current trends and recommended changes in extended-care placement of mental patients: the Illinois system as a case in point*

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National statistics leave no doubt that the resident population of public mental hospitals has been declining since 1955 (Paul 1969). Given major impetus from the community mental health ideology incorporated in the 1963 Community Mental Health Centers Act (Public Law 88-164), the reduction in the resident population of public mental hospitals has continued at an accelerated rate since 1971, when the number and rate of annual admissions also began to decline (Taube and Meyer 1975). On a nationwide scale the apparent result of the expanded community mental health movement was a reduction in average daily patient load (ADPL) in State mental hospitals from 505,000 in 1963 to 249,000 in 1973 (Jones 1975).

Three Trends Contributing to the Public Mental Hospital Population Decline

Three trends appear to have contributed to the reduction in the hospital resident population. All three emanate from the implementation of the community mental health philosophy—that is, the use of community resources for the prevention or treatment of disorders as an alternative to prolonged care in traditional mental hospitals (Smith and Hobbs 1969).

Rapid Turnover of Acute Patients

The earliest contributions to the decline in mental hospital resident beds were associated with the introduction of psychotropic drugs, unit decentralization with "open door" philosophies, and active precare and aftercare in the community (Paul 1969). All of these efforts focused upon short stays in residence in mental hospitals with a resulting rapid turnover of inpatients. Through the mid-1960's, Glass (1965) noted that the rapid turnover involved only acute patients and less than a third of resident beds. The remaining two-thirds of resident hospital beds were still filled with a static, chronically institutionalized population. Nevertheless, recent figures show 88 percent of functional psychotics to be released from State and county mental hospitals within 6 months of admission (Taube and Redick 1973), clearly contributing to the overall reduction in ADPL.

Establishment of New Community-Based Treatment Facilities

The second trend contributing to the decline in mental hospital resident beds is the increased establishment of smaller local and regional treatment facilities. These new facilities, including federally sponsored Comprehensive Community Mental Health Centers, Illinois Regional Centers, psychiatric units in private and public general hospitals, halfway houses, and similar transitional facilities have increased geometrically in number since the mid-1960's (Gunderson and Mosher 1975, Kris 1964, Lamb 1967, Ozarin and Witkin 1975, Reidy 1964, and Yolles 1966). Such new community-based facilities serve to reduce admissions to public mental hospitals, both as a function of active extramural efforts to channel people with problems to alternative treatment sources, and by the addition of new beds that
functionally replace beds in public mental hospitals. Like rapid turnover within traditional hospitals, however, the focus on new facilities and community intervention has contributed to a significant reduction in traditional hospital beds, largely for initial admissions and acute problems, but has not had much impact on the chronically institutionalized (Chu and Trotter 1974 and Smith, Kaplan, and Siker 1974).

**Extended-Care Placement of Chronic Mental Patients**

Since the mid-1960's, a third trend has involved the long-stay resident of mental hospitals, especially in more "progressive" States such as California, Illinois, and New York where inpatient beds have been reduced as much as 58 percent from 1967 to 1973 (Taube 1975). The aggressive placement of long-stay mental patients in private extended-care facilities—for example, foster homes, nursing homes, shelter-care homes, or other board-and-care facilities—accounts for nearly all of the reductions in the chronic population, as few long-stay patients remain out of mental institutions if they are not so placed (Mendel 1974 and Rieder 1974). The greatest relative proportions of such placements (e.g., reduction in resident beds of over 78 percent in California and 84 percent in Illinois) have involved movement of geriatric patients to nursing homes for continued custodial care (Taube 1975). The remainder of these placements, however, involve the younger long-stay patient. The extent of these patient movements can be observed in the State of Illinois where, as of November 1974, more private extended-care beds were occupied by ex-residents of Department of Mental Health and Developmental Disabilities (DMHDD) facilities—hospitals and regional centers—than were currently occupied in DMHDD facilities themselves (Ragan 1974).

**Hospital Population Decline Is Not Equivalent to More Effective Intervention**

**Rapid Turnover and New Facilities Have Not Resulted in Improved Patient Functioning**

Mental health professionals were initially enthusiastic about the decline in the public mental hospital resident population (Tyce and Rynearson 1966). This development was taken as evidence for the effectiveness of community-based treatment (Cochran 1974). The practical operations involved in the decline of hospital beds as a result of increased emphasis on rapid turnover facilities and alternatives to hospitalization, however, have recently been the focus of serious questions. Long-term followups have failed to maintain the early promise of some intervention procedures (e.g., Davis, Dinitz, and Pasamanick 1972). Additionally, the level of functioning in the community of discharged mental patients—even those with acute problems—has been, at best, marginal (Erickson 1975). Further, the trend toward short stays and rapid turnover has been associated with parallel increases in readmission and multiple admission rates. A recent review of the literature, in fact, set a 1-year expected recidivism rate at 40 to 50 percent of discharges (Anthony et al. 1972), with the most recent available data on functional psychoses reporting that over 72 percent of institutional admissions were readmissions (Taube 1974).

New community mental health centers show patterns similar to State hospitals, with multiple admissions and readmissions increasing the longer a center has been in operation (Rutledge and Binner 1970). Contrary to the proposed emphasis of the community mental health ideology on earlier interventions with different technologies (e.g., Caplan 1964 and Rappaport et al. 1975), Chu and Trotter (1974) argue that actual operations in the new movement have been no different and no more effective than those previously accomplished in mental hospitals. Instead of a change in what is done for people through rapid turnover, new facilities, and alternatives to hospitalization, Chu and Trotter (1974) suggest that "more of the same" is simply occurring in different locations. As Koltuv and Neff (1968) warned earlier with regard to community-based treatment without new technology: "It is quite likely that our only accomplishment will be moving the locus in which he [the emotionally disturbed] vegetates and experiences personal misery from the custodial hospital to the community" (p. 252). Thus, with few exceptions (e.g., Marx, Test, and Stein 1973 and Stein, Test, and Marx 1975), the decline in resident beds of public mental hospitals resulting from rapid turnover, new community-based facilities, and the majority of currently existing alternative operations does not appear to reflect more effective interventions.
Extended-Care Placements Have Not Improved Rehabilitation Programming for Chronic Mental Patients

Until recently, no well-controlled evaluations had found any known institutional program to be reliably effective in the treatment of severely debilitated long-stay patients of mental institutions (Paul and Lentz, in process). Private extended-care placements have, largely, consisted of “administrative releases,” essentially declaring the placeable chronic patient to be “incurable” by default, since existing institutional programs had not made a significant impact on functioning. Although mental health professionals would like to see the goals of extended-care placements as rehabilitation, Hefferin (1968) concluded that the goals of such private facilities are frequently business first and service second. Even though there is an alarming lack of readily available data on the effectiveness of community extended-care facilities in rehabilitation, the existing literature offers no evidence that improved treatment conditions exist, on the whole, in such facilities—constituting a “national disgrace” in the view of some commentators (Reich 1973).

Professional followups of extended-care placements are notably lacking. When followup has occurred, however, a complete absence of rehabilitation programming has been found (e.g., McClannahan and Risley 1975), to the extent that some investigators maintain that patients are simply being shuffled to “back wards” in the community (e.g., Lamb and Goertzel 1971). While the level of functioning required to remain in extended-care facilities would be expected to be lower than that required of ex-patients living independently, rehospitalization rates for chronic patients discharged to such placements are still reported to range from 30 percent to over 50 percent in less than 2 years (Anthony et al. 1972 and Rieder 1974). Furthermore, in those reports where level of functioning has been assessed, declines rather than improvements in functioning have been found for chronic patients who continue to reside in community extended-care facilities (Ellsworth 1968, Epstein and Simon 1968, and Lamb and Goertzel 1972).

The State of Illinois has one of the most highly articulated systems of community extended-care facilities in the Nation. On paper, private shelter-care homes are specifically geared to serve as long-term rehabilitative facilities for younger ex-mental patients, providing trained staff and social and vocational rehabilitation programs for those who need some supervision, but who do not require nursing attention or the degree of control available in hospitals. An unpublished survey of 82 shelter-care homes housing DMHDD releases in east-central Illinois did find lower rates of rehospitalization than those reported in other States (Trout 1972). However, 59 percent of the homes reported no releases at all to less supervised living arrangements. Of the 34 homes reporting releases to more independent circumstances, ex-DMHDD patient involvement ranged from a high of 10 percent to less than 1 percent. In fact, over all homes combined, the average length of stay for ex-mental patients was over 3 years at the time of the survey, with the majority of “releases” being accounted for by death, transfer to another shelter-care home, or transfer to the more supervised environment of a nursing home. Thus, even though private extended-care facilities house a less disabled resident population, evidence to date indicates that they are no more effective in rehabilitation than public mental hospitals have been. While Paul and Lentz (in process) reported aftercare consultation procedures that prevented rehospitalization in 97 percent of cases, without decline in functioning, the reduction in the resident population of mental hospitals resulting from extended-care placement of long-stay patients on the national level largely appears to reflect only a movement of custodial care to different locations.

Community Extended-Care Facilities Must Become Long-Term Rehabilitation Centers

In spite of the ineffectiveness of current operations of extended-care facilities, several factors argue not only that it would be desirable for such facilities to become long-term rehabilitation centers, but that they may be required to do so.

Chronically Institutionalized Mental Patients Remain a Major Problem

Even after a decade of increasing discharge rates, over 72 percent of resident patients in State hospitals have been institutionalized over 1½ years, while nearly half have still been hospitalized 5 years or more (Rieder 1974). In addition to the large residual group of chronically institutionalized patients, readmissions continue
to add to the long-stay group at rates reported to range from 20 percent to 75 percent of first admission functional psychotics (Paul 1969). The previous statistics on increasing readmission rates give particular cause for concern since length of stay has been reported to increase concurrent with increases in readmissions (Kraft, Binner, and Dickey 1967). Further, a continuing buildup of chronically institutionalized patients who “silt into the care system year after year” is indicated even for those operations that report favorable outcomes for active short-stay facilities with aggressive precare and aftercare (Smith et al. 1974). Thus, while the ultimate goal of the community mental health ideology is to reduce the number of people who become “mental patients” through earlier and more effective intervention, the current reality is that the population of chronically institutionalized mental patients is not only large, but still growing.

The Phase Down of State Hospitals Places Greater Pressure on Extended-Care

For social, economic, and political reasons, State mental hospitals are in a continuing process of phasing down (Greenblatt and Glazier 1975). As State hospitals phase down, it seems clear that the trend toward placement of long-stay patients in private extended-care facilities is likely not only to increase, but also to extend to the “revolving door” patient as well, since few alternatives exist for these large groups. The current ineffectiveness of extended-care facilities in rehabilitation may become a far more serious problem as active efforts to phase down mental hospitals proceed, since these facilities have historically been able to select State mental hospital residents who were the “most promising” and least disabled. As pressures to accept more residents increase, however, lower functioning residents are likely to be accepted—possibly providing more serious problems than extended-care facilities are equipped to handle—even on a custodial basis. Such problems were recently noted to be responsible for legislative action that prevents the further phasing of State hospitals in California (APA Monitor 1974).

Even though effective treatment procedures now exist for the chronically institutionalized, the forced reduction in resident hospital populations is unlikely to allow the 2 to 3 years that would be required to bring severely disabled chronic patients to a level of relatively independent functioning (Paul and Lentz, in process). Rather, the external economic and political pressures associated with the phasing down of State facilities are to move chronic patients to private extended-care placements if their functioning allows, or as soon as effective treatment programs can improve functioning to the minimum level to accomplish such placements. Under these circumstances, long-term rehabilitation in traditional public facilities becomes improbable, even when effective treatment programs are available. In fact, in Illinois, California, and New York, where considerable phasing down of State facilities has already taken place, the prospect is high that private extended-care facilities in the community may become the major source for long-term rehabilitative efforts by default.

Judicial Decisions Affect Extended-Care Facilities

The magnitude of the problem posed by the numbers of chronically institutionalized mental patients, the pressures imposed by the phasing down of State mental institutions, and the desirability of treating psychosocial problems in nonmedical settings (Saper 1975) all argue for changing private extended-care facilities from custodial operations to rehabilitation centers on purely humanitarian and professional grounds. However, humanitarian and professional concerns seldom command reform in the way that developments in mental health law and judicial procedures have brought about changes in recent years (Greenblatt 1974 and McGarry and Kaplan 1973). Two recent court rulings, in particular, appear to be especially relevant to the future role of private extended-care facilities in the rehabilitation of chronically institutionalized mental patients.

In the summer of 1975, the Supreme Court handed down its decision on the first “right to treatment” case to reach that level of appeal (O’Connor v. Donaldson). Although there are a variety of complexities in the original case and subsequent appeals (Donaldson v. O’Connor), the High Court ruled in favor of Donaldson on the basis of a constitutional “right to liberty” for institutionalized mental patients who are capable of “surviving safely” outside of institutional confinement (see Wolfe 1975). Several concerned commentators immediately noted that the Supreme Court decision might give further justification for the “dumping” of
chronically institutionalized mental patients into the community, including the “less restrictive conditions” of private custodial facilities (APA Monitor 1975, Asch 1975, and Wolfe 1975). Thus, the Supreme Court ruling in favor of Donaldson provides a legal basis for extended-care placements of long-stay mental patients which, combined with the economic advantages of phasing down State institutions, will predictably result in major increases in such placements on a nationwide level.

While the Donaldson decision will likely increase extended-care placements, the potential for major change in management and operation of extended-care facilities is forecast in a December 1975 ruling by District Judge Aubrey Robinson (APA Monitor 1976). Ruling on a class action suit (Dixon v. Weinberger) involving the federally operated Saint Elizabeths Hospital in Washington, D.C., Judge Robinson affirmed previous guarantees of mental patients to “suitable care and treatment under the least restrictive conditions”—including extended-care placements rather than hospital confinement when patients are capable of living in community-based settings. More importantly, Judge Robinson emphasized that treatment must be made available to those placed in extended-care facilities, and that it was the responsibility of the hospital to see that such treatment was provided. In fact, a representative of the Mental Health Law Project reported that the ruling would require Government agencies to create new extended-care facilities if existing community-based facilities were not adequate.

Although the Dixon decision is currently binding only on Saint Elizabeths Hospital in Washington, D.C., it is predicted to have far-reaching implications and to form the basis for a wave of similar legal suits (APA Monitor 1976). It, thus, seems quite probable that humanitarian and professional concerns will soon be bolstered by legal substance, including at least:

- Requirements that private extended-care facilities function as effective rehabilitation centers for released chronic mental patients
- Requirements that State mental institutions maintain responsibility for funding and regulating effective treatment programs in such facilities for mental patients so placed
- Requirements that State agencies themselves create and maintain community-based extended-care facilities if private facilities fail to prove adequate to the task

Management and Regulation of the Illinois Extended-Care System

With the above developments and prospects, the failure of existing extended-care facilities to provide effective rehabilitation to ex-mental patients becomes an even more critical problem that requires close examination. In the remainder of the present paper, the operations and characteristics of shelter-care homes in Illinois will be reviewed in an attempt to delineate factors that contribute to current ineffectiveness. The Illinois system is taken as a case in point for a number of reasons. Not only is it a highly articulated system, but the authors’ experience within the system allowed access to data not typically available. Furthermore, the Illinois system has already focused upon private extended-care facilities as long-term rehabilitation sites. The basic characteristics and nature of the Illinois system appear quite similar to those that have been reported in other States at the forefront of the “deinstitutionalization” movement, including California (Atkinson 1975), New York (Easton 1974), and Hawaii (Kirk and Therrien 1975). Thus, recommendations for changes in policy and procedure that may increase the probability of more effective rehabilitation in extended-care facilities should have relevance beyond the Illinois system as well.

Current Operations of Shelter-Care Homes

By statute, the State of Illinois has established “shelter-care homes” as one of three levels of service in the extended-care facility industry. The other two levels are “intermediate” and “skilled” nursing homes, reflecting greater need for physical care. Al-

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1 New Federal guidelines do not recognize the shelter-care level of service. Consequently, Medicaid funds for shelter-care homes may stop, at least temporarily. The Department of Public Aid is using Social Security Supplemental Income (SSI) funds to help maintain shelter-care home operations, but Federal officials have indicated that this State action is improper and should stop. The Department of Public Aid is committed to the shelter-care level of service and plans to contest the recent developments, in particular the apparent end of Federal funding. At the time of this writing, many shelter-care home operators are "upgrading" their facilities to the "intermediate care" level. The Federal Govern-
though the size of shelter-care facilities is not specified in requirements, survey results found most homes to range from 15 to 140 beds (Trout 1972), although some Chicago facilities are as large as 700 beds. The bulk of staff are aide-level, but supervisory staff are typically LPN’s, with an occasional B.A. person serving as activities or program director. Other professional or medical services are handled on a consultant basis, while work programs are generally located in other facilities.

According to the Minimum Standards, Rules, and Regulations for Long-Term Care Facilities, p. vii (Illinois Department of Public Health 1970), the “shelter-care” level of service is to provide

- personal care and assistance, supervision oversight, and a suitable activities program. Provisions are made for medical care as necessary. Such facilities are for individuals who do not need nursing care, but do need personal care, assistance, supervision, and/or oversight in meeting their daily personal needs.

The inclusion of a suitable activities program in the “minimum standards” represented the State’s initial attempt to move shelter-care homes from their previous focus as terminal placements for marginal people to a rehabilitation orientation.

Not only is a suitable activities program required, but the current Long-Term Care Facilities Minimum Standards, Rules, and Regulations (Illinois Department of Public Health 1974a) also contains a provision for a therapeutic work program. Moreover, recent Department of Public Health (DPH) guidelines (Illinois Department of Public Health 1974a) explicitly provide for a social rehabilitation program as an integral part of an overall restorative program in which additional incentive payments are given to shelter-care home operators who establish such programs. The latter guidelines further state that a restorative program should assist the residents of the facility in becoming as self-sufficient as possible: physically, mentally, and socially, and should include learning or relearning those skills necessary to participate in competitive life and eventually live in a less structured environment. [p. 1]

Thus, by statute and departmental guidelines, the State has demonstrated its resolve to create a more positive psychosocial environment with a rehabilitative focus in shelter-care homes.

**Combined Involvement of Three State Agencies**

Currently the regulations of three State departments, DMHDD, DPH, and the Department of Public Aid (DPA), are intended to assure compliance with the standards set for the total restorative program, in addition to the minimum standards related to the maintenance of shelter-care residents. The three departments largely work independently of one another, but their efforts are pooled in a Long-Term Care Facilities Advisory Council, an Interagency Committee, and tri-agency inspection teams.

The Long-Term Care Facilities Advisory Council is the highest administrative level reporting to the DPH director and is responsible for the regulation of shelter-care home operations. The Council has representatives from the three departments and from interested groups, including extended-care facility operators. By statute, the Council regularly reviews and advises the DPH director on the minimum standards, rules, and regulations established for the licensing of long-term care facilities, and on the administration of such a licensing program. Any Council recommendation forwarded to the DPH director and approved then becomes policy.

The Interagency Committee developed out of a need for coordination among the three departments regulating long-term care. Representatives of the directors of DMHDD, DPH, and DPA meet weekly to discuss matters relevant to extended-care facilities, including licensing, reimbursement rates, patient classification, and regulation of facilities. Recommendations are forwarded to any one of the department directors. Three of the four Interagency Committee members (two are from DPH), also sit on the Long-Term Care Facilities Advisory Council.

Equally important for the operation of the social rehabilitation program are regional tri-agency teams...
with representatives from DPH, DPA, and DMHDD. These teams, headed by DPH, annually inspect and reevaluate the social rehabilitation programs for funding approval. On-site inspections focus on criteria developed by DPH for the social rehabilitation program (Illinois Department of Public Health 1974a). Annual inspections usually take 1 to 2 days for completion. A report is filed with DPH, and shelter-care home operators have a specified period of time to correct any failures to meet the standards or lose funding.

**Individual Role of the Department of Public Health**

The separate areas of responsibility of the code departments are especially important for the regulation of shelter-care home operations. Specifically, the Illinois Nursing Home, Shelter-Care Home, and Home for the Aged Act of 1945 directed DPH to assume legal responsibility for licensing community extended-care facilities, clarifying levels of service, and developing minimum standards, rules, and regulations (Illinois Department of Public Health 1974b). DPH, then, evaluates compliance through periodic inspections occurring three or four times per year. A preannounced licensure inspection occurs on an annual basis and takes 1 to 2 days for completion. A regional team consisting of public health nurses and geriatric home inspectors conducts the inspections that focus on all of the criteria delineated in the current Long-Term Care Facilities Minimum Rules and Regulations. The team's report is forwarded to DPH for license approval. If a shelter-care home fails to meet the minimum standards, then the operator of the home is given a specified time period to improve any shortcomings.

Still another statewide DPH team of nurses and occupational therapists annually evaluates the activities program. This team virtually follows the same procedures as the regional tri-agency teams and focuses on DPH criteria for an activities program (Illinois Department of Public Health 1974b).

**Individual Role of the Department of Public Aid**

DPA is the funding source for shelter-care home residents who cannot otherwise pay their bill, reimbursing only licensed shelter-care homes by providing funds for each shelter-care bed that is occupied by a public aid recipient. DPA case workers at the local community level periodically examine resident records and hold discussions with shelter-care home staff to determine whether a resident is appropriately placed.

Until recently DPA, alone, used a point system to determine the level of care a resident needed, i.e., shelter-care, intermediate care, or skilled nursing. Currently, in compliance with Federal guidelines, a DPH medical review team at the regional and local levels, composed of a physician, public health nurse, public aid representative, and mental health representative, using a point system, annually inspects residents’ records and interviews residents. This annual review allows the team to oversee DPA’s responsibility with respect to appropriate placements toward which Federal money is applied.

**Individual Role of the Department of Mental Health and Developmental Disabilities**

DMHDD is related to the shelter-care home system in several ways, primarily as a source of referrals and followup for shelter-care homes. DMHDD also offers educational, consultative, and backup services for local clinics and shelter-care homes. Moreover, DMHDD regulates and provides grant-in-aid funds for community agencies and “add-on” programs in shelter-care homes.2 Until 1971, DMHDD was directly responsible for placement, aftercare, and followup of the entire ex-mental patient population. Since 1971, as part of DMHDD’s continuing plan to end direct care services, the department has begun delegating responsibility for aftercare, followup, and most consultations to local clinics and staff in some regions. These local clinics and other agencies offering services related to ex-DMHDD residents residing in shelter-care homes are required by DMHDD to submit an agency plan that must be approved before DMHDD grant-in-aid funds are provided.

Once department funding is approved, DMHDD subregion and region staff make on-site visits to each

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2 DMHDD “add-on” funds are earmarked for programs to help the “developmentally disabled,” and DMHDD staff monitor these programs. In most cases, however, the entire resident population of shelter-care facilities receiving “add-on” funds is developmentally disabled. Therefore, these programs will not be discussed in any detail, since this paper focuses on shelter-care homes serving the nondevelopmentally disabled ex-mental patient resident population.
grant-in-aid agency on a monthly basis. During these visits DMHDD monitors determine whether or not a local agency is following the agency plan submitted to the department. These monitors specifically examine records showing the number and type of clients served, and the number and type of staff involved. Examination of clients' case records, appointment logs, and conversations with agency staff, extended-care facility staff, clients, and other agencies may also be used to determine whether the particular agency under examination actually is offering the service it claims to provide.

If a local agency is not following its written plan, then a process begins where the agency in question has three or four opportunities to resolve the problem before termination of funding. Of course, DMHDD staff must find an alternative service for the people receiving services from the agency in question before funds are likely to be terminated.

**Summary of the Current Regulatory Focus**

Illinois shelter-care homes, thus, are targeted to provide a specified level of service for their residents, based on established minimum standards. The State has placed increasing emphasis on the long-term rehabilitation function of shelter-care homes. The current operation finds three State agencies (DPH, DMHDD, and DPA) involved in the regulation of shelter-care homes. These State agencies share in the responsibility to monitor and regulate, not only adequate maintenance services, but also, rehabilitative programs. Although rehabilitative programming now is the stated focus, perhaps by historical accident, DPA and DPH remain the main source of funding and of most evaluative criteria, with over 90 percent of the criteria still focusing on physical plant and physical care. The additional criteria focus on "paper" programming instead of actual rehabilitation efforts. Even consultation and followup under the control of DMHDD use similar "paper" criteria. This structure for evaluation and regulation of shelter-care homes leads to little, if any, specific criteria or time devoted to evaluation of actual rehabilitation efforts.

**Costs and Profits**

While residents' benefit may underlie the attempts at structure and evaluation of shelter-care home operations, the greatest incentives for the trend toward placing mental patients in shelter-care homes are likely to come from the reduction of direct costs for the State, and from increasing profits for the shelter-care home operators. In the latter regard, it is easy to see how both State agencies and shelter-care operators have benefited: Rate schedules compiled by DPA show that, in 1973, the cost to the State was less than $3,500 per resident at a shelter-care home located in a representative county of central Illinois.3 During the same time period, annual costs per patient at the three State hospitals serving the same area were: $8,200, $11,288, and $21,039 (Illinois Department of Mental Health 1973). Even though licensing and evaluation services are not included in the $3,500 figure, shelter-care costs do not begin to approach the higher cost to the State to maintain a mental patient in the least expensive State hospital.

Shelter-care home operators have similarly profited from DMHDD placements. At the approved minimum, shelter-care homes should expect a 15 percent return on investment (American Systems, Inc., 1973) whereas Mendelson (1974) reports some returns as high as 78 percent. Moreover, there are personal verbal reports of some extended-care facilities in central Illinois netting as high as $10,000 per month on gross income of about $18,000 per month—clearly a profitable enterprise.

Strong incentives, thus, exist for the State and shelter-care home operators to continue their liaison since both parties are clearly benefiting. As the data reviewed earlier indicate, however, the citizens and residents who are involved in these shifts to extended-care placements do not appear to be benefiting. Indeed, it is questionable whether residents are not becoming worse in some shelter-care homes since the primary place of release, when it occurs, is to a State hospital or other extended-care facility—or to the cemetery.

**Bureaucratic Parallels Between VA Psychiatric Hospitals and the Illinois Shelter-Care Home System**

An examination of empirical findings within the

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3Public aid allowances for residents' personal needs were given in the amount of $8.43 per resident per month until 1974. Beginning in 1974, SSI funds for personal needs were distributed in the amount of $25 per resident per month. These allowances are in effect at the time of this writing and remain a constant factor that should be available for the operation of contingency programs for residents, but would not be involved in any interchange between home operators and the State.
Veterans' Administration (VA) hospital system sheds some light on possible factors contributing to the shelter-care home situation in Illinois. The most extensive empirical analysis regarding the effects of bureaucratic administrative procedures on psychiatric services has been reported by Ullmann (1967).

**Ullmann’s Empirical Analysis of the VA Hospital System**

Ullmann (1967) pointed out that bureaucracy, per se, is not necessarily detrimental, since it is simply “a technique for organizing the efforts of many people toward a common goal” (p. 127). However, the essential characteristics of bureaucracy—that is, specialization, hierarchy of authority, rules, and impersonality—had demonstrable negative effects on the rehabilitative efforts of VA hospitals. Ullmann’s analysis demonstrated that both systems and people seem to respond to contingent incentives in terms of funding, and on the individual level, in terms of advancement and prestige. The consequences for the system and the individuals who work in it are based on the actual criteria employed. Although VA veterans should be “rehabilitated” in a VA hospital, one of the major conclusions drawn from Ullmann’s work is that the bureaucratic structure led to the implementation and operation of criteria for funding and evaluation of treatment effectiveness which displaced rehabilitation as a goal for hospitals and staff.

**Funding and Displacement of the Rehabilitation Goal**

The average daily patient load. Developing a funding policy was among the more critical tasks for the highest decisionmaking levels in the VA system. Ullmann noted that the central office decisionmakers unwisely chose the average daily patient load (ADPL) as the basis for funding VA hospitals. In other words, a specified number of occupied beds determined the allocation of hospital funds. Obviously, the decisionmakers chose to use the ADPL for funding purposes because it was an easily obtained index of hospital “effectiveness” and provided for greater amounts of money as hospitals achieved the VA’s humanitarian mission of serving increasing numbers of veterans. However, the VA hospital system, like other large organizations, did not operate with unlimited funds. Given the limited availability of funds, if the number of occupied beds in a hospital surpassed the established ADPL, then the hospital absorbed the added costs to maintain patients. On the other hand, if the number of occupied beds fell below the existing ADPL, then both the established ADPL for the hospital and the amount of funding were reduced. Therefore, hospital administrators’ concern, reasonably, was focused on the ADPL. They became responsive to maintaining the ADPL at an “appropriate” level, and in the process, showed less concern for patient turnover measures, which would have been a more reasonable basis for evaluating effectiveness.

Distribution of funds within hospitals. Ullmann further reported that increases in per diem funds were distributed across all hospital services indiscriminately. This particular practice owed its existence to maneuvering by administrators and supervisors whose ability and position of authority within the imposed bureaucratic structure was measured in terms of increased funds and staff, rather than treatment effectiveness. As a result, wasteful spending of funds occurred in some areas that Ullmann found to be negatively associated with effective treatment. Differences in per diem funding among hospitals were especially noticeable in the areas of food and shelter, which were negatively associated with effective treatment. Ullmann reported food and shelter costs varying as much as $2.55 per patient day between two hospitals, and suggested that a single bookkeeper with some authority could have saved money in this area and applied the savings toward obtaining more treatment staff.

**Authority Structure and Displacement of the Rehabilitation Goal**

Professional authority. Ullmann described how the hierarchical authority structure in the VA hospital system led to a diffusion of authority over all levels, as a result of the size of the system, and distance of “central office” staff from working sites. This diffusion of authority was particularly evident in the coordinated effort required among all groups involved in the treatment programming, such as psychiatrists, psychologists, nurses, aides, and dieticians. Since each group had its own set of controls and standards, authority was determined along professional rather than functional lines.
Of course, individual staff members responded to the operating contingencies to which they were subject, and in practice one group inadvertently could negate the treatment efforts of another group. Thus ward psychiatrists, for example, might have to negotiate and compromise with the chief of engineering on issues related to treatment.

Network of rules. The large size of the VA hospital system had additional effects on the hierarchical authority structure. The vastness of the VA organization necessitated the establishment of a large number of administrative and supervisory levels for the purpose of facilitating communication and coordination of the treatment efforts. Administrators and supervisors used a detailed network of rules to help fulfill this responsibility. However, rules and red tape came to dominate all staff functions, with fear of reprimand for deviation from the rules inhibiting innovations and also reinforcing an emphasis on generalities rather than specifics. Therefore, constructive communication about the treatment goal was lost in the memoranda, which referred to the treatment function in vague and nebulous terms. These memoranda failed to include objective performance indices at all staff levels. Without the use of "hard" criteria, authority could not effectively facilitate treatment.

Staff evaluations and the rehabilitation goal. With the funding policy maintaining a custodial orientation and with the central office being far removed from the locales of operation, high level administrators, supervisors, and middle management personnel did not employ "hard" criteria to evaluate staff on the basis of actual work with residents or resident improvement. Instead, high level decisionmakers chose to use an impersonal means of evaluation and control: records of the percentage of time and extent to which, for example, staff contacted different diagnosed classifications and participated in training programs. The information included in these records had very little to do with actual staff interaction, quality of interaction, and nature of rehabilitation. Therefore, the criteria for evaluation reinforced staff's recordkeeping rather than actual rehabilitation efforts. Because of this structure, it was not surprising to find that time-consuming paperwork characterized VA hospital operations from the highest to the lowest echelons. To the extent that staff were occupied with paperwork, they had less time available to provide treatment; even if the staff had time, they were not reinforced for their actual treatment efforts.

Central office policy statements. Ullmann also noted problems that arose when central office decisionmakers, at a distance from performance sites, issued a policy statement regarding specific treatment procedures. Since decisionmakers did not have meaningful evaluation criteria or knowledge of actual treatment efforts, lower level staff in contact with patients frequently found policy statements impractical to implement and not in the best interests of the patients.

Similarities in the Illinois Shelter-Care Home System

Even though policy guidelines and statutes attempt to establish a rehabilitative focus, and the majority of people involved are likely to have the interests of the shelter-care residents in mind, a similar bureaucratic structure to that of the VA hospital system appears to operate in the Illinois shelter-care system. The Illinois shelter-care system and the VA hospital system can be seen, upon examination, to displace the rehabilitation goal in parallel manners.

Funding and Displacement of the Rehabilitation Goal

Number of beds occupied. The first parallel to the VA psychiatric hospital system is the policy for determining shelter-care home operators' base rate payments. DPA's base rate payments to shelter-care home operators are determined by the number of licensed beds occupied by State aid recipients. Thus, the shelter-care home operator receives revenue for each bed that remains occupied. The funding is increased for the mandatory activities program in a shelter-care home, an approved social rehabilitation program, and a physical plant that meets certain standards referred to as a "shelter factor." Moreover, DPA uses a point system that evaluates a resident in 15 categories according to the type and amount of staff time, special equipment, and medication required. The point system provides more revenue if a resident's functioning is maintained at a level that is assigned more than seven points. Therefore, the criteria for funding not only provide incentive to maintain a high percentage of beds filled with a stable, low
functioning, well-medicated resident population, but actually provide more funds if residents deteriorate, rather than improve.

Cost accounting and cost controls. The second parallel to the VA system is the nondiscriminative nature of the shelter-care home funding policy. The State fails to require shelter-care home operators to provide detailed cost accounting and cost controls for funding purposes. Instead, DPA appropriates a large proportion of its payments to cover shelter-care home costs, which are determined by cost surveys and cost models. A sizable profit, also, is assured. With the exception of the activities and social rehabilitation programs, which bring in additional revenue, the shelter-care home operator is not under any specified obligation to spend the funds on rehabilitation efforts. This policy has produced wide differences in reported shelter-care home costs on an area-wide basis (American Systems, Inc., 1973), and, thus, has the same effect as the manipulations by VA hospital administrators to obtain more funds for services and personnel that were not necessarily associated favorably with effective treatment. Similarly, the greatest proportion of funds are specifically allocated to those functions (food and shelter factor) least related to rehabilitation.

Authority Structure and Displacement of the Rehabilitation Goal

Three State agencies. The involvement of three State agencies in the regulation of shelter-care homes, each with its own set of standards and controls, leads to a diffusion of authority. The staff within each agency work to meet their agency demands, and in so doing, may negate the actions of the other agencies. For example, when DMHDD staff believe that certain conditions exist in a shelter-care home that are not conducive to the rehabilitation focus, they must go to DPH, which has the legislative authority to enforce minimum standards. DPH guidelines focus on physical care; thus, DPH may not pursue the case further, and the shelter-care home is not required to make any changes in operation.

Vagueness in evaluation criteria. Administrators and supervisors within the three State agencies, like their VA counterparts, rely on rules and memoranda for communication. Unfortunately, while the criteria related to physical plant and physical care are quite specific, memoranda referring to aspects of the rehabilitation program are vague and open to interpretation. Moreover, agency staff awareness of the benefits derived from the liaison with shelter-care homes, coupled with vague or flexible criteria, leads to a high tolerance for shortcomings in rehabilitation efforts. An example of incomplete criteria in written plans relates to the handling of problem residents. The only legal requirements for individual care are progress notes, and a written plan that is reviewed once every 60 days, at a minimum. Not only is there a reliance upon this “paper plan,” but there is no direction provided to deal with residents possessing significant behavior deficits or demonstrating aggressive behavior, with the exception of using restraints when required and prohibiting seclusion. It is not an uncommon practice to transfer such problem residents from one home to another, or to a State facility, rather than to attempt rehabilitation.

Method of evaluation. Similar to the VA hospital system, the distance between the central site of funding and individual shelter-care homes leads to further displacement of the rehabilitation goal. This third parallel leads to an impersonal means of control and regulation in the form of infrequent onsite inspections for licensure and incentive program approval. While the most constructive inspections should include “hard” criteria, such as staff-resident interaction and rate of release, the inspections focus only on written program descriptions, physical plant, and physical care criteria.

The licensure inspection teams enforce standards delineated in the Long-Term Care Facilities Minimum Standards, Rules, and Regulations (Illinois Department of Public Health 1974b) in which, as stated earlier, well over 90 percent of the criteria focus on the physical plant and physical care of residents. Moreover, the criteria related to rehabilitation efforts require written responses; consequently written records, plans, and documentation are what actually become measured. Similarly, the tri-agency and activities inspection teams do not use “hard” criteria for evaluating the rehabilitative programming, but rather focus on an examination of resident care plans; basic records; written educational training programs for staff; equipment and furnishings; written procedures that include restorative techniques, documentations of consultations, staffing plans, and job descriptions; and additional written policies.

The emphasis on physical plant and physical care, as well as the inspection of records as the State’s mode
of evaluating the rehabilitation effort, reinforces specific action by home operators and directors of incentive programs. Thus, in addition to the physical care of residents and the maintenance of the physical plant, a primary task of home operators and incentive program directors has become to generate reports. These individuals are particularly overburdened with the paper work necessary to meet the evaluation criteria. This paper work also filters down and occupies much of the nurses', consultants', and aides' time. The detailed recording of the shelter-care home operation is a time-consuming effort that takes away from actual rehabilitative work with the residents.

Policy by fiat. As in the case of the VA hospital system, decisionmakers are removed from the locales of operation, and this situation leads to the same problems experienced by the VA. An example of such decisionmaking by fiat is a restriction on the use of seclusion as a rehabilitation procedure. A limiting decision has been made with regard to seclusion simply on the basis of “misplaced humanitarianism,” with no evaluation of the effects of seclusion ever carried out in Illinois shelter-care homes—even though solid evidence exists regarding the positive humanitarian effects achieved by selective use of seclusion (Paul and Lentz, in process).

Summary of Parallel Bureaucratic Effects

Both people and systems do appear to respond to contingent incentives. Ullmann's analysis of the VA system provides convincing arguments that positive consequences for the VA hospital system and individuals working in it are determined by the actual funding and evaluation criteria employed. These criteria, which serve as the basis for receipt of funds, individual advancement, and prestige in the VA system, also lead to a displacement of the treatment goal. Shelter-care homes in Illinois operate on a profit basis, rather than the simple maintenance funding for VA hospitals. However, the use of similar funding and evaluation criteria within a parallel bureaucratic structure appears to produce a similar displacement of the rehabilitation function to that found in the VA system. In both systems displacement occurs because the criteria for funding do not provide incentive for resident improvement. Instead, the monetary incentive is to maintain a certain number of beds filled for maximum funding; it is even advantageous that beds remain occupied with a stable or deteriorating population. Furthermore, the bureaucratic structure imposed on both systems creates additional displacement of effort for those working within it. Specific bureaucratic structural characteristics produce an emphasis on impersonal rules, written reports and red tape, and a blurring of authority, all of which result in further displacement of the rehabilitation goal, and thereby, appear actually to support ineffective treatment.

General Recommendations for Change in Regulation of Shelter-Care Facilities

Although State agencies and shelter-care home operators may basically favor rehabilitation, the State must save money whenever possible, and home operators must profit to remain in business. Since the current structure of evaluation and regulation provides incentives that displace the goals of rehabilitation, bureaucratic policy changes must be made to support rehabilitation as a goal before specific programmatic improvements can be implemented. In this section we shall propose some general principles for such changes, with specific operational procedures being proposed in the next section.

Recommended Changes in Bureaucratic Operation and Policy

Following Ullmann's lead in recommendations for improving the VA system, the foregoing analysis suggests changes in the monitoring and regulations affecting shelter-care homes in order to foster rather than displace the primary goal of rehabilitation of residents. Rehabilitation can first be fostered with bureaucratic policy changes in the criteria and mode of evaluation for funding, and in the evaluation of staffing and incentive programs.

Recommended Changes in Funding Criteria

Funding of "shelter and maintenance" should be standardized and based on the actual costs for separate functions. This change in funding policy would enable the State to reimburse shelter-care home operators only for the actual "hotel costs" per resident, versus
the current situation, which provides major reimbursement for such costs, thereby guaranteeing a high profit without the use of cost controls and cost accounting. Funding based upon standardized actual “hotel costs” might eliminate needless spending, and would provide home rehabilitation services would be required to obtain more revenue. Implementation of this funding policy should require shelter-care home operators to file detailed cost accounting reports annually with the State. Accurate data gathering, data storage, and regular updating should be possible with the use of existing computer technology, without requiring any more time than procedures currently employed.

All other funding should be explicitly allocated as performance-contracting incentives based upon actual rehabilitation criteria. Operators and staff of shelter-care homes need direct incentives to provide effective rehabilitation, rather than incentives to generate paper and maintain a static or deteriorating resident population. Therefore, funding above the break-even point (including a 15 percent return on investment) for hotel costs should be based on performance contracts determined by resident functioning, improvement in functioning, and turnover with community stay in less structured environments.

A specific proposal with dollar cost examples is presented later in the current paper. For present purposes, we recommend that small incentive payments be added to the base for hotel costs for accepting lower functioning residents at initial entry, and for submitting and gaining approval for proposed treatment programs. However, increases and decreases in funds for “approved” treatment programs should be based on documentation of the quality of continuing performance, with incentive payments to both staff and operators. The largest incentive payments should be contingent upon documented improvement in resident functioning, in the form of functional bonuses to the staff and operators over periodic assessments—with losses in funding occurring contingent upon resident deterioration.

For most residents, obtaining employment would be a critical step in rehabilitation, and home operators and staff need to be provided enough incentive to help support residents through training for competitive employment and continued release. One means for providing incentive to both residents and facilities would be to allow some portion of a resident’s earnings from increasing levels of competitive employment to be saved as a nest egg for residents’ use after release. However, if facilities could receive the remainder of the resident’s earnings as rent, while continuing to receive public aid payments for a limited time period, the largest functional bonus would be awarded for the release of a resident into independent living. Although the latter recommendations would require changes in existing statutes, as well as policy, they may be the most important incentive components for strengthening the focus on rehabilitation.

**Recommended Changes in Authority Structure**

Responsibility for the regulation of extended-care operations should be merged into a single agency. Bureaucratic problems could be considerably reduced if the three State agencies were merged into one agency for the purpose of regulating extended-care facilities, including shelter-care homes. Decreasing the number of involved staff, with placement under one set of standards and controls, should lead to more effective use of authority, more personal accountability, and improved communication and coordination.

Since DMHDD staff have the responsibility and knowledge of rehabilitation, it appears that DMHDD would be the reasonable choice—if shelter-care homes are to become rehabilitation centers—for becoming the single regulatory agency. DMHDD, in fact, may be required to assume this responsibility if the anticipated court actions following the Dixon decision come to pass. DPH and DPA, with their main responsibilities for physical care and funding, respectively, ought to assume a secondary role under DMHDD with regard to rehabilitation centers, at most. Thus, DMHDD, or a single separate agency, should become the ultimate authority with power, if necessary, to modify regulations and responsibility for licensing certification when shelter-care homes meet minimum DPH requirements. Moreover, as stated above, current DPA criteria for funding, with the exception of determining indigence, should be abandoned to allow the establishment of incentive funding for homes and people in them.

Procedural rules should be reduced to a minimum, with focus on utility criteria. A reduction in the excessive number of procedural rules could lead to more individual accountability and constructive communication among State decisionmakers and home inspectors.
Furthermore, greater emphasis on utility criteria could also reduce the excessive time spent by State inspectors enforcing paper and physical plant criteria. New criteria should focus on actual shelter-care staff activity and the outcome of their rehabilitation efforts. A change to emphasis on utility criteria could appropriately facilitate active rehabilitation efforts, while record-keeping and physical plant should assume a secondary role to document minimum requirements in shelter-care operations.

**Staff evaluations in homes should be based upon actual rehabilitation efforts and contact with residents.** This recommendation alters the focus of evaluation in which shelter-care staff are now evaluated for maintaining paper records and physical plant and for keeping costs down for the home operators. The proposed change in staff evaluation follows from the above recommendation for implementation of utility criteria. The implementation of approved rehabilitation programs, external evaluators should apply specific criteria in the direct evaluation of staff performance. The mode of evaluation should focus on staff’s actual rehabilitation efforts and minimize the current overconcern for physical plant and recordkeeping. The shift to such utility criteria could lead home operators to increase money spent in the rehabilitation area and redirect staff activity toward offering a maximum rehabilitation effort.

**Policies for specific treatment procedures should be granted approval on the basis of a proper review of proposals, but specific continuation should be based on data and “hard” evaluation.** This recommendation emphasizes the implementing of reasonable proposals for treatment procedures on a trial basis, rather than establishing static treatment procedures by distant fiat.

Policies that dictate what specific treatment procedures can or cannot be implemented would not be adopted without a review of proposals to allow evaluation of potentially effective treatment procedures in shelter-care homes. Regional committees of mental health professionals within DMHDD could review and approve proposals. The documented and differential effectiveness of treatment procedures would then determine which techniques should continue in use.

**Recommended Changes in Assessment and Treatment Technology**

The above recommendations all require a drastic change in the mode of evaluation of programs, homes, and staff activity, and of viable treatment technologies for homes to implement.

The usual turnover and community-stay criteria used in hospital research could be relatively easy to employ (Gurel 1966), but additional changes in evaluation are needed. Criteria for evaluation of programs must determine what staff are actually doing and, therefore, require contact with staff. Similarly, continuing data on resident functioning, improvement, and release rates can lead to upgrading treatment procedures and a more utilitarian evaluation of effectiveness. A promising alternative approach involves the external validation of rehabilitative programs by trained observers who focus on what residents do, changes in resident level of functioning, and what staff actually do (Paul and Lentz, in process).

**An objective observational data base could serve as a mode of evaluating resident level of functioning and in-home improvement.** The Time-Sample Behavioral Checklist (TSBC) is a reliable observational assessment instrument in which all resident behavior is coded in behavioral classes within several categories. These low-inference behavioral recordings may be used for objective individual assessment and programming and may be combined to yield global scores for overall treatment evaluation (Mariotto and Paul 1974, Paul and Lentz, in process, and Redfield and Paul 1976). Data obtained by employment of the TSBC or similar instruments by professional observers working for the regulatory agency—taking full-week samples, bimonthly—could reduce the nonutilitarian paper work of all staff, while providing “hard data” on resident behavior and improvement on which to base funding.

**An objective observational data base could serve as a mode of monitoring and evaluating staff activity.** Objective assessment of staff activity and treatment programs can also be obtained through the use of observational assessments by trained observers. The Staff-Resident Interaction Chronograph (SRIC) reliably codes staff behavior in functional relationship to resident behavior and, thus, accurately evaluates actual time and performance “on-the-floor”—that is, what the staff actually does with regard to contacting and “treating” residents (Mariotto and Paul 1974, Paul and Lentz, in process, and Paul, McInnis, and Mariotto 1973). Data obtained on staff performance, at the same time and in the same manner resident data were collected, could
guide shelter-care staff rehabilitation efforts, and objectively determine whether proposed programs were being carried out.

Specific treatment procedures are needed with a focus on identified targets of rehabilitation. All previous recommendations are prerequisites to reliable implementation of specific treatment procedures. However, the technology is currently available for effective treatment programs to be introduced in community extended-care facilities if and when other changes make such efforts viable (see Paul and Lentz, in process).

Specific Proposals for Implementing Recommendations: Possible Costs and Benefits

Direct Care Costs and Incentives

Existing Payment Structure

While the direct cost to the State for maintaining ex-DMHDD residents in shelter-care homes is less than the cost of State mental hospital care, the cost per case is still higher under current custodial conditions than under conditions that would reasonably rehabilitate shelter-care residents. In fiscal year 1973, the last year in which complete data were available, the monthly rate of State payments to licensed shelter-care homes for each bed occupied by a public aid recipient was distributed in the following way: (a) $219 for room, board, and laundry; (b) $40 for a "shelter factor" for homes meeting higher physical plant standards; and (c) $8 for activities and $12 for social rehabilitation programs. Implementation of the earlier recommendations regarding the use of cost accounting and actual rehabilitation criteria for funding purposes would result in a change in the mode of distribution of funds.

Proposed "Shelter and Maintenance" Base

Instead of a fixed base with a large incentive for a physical plant that meets higher standards and low incentives for rehabilitation programs, first a fixed-base payment should be determined by the actual local area cost for the food, shelter, and maintenance factor. These costs include administrative and support staff; building, equipment, and furniture depreciation; and a 15 percent return on operators' investment. Data obtained from a representative 120-bed, shelter-care home in east-central Illinois show that in 1973 the actual cost for food, shelter, and maintenance was $188 per resident per month. Using this cost breakdown, a fixed-base payment of $188 per resident per month would be sufficient to maintain shelter-care residents in an approved physical plant, with approved food and a minimum number of caretaker staff (including all aides), while the home operator would still receive reimbursement for costs, plus a 15 percent return on initial investment.

The difference between $188 per resident per month and the existing base rate of $279 per resident per month—which already supports a custodial orientation—could then be used to provide incentive payments for an increase in treatment staff, supplies, and effective rehabilitative programming. The remaining payments of $91 per resident per month from the 1973 payment rate in a 120-bed home would leave $131,040 per year for distribution as incentive bonuses to the home operators and staff, even if no additional funds were allocated.

Proposed Incentive Payment Structure

Presume that the following additional payment structure (in constant 1973 dollars) might be established as an operating base for recommended changes in funding.

Resident functioning at entry. An additional payment of $0 to $18 per resident per month could be provided, based on each resident's level of functioning at entry. An objective basis for determining payment rates at entry could be established on the basis of observed functioning on the standardized observational instrument (TSBC) covering a range of 10 equal interval deciles (see Paul and Lentz, in process). The $0 to $18 per resident per month could be distributed in 2 steps from the highest ($0) to the lowest ($18) decile of functioning. If these payments were equally divided between staff and operator, equal distribution of levels of functioning at entry would provide staff with an average increment of $20 per month and provide an additional $6,480 per year incentive to the operator. In place of the current point system, these graded amounts would provide incentive for home operators to work with lower functioning residents as well as compensation for the staff time involved.
Approved treatment program. An amount of $13 per resident per month could be added to the fixed-base payment for the existence of an approved program from a submitted proposal. The $13 would cover actual 1973 costs for rehabilitation supplies, two professional treatment staff, and mental health consultants, plus $810 per year profit to the operator of the 120-bed home. The following three conditions could then provide incentive for home operators to maintain rehabilitation programs with maximally proficient staff: (a) continued receipt of the above $13 addition to the base payment, contingent on bimonthly observations (SRIC) documenting the implementation of the rehabilitation program; (b) minor deviations from the rehabilitation program, penalized by a reduction of the payment rate for successive 2-month periods—the reduction being the amount of the operator's profit for having an approved rehabilitation program; (c) implementation of more than minimal levels for an approved rehabilitation program, determined by bimonthly observations, increases monthly payments by up to $30 per bed per month, which could be divided equally between staff (for an average incentive bonus of $66.67 per month) and the home operator (an additional $21,600 profit per year).

Bonus for resident improvement. A $150 bonus contingent upon each significant resident advancement of at least one decile above the previously observed high level of functioning on bimonthly assessments (TSBC) should provide incentive for bringing about improvement. Each significant lowering in a resident's level of functioning could result in a required return of one-half the earned bonus, to be paid back when the resident improved once again. By distributing the improvement bonus between operator (10 percent) and staff (90 percent), the staff in a 120-bed home would receive an average bonus of $5 for each significant improvement in resident functioning, while the operator would receive $15.

Incentive from resident employment. Residents employed both part time and full time in sheltered workshops and competitive employment might be charged 30 percent of their earned wages as partial payment to the facility for room and board while State payments continued at the established level. If residents were placed 15 hours per week in a sheltered workshop (at $.50 per hour) at the 5th decile of TSBC functioning, and 30 hours per week in a sheltered workshop at the 6th decile of TSBC functioning, then $9.75 and $19.50 per month, respectively, would be available to operator and staff. Similarly, if residents at the 7th and 8th TSBC deciles were to gain competitive employment on a half-time basis (at $2.00 per hour), then an additional $52 per month would be available to the operator and staff as incentive to further resident employment and functioning from retained earnings, while placing incentives on further movement. Full-time employment of residents at the 9th or 10th TSBC deciles would provide an additional $104 per month for incentive distribution to operator and staff. In fact, the incentive would be so high that a 6-month maximum should be placed upon the length of time such distributions from competitive employment would be allowed. The latter limit should provide each resident with a minimum $1,000 nest egg upon release.

Bonus upon successful release. If operators could continue to receive regular monthly payments from public assistance for each released resident for 3 months after release, combined with the $150 improvement bonus, a total incentive averaging $870 for each successful release would be provided. In order to prevent inappropriate releases, the latter incentive payment would have to be repaid if a released resident returned within 90 days, with no additional bonuses being paid until the returning resident was released once again.

Summary of Proposed Payment Structure

Instead of the constant $279 per month per resident actually provided for custodial operations in 1973, the above recommendations would provide a maximum $240 per month per resident for an actively functioning operation ($188 base, $13 contingent upon approved functioning rehabilitation program, $30 contingent upon maximally functioning staff in a rehabilitation program, $9 average payment for levels of functioning at entry) and only $197 per month for a purely custodial operation. The additional bonus of $150 per resident per improvement and 3 months' continuing payments for significant releases would be additional costs to the State, but available to home operators and staff only upon demonstrated movement of residents. The additional incentive payments from employed residents would provide incentive to operators and staff without cost to the State.
Examples of Direct Costs at Different Levels of Effectiveness

Some examples of differing levels of effectiveness under the above recommendations in the representative 120-bed home (in constant 1973 dollars) should be instructive. In the following examples, we assume that the staff continue to receive their “share” of monthly payments ($19.50) for the three monthly postrelease payments, and 50 percent of the incentive distribution from residents’ employment. We also assume an equal distribution over TSBC deciles for initial resident level of functioning.

A maximally effective facility. If the highest expectation for success in a maximally effective approved program would occur, each resident might move up one decile in level of functioning on every bimonthly observation, yielding 72 releases per year for a 60 percent turnover rate. The 120-bed home would then annually cost the State $505,440, of which $114,696 would be profit to the operator (beyond the guaranteed 15 percent return) and $151,254 would be distributed among staff for incentive payments (averaging $5,602 per staff member, over and above regular salaries). While the latter figure would cost the State $103,680 more than actual 1973 payments under custodial operation, the per case per year cost would be reduced by $715.50.

A maximally ineffective facility. At the other extreme, a totally ineffective 120-bed home, without an approved program and no resident movement, would cost the State $283,680 for the year, of which $6,480 would be profit to the operators (beyond the guaranteed 15 percent return) with each staff member receiving $240—only if initial levels of resident functioning were equally distributed. The latter figure would cost the State $118,080 less than 1973 payments under custodial operations for a per case per year reduction of $984.

A reasonably effective facility. A more reasonable expectation would be to find a home with an active and approved rehabilitation program, an equally distributed resident population, with half of the residents moving up one decile rank every bimonthly observation period, and a 30 percent turnover rate. A 120-bed home would then annually cost the State $425,520, of which $71,793 would be profit to the operator (beyond the 15 percent return) and $89,667 would be distributed among staff for incentive payments (averaging $3,321 per staff member) for a per case per year reduction from 1973 costs of $620.30.

Cost of Recommended Changes in Evaluation

Existing Evaluation Costs

Under the existing bureaucratic structure, the estimated annual cost (in 1973 dollars) in salaries of field staff for the evaluation of the representative 120-bed shelter-care home was: (a) $910 for the medical review team, (b) $400 for a DPA caseworker’s periodic checks of resident status, (c) $288 for the licensure inspection team, (d) $84 for the activity team, (e) $189 for the tri-agency team, and (f) $2,446 for the followup of shelter-care residents. The total estimated cost to the State for evaluation and followup in the 120-bed facility, based on full-time equivalent 1973 salaries of field staff was thus $4,317 per year.

Savings From Reducing Duplication of Effort

If the recommendation for a single regulatory agency could be implemented, then the costly duplication of effort of the three State agencies could be eliminated. Although a change in the State statute would be required, a specially trained DMHDD staff person could carry out licensure and physical plant inspection. The estimated annual cost (in 1973 dollars) for a 120-bed home would be $184. Moreover, since physicians in referring facilities are already required to conduct an exit physical, appropriate placement could be determined at this time and updated during already required annual physical examinations. This procedure could replace the need for a medical review team and for periodic visits by a caseworker to determine the appropriateness of placement. The estimated savings (in 1973 dollars) would be $1,310. Also, an active and approved rehabilitation program with continuous mental health consultation already in existence could replace the need for the current followup procedure for shelter-care homes. The estimated annual savings (in 1973 dollars) would thus be $2,446.

Costs of Observational Assessment

Under the proposed method of evaluating rehabilitation programs, the 1973 cost for a single professional observer using the instruments described (TSBC and SRIC) would be approximately $349 per facility per year. This cost per observer is based on 5-day observa-
tions of both residents and staff by a regionally located team of five observers, covering 16 homes per year on a bimonthly basis. Thus, the total cost per 120-bed home per year for evaluating rehabilitative programming would be $1,747 plus $184 from licensing and physical plant inspections, for a net savings of $2,386 per 120-bed facility per year. Moreover, the proposed evaluation system would save the State additional money in the form of reduced payments to operators when observer documentation showed no resident improvement or when the rehabilitation program was not being carried out properly.

Overall Benefit

The proposed payment structure would increase the overall direct treatment cost to the State if a shelter-care home became an effective rehabilitation center. Since there would be resident turnover, however, the cost per case would decrease, and effectiveness/costs ratios increase. In the process, residents would be receiving humanitarian treatment to which they are entitled, and their level of functioning would be improving. Equally important, released shelter-care residents who assume a productive role in the community would save the State indirect costs—that is, earned wages, taxes, and purchasing power (Gunderson and Mosher 1975). Finally, the proposed changes in the mode of evaluation could lead to useful data at a reduced cost, including evaluation that would facilitate rather than impede effective rehabilitative programming.

Anticipated Problems in Implementing Recommended Changes

Obviously, all of the above recommendations could not be immediately implemented. Before any changes are made in the current system, there is an essential need that continued input from and discussion among extended-care operators, responsible State agencies, and the public be encouraged. It is to be hoped that the analysis and recommendations presented above will provide a focus for such discussion.

Even if the recommendations seem desirable and eventually workable, problems of bureaucratic lag and resistance to change can be expected. The situation created by the self-maintaining bureaucratic structure (see Saper 1975 and Ullmann 1967) is further aggravated for people working in the system who wish to change it when there is a complete turnover in top level administrations at every election. Such constant change in administration leads to a near absence of meaningful long-range planning.

Nevertheless, responsible administrative personnel in existing regulatory agencies would be well advised to begin careful planning. Changes in operations and procedures to set conditions that will encourage private extended-care facilities to become rehabilitation centers for the large group of long-stay mental patients must eventually come about. Not only are such changes desirable on humanitarian and professional grounds, but they may be suddenly foisted upon the unaware by court rulings that command obedience. Although additional work in progress is necessary to make the observational assessment systems available to others for implementation of detailed recommendations, the instrumentation and the effective, practical treatment technology do exist at the present time (Paul and Lentz, in process). Rather, the changes in regulatory statutes, operations, and policies appear to demand the major emphasis in Illinois and elsewhere—likely sooner than later if Judge Robinson’s ruling in Dixon v. Weinberger has its anticipated impact.

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