2,850	513	285	3,648	364.8	4,012.8
II. <u>Administrative Personnel</u>									
1 Supervisor	N.A.	.125	12,000	1,500	270	150	1,920	192	2,112
III. <u>TOTALS:</u>									
Program providing 4 hr/wk support		.225	21,500	2,450	441	245	3,136	313	3,449.6
Program providing 12hr/wk support		.425	21,500	4,350	783	435	5,568	556.8	6,124.8

¹ There are no costs other than staffing for this service

² One hour supervision per week to each of four clients residing in apartment or home.

³ Three hour supervision per week to each of four clients residing in apartment or home.

- B. Specialized Home Care Program - Supervised living of one to three clients in a private home in the community. Home care providers supervise and assist in activities of daily living, home management skills, utilization of community resources, etc. Each home may serve 1-3 clients. Specialized home care services will be required for a small number of clients (31) presently at the state hospital, who require residential supervision and some assistance in community adjustment. They include: a few mentally retarded adults; adolescents with minimal needs other than adult supervision in other than their natural home; and some chronically handicapped persons. These services are also planned for some clients (13) presently residing in the community, but with a history of recurring hospitalizations.

Essential to the success of the Specialized Home Care program are the selection of families and the provision of on-going consultation and back-up support staff.

A Start-up budget for a maximum of four homes should include:

1 Full-time Coordinator (for six months)	7,500
Consultation (training families)	4,500
Total	12,000

Program Consisting of Four Homes Serving a Maximum of 12 Clients

(Figures based on 4.2 family members at 2.65@hr.)¹

STAFFING/COST SCHEDULE

<u>II. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotals</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
FAMILY MEMBER, providing in-home training	Two Hrs/Day per client	4.2	5,512 (2.65/hr, for 40 hr week)	23,150	4,167	2,315	29,632	N.A.	29,632
(6 hrs per home, per day 4 homes, 3 clients, per home)									

II. Administrative Personnel

DIRECTOR	1.0	15,000	15,000	2,700	NA	17,700	NA	17,700
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III. Operating Costs

Room and Board \$5.00/Day/Client

21,900

	<u>Shift</u>	<u>FTE's</u>	<u>Full Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
IV. Program Total:	NA	5.2	20,512	38,150	6,867	2,315	47,332	N.A.	47,332

V. Unit Cost: 10.81 per Day

Average Annual per Client Cost \$ 3,944.33

¹ This, as other full time equivalent figures is based on a 40 hour week. Family members providing two hours supervision per day per client for a 12 client program (4 homes, 3 clients per home) will require a total of 168 hours or 4.2 forty hour work weeks.

- C. SUPERVISED APARTMENT PROGRAM - A community-based residential program providing structure and supervision to adults living in apartments. Supervision and teaching of daily living skills are provided to assist clients to move to less restrictive settings. Either a supervised apartment or supervised group home setting will be necessary for the majority of the clients (255) presently at the state hospital. These include the majority of the mentally retarded population; elderly clients with psychiatric symptomatology and need for assistance with community adjustment; and some chronically handicapped clients with psychiatric symptomatology and/or need for assistance with community adjustment.

These settings are also planned for a few (12) clients presently residing in the community but with a history of recurring hospitalizations.

The following staffing and cost estimates are for a program consisting of one apartment, housing four clients.

<u>STAFFING/COST SCHEDULE</u>									
<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G & A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS (7-11 a.m.)	.5	9500	4,750	855	475	6,080	608	6,688
1 MENTAL HEALTH WORKER	S&S DAYS	.4	9500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	M-F EVE's	1.0	9500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S&S EVE's	.4	9500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	FLOAT	.35	9500	3,325	598.5	332.5	4,256	N.A.	4,256
1 MENTAL HEALTH WORKER	7 NIGHTS (on call)	N.A.	N.A.	5,000	900	500	6,400	N.A.	6,400
CONSULTATION	AS NEEDED	N.A.	N.A.	1,300	N.A.	N.A.	1,300	N.A.	1,300
<u>Sub-Totals:</u>		<u>2.65</u>	<u>47,500</u>	<u>31,475</u>	<u>5,431.5</u>	<u>3,017.5</u>	<u>39,924</u>	<u>2,796.8</u>	<u>42,720.8</u>
<u>II. Administrative Personnel</u>									
1 DIRECTOR	N.A.	.25	15,000	3,750	675	375	4,800	N.A.	4,800
1 SECRETARY/BOOKKEEPER	N.A.	.125	7,200	900	162	90	1,152	N.A.	1,152
<u>Sub-Totals:</u>		<u>.375</u>	<u>22,200</u>	<u>4,650</u>	<u>837</u>	<u>465</u>	<u>5,952</u>	<u>N.A</u>	<u>5,952</u>

ShiftFTE'sFull/Part
SalaryAgency
SalaryTravelFoodMedicalOtherIII. Operating Costs

Rent and Utilities
Maintenance
Telephone
Insurance
Food
Transportation
Other

4,200
1,000
300
500
4,500
600
-

Sub-Totals:

11,100IV. Program Total3.02569,70036,1256,268.5 3,482.545,8762,796.859,772.8

-15-

V. Unit Cost: \$40.94 per DAY

Average Annual per Client Cost: \$ 14,943.10

NOTES:

Apartment programs serving more or less than four clients will require appropriate modifications in staffing patterns.

Float position provides extra staff coverage whenever most needed, i.e., in emergencies, client illness, to attend meetings, to provide extra coverage during special activities, etc. See recommended breakdown following page.

Coverage during sleeping hours may be either provided by staff sleeping at apartment on a rotating basis or by additional staff-provided room in exchange for availability in case of emergency. Staff paid at minimum wage for four hours if disturbed during sleeping hours for emergency duty. If two apartments are in same building coverage may be provided by one staff person with intercom between apartments. Cost based on estimate of coverage needed.

Consultation is based on \$25/per hour for one hour per week.

PROGRAM TYPE Supervised Apartment - 4 Clients

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On	= 7-11 a.m.	= 3-11 p.m.	= As Needed	
	Hours per day	= 4	= 8	= 2	
	Hours per week	= 20	= 40	= 10	
	No. of staff	= 1	= 1	= 1	1.75
	Total F.T.E.s	= .5	= 1	= .25	
WEEK ENDS	On	= 7 a.m. - 3 p.m.	= 3 - 11 p.m.	= As Needed	
	Hours per day	= 8	= 8	= 2	
	Hours per week	= 16	= 16	= 4	
	No. of staff	= 1	= 1	= 1	.9
	Total F.T.E.s	= .4	= .4	= .1	

- D. Supervised Group Home - A small community based group living facility providing room, board and supervision in daily living skills for persons in need of long term maintenance. Supervision and teaching of daily living skills are provided to assist clients to move to less restrictive settings. Either a supervised apartment or supervised group home setting will be necessary for the majority of clients (255) presently at the state hospital. These include the majority of the mentally retarded population; elderly clients with psychiatric symptomatology and need for assistance with community adjustment; and some chronically handicapped clients with psychiatric symptomatology and/or need for assistance with community adjustment.

STAFFING/COST SCHEDULE

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS (7-11 a.m.)	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S-S DAYS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	M-F EVES.	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S-S EVES.	.4	9,500	3,800	634	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	FLOAT	.87	9,500	8,265	1,487.7	826.5	10,579.2	NA	10,579.2
1 MENTAL HEALTH WORKER	7 NIGHTS ON CALL	NA	NA	5,000	900	500	6,400	NA	6,400
1 CONSULTANT	NA	NA	NA	2,600	NA	NA	2,600	NA	2,600
Sub-Totals:		<u>3.67</u>	<u>47,500</u>	<u>42,465</u>	<u>7,175.7</u>	<u>3,986.5</u>	<u>53,627.2</u>	<u>3,404.3</u>	<u>57,032</u>

II. Administrative Personnel

1 DIRECTOR	NA	.5	15,000	7,500	1,350	750	9,600	NA	9,600
1 BOOKKEEPER/SECRETARY	NA	.25	7,200	1,800	324	180	2,304	NA	2,304
Sub-Totals:		<u>.75</u>	<u>22,200</u>	<u>9,300</u>	<u>1,674</u>	<u>930</u>	<u>11,904</u>	NA	<u>11,904</u>

	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
III. <u>Operating Costs</u>									
Rent and Utilities									<u>8,400</u>
Maintenance									<u>2,000</u>
Telephone									<u>600</u>
Insurance									<u>1,000</u>
Food									<u>9,000</u>
Transportation									<u>1,200</u>
Other									<u>0</u>
Sub-Totals:									<u>22,200</u>
IV. <u>Program Total:</u>		<u>4.42</u>	<u>69,700</u>	<u>51,765</u>	<u>8,849.7</u>	<u>4,916.5</u>	<u>65,531.2</u>	<u>3,404.8</u>	<u>91,136</u>

V. Unit Cost: 31.21 Per Day

Average Annual per Client Cost: 11,392

NOTES:

Float position provides extra staff coverage whenever most needed, i.e., in emergencies, client or staff illness, to attend meetings, to provide extra coverage during special house activities, etc. See recommended breakdown following page.

Coverage during sleeping hours may be either provided by staff sleeping at home on a rotating basis or by additional staff - provided room in exchange for availability in case of emergency. Staff paid at minimum wage for four hours if disturbed during sleeping hours for emergency duty.

Consultation is based on \$25/per hour for two hours per week.

PROGRAM TYPE Supervised Group Home - 8 Clients

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On = <u>7-11 a.m.</u> Hours per day = <u>4</u> Hours per week = <u>40</u> No. of staff = <u>2</u> Total F.T.E.s = <u>1</u>	= <u>3-11 p.m.</u> = <u>8</u> = <u>40</u> = <u>1</u> = <u>1</u>	Staff will sleep in apartment and be available in emergency situations.	= <u>As Needed</u> = <u>5</u> = <u>25</u> = <u>1</u> = <u>.62</u>	<u>2.62</u>
WEEK ENDS	On = <u>7 a.m.-3 p.m.</u> Hours per day = <u>8</u> Hours per week = <u>16</u> No. of staff = <u>1</u> Total F.T.E.s = <u>.4</u>	= <u>3-11 p.m.</u> = <u>8</u> = <u>16</u> = <u>1</u> = <u>.4</u>	Staff will sleep in apartment and be available in emergency situations.	= <u>As Needed</u> = <u>5</u> = <u>10</u> = <u>1</u> = <u>.25</u>	<u>1.05</u>

E. Transitional Apartment Program - A community based transitional apartment program with a maximum of four persons per apartment, operating 24 hours a day providing room, board, and supportive services including supervision and intensive training in daily living skills. Residents are usually expected to move to a more independent and/or less intensive living situation within one year. Either a transitional apartment or transitional community residence is required for a small number of clients (29) as they leave the state hospital setting. They include: mentally retarded clients with some behavioral problems and the need for assistance with community adjustment; elderly clients with some behavioral problems, psychiatric symptomatology and community adjustment needs; adolescents with psychiatric symptomatology; and chronically handicapped persons with some behavioral problems, psychiatric symptomatology and the need for assistance with community adjustment.

The following staffing and cost estimates are for a program consisting of one apartment housing four clients.

STAFFING/COST SCHEDULE

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS (7-11 a.m.)	.5	9,500	4,750	855	475	6,080	608	6,688
1 MENTAL HEALTH WORKER	S-S DAYS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	M-F EVES.	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S-S EVES.	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	M-F NIGHTS	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S-S NIGHTS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	FLOAT	.43	9,500	4,085	735.30	408.50	5,228.8	NA	5,228.8
CONSULTATION	AS NEEDED	NA	NA	1,300	NA	NA	1,300	NA	1,300
Sub-Totals:		<u>4.13</u>	<u>66,500</u>	<u>40,535</u>	<u>7,028.3</u>	<u>3,923.</u>	<u>51,520.8</u>	<u>4,499.2</u>	<u>56,020.0</u>

II. Administrative Personnel

1 DIRECTOR	NA	.25	15,000	3,750	675.	375	4,800	NA	4,800
1 SECRETARY/BOOKKEEPER	NA	.125	7,200	900	162	90	1,152	NA	1,152

	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
III. <u>Operating Costs</u>									
Rent and Utilities									<u>4,200</u>
Maintenance									<u>1,000</u>
Telephone									<u>300</u>
Insurance									<u>500</u>
Food									<u>4,500</u>
Transportation									<u>600</u>
Other									<u>0</u>
Sub-Totals:									<u>11,100</u>
IV. <u>Program Total:</u>		<u>4.505</u>	<u>88,700</u>	<u>45,185</u>	<u>7,865.3</u>	<u>4,388</u>	<u>57,472.8</u>	<u>4,499.2</u>	<u>73,072.0</u>

V. Unit Cost: \$50.05 Per Day

Average Annual per Client Cost: 18,268

NOTES:

Transitional apartment programs serving more or less than four clients will require appropriate modifications in staffing patterns.

Float position provides extra staff coverage whenever most needed, i.e., in emergencies, client illness, to attend meetings, to provide extra coverage during special house activities, etc. See recommended breakdown following page.

If two apartments are in same building coverage during sleep hours may be provided by one staff person with intercom between apartments.

Consultation is based on \$25/per hour for one hour per week.

PROGRAM TYPE Transitional Apartment Program - 4 Clients

WEEK DAYS	DAY	EVE	NIGHT	FLOAT	TOTAL
On	7-11 a.m.	3-11 p.m.	11 p.m.-7 a.m.	As Needed	
Hours per day	4	8	8	2.5	
Hours per week	20	40	40	12.5	
No. of staff	1	1	1	1	
Total F.T.E.s	.5	1	1	.31	2.81
On	7 a.m.-3 p.m.	3-11 p.m.	11 p.m.-7 a.m.	As Needed	
Hours per day	8	8	8	2.5	
Hours per week	16	16	16	5	
No. of staff	1	1	1	1	
Total F.T.E.s	.4	.4	.4	.12	1.32

E.1 Transitional Community Residence - A community based living facility operating 24 hours a day providing room, board, and supportive services including supervision and intensive training in daily living skills. Residents are usually expected to move to a more independent and/or less intensive living situation within one year. Either a transitional apartment or transitional community residence is required for a small number of clients (29) as they leave the state hospital setting. They include: mentally retarded clients with some behavioral problems and the need for assistance with community adjustment; elderly clients with some behavioral problems, psychiatric symptomatology and community adjustment needs; adolescents with psychiatric symptomatology; and chronically handicapped persons with some behavioral problems, psychiatric symptomatology and the need for assistance with community adjustment.

STAFFING/COST SCHEDULE

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS	1.0	9,500	9,500	1,710	950	12,160	1,216	13,376
2 MENTAL HEALTH WORKERS	S-S DAYS	.8	9,500	7,600	1,368	760	9,728	972.8	10,700.8
2 MENTAL HEALTH WORKERS	M-F EVES.	2.0	9,500	19,000	3,420	1,900	24,320	2,432	26,752
2 MENTAL HEALTH WORKERS	S-S EVES.	.8	9,500	7,600	1,368	760	9,728	972.8	10,700.8
1 MENTAL HEALTH WORKER	M-F NIGHTS	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S-S NIGHTS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
CONSULTATION	NA	NA	NA	2,600	NA	NA	2,600	NA	2,600
Sub-Totals:		<u>5.2</u>	<u>57,000</u>	<u>59,600</u>	<u>10,260</u>	<u>5,700</u>	<u>75,560</u>	<u>7,296</u>	<u>82,856</u>

II. Administrative Personnel

DIRECTOR	NA	.5	15,000	7,500	1,350	750	9,600	NA	9,600
SECRETARY/BOOKKEEPER	NA	.25	7,200	1,800	324	180	2,304	NA	2,304
Sub-Totals:		<u>.75</u>	<u>22,200</u>	<u>9,300</u>	<u>1,674</u>	<u>930</u>	<u>11,904</u>	NA	<u>11,904</u>

	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
III. <u>Operating Costs</u>									
Rent and Utilities									8,400
Maintenance									2,000
Telephone									600
Insurance									1,000
Food									9,000
Transportation									1,200
Other									-
Sub-Totals:									22,200
IV. <u>Program Total:</u>		<u>5,95</u>	<u>79,200</u>	<u>68,900</u>	<u>11,934</u>	<u>6,630</u>	<u>87,464</u>	<u>7,296</u>	<u>116,960</u>

V. Unit Cost: \$40.05 per DAY

Average Annual per Client Cost: \$14,620

NOTES:

Consultation is based on \$25/per hour for two hours per week.

PROGRAM TYPE Transitional Community Residence - 8 Clients

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On = 7 a.m. - 3 p.m. Hours per day = 8 Hours per week = 40 No. of staff = 1 Total F.T.E.s = 1	= 3-11 p.m. = 8 = 40 = 2 = 2	= 11 p.m. - 7 a.m. = 8 = 40 = 1 = 1	= = = = =	 <u>4</u>
WEEK ENDS	On = 7 a.m. - 3 p.m. Hours per day = 8 Hours per week = 16 No. of staff = 2 Total F.T.E.s = .8	= 3-11 p.m. = 8 = 16 = 2 = .8	= 11 p.m. - 7 a.m. = 8 = 16 = 1 = .4	= = = = =	 <u>2</u>

F. Apartment Program with Physical Care Component - A community based apartment program with a maximum of four persons per apartment that provides daily assistance and training in basic activities of daily living and physical care for clients with high A.D.L. needs. Either an apartment program or group home with a physical care component will be necessary for a small number of clients (42) leaving the state hospital. They include: persons whose primary problem is poor physical health; mentally retarded, elderly and chronically handicapped clients who only need assistance with basic activities of daily living such as feeding, toileting and dressing.

The following staffing and cost estimates are for a program consisting of one apartment housing four clients.

STAFFING/COST SCHEDULE

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
2 MENTAL HEALTH WORKER	M-F DAYS*	.75	19,000	7,125	1,282.5	713	9,120	912	10,032
1 MENTAL HEALTH WORKER	S&S DAYS	.4	9,500	3,800	684	380	4,864	4,864	5,350.4
1 MENTAL HEALTH WORKER	S&S DAYS	.1	9,500	950	171	95	1,216	121.6	1,337.6
1 MENTAL HEALTH WORKER	M-F EVES.	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 LPN	M-F EVES.	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 LPN	S&S EVES.	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	S&S EVES.	.2	9,500	1,900	342	190	2,432	243.2	2,675.2
1 MENTAL HEALTH WORKER	M-F NIGHTS	1	9,500	9,500	1,710	950	12,160	1,216.	13,376
1 MENTAL HEALTH WORKER	S&S NIGHTS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	FLOAT	.25	9,500	2,375	427.50	237.50	3,040	NA	3,040
CONSULTANT: R.N.	NA	NA	NA	1,950	NA	NA	1,950	NA	1,950
CONSULTANT: M.H. PROFESSIONAL	NA	NA	NA	1,300	NA	NA	1,300	NA	1,300
Sub-Totals:		<u>5.5</u>	<u>104,500</u>	<u>53,550</u>	<u>9,405</u>	<u>5,224</u>	<u>70,130</u>	<u>10,761.6</u>	<u>76,514</u>

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II. Administrative Personnel

1 DIRECTOR	NA	.25	15,000	3,750	675.	375	4,800	NA	4,800
1 SECRETARY/BOOKKEEPER	NA	.125	7,200	900	162	90	1,152	NA	1,152
Sub-Totals:		<u>.375</u>	<u>22,200</u>	<u>4,650</u>	<u>837</u>	<u>465</u>	<u>5,952</u>	<u>NA</u>	<u>5,952</u>

* See page 28 for recommended hours on duty.

	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>18%</u>	<u>10%</u>	<u>Subtotal</u>	<u>Salary Factor (x.10)</u>	<u>TOTAL</u>
III. <u>Operating Costs</u>									
Rent and Utilities									4,200
Maintenance									1,500
Telephone									300
Insurance									750
Food									4,500
Transportation									600
Other									0
Sub-Totals:									11,850
IV. <u>Program Total:</u>		<u>5,875</u>	<u>126,700</u>	<u>58,200</u>	<u>10,242</u>	<u>5,689</u>	<u>76,082</u>	<u>6,384</u>	<u>94,316</u>

V. Unit Cost: 64.60 Per Day

Average Annual per Client Cost: 23,579

NOTES:

Apartment programs serving more or less than four clients will require appropriate modifications in staffing patterns.

Float position provides extra staff coverage whenever most needed, i.e., in emergencies, client illness, to attend meetings, to provide extra coverage during special house activities, etc. See recommended breakdown following page.

Consultation by Registered Nurse for 2.5 hours per week at \$15 per hour.

Consultation by Mental Health Professional for 1 hour per week at \$25 per hour.

PROGRAM TYPE Apt. Program with Physical Care Component - 4 Clients

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On = 7-11a.m. / 7-9a.m. Hours per day = 4 2 Hours per week = 20 10 No. of staff = 1 1 Total F.T.E.s = .5 .25	= 3-11 p.m. = 8 = 40 = 2 = 2	= 11p.m.-7a.m. = 8 = 40 = 1 = 1	= As Needed = 2 = 10 = 1 = .25	4.0
WEEK ENDS	On 7a.m.-3p.m. / 9-11 a.m. Hours per day = 8 2 Hours per week = 16 4 No. of staff = 1 1 Total F.T.E.s = .4 .1	3-11p.m. / 6-10 p.m. = 8 4 = 16 8 = 1 1 = .4 .2	= 11p.m.-7a.m. = 8 = 16 = 1 = .4	= = = = =	1.5

F.1 Group Home with Physical Care Component - A community based living facility providing room, board and daily assistance and training in basic activities of daily living and physical care for clients with minimum behavioral problems and high A.D.L. needs. Either an apartment program or group home with a physical care component will be necessary for a small number of clients (42) leaving the state hospital. They include: persons whose primary problem is poor physical health; mentally retarded, elderly and chronically handicapped clients who only need assistance with basic activities of daily living such as feeding, toileting and dressing.

STAFFING/COST SCHEDULE

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS	1.0	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER*	M-F DAYS	.37	9,500	3,515	632.7	351.5	4,499.2	449.92	4,949.12
2 MENTAL HEALTH WORKERS	S-S DAYS	.8	9,500	7,600	1,368	760	9,728	972.8	10,700.8
1 MENTAL HEALTH WORKER	M-F EVES.	1.0	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S-S EVES.	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	M-F EVES.	.5	9,500	4,750	855	475	6,080	608.	6,688
1 MENTAL HEALTH WORKER	S-S EVES.	.2	9,500	1,900	342	190	2,432	243.2	2,675.2
1 LPN	M-F EVES.	1.0	9,500	9,500	1,710	950	12,160	1,216.	13,376
1 LPN	S-S EVES.	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	M-F NIGHTS	1.0	9,500	9,500	1,710	950	12,160	1,216.	13,376
1 MENTAL HEALTH WORKER	S-S NIGHTS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
CONSULTATION, RN	NA	NA	NA	3,900	NA	NA	3,900	NA	3,900
CONSULTATION, MENTAL HEALTH PROFESSIONAL	NA	NA	NA	2,600	NA	NA	2,600	NA	2,600
<u>Sub-Totals:</u>		<u>8.07</u>	<u>104,500</u>	<u>73,665</u>	<u>12,089.7</u>	<u>6,716.5</u>	<u>92,471.2</u>	<u>8,597.12</u>	<u>101,068.32</u>

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II. Administrative Personnel

1 DIRECTOR	NA	.5	15,000	7,500	1,350	750	9,600	NA	9,600
1 SECRETARY/BOOKKEEPER	NA	.25	7,200	1,800	324	180	2,304	NA	2,304
<u>Sub-Totals:</u>		<u>.75</u>	<u>22,200</u>	<u>9,300</u>	<u>1,674</u>	<u>930</u>	<u>11,904</u>	<u>NA</u>	<u>11,904</u>

* See page 31 for recommended hours on duty.

	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
III. <u>Operating Costs</u>									
Rent and Utilities									8,400
Maintenance									3,000
Telephone									600
Insurance									1,500
Food									9,000
Transportation									1,200
Other									0
Sub-Totals:									23,700
IV. <u>Program Total:</u>		<u>8.82</u>	<u>126,700</u>	<u>82,965</u>	<u>13,763.7</u>	<u>76,465</u>	<u>104,375.2</u>	<u>8,597.12</u>	<u>136,672.32</u>

V. Unit Cost: 46.80 Per Day

Average Annual per Client Cost: 17,084.04

NOTES:

Consultation by Registered Nurse for five hours per week at \$15/per hour.

Consultation by Mental Health Professional for 2 hours per week at \$25 per hour.

PROGRAM TYPE Group Home with Physical Care Component

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On 7a.m.-3p.m./7-10a.m. Hours per day = 8 3 Hours per week = 40 15 No. of staff = 1 1 Total F.T.E.s = 1 .37	= 3-11p.m./6-10p.m. = 8 4 = 40 20 = 2.0 1 = 2.0 .5	= 11p.m.-7a.m. = 8 = 40 = 1 = 1	= = = = =	4.87
WEEK ENDS	On 7a.m.-3p.m. Hours per day = 8 Hours per week = 16 No. of staff = 2 Total F.T.E.s = .8	= 3-11p.m./6-10p.m. = 8 4 = 16 8 = 2.0 1 = .8 .2	= 11p.m.-7a.m. = 8 = 16 = 1 = .4	= = = = =	2.2

- G. Apartment Program with Behavioral Emphasis - A community based apartment program with a maximum of four persons, per apartment providing room, board and intensive services within the apartment for persons with serious behavior problems. The program is designed to replace problematic behaviors with appropriate living skills so the individual may move to a less restrictive, more normalized environment. Residents will have low physical care needs. Either an apartment program or group home with behavioral emphasis will be necessary for a small number of clients (21) presently at the state hospital. They include some persons with chronic brain syndrome who do not need nursing home care; elderly and chronically handicapped clients with behavioral problems, psychiatric symptomatology and assistance with community adjustment skills.

The following staffing and cost estimates are for a program consisting of one apartment, housing four clients.

STAFFING/COST SCHEDULE

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS (7-11 a.m.)	.5	9,500	4,750	855	475	6,080	608	6,688
1 MENTAL HEALTH WORKER	M-F DAYS (7-9 a.m.)	.2	9,500	1,900	342	190	2,432	243.2	2,675.2
2 MENTAL HEALTH WORKERS	S&S DAYS	.8	9,500	7,600	1,368	760	9,728	972.8	10,700.8
2 MENTAL HEALTH WORKERS	M-F EVES.	2.0	9,500	19,000	3,420	1,900	24,320	2,432	26,752
2 MENTAL HEALTH WORKERS	S&S EVES.	.8	9,500	7,600	1,368	760	9,728	972.8	10,700.8
1 MENTAL HEALTH WORKER	M-F NIGHTS	1.0	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S&S NIGHTS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	FLOAT	.35	9,500	3,325	598.5	332.5	4,256	NA	4,256
CONSULTATION	AS NEEDED	NA	NA	1,950	NA	NA	1,950	NA	1,950
Sub-Totals:		<u>6.05</u>	<u>76,000</u>	<u>59,425</u>	<u>10,345.5</u>	<u>5,747.5</u>	<u>75,518.0</u>	<u>6,931.2</u>	<u>82,449.2</u>
<u>II. Administrative Personnel</u>									
1 DIRECTOR		.25	18,000	4,500	810	450	5,760	NA	5,760
1 SECRETARY/BOOKKEEPER		.125	7,200	900	162	90	1,152	NA	1,152
Sub-Totals:		<u>.375</u>	<u>25,200</u>	<u>5,400</u>	<u>972</u>	<u>540</u>	<u>6,912</u>	<u>NA</u>	<u>6,912</u>

	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
III. <u>Operating Costs</u>									
Rent and Utilities									4,200
Maintenance									1,000
Telephone									300
Insurance									500
Food									4,500
Transportation									600
Other									-
Sub-Totals:									11,100
IV. <u>Program Total:</u>		<u>6.425</u>	<u>101,200</u>	<u>64,825</u>	<u>11,317.5</u>	<u>6,287.5</u>	<u>82,430</u>	<u>6,931.2</u>	<u>100,461.2</u>

V. Unit Cost: 68.80 Per Day

Average Annual per Client Cost: 25,115.30

NOTES:

An Apartment Program with Intensive Behavioral Emphasis to meet the needs of persons with severe self destructive or other destructive behaviors should provide two mental health workers per apartment for each weekday (7 a.m. - 3 p.m.) shift as it is anticipated that it will be necessary for residence workers to accompany clients to their day programs. A small number of clients (15) at the state hospital will require an apartment or group home with intensive behavioral emphasis.

Program serving more or less than four clients will require appropriate modifications in staffing patterns.

It is recommended that the program director be a psychologist or other mental health professional knowledgeable in behavior modification techniques.

Float position provides extra staff coverage whenever most needed, i.e., in emergencies, client or staff illness, to attend meetings, to provide extra coverage during special house activities, etc. See recommended breakdown following page.

Consultation is based on \$25/per hour for 1.5 hours per week.

PROGRAM TYPE Apt. Program with Behavioral Emphasis-4 Clients

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On 7-11a.m./7-9a.m.	= 3p.m.-11p.m.	= 11p.m.-7a.m.	= As Needed	
	Hours per day = 4 2	= 8	= 8	= 2	
	Hours per week = 20 8	= 40	= 40	= 10	
	No. of staff = 1 1	= 2	= 1	= 1	
	Total F.T.E.s = .5 .2	= 2	= 1	= .25	3.95
WEEK ENDS	On 7a.m.-3p.m.	= 3p.m.-11p.m.	= 11p.m.-7a.m.	= As Needed	
	Hours per day = 8	= 8	= 8	= 2	
	Hours per week = 16	= 16	= 6	= 4	
	No. of staff = 2	= 2	= 1	= 1	
	Total F.T.E.s = .8	= .8	= .4	= .1	2.1

Staff: Client Ratio = 14.8:1
= 1.85:1

Total D.C. Staff = 6.05
X 1.23 = 7.4
If Apt. X 2 = 4.8
+ .9 Dir. = 15.3

PROGRAM TYPE Apt. Program with Intensive Behavioral Emphasis - 4 Clients

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On	= 7a.m.-3p.m.	= 3p.m.-11p.m.	= 11p.m.-11p.m.	= As Needed*
	Hours per day	= 8	= 8	= 8	= 4
	Hours per week	= 40	= 40	= 40	= 20
	No. of staff	= 2	= 2	= 1	= 1
	Total F.T.E.s	= 2	= 2	= 1	= .5
WEEK ENDS	On	= 7a.m.-3p.m.	= 3p.m.-11p.m.	= 11p.m.-7a.m.	= As Needed*
	Hours per day	= 8	= 8	= 8	= 4
	Hours per week	= 16	= 16	= 16	= 8
	No. of staff	= 2	= 2	= 1	= 1
	Total F.T.E.s	= .8	= .8	= .4	= .2
					5.5
					2.2

* Backup for nighttime staff

- G.1 Group Home with Behavioral Emphasis - A community based living facility providing room, board, and intensive services within the home for persons with serious behavior problems. The program is designed to replace problematic behaviors with appropriate living skills so the individual may move to a less restrictive, more normalized environment. Residents will have low physical care needs. Either an apartment program or group home with behavioral emphasis will be necessary for a small number of clients (21) presently at the state hospital. They include some persons with chronic brain syndrome who do not need nursing home care; elderly and chronically handicapped clients with behavioral problems, psychiatric symptomatology and assistance with community adjustment.

STAFFING/COST SCHEDULE

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS	1.0	9500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	M-F DAYS (7-10 a.m.)	.37	9500	3,515	632.7	351.5	4,499.2	449.92	4,949.12
3 MENTAL HEALTH WORKERS	S&S DAYS	1.2	9500	11,400	2,052	1,140	14,592	1,459.2	16,051.2
3 MENTAL HEALTH WORKERS	M-F EVE's	3.0	9500	28,500	5,130	2,850	36,480	3,648	40,128
3 MENTAL HEALTH WORKERS	S&S EVE's	1.2	9500	11,400	2,052	1,140	14,592	1,459	16,051
1 MENTAL HEALTH WORKER	M-F NIGHTS	1.0	9500	9,500	1,170	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S&S NIGHTS	.4	9500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	7 NIGHTS (on call)	N.A.	N.A.	5,000	N.A.	N.A.	5,000	N.A.	5,000
CONSULTATION	AS NEEDED	N.A.	N.A.	3,900	N.A.	N.A.	3,900	N.A.	3,900
Sub-Totals:		<u>8.17</u>	<u>66,500</u>	<u>86,515</u>	<u>15,140.7</u>	<u>7,761.5</u>	<u>108,247.2</u>	<u>9,934.72</u>	<u>118,181.72</u>

II. Administrative Personnel

1 DIRECTOR	N.A.	.5	18,000	9,000	1,620	900	11,520	N.A.	11,520
1 SECRETARY/BOOKKEEPER	N.A.	.25	7,200	1,800	324	180	2,304	N.A.	2,304

Sub-Totals: 75 25,200 10,800 1,944 1,080 13,824 13,824

	<u>Shift</u>	<u>PT's</u>	<u>Salary</u>	<u>Salary</u>	<u>18%</u>	<u>10%</u>	<u>Costs</u>	<u>Factor</u>	<u>TOTAL</u>
							<u>Subtotal</u>	<u>x.10)</u>	
<u>III. Operating Costs</u>									
Rent and Utilities									<u>8,400</u>
Maintenance									<u>2,000</u>
Telephone									<u>600</u>
Insurance									<u>1,000</u>
Food									<u>9,000</u>
Transportation									<u>1,200</u>
Other									<u>-</u>
Sub-Totals:									<u>22,200</u>
IV. <u>Program Total:</u>	<u>8.92</u>		<u>91,700</u>	<u>97,315</u>	<u>17,084.7</u>	<u>8,841.5</u>	<u>122,071.2</u>	<u>9,934.72</u>	<u>154,205.72</u>

V. Unit Cost: \$52.81 per DAY

Average Annual per Client Cost: \$ 19,275.73

NOTES:

It is recommended that the program Director be a psychologist or other mental health professional, knowledgeable in behavior modification techniques.

In addition to one M/H Worker awake and on duty, staff will provide on call back up by sleeping at house on rotating basis, or by additional staff-provided room in exchange for availability in case of emergency. Staff paid at minimum wage for four hours if disturbed during sleeping hours for emergency duty. Cost is based on estimated duty time.

A Group Home with Intensive-Behavioral Emphasis to meet the needs of persons with severe, self destructive behaviors should provide two additional M/H Workers on the weekday (7 a.m.-3 p.m.) shift as it is anticipated that it will be necessary for residence workers to accompany clients to their day programs. A small number of clients (15) at the state hospital will require an apartment or group home with intensive behavioral emphasis.

Consultation is based on \$25/per hour for 3 hours per week.

PROGRAM TYPE Group Home with Behavioral Emphasis - 8 Clients

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On	= <u>7am-3pm</u> <u>7am-10am</u>	= <u>3-11pm</u>	= <u>11pm-7am.</u>	
	Hours per day	= <u>8</u> = <u>3</u>	= <u>8</u>	= <u>8</u>	
	Hours per week	= <u>40</u> = <u>15</u>	= <u>40</u>	= <u>40</u>	
	No. of Staff	= <u>1</u> = <u>1</u>	= <u>3</u>	= <u>1</u>	
	Total F.T.E.s	= <u>1</u> = <u>.37</u>	= <u>3</u>	= <u>1</u>	= <u>5.37</u>
			Additional back up provided by second person sleeping at house.		
WEEK ENDS	On	= <u>7am-3pm</u>	= <u>3-11pm</u>	= <u>11pm-7am</u>	
	Hours per day	= <u>8</u>	= <u>8</u>	= <u>8</u>	
	Hours per week	= <u>16</u>	= <u>16</u>	= <u>16</u>	
	No. of Staff	= <u>3</u>	= <u>3</u>	= <u>1</u>	
	Total F.T.E.s	= <u>1.2</u>	= <u>1.2</u>	= <u>.4</u>	= <u>2.8</u>
			Additional back up provided by second person sleeping at house		

PROGRAM TYPE Group Home with Intensive Behavioral Emphasis 8 Clients

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On = 7am-3pm	= 3pm-11pm	= 11pm-7am	= _____	<u>8</u>
	Hours per day = 8	= 8	= 8	= _____	
	Hours per week = 40	= 40	= 40	= _____	
	No. of Staff = 3	= 3	= 2	= _____	
	Total F.T.E.s = 3	= 3	= 2	= _____	
WEEK ENDS	On = 7am-3pm	= 3pm-11pm	= 11pm-7am	= _____	<u>4.4</u>
	Hours per day = 8	= 8	= 8	= _____	
	Hours per week = 16	= 16	= 40	= _____	
	No. of Staff = 3	= 3	= 2	= _____	
	Total F.T.E.s = 1.2	= 1.2	= 2	= _____	

- H. Apartment Program with Physical Care Component and Behavioral Emphasis - A community based apartment program with a maximum of four persons per apartment that provides both intensive behavioral program intervention as well as physical care and help with activities of daily living. According to the Region I Client Evaluation Survey no persons have been identified as requiring this kind of program at the present time.

The following staffing and cost estimates are for a program consisting of one apartment, housing four clients.

STAFFING/COST SCHEDULE

<u>I. Direct Care Personnel</u>	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
1 MENTAL HEALTH WORKER	M-F DAYS	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	M-F DAYS (7-11 a.m.)	.5	9,500	4,750	855	475	6,080	608	6,688
2 MENTAL HEALTH WORKERS	S-S DAYS	.8	9,500	7,600	1,368	760	9,728	972.8	10,700.8
1 MENTAL HEALTH WORKER	M-F EVES.	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S-S EVES.	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 LPN	M-F EVES.	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 LPN	S-S EVES.	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	M-F NIGHTS	1	9,500	9,500	1,710	950	12,160	1,216	13,376
1 MENTAL HEALTH WORKER	S-S NIGHTS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1 MENTAL HEALTH WORKER	FLOAT	.7	9,500	6,650	1,197	665	8,512	NA	8,512
CONSULTATION(R.N.&M.H. Professional)	NA	NA	NA	3,250	NA	NA	3,250	NA	3,250
Sub-Totals:		<u>7.2</u>	<u>95,000</u>	<u>71,650</u>	<u>12,312</u>	<u>6,840</u>	<u>90,802</u>	<u>7,904</u>	<u>98,706</u>
<u>II. Administrative Personnel</u>									
DIRECTOR	NA	.25	18,000	4,500	810	450	5,760	NA	5,760
SECRETARY/BOOKKEEPER	NA	.125	7,200	900	162	90	1,152	NA	1,152
Totals:		<u>.375</u>	<u>25,200</u>	<u>5,400</u>	<u>972</u>	<u>540</u>	<u>6,912</u>	<u>NA</u>	<u>6,912</u>

	<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Coverage Factor (x.10)</u>	<u>TOTAL</u>
III. <u>Operating Costs</u>									
Rent and Utilities									4,200
Maintenance									<u>1,500</u>
Telephone									300
Insurance									<u>750</u>
Food									<u>4,500</u>
Transportation									<u>600</u>
Other									<u>0</u>
Sub-Totals:									<u>11,350</u>
IV. <u>Program Total:</u>		<u>7.575</u>	<u>120,200</u>	<u>77,050</u>	<u>13,284</u>	<u>7,380</u>	<u>97,714</u>	<u>7,904</u>	<u>117,468</u>

V. Unit Cost: 80.46 Per Day

Average Annual per Client Cost: 29,367

NOTES:

Program serving more or less than four clients will require appropriate modifications in staffing patterns.

It is recommended that the Program Director be a psychologist or other mental health professional knowledgeable in behavior modification techniques.

Float position provides extra staff coverage whenever most needed, i.e., in emergencies, client illness, to attend meetings, to provide extra coverage during special house activities, etc. See recommended breakdown following page.

Consultation by Registered Nurse for 2.5 hours per week at \$15/per hour.

Consultation by Mental Health Professional for 2 hours per week at \$25/per hour.

PROGRAM TYPE Apt. Program with Physical Care and Behavioral Emphasis - 4 Clients

WEEK DAYS	DAY					NIGHT	EVE					FLOAT	TOTAL
	On	7am-3pm	3pm-7am	7am-11am			3-11pm						
	Hours per day	= 8	= 4				= 8					= As Needed *	
	Hours per week	= 40	= 20				= 40					= 20	
	No. of Staff	= 1	= .5				= 2					= 1	
	Total F.T.E.s	= 1	= .5				= 2					= .5	5
WEEK ENDS	On	7am-3pm	3pm-7am	7am-11am			3-11pm					As Needed *	
	Hours per day	= 8	= 4				= 8					= 4	
	Hours per week	= 16	= 20				= 16					= 8	
	No. of Staff	= 2	= .5				= 2					= 1	
	Total F.T.E.s	= 2	= .5				= 2					= .2	2.2

of early living. According to the Region, it is
requiring this kind of program at the present time.

STAFFING/COST SCHEDULE

I. Direct Care Personnel		Shift	FTE's	Equivalent Full/Time Salary	Actual Salary	Fringe 18%	G&A 10%	Staff Costs Subtotal	Cover Factor (x.10)	TOTAL
2	MENTAL HEALTH WORKERS	M-F DAYS	2.0	9,500	19,000	3,420	1,900	24,320	2,432.0	26,752
3	MENTAL HEALTH WORKERS	S-S DAYS	1.2	9,500	11,400	2,052	1,140	14,592	1,459.2	16,051.2
2	MENTAL HEALTH WORKERS	M-F EVES.	2.0	9,500	19,000	3,420	1,900	24,320	2,432	26,752.
2	MENTAL HEALTH WORKERS	S-S EVES.	.8	9,500	7,600	1,368	760	9,728	972.8	10,700.8
1	LPN	M-F EVES.	1.0	9,500	9,500	1,710	950	12,160	1,216	13,376
1	LPN	S-S EVES.	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1	MENTAL HEALTH WORKER	M-F NIGHTS	1.0	9,500	9,500	1,710	950	12,160	1,216	13,376
1	MENTAL HEALTH WORKER	S-S NIGHTS	.4	9,500	3,800	684	380	4,864	486.4	5,350.4
1	MENTAL HEALTH WORKER	7 NIGHTS (On Call)	NA	NA	5,000	NA	NA	5,000	NA	5,000
CONSULTATION (R.N. & M.H. Professional)		NA	NA	NA	5,200	NA	NA	5,200	NA	5,200
<u>Sub-Totals:</u>			<u>8.8</u>	<u>76,000</u>	<u>88,800</u>	<u>15,048</u>	<u>8,360</u>	<u>117,208</u>	<u>10,700.8</u>	<u>127,908.8</u>

II. Administrative Personnel

1	DIRECTOR	NA	.5	18,000	9,000	1,620	900	11,520	NA	11,520
1	SECRETARY/BOOKKEEPER	NA	.25	7,200	1,800	324	180	2,304	NA	2,304
<u>Sub-Totals:</u>			<u>.75</u>	<u>25,200</u>	<u>10,800</u>	<u>1,944</u>	<u>1,080</u>	<u>13,824</u>	<u>--</u>	<u>13,824</u>

(11)

<u>Shift</u>	<u>FTE's</u>	<u>Equivalent Full/Time Salary</u>	<u>Actual Salary</u>	<u>Fringe 18%</u>	<u>G&A 10%</u>	<u>Staff Costs Subtotal</u>	<u>Cover Factor (x.10)</u>	<u>TOTAL</u>
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III. Operating Costs

Rent and Utilities								8,400
Maintenance								3,000
Telephone								600
Insurance								1,500
Food								9,000
Transportation								1,200
Other								0
Sub-Totals:								23,700

IV. <u>Program Total:</u>	<u>9.5</u>	<u>101,200</u>	<u>99,600</u>	<u>16,992</u>	<u>9,440</u>	<u>131,032</u>	<u>10,700.8</u>	<u>165,432.8</u>
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V. Unit Cost: \$56.65 Per Day

Average Annual per Client Cost: 20,679.10

NOTES:

It is recommended that the program director be a psychologist or other mental health professional knowledgeable in behavior modification techniques.

In addition to one M/H worker awake and on duty, staff will provide on call back-up by sleeping at house on rotating basis, or by additional staff - provided room in exchange for availability in case of emergency. Staff paid at minimum wage for four hours if disturbed during sleeping hours for emergency duty.

Consultation by Registered Nurse for 5 hours per week at \$15/per hour.

Consultation by Mental Health Professional for 4 hours per week at \$25/per hour.

PROGRAM TYPE Group Home with Physical Care and Behavioral Emphasis Component

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On = <u>7am-3pm</u>	= <u>3-11pm</u>	= <u>11pm-7am</u>	= _____	<u>6.0</u>
	Hours per day = <u>8</u>	= <u>8</u>	= <u>8</u>	= _____	
	Hours per week = <u>40</u>	= <u>40</u>	= <u>40</u>	= _____	
	No. of Staff = <u>2</u>	= <u>3</u>	= <u>1</u>	= _____	
	Total F.T.E.s = <u>2</u>	= <u>3</u>	= <u>1</u>	= _____	
WEEK ENDS	On = <u>7am-3pm</u>	= <u>3-11pm</u>	= <u>11pm-7am</u>	= _____	<u>2.8</u>
	Hours per day = <u>8</u>	= <u>8</u>	= <u>8</u>	= _____	
	Hours per week = <u>16</u>	= <u>16</u>	= <u>16</u>	= _____	
	No. of Staff = <u>3</u>	= <u>3</u>	= <u>1</u>	= _____	
	Total F.T.E.s = <u>1.2</u>	= <u>1.2</u>	= <u>.4</u>	= _____	

COMPARISON OF PER DIEM AND PER ANNUM COSTS

Comparison of Per Diem and Per Annum Costs

The following costs are based on eight client programming	<u>Per Diem</u>	<u>Per Annum</u>
Support Services to Clients Residing in Non-DMH Provided or Funded Housing		
a. Consultation to Nursing/Rest/Boarding Homes	\$	\$
b. Consultation to Persons residing in Cooperative Apartments or Homes		
Specialized Home Care Program	15.81	5,769.33
Supervised Apartment Program	40.94	14,943.10
Supervised Group Home	31.21	11,392.00
Transitional Apartment Program	50.05	18,268.00
Transitional Community Residence	40.05	14,620.00
Apartment Program with Physical Care Component	64.60	23,579.00
Group Home with Physical Care Component	46.12	16,834.04
Apartment Program with Behavioral Emphasis	68.80	25,115.30
Apartment Program with Intensive Behavioral Emphasis	80.70	29,462.50
Group Home with Behavioral Emphasis	52.81	19,275.73
Group Home with Intensive Behavioral Emphasis	61.97	22,619.05
Apartment Program with Physical Care Component and Behavioral Emphasis	80.46	29,367.00
Group Home with Physical Care Component and Behavioral Emphasis	56.65	20,679.10

Staff Responsibilities

Director/Administrator

- Overall responsibility and authority for management of residential program, including supervision of direct care staff.
 - Oversee liaison and coordination of services with community mental health network.
 - Represent the residential program in community relations efforts.
 - Provide or arrange for pre-service and in-service training of direct care staff.
 - Management of fiscal aspects of program operation and maintenance of data as required.
 - Develop and implement ongoing program evaluation methods.
-

Direct Care Staff

Weekdays: Day Shift

- Assist with a.m. routine including breakfast, dressing, medication supervision, etc. in preparation for day time activity.
- Attend residence and interagency staff meetings related to residents.
- Transport residents to non-routine appointments, when appropriate.
- Assist clients who are at home during day because of sickness, malingering, between day programs, etc.
- Take part in prospective resident screening and evaluations.
- Be available to meet with repairmen, inspectors, prospective residents, etc.
- Do household errands.
- Perform daily record keeping and exchange information with evening shift.

Weekdays: Evening Shift

- Be available to greet residents returning from day time activity.
- Coordinate/supervise dinner preparations and clean up.
- Assist residents engaging in daily chores.
- Hold house meetings and informal discussion groups with residents.
- Meet with residents on individual basis to discuss concerns, problems, etc. of the day/week.

- Assist residents, as necessary, in pursuing community recreational activities.
 - Perform daily record keeping and exchange information with night staff.
-

Direct Care Staff

Weekends: Day and Evening Shifts

- Assist with a.m. routine including breakfast, dressing, medication supervision, etc.
 - Supervise, with with and teach residents as they engage in weekly household maintenance chores, menu planning, weekly shopping, etc.
 - Meet individually with residents as they define and pursue individual goals for the coming week and review goals for previous week.
 - Assist residents when necessary and appropriate to plan and engage in weekend social/recreational activities.
 - Perform daily record keeping and exchange information between shifts.
 - Coordinate/supervise lunch and dinner preparations and clean up.
 - Assist with p.m. routine, including personal hygiene activities, medication supervision, etc.
-

Direct Care Staff

Weekend and weekday: Night Shift

- Be available in case of any nighttime emergency and see that residents are home from any evening activity in community.
- Do any household maintenance or repairs residents unable to do.
- Do all major record keeping activities, such as Title XX form completion, etc.
- Assist with a.m. ADL activities and nighttime medication taking.

ATTACHMENT C

NON RESIDENTIAL TREATMENT

AND SUPPORT SERVICES

PROGRAM MODELS

Prepared for the Massachusetts
Department of Mental Health
Region I Planning Process

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With the Northampton
Planning Team

AMENDED FINAL DRAFT

NONRESIDENTIAL TREATMENT
AND SUPPORT SERVICES

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INTRODUCTION

A. The Program Models

The program models described herein are designed to provide mentally disabled persons living in the community with those treatment and support services appropriate to their needs. Taken together, they represent a continuum of programs that vary in structure and intensity but which should enable clients to progress towards independent, productive lives in the community. Some programs are primarily clinical and offer a range of treatment modalities in a medically oriented environment; some are distinctively nonclinical and provide training in various social, physical, vocational, and educational skills to assist clients in gaining such independence; and finally others are chiefly supportive, giving clients help, when necessary, in responding to the demands of community living. Although available to all mentally disabled persons living in the community, these models are principally intended to complement community residential alternatives by serving the nonresidential program needs of clients living in those settings. It is the expectation that such clients will participate in these nonresidential programs or other activities such as employment or schooling five days per week. Thus these programs are but one piece of a comprehensive network of a community mental health system.

The separate models presented below are designed to be unified in multiple ways. First, the assessment unit draws into the evaluation and treatment planning process representatives from those services that clients are to receive. In this way even before client treatment plans

are implemented, key caregivers meet to discuss a client's needs and total program.

This initial unification is carried forward by community service coordinators who assume primary responsibility for the whole client, and insure that the client is not treated atomistically. It would be a mistake, however, to view the community service coordination function as merely a "liaison" one. Community service coordinators will establish "supportive human relationships" with their clients, providing counseling aimed at bolstering clients' coping skills and self esteem. Through these relationships community service coordinators will develop a multi-level knowledge of their clients' service needs and how these needs fit together.

Another dynamic for unification provided for in this plan is that the various programs can share staff, so that persons employed part time by one program might also be employed part time by another. This coemployment will be facilitated by the fact that many programs, in particular the

1

It should be noted that the community service "coordinators" functions are ones that are sometimes assigned to aftercare workers or psychotherapists in other systems. The model of community service coordination proposed here is designed to emphasize several aspects of these functions which become problematic in systems that rely on aftercare or psychotherapy.

- In contrast to the concept of aftercare, community service coordination as proposed here is not restricted to discharged clients and a post-hospitalization period. Instead it is a service designed for a spectrum of clients ranging from those who are recently discharged to those who have never been in the hospital but are at risk and those who are currently hospitalized. Moreover, it is explicitly designed to be available to such clients as long as they are in need of any mental health services

- Community Service coordination also assumes that most clients will need a variety of services which must be coordinated to be effective. Helping clients to obtain these services and insuring that they are coordinated involves working with clients on a variety of problems, many of which are neither psychological nor psychiatric, in a variety of settings, for flexible amounts of time. Psychotherapy provided in an office for a fixed amount of time is ill suited to these functions. Moreover, only a minority of clients are appropriate for the specialized behavior modification or intrapsychically oriented treatments specifically associated with psychotherapy.

"clinical" ones: assessment, community service coordination, crisis intervention, psychotherapy, family therapy, respite care and medication/nursing are intended to be co-located in and an integral part of a community mental health center.

Finally, other mental health and generic social services that may be physically separate from a mental health center will be integrated into the care system by means of affiliation agreements maintained by coordination staff in area offices, by umbrella activities of community service coordinators and assessment team members and by day to day working interactions among other program staff.

In conformity with the principles of normalization, these models specifically exclude all generic services that are otherwise available in the community. Clients should be encouraged to use generic educational, transportation, health, legal and other services; mental health staff should assist generic service providers in making their services accessible to mental health clients. To the extent that mental health clients are denied such services, Area based advocates should assist clients in gaining access to those agencies and organizations.

→ Given the dearth of existing, generally accepted nonresidential prototypes, the attached models set forth the overall purpose and particular elements of each program and include a reasonably accurate projection of the range of costs for serving clients with intensive and moderate needs. As new data and information are generated through the implementation of these programs, refinements and adjustments will necessarily be made.

B. Population to Be Served

It is recognized that some of the treatment and support services described in the attached models are presently being offered in some form, although there is a considerable variance between Areas. Moreover, certain nonresidential services such as prescreening, crisis intervention, and community service coordination are not available anywhere in the Region. These program models are designed to supplement existing services in order to meet the needs of persons who are or may be hospitalized due to the inadequacy or total unavailability of appropriate community treatment and support programs. Based on a thorough review of data supplied by the Northampton State Hospital, the Regional Office, and the client assessment survey, this population includes approximately 2100 mentally disabled persons in Region 1. (See Analysis of Population in Region 1.) In addition, there are approximately 4000 other persons now receiving partially adequate mental health services from existing programs which are essential in preventing their hospitalization. For purposes of the planning process, it is assumed that the attached models must be integrated with existing Area programs in a manner that does not decrease or dilute the services presently being provided to persons living in the community.

C. Staffing and Costs

1. Staffing

The attached models include only a staffing pattern and projection of costs. Staffing is in terms of full time equivalents (FTE's) and not actual persons. One FTE may be one person working 40 hours, two

people working 20 hours, etc. No detailed employment objectives, lines of authority, hiring procedures, or staff training element is included. Standards for nonresidential programs should be developed that address these issues by establishing guidelines for service providers in their development of clear personnel policies.

Regular training is essential to the viability of the entire community care system and participation in ongoing training programs is included as a portion of each person's nondirect care responsibilities. In addition, time is allocated for staff meetings, client conferences, record keeping, consultation, education, liaison with other agencies, and travel. It is assumed that most staff would spend 70% of their time in direct care tasks and only 30% in nondirect care responsibilities. The latter figure is significantly less than that used by the National Institute of Mental Health in computing similar staffing requirements and is estimated to be somewhat less than that presently being practiced in community mental health centers in the Commonwealth.

Provided with each program model is a service analysis. These analyses quantify the work to be done by a program and the staff time available for performing it. These and certain other statistics are used to check the appropriateness of the programs' projected utilization, direct and non-direct care staffing and unit costs.

Although the models do not include separate components or staffing patterns for different client subpopulations such as elderly, mentally retarded or adolescent, it is clearly recognized that the actual implementation of the models, particularly day treatment, day

activity and sheltered workshop, may differ. The special needs of each subpopulation would affect both the content of a client's program and the qualifications of the individual staff person, but not the actual model or staffing pattern.

2. Costs

In light of the current cost of medical insurance, social security, and other employee benefits, the models adopt a standard fringe of 18%. Similarly a figure of 20% of direct care salaries is regularly used to compute the cost of overhead, which includes equipment maintenance and replacement, supplies, postage, travel, office rental, telephone, auditing costs, and legal expenses.

For those services open 50 weeks a year (i.e. offering staff a 2 week vacation) approximately 11% of staff time was estimated to be necessary to cover sick days, accidents and other types of legitimate absences. This figure was computed as follows:

250 working days per year to cover (= 50 weeks x 5 days per week)
 15 sick days
 3 personal days
 7 other (average number per year, due to: industrial accidents,
 maternity/education leave, extended vacation, death
 days, etc.)
 25 Total lost days
 225 Average number of days worked per year
 1.11 Factor to cover lost days = $225 \div 250$

No reference is made in program elements to expected start-up costs, including office equipment and initial training. Approximately \$600 should be added for each staff person to every program model, 20% of which is allocated to training and the remainder to

equipment. A portion of these expenses may be reduced through the use of certain equipment from other state facilities and institutions. In addition, \$5,000 should be allocated for the purchase of a vehicle for each program that provides transportation (day treatment, day activity and pre-vocational training/sheltered workshops). A summary of start-up costs is shown in Table 1.

D. Administration

It is the expectation that each Area will have the administrative capacity to coordinate the delivery of services between residential and nonresidential programs pursuant to individual service plans (ISP). However, these models also locate within services the clerical personnel necessary to meet their secretarial, receptionist, record keeping and bookkeeping needs. Along with overhead, these administrative costs amount to an average of 20% of the total program cost. The quality control and monitoring functions of the system will be performed by the Regional Office. Although the program models set forth a standard staffing pattern to be used for every Area, the Regional Services Administrator would retain the discretion to shift and distribute resources between areas in order to ensure an equitable per client allocation. Finally, each client will have a community service coordinator and each Area a client advocate to facilitate the delivery of appropriate services in the least restrictive environment.

I. ASSESSMENT TEAM

The Assessment Team will provide a major coordinating, evaluation, assessment and individual treatment planning function for the 427 at risk persons in each DMH area in Region I. The Team will provide a core interdisciplinary staff and will draw upon professionals from the Medication, Community Service, Crisis Intervention, and Psychotherapy Programs to provide an individual interdisciplinary team for each client. The individual client's team will be responsible for drafting and annually reviewing individual service plans for the client. More frequent than annual reviews may be requested by the community service coordinator, may be planned by the client's team or may be required because of a crisis incident. The Team ideally should be based in a community mental health center.

A. Definition

A program designed to provide initial screening, assessment and service planning for all at risk persons in the DMH service system and to annually or more frequently review and update the initial service plan.

B. Program Elements

Program will

1. Provide initial screening, assessment and individual service plans for persons seeking DMH services who have been previously hospitalized or would be at the risk of hospitalization if comprehensive community services were not available.
2. Receive referrals from public and private agencies as well as self-referrals.
3. Utilize staff from the Medication, Crisis, Psychotherapy Counseling and Community Service Programs to create

interdisciplinary teams to carry out screening, assessment, and individual service planning.

4. Determine the range of appropriate DMH services and services of other public and private agencies for each client.
5. Refer clients for placement and ongoing service monitoring the Community Service Coordination Program.
6. Periodically, but at least annually, reevaluate all individual service plans and reevaluate upon request of any service program or community service coordinator.
7. Provide screening, assessment, and individual service plans for clients referred from the Crisis Unit after initial crisis resolution.
8. Reevaluate individual service plans upon requests of Medication, Community Service Coordination, Crisis and/or Psychotherapy Programs.

C. Clients

(427) area clients could be assessed at least once annually by this program model. Some clients, such as those who become acutely disturbed, behave in unexpected and dangerous ways, appear ready for less restrictive services or whose progress appears blocked, might be re-evaluated more frequently. The average number of assessments per client is projected to be one and one half. The annual program capacity is 640 evaluations.

Staffing/Cost Schedule

10

for: Assessment Team :

I. <u>Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Clin. Director/Sr. Clinician	0.5	25,000	12,500	2250	2500	17250
B. Psychiatrist	1.0	45,000	33,750	6075	6750	46,575
C. PhD Psychologist	1.0	22,000	22,000	3960	4400	30360
D. MSW Psychiatric	1.0	16,000	16,000	2880	3200	20080

Sub-Totals: 3.25 84,250 15,165 16,850 114,265

II. Administrative Personnel

A. Program Administrator	0.5	25,000	12,500	2250		17250
B. Secretaries @ 7,500	2.0	15,000	15,000	2700		20700

Sub-Totals: 2.5 27,500 4950 37,950

III. Program Supplies & Equip.

0

IV. Client Supplies & Equip.

0

V. Transportation

0

VI. Misc. (Specify)

0

Program Total 5.75 111,750 20,115 16,350 152,215

Unit Cost: \$40 per hour

Average Episode Cost: \$238

\$238 per assessment

Average Annual per Client Cost \$356

Service Analysis

71

SERVICE: Assessment Team

Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per dayAssess.</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Intake, screening, assessment, indiv. service plans & referral to Community serv. workers	6.0	N.A.	6.0	1) psych.eval. - 2 hrs.
B. Periodic reevaluation -at least annually				2) psychol.eval. - 2 hrs.
C. Reevaluations upon req.				3) fam. & social serv. eval. - 2.5 hrs.
<u>Utilization Analysis</u>				

<u>Annual Prog. Capacity/# of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Direct Serv. Hrs. of D. Serv. Hrs. Avail.</u>
427	1.5	N.A.	6.0	3843 ¹	3843 ÷ 3847 = 100%

<u># Dir. Care Staff avail. for Dir. Serv.</u>	<u>* Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail. for Direct Serv (x.7)</u>
3.25	40	50	6760	4732 ÷ 1.23 = 3847

Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
752,216	99,415	Admin. = 37950 O.H. = 16850	54800 ÷ 152216 = 36%
<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>	
\$ 39.60 per client hour			
237.60 per assessment	\$237.60	\$356.40	

Staffing Pattern Analysis

Direct Care Staff/Program Census Ratio: 1.5 : 427 = .008 : 1

Administrative Staff/Direct Care Staff Ratio: 2.5 ÷ 3.25 = .77 : 1

Comments

¹ Total client hours = total staff direct service hours

II. COMMUNITY SERVICE COORDINATION PROGRAM

Community service coordinators should be closely related to the Assessment Team which will serve as the intake point for at risk clients in an Area. They should be assigned after the Assessment Team screening and once it is determined that DMH services will be made available to the client through an individual community service plan. Each service coordinator should have a caseload which reflects a range of client difficulties since long term ability to constantly handle the clients most disorganized and frequently in crisis is limited.

A. Definition

Community service coordination involves responsibility for establishing a supportive human relationship with each client; providing intermittent supportive counseling with respect to problems in daily living; coordinating, monitoring and initiating changes in the agreed upon service plan for a client; providing continuity for clients as they move through various services of the system; and advocating for client vis a vis the mental health and generic service systems.

B. Program Elements

Program will

1. Work closely with Assessment Team to receive referrals of clients for whom DMH services are being planned.
2. Establish a primary support relationship with the client through periodic individual meetings at a clinic location and in the field (e.g., in a client's home, residential program or day program).
3. Meet periodically with the program staff or individuals providing services for the client to monitor client's progress

and services and to assure linkages and communication among services when a client is receiving more than one service.

4. Aid client's transition from one service or program to another.
5. Assist clients in meeting demands of community living, including advocating for the client's needs with community agencies and other service providers.
6. Act as resource for referral and assistance of clients in obtaining generic education, employment and recreation services.
7. Arrange for periodic reevaluations of client by the Assessment Team and referral to other services when appropriate or discharge planning and recommendations when appropriate.
8. Receive consultations from the Assessment Team, Crisis Unit, and Medication Unit.
9. Casework supervisors will assist in staffing individual service planning teams drawn up by the Assessment Team and will provide direct care two days per week.

C. Clients

This program model will provide Community Service coordination to 427 clients at any one time. The caseload for an individual community service worker will be between 30 and 35 clients. No worker will have more than 5 acute severely disturbed clients. Clients are projected to need Community Service coordination for 50 weeks annually.

Staffing/Cost Schedule

SERVICE: Community Service Coordination

<u>Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Community Service Coordinators @ 10,000ea.	14.0	140,000	140,000	25,200	28,000	193,200
B. Case Work Supervisors @ 15,000 ea.	3.0	45,000	45,000	8,100	9,000	62,100

Sub-Totals:	<u>17.0</u>	<u>185,000</u>	<u>33,300</u>	<u>37,000</u>	<u>255,300</u>
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I. Administrative Personnel

A. Director	1.0	18,000	18,000	3,240	21,240
B. Secretaries @ 7,500ea.	4.0	30,000	30,000	5,400	35,400

Sub-Totals:	<u>5.0</u>	<u>48,000</u>	<u>8,640</u>	<u>56,640</u>
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II. Program Supplies & Equip.

0

III. Client Supplies & Equip.

0

IV. Transportation

0

V. Misc. (Specify)

0

II. Program Total	<u>22.0</u>	<u>233,000</u>	<u>41,940</u>	<u>37,000</u>	<u>311,940</u>
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III. Unit Cost: 17.34 per hour
 per

mild= 233
 Average Episode Cost: mod.= 931
 sev.= 1863
 Average Annual per Client Cost 233,931,1363

Service Analysis

15

SERVICE: Community Service CoordinationProgram Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Commun. Serv. Coord. meetings with clients	- mild. dist. clients (43%) 25		.25	Clients seen 1 hr. per
B. Client advocacy	- mod. dist. clients (43%) . . .1.0		1.0	Clients seen 1 hr. per
	- severely dist. clients (14%) . . .2.0		2.0	Clients seen 2 hrs/week

Utilization Analysis

<u>Annual Prog. Capacity/# of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Direct Serv. Hrs. of D. Serv. Hrs. Avail.</u>
184	1	50	.25	2300 ¹	17480 ÷ 20432 =
184	1	50	1.0	9180	
60	1	50	2.0	6000	86%.
# Dir. Care Staff				17480	Total Hrs. Avail.
B. avail. for Dir. Serv.	# Hrs./Wk.	# Weeks	Total Hrs. Avail.	for Direct Serv (x.7)	
16.2 ²	40	50	32400	22680 ÷ 1.11 = 20432	

Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
325740	230100	Admin. = 56640 O.H. = 39000 95640	95640 ÷ 325740 = 29%
<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>	
\$ 17.84 per client hour	mild = 232.87	 232.87	
_____ per _____	mod. = 968	 931.50	
	sev. = 1937	 1863.00	

Staffing Pattern AnalysisDirect Care Staff/Program Census Ratio: 15.2 : 427 = .036 : 1Administrative Staff/Direct Care Staff Ratio: 5 ÷ 17 = .29 : 1Comments

Total client hours = total staff direct service hours

² Includes 3 supervisors available for direct service 2 days per week = 48 ÷ 40 = 1.2 FTE's

(134)

III. PSYCHOTHERAPY COUNSELING PROGRAM

Access to regular psychotherapy, in addition to that provided through DMH residential or day programs, will be provided through referral by the Assessment Team or the community service coordinator. The therapists will work closely with the Assessment Team and the Community Service Coordination Program and will aid in staffing individual service planning teams structured by the Assessment Program. Since it is expected that support for problems of daily living would be offered by the community service coordinators and residential or day program staff, therapy should be considered a supplementary service available to those clients where day-to-day supportive help is not sufficient and individual therapy is recommended.

A. Definition

Family and individual psychotherapy services will provide regular supportive therapy oriented to short term needs and goals of clients and families as a supplement to DMH residential or day services, or as the sole service for some DMH clients.

B. Program Elements

Program will

1. Receive referrals of potential clients from the Assessment Team or Community Service Coordinator as part of client's overall service plan.
2. Meet periodically (ranging from several times weekly to once or twice a month) with the client and/or family for one hour supportive therapy sessions directed to short term needs and goals of client.
3. Report to the Community Service Coordinator progress or problems with the client.

4. Make recommendations to Community Service Coordinator on changes in the client's service plan as may become apparent.
5. Aid in staffing individual service planning teams structured by the Assessment Team.
6. Receive consultation from the Assessment Team, Medication Unit and Crisis Unit.

C. Clients

Psychotherapy/counseling will be available for those clients who require intense, specialized assistance in modifying behaviors which they experience as problematic, resolving intrapsychic conflicts which interfere with their functioning and/or acquiring the skills and attitudes necessary to making and maintaining close interpersonal relationships. Therapy and counseling may be individual, group, or family, depending on client needs.

This program model will serve 44 clients per area (10 per cent) annually providing approximately one hour per week of psychotherapy for 50 weeks per year. Each therapist would carry a caseload of 22 clients.

Staffing/Cost Schedule

Service: Psychotherapy/Counseling:

18

<u>I. Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Psychotherapists @ 21,000 ea.	2	42000	42000	7560	8400	57960

Sub-Totals:

<u>2</u>	<u>42000</u>	<u>7560</u>	<u>8400</u>	<u>57960</u>
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II. Administrative Personnel

A secretary @ \$7,500	.5	7,500	3,750	675	NA	4425
						2385

Sub-Totals:

<u>.5</u>	<u>3,750</u>	<u>675</u>	<u>4425</u>
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III. Program Supplies & Equip.

0

IV. Client Supplies & Equip.

0

V. Transportation

0

VI. Misc. (Specify)

0

Program Total

<u>2.5</u>	<u>45,750</u>	<u>8235</u>	<u>3400</u>	<u>62385</u>
------------	---------------	-------------	-------------	--------------

Unit Cost: \$28.36 per client hour

Average Episode Cost: 1418

per _____

Average Annual per Client Cost 1418

Service Analysis

19

SERVICE: PsychotherapyI. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Intake and hourly sessions directed towards short term needs	N.A.	1.0	1.0	

II. Utilization Analysis

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Direct Serv. Hrs. of D. Serv. Hrs. Avail.</u>
44	1	50	1	2200 ¹	2200:2523=87

<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail. for Direct Serv. (2)</u>
2	40	50	4000	2800:1.11=2523

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: OSA to Total Cost</u>
62385	49560	O.H. = 8400 Admin. = 4425 12825	12825 ÷ 62385 = 21%
<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>	
28.36 per client hour _____ per _____	\$1418	\$1418	

IV. Staffing Pattern AnalysisDirect Care Staff/Program Census Ratio: 2.44 = .045:1Administrative Staff/Direct Care Staff Ratio: 5.2 = 25:1V. Comments

1. Total client hours = to total staff direct service hours.

IV. RESPITE CARE SERVICES

For those clients who are living at home with immediate family or relatives, or in specialized home care, or those adolescents who are placed in foster care, some relief (consistent with Department policies) from constant supervision and care by the family, relative and/or foster family should be provided. Respite care services which would allow such a family or foster family to take a trip or vacation (or relief, required for emergency reasons such as the primary family member is hospitalized) are vital components in the ability of families to maintain some chronically handicapped persons at home on a long term basis. Respite care can involve day time and evening (less than overnight), and overnight care of varying lengths, either in the client's home while the family is absent, in the home of a trained provider, or in an apartment program or community residence.

A. Definition

Respite care provides relief for a family from daily care and supervision of a DMH client who is residing in a family setting, whether natural family, relative, foster family, or other types of specialized home care. Respite care may extend from a few hours up to 30 days of care provided in the client's home, in the home of a trained community provider or in DMH community-based housing.

B. Program Elements

Program will

1. Receive referrals from the family and/or client's community service coordinator but provide service only after consulting with the community service coordinator.

2. Provide day time/evening relief for a few hours on a regular or intermittent basis or overnight care for up to 30 days a year on a regular or intermittent basis in the client's home, trained community provider's home or DMH community-based housing.
3. Continue as much as possible client's daily routine.

C. Clients

For any clients living with immediate family members, friends or relatives or in specialized home care, who require constant supervision. This program will provide respite care services to 75 clients annually for an average of 2 weeks.

Staffing/Cost Schedule

I. Respite Care Coordinator :

22

<u>Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Respite Care Coord.	0.75	14000	10500	1890	2100	14490
B. Training Coord./Com- mun. Provider Recruiter	0.25	12000	3000	540	600	4140

Sub-Totals:	<u>1.0</u>	<u>13500</u>	<u>2430</u>	<u>1700</u>	<u>18630</u>
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II. Administrative Personnel

A. Administrative Coord.	0.25	14000	3500	630	n.a.	4130
B. Training & Recruit. Admin.	0.25	12000	3000	540	n.a.	3540
C. Secretary	0.5	7500	3750	675	n.a.	4425

Sub-Totals:	<u>1.0</u>	<u>10250</u>	<u>1845</u>	<u>12095</u>
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III. Program Supplies & Equip.

0

IV. Client Supplies & Equip.

0

V. Transportation

0

VI. Misc. (Specify)

a. Fees for service = 14 overnights or 12 days da. care @
\$3. per hour for days or \$20. per night: \$280 x 75 clients = 20900

VII. Program Total	<u>2.0</u>	<u>30250</u>	<u>5445</u>	<u>1700</u>	<u>31625</u>
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VIII. Unit Cost: \$6.15 per client hour Average Episoda Cost: 689
49.20 per 3 hr. da. or Average Annual per Client Cost 689
night

Service Analysis

23

SERVICE: Respite CareI. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Day and/or Night Residential Care				

II. Utilization Analysis

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Dire Serv. of D. Hrs. A</u>
75	1	2	56	8400 ¹	N.A.

<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Av. for Direct Ser</u>
1	40	50	2000	1400 ÷ 1.11 = 12

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
51625	15930	O.H. = 2700 Admin. = 12095 14795	14795 ÷ 51625 = .29%
<u>Total Cost per Unit of Service</u>		<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>
\$6.15 per client hour			
per 8 hr. day or			
\$49.20 nighr		688.80	688.80

IV. Staffing Pattern Analysis

Direct Care Staff/Program Census Ratio: N.A.

Administrative Staff/Direct Care Staff Ratio: 1:1 = 1.0

V. Comments

1. Total client hours = total staff direct service hours

(142)

V. FAMILY SUPPORT SERVICES

In addition to Respite Care and Psychotherapy Counseling Programs, natural families, foster families and specialized home care programs who maintain a client at home may need some additional specialized training and direction to help them with their DMH family member. Rather than creating an entirely separate component, such programs should be contracted, via a family and individual psychotherapy counseling program or a respite care program, with the addition of a staff member in each area who focuses primarily on family management help. This person would be responsible for meeting with family members on issues relating to maintaining clients at home in addition to traditional family counseling. The services should be directed to specific short term goals and not be designed as a long term maintenance program. Maintenance should be provided through periodic family and individual psychotherapy and the Community Service Coordination Program.

A. Definition

Family support services consist of specific, short term training and behavior management skills help which is provided to families of DMH clients who are living at home, with a relative, foster family or in specialized home care.

B. Program Elements

Program will

1. Receive referrals from the Assessment Team and/or community service coordinators.
2. Meet with family members to identify and provide help in resolving training and behavior management needs of clients where family, as opposed to pro-

fessional intervention, is necessary and appropriate.

3. Keep community service coordinator informed of family's progress and skill attainment.
4. In consultation with community service coordinator and family, terminate services when goals are achieved.

C. Clients

For families with clients at home who need assistance to help them cope with and aid the clients. This program will provide services to a total of 40 families annually for an average of 15 weeks. A therapists' weekly caseload is projected to be 12 families, each family to be seen on the average once a week for approximately 2 hours.

Staffing/Cost Schedule

Service: Family Support Services :

26

<u>I. Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Family Therapy Specialist	1.0	20,000	20,000	3,600	4,000	27,600

Sub-Totals:	1.0	20,000	3,600	4,000	27,600
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II. Administrative Personnel

Sub-Totals:	0	0	0	0
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III. Program Supplies & Equip.

0

IV. Client Supplies & Equip.

0

V. Transportation

0

VI. Misc. (Specify)

0

VII. Program Total	1.0	20,000	3,600	4,000	27,600
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VIII. Unit Cost: \$23 per client hour
 \$46 per session

Average Episode Cost: \$690
 Average Annual per Client Cost: \$690

Service Analysis

27

SERVICE: Family Support ServiceI. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Commer</u>
A. Short term family support		2	2	

II. Utilization Analysis

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>* Dire Serv. of D. Hrs. A</u>
40	1	15	2	1200 ¹	1200 ÷ 126

<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Ave for Direct Ser</u>
1	40	50	2000	14000 ÷ 1.11 = 1

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
27600	23600	O.H. = 4000	4000:27600 = 14%

<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>
\$23 per client hour	\$690	\$690
\$46 per session		

IV. Staffing Pattern AnalysisDirect Care Staff/Program Census Ratio: 1:40 = .025:1

Administrative Staff/Direct Care Staff Ratio: _____

V. Comments

1. Total client hours = Total staff direct service hours

(146)

VI. MEDICATION UNIT/NURSING SUPPORT

All clients in each Area will need an initial evaluation to determine the need for and type of medication. In addition, all clients who receive medication will need professional monitoring of the medication. Some DMH clients will need monitoring of physical health care needs that relate to the use of medication, and which cannot be obtained from generic services such as the V.N.A. Non-medical supervision of administration of medication - when necessary - should be a responsibility of residential and day program staff. This program should be based in close physical proximity to the Assessment Team. Staff of this program will work closely with the Assessment Team and will aid in staffing individual service planning teams for all at risk DMH clients in the area.

A. Definition

A program designed to evaluate, in conjunction with the Assessment Team, the need for medication for all at risk DMH clients in the Area, to prescribe and monitor medication for those clients who require it, and to provide supplementary home nursing visits for those persons having physical health care needs related to medication.

B. Program Elements

Program will

1. Aid in staffing individual service planning teams structured by the Assessment Team.
2. In conjunction with the Assessment Team, evaluate the need for medication for all clients and for those requiring medication, determine appropriate

medication type, dosage and frequency.

3. Periodically monitor medication effects of clients through client appointments at a clinic or home visits (75% clinic visits; 25% home visits).
4. Provide consultation to DMH residential and day programs on medication issues.
5. Provide periodic home visits designed to deliver or monitor general health care in conjunction with medication needs through coordination with V.N.A.'s and when V.N.A. services are not adequate.
6. Provide regular weekday coverage for determining medication needs and administering medication for Crisis Unit clients.

C. Clients

Assessment will be provided all clients. Medication will be provided to clients requiring it to control mental or somatic symptoms not amenable to less restrictive treatments. Medication for physical illnesses will only be given to clients who do not have access to generic health services. This model can provide medication assessments to 427 clients annually. It can also provide medication monitoring and medication related services to 256 persons of the 427. The average client would be seen once per 2 weeks.

Staffing/Cost Schedule

Office: Medication/Nursing Support :

30

<u>I. Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Clinical Director (RN)	.5	15,000	7,500	1,350	1,500	10,350
B. Psychiatrist	.75	45,000	33,750	6,075	6,750	46,575
C. RN's @ 12,000 ea.	2.0	24,000	24,000	4,320	4,800	33,120

Sub-Totals: 3.25 65,250 11,745 13,050 90,045

<u>II. Administrative Personnel</u>						
A. Administrator	.5	15,000	7,500	1,350		8,850
B. Billing/Appts. Secy.	1.0	7,500	7,500	1,350		8,850

Sub-Totals: 1.5 15,000 2700 17,700

<u>III. Program Supplies & Equip.</u>						0
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<u>IV. Client Supplies & Equip.</u>						0
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<u>V. Transportation</u>						0
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<u>VI. Misc. (Specify)</u>						0
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<u>Program Total</u>	4.75	80,250	14,445	13,050	107,745
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Unit Cost: 10.89 per client hr.

Average Episode Cost: 386.30 med mon.

21.78 per assessmt.

Average Annual per Client Cost 407.32 med.

monitoring plus assessment (149)

Service Analysis

31

SERVICE: Medication/Nursing Support

I. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Medication Group		1.0	.12	8 clients:1
B. Medication Review		.25	.25	
C. Physical health care (limited)		.2	.2	
			.57	
D. Medical Assess. for all clients		1.45	.28	
			2 hrs per assess.	

II. Utilization Analysis

<u>Annual Prog. Capacity/# of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Direct Serv. Hrs of D. Ser Hrs. Avail</u>
427	1	1	2	954	2818 : 381
256	1	26	.28	1864	73%
				2818	
<u># Dir. Care Staff avail. for Dir. Serv. # Hrs./Wk. # Weeks</u>				<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail for Direct Serv</u>
3.25	40	52		6760	4732 : 1.23 =

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
107745	76995	O.H. = 15,300 Admin. = 17,700 33,000	33000 : 107745 = 31%
<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>	
\$10.26 per client Hour 1	\$386.80	\$407.32	
\$20.52 per Assess			

IV. Staffing Pattern Analysis

Direct Care Staff/Program Census Ratio: $3.5:427 = 008:1$

Administrative Staff/Direct Care Staff Ratio: $1:3.5 = .29:1$

V. Comments

¹ Total Client hours

Assessments $427 \times 2 = 854$ client hours

Medication monitoring $256 \times 1.45 \times 26 = 9651.2$ hours

Total client hours = 10505.2

² 25% of staff time to be spent in support of crisis intervention unit and assessment team

(150)

VII. CRISIS INTERVENTION UNIT

This program will respond to crises in homes, DMH residences or day programs and will act as the intake point for all clients in crisis. It will work closely with the Assessment Team to initiate reevaluation of clients in crisis if they are already in the DMH service system or to initiate an assessment and individual service plan if the client is new to the DMH service system. The program will receive referrals from a community service coordinator, a DMH contracted program (day or residential), other public and private agencies, the client or any citizen. It will have the capacity to respond to a crisis through visits to the client's home, bringing the client to a clinic location or providing temporary residential services in a small residential setting exclusively reserved for clients in crisis but preferably operated by a nonprofit community agency which is also providing other residential services for DMH. In all cases there must be adequate staff to be with, support and follow the client through the crisis for up to five days. The Crisis Intervention Program will receive back up support from the Assessment Team. For clients not capable of returning to some residential setting or their home after five days, for highly assaultive persons, or those needing medical attention, voluntary or involuntary inpatient services in general hospitals will have to be considered.

A. Definition

A program designed to provide crisis intervention on a 24 hour a day, 7 days a week basis for up to five days, 24 hours a day, to clients both new to the DMH system and those already receiving DMH services.

B. Program Elements

Program will:

1. Be available on a 24 hour, 7 day a week basis to respond to mental health crises of new, former or current DMH clients.
2. Provide crisis intervention services of a short term nature (1-5 days), including residential services.
3. Provide consultation in crisis intervention to DMH contracted programs, hospitals, police departments and other public and private agencies.
4. Receive referrals from any DMH program, from public or private agencies or individuals, and from clients and families.
5. Make arrangements for reevaluation of the client's individual service plan or initiate assessment and service planning for clients new to the DMH system with the Assessment Team.
6. Utilize the Medication Unit and Assessment Team professionals as back-up during regular working hours for providing prescriptions and recommendations in handling crisis situations. Utilize on-call psychiatrist(s) and psychologist(s) for evenings, nights and weekends.
7. Along with the Assessment Team, initiate plans to be implemented for the client at the end of the 5 day crisis intervention period.

C. Clients

This service will be available for clients who are acutely and severely disturbed including those who may be dangerous to themselves or others, extremely psychotic, intoxicated, or experiencing some severe life crises. This model is designed to provide emergency services to 161 clients. 89 of these are projected to require regular emergency service and 72 the intensive services. These clients will generate 411 emergency episodes per year.

Staffing/Cost Schedule

Service: Crisis Intervention Unit :

35

<u>I. Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Prog. Dir. & Sr. Clinician	0.75	25,000	18,750	3,375	3,750	25,875
B. MSW, Psychiatric (Fam. Treatment Background)	1.0	16,000	16,000	2,880	3,200	22,000
C. RNs Psychiatric @ 13,000 ea. (rotating shifts or on call)	3.0	39,000	39,000	7,020	7,800	53,820
D. Mental Health Workers @ \$12,000 ea. (rotating shifts or on call)	6.0	72,000	72,000	12,960	14,400	99,360
E. Psychiatric Consultation 7 da. 24 hr.	0.5	53,100	26,550	N. A.	N. A.	26,550
F. Crisis Man. Consult. 7 da. 24 hr.	0.5	25,960	12,980	N. A.	N. A.	12,980

Sub-Totals:

11.75

185,280

26,235

29,150

240,665

II. Administrative Personnel

A. Administrator	0.25	25,000	6,250	1,125	N. A.	7,375
B. Sect's. @ 7,500 ea.	2.0	15,000	15,000	2,700	N. A.	17,700

Sub-Totals:

2.25

21,250

3,825

25,075

III. Program Supplies & Equip.

0

IV. Client Supplies & Equip.

0

V. Transportation

0

VI. Misc. (Specify)

Residential Costs - Retainer fee plus \$20 per night for 432 nights per year.

3,640

VII. Program Total

14.00

206,530

30,060

29,150

274,380

VIII. Unit Cost:

\$23.24 per client hour for
reg. emergencies

\$24.07 per intensive
hour

Average Episode Cost: 1733.00 for intensive
92.95 per reg.

Average Annual per Client Cost 278.38 for
3460.00 for intensive

577.68 per day

(154)

PROGRAM TYPE 24 Hour, 7 Day Emergency and Crisis Intervention

	DAY	EVE	NIGHT	FLOAT	TOTAL
WEEK DAYS	On = <u>7AM - 3PM</u>	= <u>3 - 11PM</u>	= <u>11PM - 7AM</u>	= <u>As Needed</u>	
	Hours per day = <u>8</u>	= <u>8</u>	= <u>8</u>	= <u>RN MHA</u>	
	Hours per week = <u>40</u>	= <u>40</u>	= <u>32</u>	= <u>3 10</u>	
	Nb. of Staff = <u>2.75</u>	= <u>2</u>	= <u>1</u>	= <u>15 50</u>	
	Total F.T.E.s = <u>2.75</u>	= <u>2</u>	= <u>.8</u>	= <u>Flex.</u>	<u>8.05</u>
	.75 clinical director		(Mon. - Thurs.)	.4 1.3	.75 Clin. Dir.
	1.0 social worker	1.0 RN	1.0 MHA	MD Crisis	1.0 Soc. Work.
	1.0 MHA	1.0 MHA		3 3	4.1 MHAs
	(1 RN from medic. grp on call)			15 15	.8 MD & Crisis Special
				Flex.	
				.4 .4	
				Tot. = 2.5	
WEEK ENDS	On = <u>7-3</u>	= <u>3 - 11PM</u>	(Fri. - Sun.)	= <u>As Needed</u>	
	Hours per day = <u>8</u>	= <u>8</u>	= <u>11PM - 7AM</u>	= <u>RN MHA</u>	
	Hours per week = <u>16</u>	= <u>16</u>	= <u>8</u>	= <u>3 10</u>	
	No. of Staff = <u>2</u>	= <u>2</u>	= <u>24</u>	= <u>6 20</u>	
	Total F.T.E.s = <u>.8</u>	= <u>.8</u>	= <u>2</u>	= <u>Flex.</u>	<u>4.1</u>
			= <u>1.2</u>	= <u>2 .5</u>	1.6 RNs
	1 RN	1 RN	1 RN	MD Cris	1.9 MHAs
	1 MHA	1 MHA	1 MHA	Spec	.6 MD & Crisis Spec.
				3 3	
				6 15	
				Flex.	
				.2 .4	

Staff: Client Ratio =
=

Total D.C. Staff = 12.15
X 1.23 = Included in Float
If Apt. X 2 =
+ Dir. =

Service Analysis

37

SERVICE: Emergency/CrisisI. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. 24 hrs, 7 day avail. intake & referral	N.A.	4	6	
B. Intensive care (24 hr. specializing)	24	72	72	... Extra staffing for average episode; IMHA per shift per day

II. Utilization Analysis

Annual Prog. Capacity/# A. <u>of Clients</u>	Average # Episodes per Client	Average # weeks per Episode	# Direct Serv. Staff Hrs. per Client per Wk.	Total Staff Direct Serv. Hrs. Clients	% Direct Serv. Hrs. of D. Serv. Hrs. Avail.
1. Reg. Emerg. s-89	3	N.A.	6	1602	11970 ÷ 13909 = .86
2. Intens. Emergs-72	2	N.A.	72	10368	
161				11970	
# Dir. Care Staff					
B. <u>avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail. for Direct Serv (x.7)</u>	
11:75	40	52	24,440	17108 ÷ 1.23 = 13909	

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
A. Regular= 24,817	208385	Admin.=25072	54222 ÷ 274380 = 20%
B. Intern.=249,563		O.H. =29150	
274,380		54222	
<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>	
A. Reg. \$23.24 Per client hour ¹	A. Reg = 92.96	A. Reg. = 278.88	
B. Int. \$24.07 Per hr	B. Int = 1733.00	B. Int. = 3466.00	
577.68 per day			

IV. Staffing Pattern AnalysisDirect Care Staff/Program Census Ratio: 12.15:161 = .075: 1Administrative Staff/Direct Care Staff Ratio: 2.25:11.75 = .19:1V. Comments

Total Client hours: Reg emergency clients = 89x3x4 = 1068 client hours
 Int. emergency clients = 72x2x72 = 10368
 Total client hours = 11436

(156)

VIII. INPATIENT PROGRAMS

Treatment will be provided in general hospitals with psychiatric capacity. Referrals will be made from the Crisis Intervention Program and directly from the community. Depending on the length of stay of the client, the Inpatient Program will perform assessment, evaluation and treatment planning functions and initiate on-site treatment. If the stay is less than four days, assessment and treatment planning will be referred to the Assessment Team. The Inpatient Unit will work cooperatively with the Assessment Team and Crisis Unit and referral to other DMH services will take place only through the Assessment Team.

A. Definition

To provide short term involuntary or emergency hospitalization (under 30 days) for assaultive persons who are in crisis and who cannot be served at the time in other DMH residential, day, or crisis intervention programs.

B. Program Elements

Program will

1. Receive referrals from the community or the Crisis Unit.
2. Provide short term crisis intervention, assessment, treatment planning and initiate treatment programs for clients.
3. Refer to and coordinate with Area Crisis Unit and Assessment Team.

Program could

1. Provide shelter and treatment in the evenings for clients who participate in Day Treatment, Day Activity, Vocational

Training, or other programs during the day.

2. Provide shelter and treatment on the weekends for clients who participate in Day Treatment, Day Activity, Vocational Training, or other programs during the weekdays.

C. Staffing/Costs

Approximately 4 beds should be provided in a general hospital located in each Area. The costs of care in the hospital should be paid through insurance or Medicaid.

D. Clients

For those clients needing constant or specialized medical supervision in a medical environment including those requiring involuntary care. Approximately 4 beds annually are estimated to be necessary. The costs of care in the hospital should be paid through private insurance or Medicaid.

IX. DAY TREATMENT PROGRAMS

These programs will be utilized primarily by clients requiring DMH housing but not exclusively so. They should be viewed as relatively intensive therapeutic programs which should serve clients for an average of 16 weeks with treatment directed toward specific goals. Clients should then be able to move to less intensive services such as supportive psychotherapy counseling, day activity, employment, or educational programs. Referrals, along with individual service plans, will be received from the Assessment Team and monitoring of individual service plans will be conducted by a community service coordinator.

A. Definition

Day treatment programs provide a structured, five day a week, day time program including psychiatric services, individual and group therapy, milieu therapy, medical services, educational services, and social and vocational rehabilitation on a relatively short-term basis directed to individual treatment goals.

B. Program Elements

Program will

1. Receive referrals from Assessment Team.
2. Implement individualized service plans directed toward movement of client into less intensive services.
3. Provide a range of medical, therapeutic, educational, social and vocational services.
4. Regularly consult with each client's community service coordinator and together with community service coordinator plan for client leaving program when client reaches goals

originally agreed upon or when for other reasons, termination of program seems appropriate.

5. Provide for transportation of clients to and from program.
6. Meet periodically with client's family and/or residential placement staff to discuss client progress.

C. Clients

For acutely disturbed clients who need intensive supervision for severe psychosis, medical disorders or behavioral problems. The annual number of clients to be served by this model is 60. The average client is estimated to need 16 weeks of care. The census capacity of the program at any one time is 20.

Staffing/Cost Schedule

Service: Day Treatment :

42

I. <u>Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
1. R.N.	.5	17,000	8,500	1530	1700	11,730
2. Psychiatric MSW	1	16,000	16,000	2880	3200	22,080
3. Occ/Voc Therapist	.5	14,000	7,000	1260	1400	9,660
4. M H worker @ 9500 ea	3	28,500	28,500	5130	5700	39,330
5. Psychologist	.5	11,000	5,500	990	1100	7,590
6. Psychiatrist (consult)	.25	53,100	13,275	n.a.	n.a.	13,275

Sub-Totals: 5.75 78,775 11,790 13,100 103,665

II. Administrative Personnel

Director	0.5	17,000	8,500	1,530	N.A.	10,030
Secretary	1.0	7,500	7,500	1,350	N.A.	8,850

Sub-Totals: 1.5 16,000 2,880 18,880

III. Program Supplies & Equip.

0

IV. Client Supplies & Equip.

5,000

V. Transportation

7,000

VI. Misc. (Specify)

0

VII. Program Total 7.25 94,775 14,670 13,100 134,465

VIII. Unit Cost: 4.67 per client hr

Average Episode Cost: 2241.60

28.02 per da

Average Annual per Client Cost 2241.60

Service Analysis

43

SERVICE: Day Treatment

I. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Intake, Treatment Plan	N.A.	N.A.	N.A.	
B. Brief psycho therapy	N.A.	1.0	1.0	
C. Voc. Counsel.	N.A.	1.0	1.0	
D. Group ther.	1	5.0	1.0	10 clients: 2 sta
E. O.T.	3	15.0	2.0	15 clients: 2 sta
F. Meetings with fam/resid staff	N.A.	.5	.5	2 staff spend to 1 hr per mo.
G. Recreation	N.A	<u>7.5</u>	<u>1.0</u>	15 clients: 2 sta
II. <u>Utilization Analysis</u>		30	6.5	

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u># Direct Serv. Hrs. of D. Serv Hrs. Avail</u>
60	1	16	6.5	6240	6240-7252=

<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail. for Direct Serv (</u>
5.75	40	50	11500	8050+1.11 = 7252

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
34465	90565	Admin = 18,800 O.H. = 13,100 31,100	31100 ÷ 134465 = 23%
<u>Total Cost per Unit of Service</u>		<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>
<u>4.67</u> per client hour ¹			
<u>28.02</u> per day		2241.60	2241.60

IV. Staffing Pattern Analysis

Direct Care Staff/Program Census Ratio: 5.75:20 = .29:1

Administrative Staff/Direct Care Staff Ratio: 1.5:5.75 = .26:1

V. Comments

¹ Total Client hours = 60x16x30 = 28800

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X. DAY ACTIVITY TREATMENT PROGRAMS

The major distinction between day activity and day treatment programs is that some clients may utilize day activity programs on a long term basis whereas day treatment programs should be designed as more intensive and limited to a short term. Day activity programs will be oriented for chronic or stable clients (including MR) who may be preparing for sheltered workshops or some supervised employment setting but who have limited potential for independent employment and self-support. They will include a prevocational training component similar to, but separate from, the sheltered workshop serving more independent clients.

A. Definition

Day activity programs consist of a daily, five day a week, structured program of social, educational, vocational, rehabilitation and activities of daily living training oriented to individual services plans and goals of clients, including both those requiring a short term transitional service and others requiring a longer term maintenance service.

B. Program Elements

Program will

1. Receive referrals from Assessment Team, Day Treatment, and Community Service Coordinator.
2. Implement individualized service and training plans directed either to movement of clients on to sheltered workshops or other vocational programs or to maintenance of clients who cannot move to less structured settings.
3. Provide training in social, educational, vocational,

rehabilitation and activities of daily living skills.

4. Regularly consult with each client's community service coordinator and together with the community service coordinator, plan for client's leaving the program or any necessary adjustments for long term clients, including placement in sheltered workshop.
5. Meet periodically with family and/or residential placement staff to discuss client's progress.
6. Provide for transportation of clients to and from program.

C. Clients

For clients who are not acutely disturbed but who need long term support and supervision to assist them in dealing with chronic and/or very debilitating problems. The program model would serve 30 clients at any one time. The expected length of service for an average client is 50 weeks. Consequently the number of clients one program can serve annually is 30.

Staffing/Cost Schedule

Service: Day Activity Treatment :

46

<u>I. Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Program Director	.5	16,000	8,000	1440	1600	11,040
B. MSW Psychiatric	.5	16,000	8,000	1440	1600	11,040
C. Psychologist	.5	20,000	10,000	1800	2000	13,800
D. Education Specialist	.5	14,000	7,000	1260	1400	9,660
E. Occupational Therapist	1.	14,000	14,000	2520	2800	19,320
F. Mental Health Workers @ 9500 ea	3.	28,500	28,500	5130	5700	39,330
G. Vocational Counselor Consult	.2	20,700	4,140	N.A.	N.A.	4,140
Sub-Totals:	6.2		79,640	13,590	15,100	108,330
<u>II. Administrative Personnel</u>						
A Administrator	.5	16,000	8,000	1,440		9,440
B Secretary	.5	7,500	3,750	675		4,425
Sub-Totals:	1.		11,750	2,115		13,865
<u>III. Program Supplies & Equip.</u>						0
<u>IV. Client Supplies & Equip.</u>						7,000
V. <u>Transportation</u> (Bus Driver, Insurance, Maintenance)						7,000
VI. <u>Misc. (Specify)</u>						0
VII. Program Total	7.2		75,500	15,705	15,100	136,195

VIII. Unit Cost: _____ per _____ Average Episode Cost: _____
 _____ per _____ Average Annual per Client Cost: _____

Service Analysis

47

SERVICE: Day Activity TreatmentI. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Intake, service plan	N.A.	N.A.	N.A.	
B. Counseling (Supportive)	N.A.	.33	.33	
C. Voc. Counseling	N.A.	.25	.25	
D. Voc. Training/O.T.	3	15.0	2.0	15 clients: 2 sta
E. ADL Group	1	5.0	1.0	10 clients: 2 sta
F. Meet with Family/Resid. staff	N.A.	.5	.5	2 staff spend total 1 hr per m
G. Recreation	N.A.	7.5	1.0	15 clients: 2 sta
II. <u>Utilization Analysis</u>		28.58	5.08	

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Direct Serv. Hrs. of D. Serv. Hrs. Avail.</u>
30	1	50	5.08	7620	7620 ÷ 7820 = .97

<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail. for Direct Serv. (b)</u>
6.2	40	50	12400	8680 ÷ 1.11 = 7820

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
136195	93230	Admin. = 13865 O.H. = 15100 28965	28965 - 136195 = 21%
<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>	
3.18 per client hour ¹	\$4540	\$4540	
18.18 per day			

IV. Staffing Pattern AnalysisDirect Care Staff/Program Census Ratio: $6.2:30 = .21$ Administrative Staff/Direct Care Staff Ratio: $1:6.2 = .16$ V. Comments¹ Total client hours = $30 \times 50 \times 28.58 = 42870$

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XI. VOCATIONAL REHABILITATION

Vocational services should, wherever possible, be utilized in the community, rather than creating special programs for DMH clients. Clients who do not require intensive supervision in Day Treatment or Day Activity Programs would presumably be able to participate in a CETA, WIN, NYC, OIC, or other privately financed job training program with the supportive help of their family and/or residential placement counselor or their community service coordinators. For those persons needing additional support and assistance in locating employment, a transitional employment and job placement program is necessary. For persons not yet capable of working in regular employment settings, a prevocational and sheltered workshop program would be created.

While a number of vocational rehabilitation services and program models are being proposed, we realize that there are many other types of programs that can and should be encouraged to develop. The absence of such programs from this model is not to imply that new, creative, and innovative approaches to vocational rehabilitation should not be encouraged. Some specific models that are valuable for different client ability levels and interests include client managed businesses, outdoor work programs, and cottage industries.

A. PREVOCATIONAL TRAINING/SHELTERED WORKSHOPS

Prevocational training and sheltered workshops should be established with the primary goal of teaching basic work skills and providing employment opportunity in a supervised and structured setting which will also meet the client's social and rehabilitation needs. It is expected that some percentage of the clients will eventually move on to other employment settings. The capacity to provide such movement must be included, in addition to the provision of long term useful employment on a maintenance basis for a number of clients.

1. Definition

Prevocational training provides a structured employment setting for the teaching of basic work skills to persons not yet able to perform independently in a sheltered workshop. A sheltered workshop provides vocational training and rehabilitation services, and work activity acquired through contracts with private industry. This training is designed primarily as an intermediate step for clients capable of moving on to independent employment, but also serves as a long term setting for clients with limited potential to obtain independent employment.

2. Program Elements

Program will

- a. Receive referrals from Assessment Team, Day Treatment, and Community Service Coordinator.
- b. Implement individualized vocational plans, as prepared by program staff, directed toward movement of clients to independent employment or to productive maintenance

of sheltered employment.

- c. Provide supportive counseling related to employment and employment related problems.
- d. Regularly consult with each client's community service coordinator and together with the community service coordinator, plan for any changes in the client's service plan.
- e. Meet periodically with client's family and/or residential placement counselor to discuss client's progress or status.
- f. Provide transportation to and from program.

C. Clients

For clients with severe or multiple disabilities who lack basic work and social skills. This program model will serve 38 clients annually, and 30 clients at any one time. The average length of service per client is 39 weeks.

Staffing/Cost Schedule

Service: Pre-vocational Training/Sheltered Workshop

51

<u>I. Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOT</u>
A. Program Director	.5	18,000	9,000	1620	1800	1242
B. Voc./Rehab. Specialist	1.	15,000	15,000	2700	3000	2070
C. LPN	.5	8,000	4,000	720	800	552
D. Work Supervisors @ 10,000 ea	3.	30,000	30,000	5400	6000	4140
Sub-Totals:	5.	58,000	10,440	11,924	80,04	
<u>II. Administrative Personnel</u>						
A. Administrator	.5	18,000	9,000	1,620	10,62	
B. Secretary	.5	7,500	3,750	675	4,425	
C. Bookkeeper	.5	8,000	4,000	720	4,720	
Sub-Totals:	1.5	16,750	3,015	20,165		
<u>III. Program Supplies & Equip.</u>						0
<u>IV. Client Supplies & Equip.</u>						
Manufacturing Materials						20,000
<u>V. Transportation</u>						
Bus driver, insurance, maintenance						7,000
<u>VI. Misc. (Specify)</u>						
A. Employee (client) wages @ \$40 per week, 30 clients, 50 weeks				= 60,000		60,000
B. Employee (client) fringe @ 10%				= 6,000		
<u>VII. Program Total</u>	6.5	74,750	13,455	11,924	192,925	
Minus \$100,000 received Program Income					92,925	
<u>VIII. Unit Cost:</u>	2.02	per client hour	Average Episode Cost:	2441.40		
	2.52	per client day	Average Annual per Client Cost	2441.40		

Service Analysis

52

SERVICE: Prevocational/Sheltered WorkshopI. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
1. Provide structured employment & related services	6	30	.3	30 clients:3 staf
3. Voc. Counseling	N.A.	$\frac{1}{31}$	$\frac{1}{4}$	

II. Utilization Analysis

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Direct Serv. Hrs. of D. Serv. Hrs. Avail.</u>
38	1	39	4	5928	$5928 \div 6306 = 93\%$
<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail. for Direct Serv (x.7)</u>	
5	40	50	10.000	$7.000 \times 1.11 = 6306$	

I. Cost Analysis

<u>Total Net Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
Net 92805	68440	Admin = 20165	$32089 \div 192805 = 17\%$
Gross 92805		O.H. = 11924	
		32089	
<u>Total Net Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>	
$\frac{2.02}{12.52}$ per client hour ¹			
per day	2441.40	2441.40	

Staffing Pattern AnalysisDirect Care Staff/Program Census Ratio: $5:30 = .17:1$ Administrative Staff/Direct Care Staff Ratio: $1.5:5 = 3:1$ Commentstotal client hours = $38 \times 38 \times 31 = 45942$

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B. TRANSITIONAL EMPLOYMENT/JOB PLACEMENT

1. Definition

Transitional employment programs assist clients capable of engaging in gainful employment if provided with necessary counseling, support, and training. Job placements help clients locate and continue in independent/competitive employment.

2. Program Elements

Program will

- a. Receive referrals from Assessment Team, Day Treatment, Day Activity, and Sheltered Workshop Programs.
- b. Implement vocational service plans to promote client's moving to independent employment.
- c. Provide on-job training, counseling, and supervision.
- d. Pay subsidies to private industry or public employer.
- e. Assist clients in locating competitive employment.

3. Clients

For clients high in community adjustment potential with sufficient work and social skills for engaging in independent/competitive employment given support. This program model will serve 30 clients at any one time. Clients will receive, on the average, service for 26 weeks. The number of clients served annually by this program will be 60.

Staffing/Cost Schedule

Site: Transitional Employment/Job Placement:

54

I	<u>Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
	Job Support/Placement Specialists @ 12,000 ea	1.5	18,000	18,000	3240	3600	24,840
	Vocational Counselor	.5	15,000	7,500	1350	1500	10,350

Sub-Totals: 2.0 25,500 4,590 5,100 35,190

Administrative Personnel

A. Secretary	.5	7,500	3,750	675	4,425
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Sub-Totals: .5 3,750 675 4,425

Program Supplies & Equip.

Client Supplies & Equip.

Transportation

Misc. (Specify)

A. Pay subsidies @ minimum wage -25% weekly salary for 15 clients, i.e., \$26.50 per week x 52 weeks

20,670

Program Total

2.5 29,250 5,265 5,100 60,285

Unit Cost: 18.23 per client hour for
T & P w/subsidy
per _____

Average Episode Cost: 367.20 for T&P w/sub
1745.20 for T&P w/sub
Average Annual per Client Cost 367.20 for T&P (173)
1745.20 w/ sub
431.05 job
placement

Service Analysis

E

SERVICE: Transitional Employment/Job Placement

I. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Cor</u>
A. Vocational counseling	N.A.	.25	.25	
B. OJT Counseling & support	N.A.	.5	.5	
		.75		
C. Job placement			28 hours per wk. (70 %)	

II. Utilization Analysis

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% D Ser of Hrs</u>
TEP 60 Placement:	1	26	.75	1170 1400 2570	2570+ 8
<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. for Direct</u>	
2.5	40	50	5000	3500 ÷ 1.11 = :	

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
TEP 35038.5 ¹ Placement 33526.5 68565	37170	Admin. = 4425 O.H. = 5300 9725	9725 ÷ 68565 = 44%
<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>	
12.28 per client hour ²	239.46 TEP with subsidy	239.46 TEP without subsidy	
per TEP w/o subsidy	1617.46 with subsidy	1617.46 TEP with subsidy	
		558.77 per client job places for 60 clients	

IV. Staffing Pattern Analysis

Direct Care Staff/Program Census Ratio: $2.5 \div 60 = .04:1$

Administrative Staff/Direct Care Staff Ratio: $15:2.5 = .20:1$

V. Comments

¹ TEP Cost = 14368.5 = personnel, overhead
20670 = subsidy

² Total client hours = $60 \times .75 \times 26 = 1170$

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Staffing/Cost Schedule

Service Job Developer :

56

I. <u>Direct Care Personnel</u>	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
A. Job Developer	1.	16,000	16,000	2880	3200	22,080

Sub-Totals:

1.

16,000

2880

3200

22,080

II. Administrative Personnel

Sub-Totals:

III. Program Supplies & Equip.

IV. Client Supplies & Equip.

V. Transportation

VI. Misc. (Specify)

Program Total

1.

16,000

2880

3200

22,080

Unit Cost: _____ per _____

Average Episode Cost: _____

_____ per _____

Average Annual per Client Cost _____

Service Analysis

57

SERVICE: Job DeveloperI. Program Content Analysis

<u>Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Job development				1 per A.

II. Utilization Analysis

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Direct Serv. Hrs. of D. Se. Hrs. Ava</u>
90					

<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail for Direct Serv</u>
1	40	50	2000	14000-1.11 = 12

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
22080	18.880	3200	3200÷22080 = 14.6

<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>
<u>N.A.</u> per client hour	N.A.	\$245.33
<u>N.A.</u> per _____		

IV. Staffing Pattern AnalysisDirect Care Staff/Program Census Ratio: 1:90 = .01:1

Administrative Staff/Direct Care Staff Ratio: _____

V. Comments

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XII. RECREATIONAL/SOCIALIZATION PROGRAM

In general, clients should use regular community programs at adult education centers, the YMCA-YWCA, and other recreational locations. Segregating clients for special programs of a general recreational nature is not conducive to normalization. To the maximum extent possible they should be encouraged to go on their own or in small groups of 2-3 to generic programs for additional activities. To facilitate use of generic programs and integration of clients into adult education programs, community centers or YMCA-YWCA programs, there should be funding for a part-time liaison staff person at the generic program, and regular membership or tuition fees for the activities. The role of the liaison person would be merely to be familiar with DMH clients using the program and to respond to any problems that might arise. Other recreation/socialization services such as social clubs and self-help groups should be facilitated by the community service coordinators and residential staff.

A. Definition

Funds should be provided to community centers, YMCA, YWCA or adult education programs utilized regularly by 10 or more DMH clients living in DMH housing or in non-DMH housing, to provide one extra part-time staff liaison and necessary membership or tuition fees.

B. Program Elements

Program will

1. Receive names of DMH clients who plan to utilize the program from DMH residences and community service coordinators.

2. Aid in assuring that clients can participate in regular ongoing activities which interest them.
3. Communicate periodically with referral person as to involvement of clients.
4. Communicate, when necessary, with referral person as to any problems that arise with DMH clients.

C. Clients

For clients high in community adjustment potential with sufficient social skills to participate in generic social and recreational activities. This model will provide service for up to 30 clients at any one time.

Staffing/Cost Schedule

Service: Recreation/Socialization

					60	
	<u>FTE's</u>	<u>Full Salary</u>	<u>Program Salary</u>	<u>Fringe 18%</u>	<u>Overhead 20%</u>	<u>TOTAL</u>
I. <u>Direct Care Personnel</u>						
A. <u>Liaison Specialist</u>	.5	9,000	4,500	810.	900	6,210

Sub-Totals:

.5

4,500

810

900

6,210

II. Administrative Personnel

Sub-Totals:

III. Program Supplies & Equip.

IV. Client Supplies & Equip.

V. Transportation

VI. Misc. (Specify)

A. Client memberships and tuition

1,500

VII. Program Total

.5

4,500

810

900

7,710

VIII. Unit Cost: _____ per _____

Average Episode Cost: _____

Average Annual per Client Cost: 257

Service Analysis

61

SER DE: Recreation/SocializationProgram Content Analysis

<u>I. Client Service</u>	<u>Client Hrs. per day</u>	<u>Client Hrs. per week</u>	<u>Staff Hrs. per Client per Wk.</u>	<u>Comments</u>
A. Facilitate client involvement in generic social & recreational activities				

II. Utilization Analysis

<u>Annual Prog. Capacity/# A. of Clients</u>	<u>Average # Episodes per Client</u>	<u>Average # weeks per Episode</u>	<u># Direct Serv. Staff Hrs. per Client per Wk.</u>	<u>Total Staff Direct Serv. Hrs. Clients</u>	<u>% Direct Serv. Hrs. of D. Serv. Hrs. Avail.</u>
--	--	--	---	--	--

30

<u># Dir. Care Staff B. avail. for Dir. Serv.</u>	<u># Hrs./Wk.</u>	<u># Weeks</u>	<u>Total Hrs. Avail.</u>	<u>Total Hrs. Avail. for Direct Serv.</u>
.5	40	50	1000	700 + 1.11 = 263

III. Cost Analysis

<u>Total Cost</u>	<u>Direct Care Personnel Cost</u>	<u>Overhead & Administration</u>	<u>Ratio: O&A to Total Cost</u>
7,710	5,310	900	900 ÷ 5310 = 17%

<u>Total Cost per Unit of Service</u>	<u>Total Cost per Episode</u>	<u>Total Cost per Client</u>
N.A. per client hour per	N.A.	\$257

VI. Staffing Pattern AnalysisDirect Care Staff/Program Census Ratio: .5 : 30 = .02 : 1

Administrative Staff/Direct Care Staff Ratio: _____

V. Comments

(100)

XIII. TRANSPORTATION

Transportation of clients to and from programs and appointments is an ongoing problem for all mental health and social service providers. Creating separate transportation systems, however, is not cost effective or manageable, given the varying needs of clients and the fact that for some clients transportation needs will change periodically, and in some cases, frequently. For this reason transportation should be included in full time Day Activity, Day Treatment and Sheltered Workshop Programs. In addition, most residential programs will find that staff have to provide transportation for clients' appointments or other special needs, as well as for social and recreational group activities. Funding for these programs should include the purchase of a vehicle and ongoing transportation costs. Individual transportation to clinics, counseling, jobs, higher education and non-DMH training for those not in DMH residences would be arranged by the client with assistance from the community services coordinator if necessary.

XIV. EDUCATIONAL PROGRAMS

Educational needs of clients who require intensive DMH services should be met in the context of Day Treatment and Day Activity Programs. Clients who are then able to move into adult education programs or college courses should be encouraged and aided to do so. All youth (age 22 and under) should receive CORE evaluations and be provided services via their local board of education. For adolescents, these services should include a comprehensive day treatment/educational program specifically designed to meet their needs as identified in the CORE evaluation. Pursuant to Chapter 766, it is the responsibility of local school boards to implement such programs.

ATTACHMENT D

AMENDED FINAL DRAFT

RESIDENTIAL PLACEMENT RECOMMENDATIONS FOR MENTALLY DISABLED PERSONS IN REGION I

I. INTRODUCTION

This document sets forth the number and type of residential placements that must be designed and created for the mentally disabled population in Region I. Having drafted a general description of 12 residential models, including staffing patterns and costs (see Community Residential Alternatives), and having grouped the disabled population into 22 clusters representing different client needs (see Summary of Clusters for Northampton State Hospital), it was then necessary to match each cluster with a primary and, if appropriate, secondary placement recommendation. The conclusions of the matching process are set forth in Part II.

While most clusters are assigned only one primary placement recommendation, in certain cases several primary placement recommendations are suggested. Wherever an apartment placement is recommended as a first choice, it is always coupled with a group home or transitional community residence. This reflects the fact that both placements are programmatically approximately the same, and that the determination of which should be created and funded is primarily an administrative choice best left to the implementation phase of this planning process. In certain other cases two or more placements are suggested as first choices with percentages assigned to each. In these cases it is recognized that the least restrictive alternative is most desirable, but given the institutionalization of some persons in that cluster, immediate placement in that alternative may not be appropriate for all clients in that cluster. It is clearly intended, however, that such clients will be provided necessary training and support as to enable them to move into the less restrictive placement shown as soon as possible. Secondary placements are considered to be less desirable than the primary placements for most clients; however, they are to be considered as options for certain clients in clusters with documented special needs.

The Summary of Clusters and the Analysis of the Mentally Disabled Population (Appendix E) describe the number of persons¹ in each cluster for both the Hospital and community populations.

¹It should be noted that, pursuant to the precedential rules described in the Summary of Clusters, adolescent, mentally retarded, chronic, and acute clients with serious behavioral problems were initially factored out and placed in the assaultive cluster (c).

Given this frequency distribution and the matching of clusters and residential models, it is possible to determine the number of placements for each subpopulation that must be created in each type of residential program. The residential needs of the Hospital subpopulations and the community subpopulations are set forth in Parts III and IV, respectively. A table describing the total number of placements in each residential alternative for all mentally disabled persons in Region I is in Part V.

II. CLUSTER → MODEL MATCHING

Cluster	Characteristic	Residential Placement Recommendation		
		First	Second	Third
A	High Health	Supervised Apt. or Group Home w/ Physical Care	Nursing Home (II) w/ Support Services	
B	Chronic Brain Syndrome	Supervised Apt. or Group Home w/ Behavioral Emphasis	Nursing Home w/ Support Services	
C	Assaultive Behavior	Supervised Apt. or Group Home w/ Additional Behavioral Emphasis		W
D	MR	Supervised Apt. or Group Home w/ Physical Care		
E	MR	Transitional Apt. or Community Residence		
F	MR	Home Care (15%); Supervised Apt. or Group Home (85%)		

II. CLUSTER - MODEL MATCHING (Continued)

Cluster	Characteristic	Residential Placement Recommendation		
		First	Second	Third
G	Elderly	Supervised Apt. or Group Home w/ Behavioral Emphasis		
H	Elderly	Supervised Apt. or Group Home w/ Physical Care		
J	Elderly	Transitional Apt. or Community Residence		
K	Elderly	Supervised Apt. or Group Home		
L	Elderly	Transitional Apt. or Community Residence		
M	Elderly	Non-DMH Housing w/ Support (15%); Supervised Apt. or Group Home (85%)		
N	Adolescent	Home Care (50%); Transitional Apt. (50%)		
O	Acute	(Crisis Intervention)	(General Hospital)	
P	Acute	(Crisis Intervention)	(General Hospital)	
Q	Chronic	Supervised Apt. or Group Home w/ Behavioral Emphasis		

II. CLUSTER - MODEL MATCHING (Continued-1)

Cluster	Characteristic	Residential Placement Recommendation		
		First	Second	Third
R	Chronic	Supervised Apt. or Group Home w/ Physical Care		
S	Chronic	Transitional Apt. or Community Residence		
T	Chronic	Supervised Apt. or Group Home		
U	Chronic	Supervised Apt. or Group Home		
V	Chronic	Non-DMH Housing (15%); Home Care (10%); Supervised Apt. or Group Home (75%)		5
W	Chronic	Non-DMH Housing w/ Support (50%); Home Care (50%)		

III. FREQUENCY DISTRIBUTION OF RESIDENTIAL PLACEMENTS FOR HOSPITAL POPULATION

The following distribution shows the residential placements for all persons in the Hospital on a given day. It is based on the data gathered from the client assessment survey with respect to the Hospital population as of September 17, 1977. Thus it includes an average daily census of persons within the acute and recidivist subpopulations, as well as all persons in the long-term hospitalization group.

Model Code	Model Type	No. of Primary Placements	No. of Secondary Placements
A	Non-DMH Housing w/Support	28	
B	Specialized Home Care	31	
C, D	Supervised Apartment/Group Home	255	
E, E ₁	Transitional Apartment/ Community Residence	29	
F, F ₁	Supervised Apartment/Group Home with Physical Care	36	
G, G ₁	Supervised Apartment/Group Home with Behavioral Emphasis	15	
H, H ₁	Supervised Apartment/Group Home with Physical Care and Behavioral Emphasis	0	
G, G ₁	Supervised Apartment/Group Home with Intensive Behavioral Emphasis	15	
	Nonresidential Crisis Inter- vention/General Hospital*	23	
A	Non-DMH Housing w/Support Services (Nursing Home)	26	

*To the extent nonresidential crisis intervention is not available or not appropriate, beds in general hospitals will be necessary (see Part IVA, following).

IV. FREQUENCY DISTRIBUTION FOR NON-HOSPITAL SUBPOPULATIONS

A. Acute Subpopulations

A significant portion of the thirty-two persons in this subpopulation who are hospitalized at any given time could best be served by non-residential crisis intervention services. (See Nonresidential Treatment and Support Models--Crisis Intervention). Although this subpopulation is comprised only of persons with no prior admissions to the Hospital, a portion of this subpopulation may have been receiving mental health services through outpatient clinics and support programs, while the remainder of this group had no previous contact with the mental health system. For both components of this subpopulation, however, a non-residential crisis intervention program is appropriate and has already been included in Part III, above.

Because a non-residential program does not have the capability of responding to the security needs of highly assaultive or committed persons, a limited number of general hospital psychiatric beds will be necessary. Given the small number and rapid turnover of such cases, twenty hospital beds should meet the needs of the Region. These placements would be created in private hospitals located in each DMH ARea, and would include the capacity to accept involuntary clients. An additional twenty voluntary psychiatric beds should be created in these hospitals, thus providing a total of forty beds in the Region. It is interesting to note that a detailed study of general hospital resource allocations by the Western Massachusetts Health Planning Council indicated that, beyond the eighty beds specifically designated for psychiatric services, an additional forty beds were often used to meet the needs of psychiatric patients. Although any new hospital beds may have to go through the Determination of Need procedure, it is clear that the failure to create the necessary hospital placements would significantly undermine the other residential placement distributions.

B. Recidivist Subpopulation

Although almost all of the 1076 persons in this subpopulation will require some form of mental health services to prevent their rehospitalization, only a small percentage (150 persons) will need a residential placement. Most of the residential needs of this subpopulation should be reflected in the 81 placements for this group, included in Part III (see also Appendix E of the Final Draft of the Population Analysis). Given the size of this subpopulation, however, it is somewhat difficult to determine the precise

number of persons who will need residential placement at any given time. It is reasonable to assume that a small number of additional placements will be needed to meet the need of individuals in this subpopulation who are in acute crisis or need extensive support subsequent to such crisis. The needs of this group for non-residential crisis services and general hospital beds have already been included in the placements set forth in Part III and Part IVA. Many others, however, may require intensive support to live in their own apartment or home. On the basis of data on the recidivist population of the Northampton State, approximately 500 persons per year must be provided this level of support.

<u>Model Code</u>	<u>Model Type</u>	<u>No. of Primary Placements</u>
A	Non-DMH Housing with Support	500
B	Specialized Home Care	13
C, D	Supervised Apartment/Group Home	12

C. Long Term Subpopulation

All of the 362 persons in this subpopulation who will need residential placement have already been included in Part III

D. Discharged Subpopulation

Since all 172 persons in this subpopulation presently reside in nursing or rest homes, they will only need psychiatric support services in their residences. Given the lack of adequate staff or other resources of almost all nursing and rest homes to address the needs of former Hospital patients, additional support services are necessary to avoid having the nursing home become a mini-institution with inadequate treatment.

<u>Model Code</u>	<u>Model Type</u>	<u>No. of Primary Placements</u>
A	Non-DMH Housing with Support (Nursing Home)	172

IV. FREQUENCY DISTRIBUTION OF RESIDENTIAL PLACEMENTS FOR ALL
MENTALLY DISABLED PERSONS IN REGION I

<u>Model Type</u>	<u>No. of Placements</u>
Non-DMH Housing with Support	528
Specialized Home Care	44
Supervised Apartment/Group Home	267
Transitional Apartment/Community Residence	29
Supervised Apartment/Group Home with Physical Care	36
Supervised Apartment/Group Home with Behavioral Emphasis	15
Supervised Apartment/Group Home with Physical Care and Behavioral Emphasis	0
Supervised Apartment/Group Home with Intensive Behavioral Emphasis	15
Nonresidential Crisis Intervention/ General Hospital	23
Non-DMH Housing w/Support Services (Nursing Home)	<u>198</u>
Subtotal	1155
No residential support needed	<u>980</u>
Total	2135

ATTACHMENT E

NONRESIDENTIAL PROGRAM RECOMMENDATIONS FOR MENTALLY DISABLED PERSONS IN REGION I

FINAL DRAFT

I. Introduction

This document sets forth the number and type of nonresidential placements that must be designed and created for the mentally disabled population in Region I. Having drafted a general description of 15 nonresidential models, including staffing patterns and costs (see Nonresidential Treatment and Support Programs) and having grouped the disabled population into 22 clusters representing different client needs (see Summary of Clusters for Northampton State Hospital), it was then necessary to match each cluster with the program(s) appropriate to the needs of those clients. The conclusions of the matching process are set forth in Part II.

A comprehensive nonresidential system must have the capacity to assist approximately 2100 persons in Region I or roughly 427 persons in each of the five Areas. While some models, such as the assessment and community service coordination programs, are designed to serve all persons, others, such as day treatment, day activity, prevocational/sheltered workshop, and transitional employment/job placement represent a continuum along which clients should progress as they move towards full integration in the community. Thus only a percentage of any one cluster will need a particular program on this continuum at a given time. The percentages used for these program models reflect the clients' present needs, as determined by the client assessment survey data, with due weight given to the institutionalization that most of the Hospital population has experienced.

A few models, such as counseling, respite care, and family support, are limited programs that should be available for a relatively small number of persons. Although it is possible to determine which clusters are likely to require these services, as well as the total number of persons in each Area who would participate in these programs, it is not possible to calculate the precise percentage of each cluster appropriate for each model; therefore, an x is used to indicate the general conclusion that some portion of the cluster needs that program.

The Summary of Clusters and the Analysis of the Mentally Disabled Population (Appendix E) describe the number of persons in each cluster for both the Hospital and community populations. Given this frequency distribution and the matching of clusters

and residential models, it is possible to determine the number of placements in each program that must be created for each subpopulation. The nonresidential needs of the Hospital and community subpopulations are set forth in Part III. A tabulation of the total number of placements in each program for all mentally disabled persons in Region I is presented in Part IV.

It is recognized that each of the five Areas vary considerably in size and need for new programs; for the ease of computation, however, each Area is considered to have an average of 1/5 of the client population.

II. CLUSTER NONRESIDENTIAL MODEL MATCHING: Appropriateness of Program for Each Cluster

3

NONRESIDENTIAL TREATMENT OR SUPPORT PROGRAMS

Patient Characteristic	Cluster	# of Persons in Cluster	Intake/Assessment	Comm. Service Coordinator	Psychotherapy/Counseling	Respite Care	Family Support	Medication/Nursing	Prescreen./Crisis Interven.	Day Treatment	Day Activity Treatment	Pre Voc./Sheltered Workshop	Transitional Employment/Placement
High Health	A		x	x				x			x(%)		
Chronic Brain Syndrome	B		x	x				x			x(%)		
Assaultive	C		x	x	x(%)			x		x(%)	x(%)		
Mentally Retarded	D		x	x				x			x		
Mentally Retarded	E		x	x							x		
Mentally Retarded	F		x	x		x(%)	x(%)				x(%)	x(%)	
Elderly	G		x	x	x(%)			x		*	x		
Elderly	H		x	x				x		*	x		
Elderly	J		x	x	x(%)			x		*	x		
Elderly	K		x	x	x(%)			x		*	x		
Elderly	L		x	x				x(%)		*	x		
Elderly	M		x	x		x(%)	x(%)	x(%)		*	x		

*Approximately 5% (5 persons) of the elderly subpopulation will need day treatment.

(194)

II. CLUSTER NONRESIDENTIAL MODEL MATCHING: Appropriateness of Program for Each Cluster

4

NONRESIDENTIAL TREATMENT OR SUPPORT PROGRAMS

Patient Characteristic	Cluster	# of Persons in Cluster	Intake/ Assessment	Comm. Service Coordinator	Psychotherapy /Counseling	Respite Care	Family Support	Medication/ Nursing	Prescreen./ Crisis Interven.	Day Treatment	Day Activity Treatment	Pre Voc./ Sheltered Workshop	Transitional Employment/ Placement
Adolescent	N		x	x	x(%)	x(%)	x(%)	x	x	x			
Acute	O		x	x	x(%)		x(%)	x	x	x			
Acute	P		x	x	x(%)		x(%)		x	**			
Chronic	Q		x	x	x(%)			x		**	x		
Chronic	R		x	x				x		**	x		
Chronic	S		x	x	x(%)			x	x	**	x		
Chronic	T		x	x	x(%)			x	x	**	x(%)	x(%)	
Chronic	U		x	x				x(%)		**	x(%)	x(%)	
Chronic	V		x	x		x(%)	x(%)	x(%)		**	x(%)	x(%)	x(%)
Chronic	W		x	x		x(%)	x(%)						x

**Approximately 18% (34 persons) of the chronic subpopulation will need day treatment.

(195)

III. CLUSTER NONRESIDENTIAL MODEL MATCHING: Number of Persons in Each Program

A. Hospital Subpopulation - 472

5

NONRESIDENTIAL TREATMENT OR SUPPORT PROGRAMS

Patient Characteristic	Cluster	# of Persons in Cluster	Intake/Assessment	Comm. Service Coordinator	Psychotherapy/Counseling	Respite Care	Family Support	Medication/Nursing	Prescreen./Crisis Interven.	Day Treatment	Day Activity Treatment	Pre Voc./Sheltered Workshop	Transitional Employment/Placement
High Health	A	33	33	33				33		*	11	*	*
Chronic Brain Syndrome	B	19	19	19				19		*	6	*	*
Assaultive	C	15	15	15	x			15		6	9		
Mentally Retarded	D	9	9	9				9			9		
Mentally Retarded	E	8	8	8							8		
Mentally Retarded	F	61	61	61		x	x				46	15	
Elderly	G	4	4	4	x			4		S**	4		
Elderly	H	17	17	17				17			16		
Elderly	J	6	6	6	x			6			6		
Elderly	K	20	20	20	x			20			18		
Elderly	L	2	2	2				1			2		
Elderly	M	52	52	52		x	x	39			49		

**Approximately 5% (5 persons) of the elderly subpopulation will need day treatment.

*Remainder of clients in this cluster receive no day or vocational services from DMH

(96T)

III. CLUSTER NONRESIDENTIAL MODEL MATCHING: Number of Persons in Each Program
A. Hospital Subpopulation (cont.)

NONRESIDENTIAL TREATMENT OR SUPPORT PROGRAMS

6

Patient Characteristic	Cluster	# of Persons in Cluster	Intake/Assessment	Comm. Service Coordinator	Psychotherapy/Counseling	Respite Care	Family Support	Medication/Nursing	Prescreen./Crisis Interven.	Day Treatment	Day Activity Treatment	Pre Voc./Sheltered Workshop	Transitional Employment/Placement
Adolescent	N	14	14	14	x	x	x	14	14	14			
Acute	O	3	3	3	x		x	3	3	3			
Acute	P	20	20	20	x		x		20		3		
Chronic	Q	5	5	5	x			5					
Chronic	R	4	4	4				4	6		3		
Chronic	S	6	6	6	x			6	6	34***	3	22	
Chronic	T	44	44	44	x			44	44		11		
Chronic	U	5	5	5				3			3	2	
Chronic	V	121	121	121		x	x	90			13	61	30
Chronic	W	4	4	4		x	x						4
TOTAL		472	472	472				332	87	62	220	100	34

***Approximately 18% (34 persons) of the chronic subpopulation will need day treatment.

(197)

III. CLUSTER NONRESIDENTIAL MODEL MATCHING : Number of Persons in Each Program

7

B. Acute Population in Community - 495

NONRESIDENTIAL TREATMENT OR SUPPORT PROGRAMS

Patient Characteristic	Cluster	# of Persons in Cluster	Intake/ Assessment	Comm. Service Coordinator	Psychotherapy /Counseling	Respite Care	Family Support	Medication/ Nursing	Prescreen./ Crisis Interven.	Day Treatment	Day Activity Treatment	Pre Voc./ Sheltered Workshop	Transitional Employment/ Placement
Adolescent	N	138	138	138	x	x	x	138	138	138			
Acute	O	45	45	45	x			45	45	45			
Acute	P	312	312	312	x				312				
TOTAL		495	495	495				183	495	183			

III. CLUSTER NONRESIDENTIAL MODEL MATCHING : Number of Persons in Each Program

C. Recidivist in Community - 996

8

NONRESIDENTIAL TREATMENT OR SUPPORT PROGRAMS

Patient Characteristic	Cluster	# of Persons in Cluster	Intake/ Assessment	Comm. Service Coordinator	Psychotherapy/Counseling	Respite Care	Family Support	Medication/ Nursing	Prescreen./ Crisis Interven.	Day Treatment	Day Activity Treatment	Pre Voc./ Sheltered Workshop	Transitional Employment/ Placement
Chronic Brain Syndrome	B	49	49	49				49			16	*	*
Assaultive	C	100	100	100	x			100		40	*	*	
Mentally Retarded	F	159	159	159		x	x				32	95	32
Elderly	M	100	100	100		x	x	50			23	*	
Adolescent	N	70	70	70	x	x	x	70	70				
Chronic	T	100	100	100	x			100	100		20	60	20
Chronic	V	369	369	369		x	x	221			55	92	221
Chronic	W	49	49	49		x	x						49
TOTAL		996	996	996				590	170	40	146	247	322

*Remainder of clients in this cluster receive no day or vocational services from DMH.

(661)

III. CLUSTER NONRESIDENTIAL MODEL MATCHING: Number of Persons in Each Program

D. Discharged to Nursing Home - 172

9

NONRESIDENTIAL TREATMENT OR SUPPORT PROGRAMS

Patient Character- istic	Cluster	# of Persons in Cluster	Intake/ Assessment	Comm. Service Coordinator	Psychotherapy /Counseling	Respite Care	Family Support	Medication/ Nursing	Prescreen./ Crisis Interven.	Day Treatment	Day Activity Treatment	Pre Voc./ Sheltered Workshop	Transitional Employment/ Placement
Elderly	G-M	172	172	172				172					

IV. FREQUENCY DISTRIBUTION OF NONRESIDENTIAL PLACEMENTS FOR
ALL MENTALLY DISABLED PERSONS IN REGION I.

	Average Area <u>Total</u>	Regional <u>Total</u>
Intake/Assessment	427	2135
Community Service Coordination	427	2135
Psychotherapy/Counseling	44	220
Respite Care	75	375
Family Support	40	200
Medication/Nursing	255	1277
Prescreening/Crisis Intervention	150 ¹	752
Day Treatment	57 ²	285
Day Activity Treatment	73	366
Pre Vocational/Sheltered Workshop	69	347
Transitional Employment/Job Placement	71	356
Recreation/Socialization	90 ³	450

¹Because of the short length of stay (1-5 days) in the crisis intervention program, one placement is capable of meeting the needs of a large number of persons (approximately 80-100). Therefore, the Area and Regional figures do not accurately reflect the number of placements needed but rather the unduplicated number of persons needing such services. As set forth in the Nonresidential Treatment and Support Programs, it is reasonable to assume that four placements is sufficient to meet the needs of approximately 400 persons in each Area.

²The average client stay in the day treatment programs is 16 weeks; one placement is thus capable of serving approximately 3 persons. As set forth in the Nonresidential Treatment and Support Program, it is reasonable to assume that a program with 20 placements can meet the needs of each Area.

³Participation in this program is not related to client cluster and therefore is not included in the preceding tables. None of the persons in the day treatment (20) or day activity treatment (73)

programs or clients in the acute (100) or discharged to nursing home (35) subpopulations will need a separate recreation program. Of the remaining 200 clients in each Area, most of whom are in the recidivist subpopulation, approximately one-half would participate in this program.

ATTACHMENT F

FINAL DRAFT

MANAGEMENT COMPONENT

I. Introduction

The Department of Mental Health has the primary and ultimate responsibility for creating and maintaining a comprehensive system of community treatment and support programs appropriate to the needs of mentally disabled persons. This responsibility is undertaken on a local level through Regional and Area Offices which develop, fund, manage, coordinate, and monitor these programs. To the extent that services are delivered through many independent providers, the Department's responsibilities can only be fulfilled if it has the management capacity to oversee a diverse delivery system. Moreover, given the clinical advantages of providing much treatment and training outside of the residential environment, the task of ensuring that its clients regularly receive appropriate services makes the Department's management responsibilities especially complex. The Regional and Area Offices presently lack adequate mental health resources to fulfill those responsibilities, since they are primarily geared to an institution based service system. In order to develop and manage quality community programs, a management component must be included in the planning design. Portions of this component like the direct care components, should be purchased through contract mechanisms. An outline of such a component, with a specific description of the organizational structure, is attached.

II. The Providers

It is expected that the actual provision of services will be done chiefly through private nonprofit corporations experienced in designing and implementing residential and non-residential programs for mentally disabled persons. The Department will contract with these independent providers pursuant to standard RFP procedures and regulations established by the Office of Administration and Finance. It is estimated that there are on the average, 40 contracts per area and 200 contracts region-wide in Region I, totalling roughly \$8 million dollars. Implementation of this plan might double their number and/or size. This increase in Area and Regional responsibility cannot be over emphasized. Area and Regional Offices provide technical assistance to vendors in developing their proposals and monitor contract operations in order to ensure that all programs are compliant with State regulations and are an integral part of a comprehensive system. If an Area elects to become a primary service provider for some of its clients, the management component must be modified accordingly. In certain cases, the Regional Office may also provide services for high risk/low incidence clients in inter-area programs. This should be reflected in Regional Office structure and staffing.

III. General Description of Functions, Management Areas and Activities

Although Regional and Area Offices address very different levels of operations, both must have the ability to perform two types of functions: planning and development and monitoring and coordination. These functions must be performed in three management areas: program management, fiscal and personnel management, and information management. Table I shows the matrix of functions by management areas and lists the major types of activities associated with each combination of function and management area. A general description of these activities follows which does not detail the difference between regional and area activities. However in sections IV and V Area and Regional Office activities are specified separately.

A. Program Management

Within the program management area three activities reflect the planning and development function. System and program development refers to planning a community care system, including residential and non-residential programs and linkages to generic services. This activity also includes developing vendors and agencies and providing technical assistance in drafting proposals. Staff training and development involves insuring that adequately trained manpower is available to meet program needs. Community development consists of working with citizen boards and councils to facilitate community acceptance and client integration. This is done by educating citizens and developing local leadership.

**Table I. Matrix of Functions by Services showing
Major Management Activities**

	Management Areas		
	Program Management	Fiscal and Personnel Management	Information Management
Functions			
Planning and Develop.	1. System and Program development 2. Training 3. Community Develop.	1. Budget Development 2. Spending Plans 3. Contracting 4. Revenue Planning	1. Long range Planning 2. Annual Planning 3. Research for Program Development
Monitoring and Coordination	1. System and program Coordination 2. Legal services 3. Program monitoring 4. Quality Assurance	1. Expenditure/Revenue Monitoring 2. Auditing 3. Personnel management	1. Client, Fiscal, Personnel and Service management information 2. Program evaluation and evaluation research

Four activities are associated with the monitoring and coordination function within program management. System and program coordination includes developing functional linkages between programs, facilitating the sharing of information when appropriate, supervising the transition of services from institutions to communities and ensuring that clients continue to move through community programs towards less restrictive, more independent living with appropriate continuity of care. Legal services differ from the area to the regional level.

At the regional level legal services consist of legal counsel to the Regional and Area Offices. Program monitoring occurs primarily at the area level. It involves overseeing the community care system. This includes reviewing and approving vendor contracts, ensuring contract compliance through periodic reviews of programs and technical assistance in the implementation of "plans of correction" in cases of non-compliance. Program monitoring also includes reviewing and resolving any complaints by clients or advocates against programs.¹ Quality assurance is primarily a regional function although Area Office staff will participate. This activity involves annual reviews of programs to assure compliance with program and professional standards. It is a crucial activity in setting the staff for program monitoring.

¹This document does not address but recognizes an important role for consumers in program evaluation.

B. Fiscal and Personnel Management

There are four activities associated with the planning and development function within the area of fiscal and personnel management. Budget development and contracting refer to the process by which dollars are assigned to accounts and vendors in compliance with state laws and regulations. Contract development can extend to assisting providers in writing contracts. Spending and revenue planning involves establishing expenditure schedules and strategies for generating revenues so that programs can operate uninterrupted by issues of fiscal solvency.

The monitoring and coordination function is reflected in three activities in the fiscal and personnel management area. Expenditure and revenue monitoring refer to tracking spending and revenues to ensure compliance with spending and revenue plans. A goal of such monitoring is to uncover variances from plans while there is time to correct them. Auditing involves monitoring contracts to ensure that vendors are operating in compliance with state fiscal regulations and laws. Personnel management and affirmative action involves facilitating the recruitment, hiring, development and maintenance of an appropriately skilled and motivated workforce composed of minority employees to a degree consistent with affirmative action guidelines.

C. Information Management

In the information management area there are three planning and development related functions. Long range planning consists of the development of explicit goals for clients and programs within a 3 to 5 year planning horizon. This goal setting is a key area of citizen involvement.

It is also a component required in most federal grant proposals and increasingly in state health and social service planning. Annual planning involves devising strategies for allocating dollars to programs. These plans are the basis for budget development. Research for program development includes needs assessment and evaluation research designed to provide information as to what client needs are and what programs most successfully meet them. This information is necessary for deciding what programs to develop and/or fund. It also provides back up for federal grants, determination of need procedures, etc.

Finally, within the information management area two activities relate to monitoring and coordination. The first is developing and maintaining client, personnel, fiscal and service management information systems. These systems information as to: types and quantities of services provided; numbers and types of clients served; staffing patterns and activities; costs. Such information is basic to most management activities. The second is program evaluation and research. This activity provides information as how well different services work for different clients. This information is the key to system and program planning.

IV. The Area Office

The primary responsibility for designing and supervising the community care delivery system lies with the Area Office. Table II shows how the activities just described translate into specific Area Office staffing and activities in support of programs for clients in the Northampton class. The number of area staff required for management support of programs for all area clients would be between 2 and 2½ times the number shown (e.g.: mentally retarded persons, children and adolescents, substance abusers, adults with mental health problems, but not at risk of state hospitalization, etc.). This table also shows which of the positions required exist and which do not. Table III depicts the organization chart for the area positions listed in Table II.

Table IV summarizes the information on Area Office staffing and provides cost information. This cost information includes salaries, fringe benefits at 18%, support costs at 15%, and 40% of electronic data processing costs of \$10,000.00 per area. The support costs are set at 15% rather than 20% (the figure used for direct care programs), because Area Offices already exist and have certain support equipment and supplies.

The data processing costs cover terminal rental at \$250.00 per month to permit decentralized data entry and report generation, at \$585.00 per month for computer time and telephone costs. The information on costs may be summarized as follows:

Positions (Pos.):	6.9
Salaries:	94,450
Fringe benefits @ 18%:	15,921
Support costs @ 15%:	17,267
Total :	<u>\$ 127,638</u>
x 5 Areas :	\$ 638,190

TABLE II

AREA STAFF AND ACTIVITIES

<u>Organizational Unit</u>	<u>Position</u>	<u>#FTE's</u>	<u>#Exist.</u>	<u>Pos.</u>	<u>Activities</u>
1. Area Director's Off.	A. Area Dir.	0.4	0.4	0	1. Develops Long range plans for Area w/Area Board 2. Develops Annual Plans with Area Board 3. Participates in personnel mgmt. including labor relations 4. Reviews plans of programs, vendors, agencies 5. Interagency coordination - area strategy 6. Sole line authority to direct service program 7. Supervises & coordinates Area Office staff
	B. Assoc. AD	0.4	0.4	0	1. Staff to AD; functions delegated by AD. 2. Community development; generic service development. 3. Provides staff work to Area Board
2. Program Services	A. Sys/Program Devel. Spec.	1.0	0	1.0	1. Develops program models, vendors, agencies 2. Develops contracts, plans and activities that are consistent with Area goals and objectives 3. Provides technical assistance to programs wishing to expand 4. Staff training and development
	B. System/Program 1.0 Coordinator		0	1.0	1. Develops linkages between institutions & communities 2. Develops linkages among community programs 3. Facilitates communication among programs 4. Insures client movement from more to less restrictive settings 5. Insures continuity of care for clients 6. Investigates and responds to client complaints
	C. System/Program 1.0 Monitor		0	1.0	1. Ongoing, on-site monitoring of program compliance with program and/or contract objectives & requirements 2. Monitors implementation of plans of corrections 3. Works with regional quality assurance team 4. Keeps Area Board informed

TABLE II (cont.)

AREA STAFF AND ACTIVITIES DEVOTED TO CLIENTS IN THE NORTHAMPTON CLASS

<u>Organizational Unit</u>	<u>Position</u>	<u>#FTE's</u>	<u>#Exist.</u>	<u># Pos.</u>	<u>Activities</u>
Fiscal & Personnel Services	D Secretary	.5	0	.5	1. Standard secretarial duties
	A Bus/Contract Manager	0.4	0	.4	1. Prepares area line item budget 2. Prepares area spending plan 3. Develops area contracts to meet accounting requirement 4. Revenue planning 5. Expenditure and revenue monitoring 6. Auditing 7. Supervises bookkeeper 8. Personnel management and labor relations
	B Bookkeeper	0.4	0	0.4	1. Supports Bus/Contract Manager in above activities
	C Secretary	0.4	0	0.4	1. Standard secretarial duties
Information Serv.	A Infor. Spec.	0.4	0	0.4	1. Long range planning 2. Annual planning 3. Reviews and summarizes research bearing on program development 4. Prepares reports for AD, Area Board, RSA, Central Office and others 5. Designs and implements program evaluation research for program development applications
	B Data Coord.	0.4	0	0.4	1. Maintains and coordinates client, fiscal, personnel and service management information systems. Inputs and Outputs data. 2. Supports activities of Information Specialist
	C Secretary	0.4	0	0.4	1. Standard secretarial duties

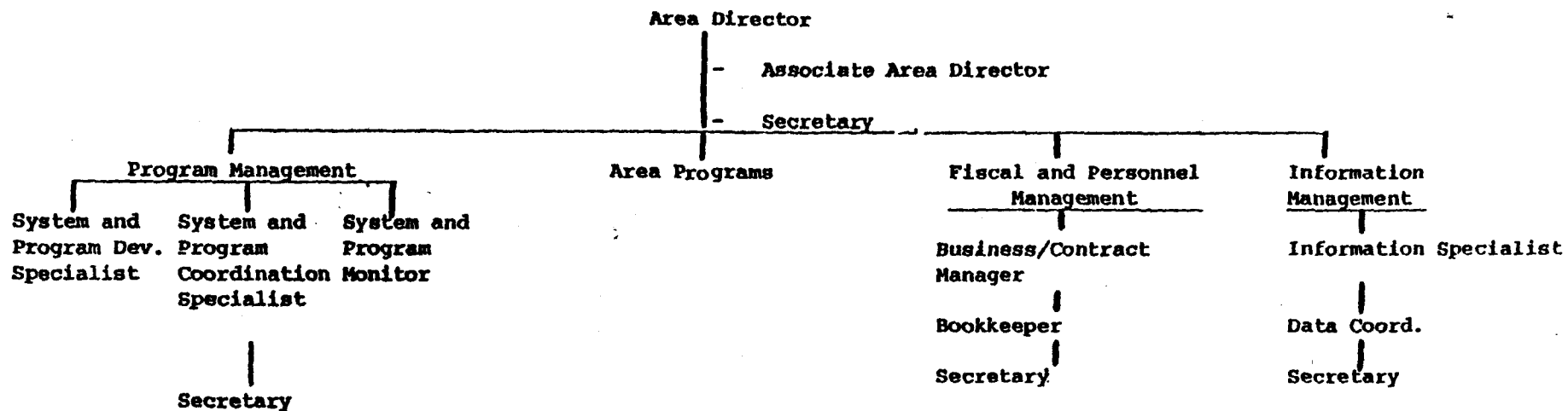


Table IV
Area office staffing and to provide Management Support
for Programs for Northampton Clients

<u>Organizational Unit</u>	<u>Position</u>	<u># FTEs</u>	<u># Exist.</u>	<u># Pos.</u>	<u>Salaries</u>	<u>Total Salaries</u>	<u>Fringe @18%</u>	<u>Support @ 15%</u>	<u>Total \$</u>	<u>All Costs</u>
Area Direct. Office	1. AD	.4	.4	0	0	12,000	N.A.	N.A.	0	12,000
	2. Assoc. AD	.4	.4	0	0	68,000	N.A.	N.A.	0	68,000
	3. Secy.	.4	.4	0	0	3,000	N.A.	N.A.	0	3,000
	Total	1.5	1.5	0	0	21,800	0	0	0	21,800
System/Prog. Develop. Management	1. Sys/Prog. Devel. Spec.	1	0	1	16,000	16,000	2,880	2,400	21,280	21,280
	2. Sys/Prog Coord.	1	0	1	16,000	16,000	2,880	2,400	21,280	21,280
	3. Sys/Prog Monitor.	1	0	1	16,000	16,000	2,880	2,400	21,280	21,280
	4. Secy.	.5	0	.5	3,750	3,750	675	562	4,987	4,987
	Total	3.5	0	3.5	51,750	51,750	9,315	7,762	68,827	68,827
Fiscal Mgmt.	1. Bus/Contr Managemr.	.4	0	.4	6,400	6,400	1,152	960	8,512	8,512
	2. Bookkeep.	.4	0	.4	3,600	3,600	648	540	4,788	4,788
	3. Secy.	.4	0	.4	3,000	3,000	540	450	3,990	3,990
	Total	1.2	0	1.2	13,000	13,000	2,340	1,950	17,290	17,290
Information Mgmt.	1. Info.Spec.	.4	0	.4	6,400	6,400	1,152	960	8,512	8,512
	2. Data Coord.	.4	0	.4	4,800	4,800	864	720	6,384	6,384
	3. Secy.	.4	0	.4	3,000	3,000	540	450	3,990	3,990
	4. EDP Support	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	4,000	4,000	4,000
	Total	1.2	0	1.2	14,200	14,200	2,556	6,130	22,886	22,886

TOTALS

8 1.5 5.9 78,950 100,750 14,211 15,842 109,003 110,801

V. The Regional Office

The ultimate responsibility for the proper design and functioning of a quality system of community programs rests with the Regional Office. In the abstract, the Regional Office must have capacities that are similar to the areas. However, concretely regional activities deal with different levels of operation than do Area Offices. For example, Regional and Area Offices both monitor programs. However, the Area Office does "hands-on" day to day monitoring while the Regional Office does quality assurance once per year.

Table V shows the concrete activities performed in the Regional Office and how these translate into regional staffing needs for the purposes of the suit. Once again management support for programs for all regional clients would require approximately 2-24 times the numbers regional staff shown. Table VI depicts the Regional Table of Organization. Table VII summarizes this information and shows staffing costs. The cost information in Table VI is the same as in Table IV. These costs aggregate as follows:

Positions:	2.5
Salaries:	36,600
Fringe @ 18%:	6588
Support @ 15%:	<u>9490</u>
TOTAL:	<u><u>52,678</u></u>

TABLE V

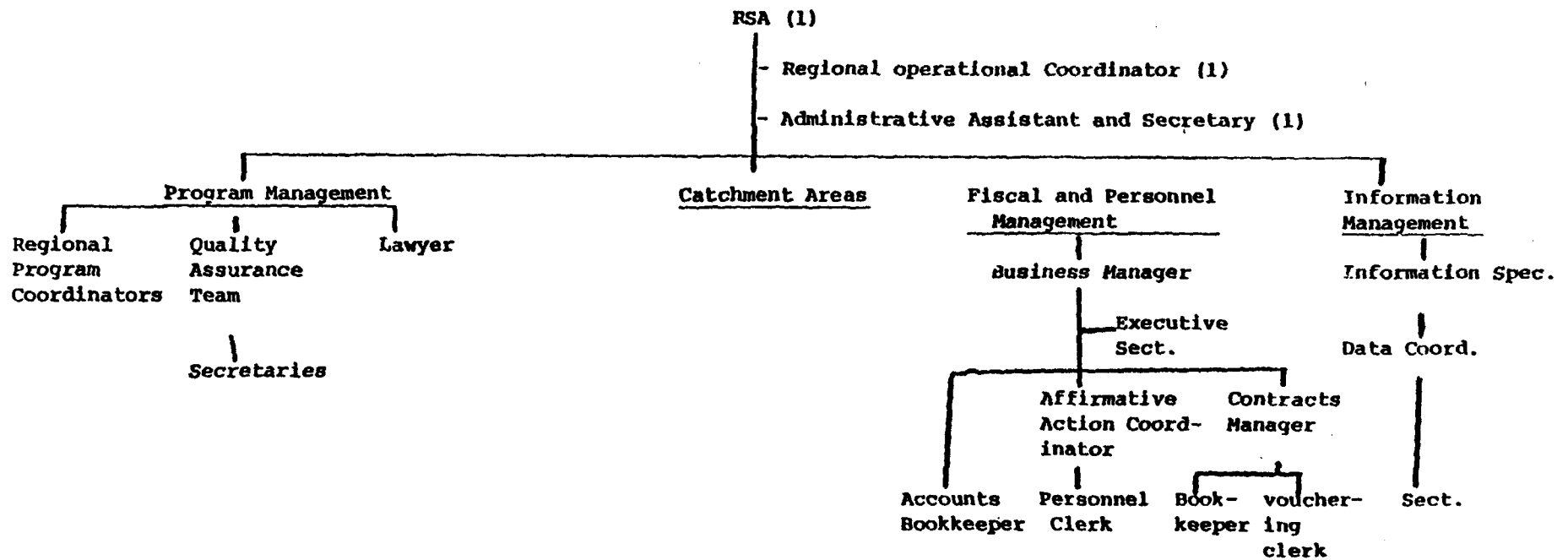
Regional Office STAFF AND ACTIVITIES

Organizational Unit	Position	#FTE's	#Edst.	#Pos.	Activities
RSA's Office	A. RSA	.4	.4	0	1. Supervises and coordinates other 3 units 2. Sole line authority to Area directors 3. Reviews and approves Area & Regional Plans & Budgets 4. Policy development 5. Sets regional goals and objectives 6. Long and short run regional planning 7. Area strategy & other interagency coordination 8. Regional resource allocation 9. Works with regional Council
	B. Administrative Asst. & Sect.	.4	.4	0	1. Works under supervision of RSA
	C. Regional Operations Coord.	.4	.4	0	1. Plans & monitors Regional activities.
Program Develop. Unit	A. Regional Prog. Coord.	2.0	2.0	0	1. Tech. Assist to areas in developing service programs, goals objectives. 2. Monitoring & approving Area work 3. Develop Regional/inter-Area programs
	B. Quality Assur. Team	3.1	2.1	1.0	1. Visit all programs yearly
	C. Lawyer	.4	0	.4	1. Legal Counsel to Regions and Areas
	D. Sect.	1.0	1.0	0	
Fiscal Management Unit	A. Business Manager	.4	1	0	1. Prepares regional Budget (211) 2. Reviews Area Budget (211) 3. Prepares regional account spending plan (212) 4. Technical assistance to Areas 5. Monitors Area spending & revenues 6. Monitors Area spending & revenues 7. Regional auditing 8. Personnel management

TABLE V (Cont.)

<u>Organizational Unit</u>	<u>Position</u>	<u>#FTE's</u>	<u>#Exist.</u>	<u>#Pos.</u>	<u>Activities</u>
Fiscal Mgmt. cont.	B. Accounts Bookkeeper	.4	0	.4	1. Works under supervision regional Bus. Man. 2. Prepares budgets for specific 3. Reviews and approves Area & Regional Plans & Budgets 4. Policy development
	C. Personnel Clerk	.4	0	.4	1. Monitors personnel changes 2. Reviews & approves 3. Provide tech. assistance
	D. Affirm. Act. Coord.	.4	.4	0	1. Monitors Affirmative Action compliance 2. Plans & implements affirm action initiatives
	E. Contracts Mgr.	.4	.4	0	1. Prepare inter-Area contracts 2. Tech. assist. on contracts to Areas & vendors 3. Review & sign off Area contracts
	G. Vouchering Clerk	.4	.4	0	1. Works under contracts mgr.
	H. Executive Secretary	.4	0	.4	
	I. Secy.	.4	.4	0	
Information Management	A. Info. special	.4	.4	0	1. Conduct research for Program Development 2. Oversee collection of multiple types of data: Area plan, Client component, CAS, Personnel, etc. 3. Train Area Information personnel
	B. Data Coord. & info. spec.	.4	.4	0	1. Works under Info. Spec.
	C. Sect.	.4	0	.4	1. Standard secretarial duties

Table VI. Regional Office Organization Chart:
Staffing Shown for entire office.



**Regional Office Staffing and Costs to Provide Management Support
to Programs for Northampton Clients.**

<u>Organizational Unit</u>	<u>Position</u>	<u># FTEs</u>	<u># Exist.</u>	<u># Pos.</u>	<u>Salaries</u>	<u>Total Salaries</u>	<u>Fringe @ 18%</u>	<u>Support @ 15%</u>	<u>Total \$</u>	<u>All Costs</u>
RSA's Office	1. RSA	.4	.4	0	0	12,000	N.A.	N.A.	0	12,000
	2. Admin. Asst.									
	Secy	.4	.4	0	0	5,600	N.A.	N.A.	0	5,600
	3. Reg. Opera. Coord.	.4	.4	0	0	8,000	N.A.	N.A.	0	8,000
	Total	<u>1.2</u>	<u>1.2</u>	<u>0</u>	<u>0</u>	<u>25,600</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>25,600</u>
Syst/Program Develop. Mgmt.	1. Reg. Progr. 2 Coord.	2	2	0	0	24,000	N.A.	N.A.	0	24,000
	2. Qual. Assur. 3.1 Team	3.1	2.1	1	18,000	47,625	3,240	2,700	23,910	53,565
	3. Atty	.4	0	.4	8,000	8,000	1,440	1,200	10,640	10,640
	4. Secy	1	1	0	0	7,500	N.A.	N.A.	0	7,500
	Total	<u>6.5</u>	<u>6.1</u>	<u>1.4</u>	<u>26,000</u>	<u>87,125</u>	<u>4,680</u>	<u>3,900</u>	<u>34,580</u>	<u>95,705</u>
Fiscal Mgmt.	1. Bus. Mgr.	.4	.4	0	N.A.	8,000	N.A.	N.A.	N.A.	8,000
	2. Accts. Book- keeper	.4	0	.4	4,000	4,000	720	600	5,320	5,320
	3. Personnel Clerk	.4	.4	0	0	3,600	N.A.	N.A.	N.A.	3,600
	4. EEO/AA Coord.	.4	.4	0	0	5,600	N.A.	N.A.	N.A.	5,600
	5. Contract Mgr.	.4	.4	0	0	6,800	N.A.	N.A.	N.A.	6,800
	6. Bookkeeper	.4	.4	0	0	3,200	N.A.	N.A.	N.A.	3,200
	7. Vouchering Clk.	.4	.4	0	0	3,200	N.A.	N.A.	N.A.	3,200
	8. Exec. Secy	.4	0	.4	3,600	3,600	648	540	4,788	4,788
	9. Secy	.4	.4	0	0	3,000	N.A.	N.A.	N.A.	3,000
	Total	<u>3.6</u>	<u>2.8</u>	<u>0.8</u>	<u>7,600</u>	<u>41,000</u>	<u>1,368</u>	<u>1,140</u>	<u>10,108</u>	<u>43,508</u>
Info. Mgmt.	1. Info Spec.	.4	.4	0	0	5,600	N.A.	N.A.	N.A.	5,600
	2. Data Coord.	.4	.4	0	0	4,800	N.A.	N.A.	N.A.	4,800
	3. Secy	.4	0	.4	3,000	3,000	540	450	3,990	3,990
	4. BDP	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	4,000	4,000	4,000
	Total	<u>1.2</u>	<u>.8</u>	<u>.4</u>	<u>3,000</u>	<u>13,400</u>	<u>540</u>	<u>4,450</u>	<u>7,990</u>	<u>18,390</u>
TOTALS		12.5	9.9	2.6	36,600	167,125	6,588	9,490	52,678	183,203

V. Summary

On the basis of the above analysis of the responsibilities and activities, resources and needs of both area and regional officer, the management component to a comprehensive community care system in all of Region will cost \$690,868 annually in addition to existing administrative personnel. A breakdown of this figure is as follows:

	Salaries	Fringe	Support	TOTAL
Personnel Costs				
5 Area Offices	472,250	79,605	86,335	638,190
1 Regional Office	36,600	6,588	9,490	52,678
Total for Region	706,500	105,975	105,975	690,868

Although this figure theoretically assumes an equal distribution of administrative resources to each area, the actual allocation of funds should be modified to reflect individual area needs and population.

ATTACHMENT G

SURVEY OF EXISTING COMMUNITY MENTAL HEALTH SERVICES

FINAL DRAFT

I. Introduction

The documents in Phase I of the planning process designed a range of residential and nonresidential program models and determined the actual number of placements which must be created in each of those models to meet the needs of the members of the plaintiff class. The Summary of Principles and Conclusions of Phase I correlated all planning documents and estimated the total cost for creating and maintaining a system of community mental health services for a specific portion of the plaintiff class who were hospitalized in a given two year period (planning population). Given the fact that some of the programs needed by the planning population already existed, although not necessarily in a form comparable to the relevant model, it thus was necessary to assess the capacity and adequacy of existing programs to serve this planning population. The resultant information could then be used to determine the actual number of new residential and nonresidential placements which must be created and the extent to which existing programs must be upgraded to satisfy the plaintiffs' needs as set forth in the Phase I planning documents.

II. The Process

After extensive discussion of various assessment techniques, a process was developed over several months to generate and analyze relevant data on the capacity and adequacy of existing programs. It was recognized at the outset that even an extensive research project using sophisticated computer methodologies would not be significantly more reliable than information gathered through individual interviews and analysis of existing contracts due to the limits on the type and accessibility of information maintained by community service providers. Therefore, a two step process was adopted which initially determined the capacity of existing programs to serve members of the planning population and which subsequently analyzed this data in light of the program models to assess their adequacy.

The data gathering phase of this process began with a review of all mental health programs funded in whole or in part by the Department of Mental Health. Through a series of questions addressed to each Area Director in separate interviews (see Appendix A), the programs in each Area which significantly serve members of the planning population were delineated and their actual client capacity determined. A list of all relevant programs, by Area, and their capacity to serve the planning population was then compiled for review and certification by the Regional Services Administrator. It was recognized that this approach not only provided a reliable measure of the extent of services

offered by existing programs to the most disabled population, but also created a standard against which all programs and Area managers could be held accountable in the future.

An adequacy assessment instrument to collect information as to each program's personnel and fiscal resources was then carefully drafted, discussed, and finalized (see Appendix B). For each program determined to significantly serve the planning population a separate staff and funding survey form was completed, either by the Area Director based on a review of contracts and other Department statistics or through a formal site visit to the service provider by the Area Director, Regional Office staff person, and a representative of the plaintiffs. Using this survey instrument, accurate information was generated as to the staff and fiscal resources of existing community programs which are available to deliver each of the model residential and non-residential services described in the planning documents.

To summarize and analyze this data, two formats were created (see Appendix C). The first described all available resources in Region I for each residential and nonresidential service and then assessed the adequacy of existing programs providing that service by comparing the available resources with the standards set forth in the planning documents. This comparison was done not only for present resources, but also for anticipated program resources included in the new FY'79 budget, as approved, and the FY'80 budget, as requested by the Department. The second format compiled the adequacy conclusions for each

service and presented a composite description of the adequacy of all existing residential and nonresidential services. This summary was again done for present resources, approved FY'79 programs, and requested FY'80 programs. The resultant data analysis, a summary of which is attached as Appendix D, provides a clear picture of which program models exist in Region I, and the capacity and adequacy of those programs to serve members of the planning population.

III. Conclusion

Based on the carefully devised process for gathering and analyzing information with respect to the capacity and adequacy of existing community programs, several conclusions emerge:

1. There is no unused capacity in existing programs to serve the present residents of the Hospital. Therefore, further census reduction in conformity with the residential and nonresidential placement recommendations set forth in the planning documents, can only be accomplished through the creation of new programs or the expansion of existing programs to serve these members of the planning population.
2. There are several residential and nonresidential programs which have the capacity to serve a specific portion of the planning population but which are inadequate, as compared to the planning documents,

to meet the needs of the members of the planning population living in the community who participate in these programs. The projected cost of upgrading these programs for community clients is \$2,801,506.

3. There are other residential and nonresidential programs which are entirely absent or only minimally available in most Areas in Region I, and which therefore must be newly created to serve the members of the planning population living in the community who need such programs. The projected cost of creating or expanding these programs for community clients is \$3,812,077.

Thus these conclusions indicate that the residential and nonresidential programs which now exist in Region I are substantially inadequate to serve the 1755 members of the planning population not presently institutionalized at the Northampton State Hospital. The total cost of upgrading these programs to provide adequate treatment in appropriate less restrictive alternatives for these persons is \$6,613,583. Some but not all of these costs include federal reimbursements under Titles XIX and XX of the Social Security Act, which would be significant for many nonresidential programs.

Therefore, in order to reduce 60% of this inadequacy in existing programs during FY'80, it will require \$2,933,421 during that year (see Appendix E). A significant portion of

this cost (\$1,404,341) is already included in and has been approved as part of the Region I budget request for FY'80. To eliminate the remaining inadequacy during FY'81, it will cost \$1,772,440 during that year.

Methodology for identifying existing community mental health services funded fully or partially by D.M.H. and for determining the extent to which these programs meet the needs of the plaintiffs' class members as set forth in the summary and documents of Phase I of the planning process.

FILTERING QUESTIONS

1. Does the reporting unit or agency operate at more than a minimum level at least one program described in the residential or non-residential program models? If so, which program (use Appendix A).

Yes

2. Is the program significantly designed and funded, pursuant to State Plan, policy, or assurances made in other litigation to serve a client population other than the members of the class as defined in the planning documents?

No

3. Is the program designed and funded to significantly serve members of the planning population, as opposed to other members of the plaintiff class (See Appendix B for description of the planning population).

Yes

Repeat above procedure for all RUs corresponding to F.Y.'79 for funding. New programs funded for F.Y.'79, new programs requested for F.Y.'80.

ADEQUACY QUESTIONS

4. What is the full capacity of the program and what percentage is designed and funded to service the planning population? (See Appendix C for capacity format).
5. What is the level of D.M.H. and non-D.M.H. funding?
6. What is the total number of staff and how are they assigned to the program under consideration. What is the resultant staff/client ratio?

DIRECTIONS

APPENDIX B

This packet includes this coversheet, a Staffing Form, a Funding Form and an Appendix of Staff Discipline Codes. All programs being surveyed are assumed to fall into one of four general categories.

Category 1

The program is equal to the agency for budget and staffing.

Category 2

The program is not equal to the total agency, but staff and budget are distinct in all but administrative overhead.

Category 3

The program is not equal to the agency. There is staff sharing but allocation of staff time to each program is clearly predetermined by agency policy and procedure.

Category 4

The program is not equal to the agency. There is a staff and/or budget sharing that is not administratively predetermined. This category would include all cases that do not fall into any of categories 1, 2 or 3 above.

The rules for applying the Funding and Staffing Forms to the four (4) categories are presented below:

<u>Category Number</u>	<u>Staffing</u>	<u>Funding</u>
1	Columns 1 through 3 and 6	Columns 1 through 4
2	Columns 1 through 3 and 6	Columns 1 through 5
3	Columns 1 through 3 and 6	Columns 1 through 5
4	Columns 1 through 6	Columns 1 through 9

In general, there are only a few general rules that apply to the Staffing Form and the Funding Form:

Staffing Form

1. Column 2 - FTE - is mandatory for computing Column 6 (Cost of Staff Person to Program) $6 = 2 \times 3(\text{salary})$
2. If 2 is not available, then Columns 4 and 5 in regard to assigned hours must be computed.
Thus $4 + 5 = 2$,
Then $2 \times 3 = 6$

Funding Form

1. Columns 3, 4 and 5 should be equal to Column 1
2. Columns 8 and 9 should be equal to Column 6
3. For Categories 2, 3 and 4 the figure for Column 5 is computed by the formula

$$\frac{1 \text{ PROGRAM BUDGET}}{6 \text{ TOTAL BUDGET}} \times 9 == 5 \text{ THE AMOUNT OF ADMINISTRATIVE OVERHEAD THAT BELONGS TO THE PROGRAM}$$

GENERAL RULE: Past experience has illustrated that while advanced planning is invaluable, no amount of foresight will allow for prediction of the occasional "special case" that may not fall into any of the four categories. In the event of any of these "special cases" being encountered, they will be so noted and all raw data will be collected on both forms. This will allow for later re-evaluation of the handling of that particular situation.

Collection of Data for the four categories will be completed by the following persons:

Categories 1, 2 and 3: The Consultant (Paul Gerson, WMTC) will explain the forms to the Area Directors and they or their designee will complete them with the consultant available for input.

Category 4: The Area Directors (possibly including other area office staff), the Consultant and Steve Ferrarone (MPAP) will meet with the program director (possibly including other agency staff) to complete the forms.

Reporting Unit Number/Program Code

(230)

FUNDING FORM

NONE OF THE FIGURES ENTERED DELOW SHOULD INCLUDE THE VALUE OF NON-PAID PERSONNEL OR ANY IN-KIND CONTRIBUTIONS.

PROGRAM BUDGET FOR: REPORTING UNIT NUMBER/PROGRAM CODE

AGENCY BUDGET FOR: _____

TOTAL	D.H.H.	PERSONNEL	NON-PERSONNEL	PROGRAM'S AMOUNT OF SHARED OVERHEAD	TOTAL	D.H.H.	PERSONNEL	NON-PERSONNEL
1	2	3	4	5	6	7	8	9

(231)

APPENDIX D

Revised Summary of Data for All Residential and Nonresidential Program Models

	COLUMN 3 RESOURCES NEEDED	COLUMN 5 FY'79 EXISTING RESOURCES	COLUMN 6 RESOURCES LACKING-- COMMUNITY CLIENTS IN EXISTING PROGRAMS	COLUMN 9 TOTAL RESOURCES LACKING-- COMMUNITY CLIENTS	COLUMN 9 TOTAL RESOURCES LACKING-- HOSPITAL CLIENTS	COLUMN 11 FY'80 EXISTING RESOURCES	COLUMN 15 RESOURCES LACKING-- COMMUNITY CLIENTS	COLUMN 15 RESOURCES LACKING-- HOSPITAL CLIENTS
Residential	6,585,102	2,677,209	488,298	936,388	3,022,585	4,494,371	414,939	1,681,273
Non- Residential	9,755,791	2,515,535	2,313,208	5,677,195	1,559,936	4,378,296	4,660,365	714,912
Total	16,340,893	5,192,744	2,801,506	6,613,583	4,582,521	8,872,667	5,075,304	2,396,185

¹ Copies of all data are available at the Region I Office in Northampton. This data includes completed funding and staffing forms for all relevant existing programs, as well as aggregated data, by Area and program model, which sets forth the deficits in client capacity and fiscal resources for both FY'79 and FY'80.

Summary of Costs of Upgrading of Programs
in FY'80 and FY'81

Used Funding for Brewster vs. Dukakis Consent Decree

- Options: 1. Program Models developed in planning process
2. Timetable for census reduction as in draft decree
3. Funding 3/5 of resources lacking for community clients in FY'80 and 2/5 in FY'81.

Start of FY'79

Existing resources for planning population (incl. SSI, Title XIX)	3,508,282
Capital Budget minus reallocation	9,801,521

Programs - FY '79 (already appropriated)

<u>FY'79 - Part Year Funding</u>		<u>Annualized - FY'80</u>	
New Funds	793,861	New Rollover	796,809
Reallocation	151,790	Reallocation	831,440
Total	945,651	Total	1,684,462

End of FY'79 - Start of FY'80

Existing Resources (incl. SSI, Title XIX)	5,192,744
Resources lacking for Community Clients	6,613,303
Resources lacking for Hospital Clients	4,582,321
Capital Budget minus reallocation	7,814,005

New Programs - FY'80 - DMH Budget Request

<u>FY'80 - Part Year Funding</u>		<u>Annualized - FY'81</u>
Community Clients - New Funds	737,137	250,000
Reallocation	667,204	1,435,940
Total	1,404,341	1,685,940
Hospital Clients - New Funds	765,986	250,000
Reallocation	595,530	1,837,074
Total	1,361,516	2,087,074
Grand Total	2,765,857	3,773,014

Above funding will permit the following:

Appropriate residential and day programs for 100 hospital clients.
Case Management services for 100 hospital and 590 community clients.
Medication aftercare services for 100 hospital and 80 community clients. Funds for 150 respite care and 480 crisis intervention episodes. Improving the funding inadequacies of 10 existing residential programs. Improving the adequacy of regional-area office staff.

New Programs - Added to FY'80 Request (due to 3/5 provision)

	<u>FY'80 Part-Year Funding (8 months)</u>	<u>Annualized - FY'81</u>
New Funds	1,529,080	2,282,209

This added funding will permit the following:

Increase the capacity of day activity programs for 100 community clients. Increase the capacity of case management services for 300 community clients. Establish 5 area assessment teams to do Individual Service Plans for all clients. Funds for additional 210 respite care and 470 crisis intervention episodes.

Total New Programs in FY'80

	<u>FY'80 Part-Year Funding</u>	<u>Annualized - FY'81</u>
New	3,032,203	2,782,209
Reallocation	1,262,734	3,273,014
Total	4,294,937	6,055,223

End of FY'80 and Start of FY'81

Existing Resources (including SSI, Title XIX)	11,247,967
Resources lacking for Community Clients	2,645,434
Resources lacking for Hospital Clients	2,495,447
Hospital Budget minus reallocation	3,735,707

New Programs - FY'81

	<u>FY'81 Part-Year Funding</u>	<u>Annualized - FY'81</u>
Community Clients - New Funds	1,772,440	1,777,581
- Reallocation		867,953
Total	1,772,440	2,645,534
Hospital Clients - New Funds	972,723	877,494
Reallocation	375,000	1,617,953
Total	1,347,723	2,495,447
Grand Total	3,120,163	5,140,881

These funds will permit the following:

Appropriate residential, day and case management services for 100 hospital clients. Remaining missing capacities:

Respite Care - 15; Family Support - 19; Medication Aftercare - 372; Case Management - 478; Prevocational - 473; Transitional Employment - 240; Recreation-Socialization - 283.

Remaining adequacy of existing programs: Counseling, Family Support, Medication Aftercare, Day Activity, Residential Programs, and Regional-Area Management.

End of FY'81 - Start of FY'82

Existing Resources (including SSI, Title XIX)	16,388,848
Resources lacking for Community Clients	0
Resources lacking for Hospital Clients	0
*Hospital Budget minus reallocation	4,000,000

*To be used for secure treatment for 50 remaining hospital clients if option is to use building on hospital grounds. Remainder is savings as physical plant is phased out and remaining support staff is reassigned.

**Maximum SSI funding is built into FY'79 through FY'81 projections; but Title XIX projections are conservative. The latter will possibly be higher than projected in FY'80 and '81 as clinics and day treatment programs qualify for free-standing Title XIX certification.

	FY 79	FY 80	FY 81	FY 82
FY 79- New Community Resources DMO, SSI, TITLE XIX	3,508,282.	3,508,282.	3,508,282.	3,508,282.
New Programs FY 79 NEW PROGRAM FUNDS	793,881.	796,809.	796,809.	796,809.
Reallocation, SSI, XIX	151,790.	831,440.	831,440.	831,440.
TOTAL	945,651.	1,684,462.	1,684,462.	1,684,462.
New Programs FY 80 NEW PROGRAM FUNDS		3,032,203.	2,782,209.	2,782,209.
Reallocation, -SSI, XIX		1,262,734.	3,273,014.	3,273,014.
TOTAL		4,294,937.	6,055,223.	6,055,223.
New Programs FY 81 NEW PROGRAM FUNDS			2,745,163.	2,655,175.
Reallocation, SSI, XIX			375,000.	2,485,706.
TOTAL			3,120,163.	5,140,881.
TOTAL COMMUNITY RESOURCES	4,453,933.	9,487,681.	14,368,130.	16,388,848.
Hospital Budget	9,801,521.	7,814,005.	5,735,707.	4,000,000.

Attachment H

Defendants' Obligations to Overcome Potential
Obstacles to Implementation

The defendants will take the following actions to overcome potential obstacles and barriers to the full implementation of this Decree:

1. Educating communities, citizens, and the general public as to the appropriateness and advantages of residents and clients living in less restrictive, more normal residential alternatives;
2. Working with local cities and towns to assist them in integrating residents and clients into the community and insuring clients equal access to generic services;
3. Opposing restrictive zoning measures and actions designed to frustrate the right of residents and clients to live in less restrictive community residences;
4. Securing the approval of determination of need applications;
5. Reviewing relevant labor contracts and collective bargaining agreements to determine methods for addressing concerns of Hospital employees;

6. Assisting service providers and vendors in increasing their capacity and efficiency to operate residential alternatives and nonresidential programs;

7. Reviewing and, where appropriate, modifying the present contracting process to eliminate burdensome administrative procedures which may be found to unduly delay reimbursement to service providers and vendors or which may be found to unnecessarily limit administrative flexibility; and

8. Working cooperatively with persons, agencies, departments, programs, or organizations not a party to this Decree and not within the direct or indirect control of the defendants to insure full compliance with the provisions of this Decree.

ATTACHMENT I

REVISED NOTIFICATION OF DISCHARGE AGREEMENT

The parties involved in the lawsuit, Brewster v. Dukakis, agree to the following:

1. As soon as possible, but in no event less than two weeks prior to the discharge, referral to a community treatment program, or placement in an alternative community facility of any member of the plaintiff class who has been at Northampton State Hospital (the Hospital) for more than thirty days, the defendants will give written notice to the plaintiffs' counsel, Steven J. Schwartz, at the Mental Patients Advocacy Project, Northampton State Hospital, of the name of the resident being discharged, referred, or placed, the proposed date for such discharge, referral, or placement, and the name and address of the community facility or program to which placement or referral will be made; and whether the resident or his guardian consents to such placement.

2. With respect to any member of the plaintiff class who has been at the Hospital for less than thirty days, the defendants will give written notice on a weekly basis to the plaintiffs' counsel, Steven J. Schwartz, at the Mental Patients Advocacy Project, Northampton State Hospital, of the name of all residents who were discharged during that week, the actual date of such discharge, and the name and address of the community facility or program to which placement or referral was made.

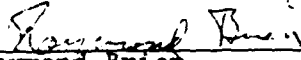
3. For all mentally retarded residents, copies of such notices will be sent to Boisfeuillet Jones, Hill and Barlow, 225 Franklin Street, Boston, Massachusetts 02110.

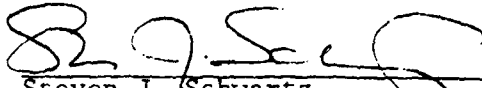
4. The Regional Services Administrator shall designate one person responsible for all such notifications of discharges, referrals, or placements.

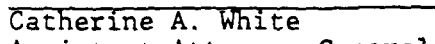
5. Upon execution of an authorization, signed by the resident, permitting Steven J. Schwartz or Boisfeuillet Jones or their designated-in-writing representative, to examine the clients' records (G.L. c. 123, §36), the Regional Services Administrator or the director of medical records of the Hospital will permit the records and files to be examined. In the event a resident is incompetent and has no guardian, the Commissioner or his designee shall approve the release of the medical records pursuant to §7.03(c)(1) of the Regulations of the Department of Mental Health.

6. The Department of Mental Health will cooperate with plaintiffs' attorneys in their desire to examine the proposed community referral or placement and to discuss its program with staff of both DMH and the community facility.

7. No part of this agreement or notification procedure shall be construed to cause a person to remain in the Hospital any longer than he/she otherwise would in the absence of such agreements or procedure.


Raymond Brien
Regional Services Administrator
DMH, Region I


Steven J. Schwartz
Attorney for Plaintiffs


Catherine A. White
Assistant Attorney General
Attorney for Defendants


Boisfeuillet Jones, Jr.
Attorney for Plaintiffs
Massachusetts Association for
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