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# A mental health treatment planning instrument as viewed by clients, service providers, and family members.

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# A MENTAL HEALTH TREATMENT PLANNING INSTRUMENT AS VIEWED BY CLIENTS, SERVICE PROVIDERS, AND FAMILY MEMBERS

A Dissertation Presented

By

BARBARA ANNE MILLER

Submitted to the Graduate School of the
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Education

# A MENTAL HEALTH TREATMENT PLANNING INSTRUMENT AS VIEWED BY CLIENTS, SERVICE PROVIDERS, AND FAMILY MEMBERS

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# DEDICATION

To Roger and Anne, whose support and love were of inestimable value.

# ACKNOWLEDGMENTS

The author wishes to express her gratitude to the clients, family members, and service providers who participated in this research and gave so willingly of their time and effort. This project would not have been possible without their help.

# ABSTRACT

## A MENTAL HEALTH TREATMENT PLANNING INSTRUMENT AS VIEWED BY CLIENTS, SERVICE PROVIDERS, AND FAMILY MEMBERS

May 1984

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In December 1980, the Massachusetts' Department of Mental Health initiated a requirement that all of its clients in a pilot geographic area receive Individual Service Plan (ISPs). ISPs were developed as a management tool and were based on similar instruments used in other fields, such as rehabilitation and education.

This ex post facto study examined some hypothesized effects of the ISP on clients, family members, and service providers. The service experience and functioning of twenty-three ISP clients and a matched group of twenty-three non-ISP clients were examined. Data were also collected from the family members and service providers of all clients to learn about the immediate effects that the ISP might have on its participants.

The project failed to reveal evidence that clients who had received an ISP benefitted by having greater knowledge of their problems, being offered and using a wider range of services than their counterparts, having more internal locus of control or a higher level of social ability than non-ISP clients. Similarly, their family members evidenced no greater involvement with them, no better understanding of their problems or of services offered to them than the family members of the control group. Service providers, however, demonstrated substantial knowledge of the ISP and advanced qualified endorsement of the instrument, primarily as a contribution to their own work.

The investigator concluded that the ISP may constitute a useful addition to the armamentarium of the service provider and, with some modifications, might contribute more directly to the service experience of clients and their families.

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# INTRODUCTION

In December 1980, the Massachusetts' Department of Mental Health (DMH) initiated the requirement that all clients in a selected pilot geographic area receive Individual Service Plans (ISPs). These ISPs were envisaged as a tool to specify clients' service needs as well as to connect those needs with indicated treatment programs.

When the study began, not all clients in the pilot area had received ISPs. And, while DMH compliance with the mandated regulation had been studied informally (Hornik, 1982; Shaw, 1981; Specht, 1982), the actual impact of the ISP requirement on clients, families, and service providers remained unexamined. This dissertation undertook such an investigation.

The framework for the study draws from historical examination of societal approaches to the problem of mental illness and from the recent limited examination of the ISP in such service efforts. These perspectives identify the apparent expectations held for the ISP, including influences on service providers, clients, and family members. The aim of the present study was to investigate some of these expected effects.

The method employed was an ex post facto comparative study to learn about the impact of the ISP on selected target variables. A sample of DMH clients in the Westfield catchment area of DMH's District I (pilot district) who had already received ISPs was matched with a sample of clients without ISPs in order to investigate the ISP influence on services offered, services actually used, and the level of satisfaction with service planning on the part of clients, families, and service providers. Interviews, questionnaires, and existing measuring instruments were employed.

The study looks at selected variables related to the near-term effects of the ISP and to participants' satisfaction with the process, but not at the possible delayed or long-term effects of the ISP on treatment outcomes. However, knowledge about the proximate effects of the ISP was expected to be useful in its own right. Understanding the immediate effects that the ISP may have on the participants and in treatment planning may invite or discourage the far more demanding research effort to establish the impact of the ISP.

This research is quasi-experimental, in that the investigator did not control introduction of the major variables. While a great number of influences affected the allocation of ISPs among the eligible population, giving the appearance of randomness, there is no reason to believe that clients were selected for ISPs entirely at random. Although all DMH clients eventually should have ISPs, at the time of this study, as a result of advocates pressuring on their behalf and other circumstantial influences, some clients received their ISPs before other clients. As a consequence, a substantial group of clients who had not received ISPs was also available. A sample of the non-ISP recipients was located which was similar in other respects to those who had received that assessment. There appeared to be no difference in diagnosis, length or number of hospitalizations, strengths, and needs between the clients who had received ISPs and the sample of clients used here who had not received them. However, the lack of random assignment leaves open the possibility that the comparison groups may have been different in relevant ways beyond the presence or absence of an ISP. Neither is it possible to be sure that the study samples reflect well the underlying population of DMH clients. A careful description of the obtained sample will clarify the sub-group of the population to which the results can be generalized most dependably.

It is important to note that a management instrument can facilitate but cannot insure good clinical assessment and intelligent service planning for clients. Thus, an ISP can be a powerful tool, but it can also be a pro-forma exercise. An examination of the Individual

Service Plans currently being piloted in the five geographic catchment areas of Western Massachusetts is timely because the results may have implications for the use of the ISP in other areas of the Commonwealth. And, knowledge about the influences that may mediate the dynamic impact of a planning tool on its participants could inform and advantage efforts to develop an effective service system. It is hoped that this study could prove useful to administrators and to service providers who are charged with the responsibility to develop community treatment for the deinstitutionalized mental patient.

# CHAPTER I

## BACKGROUND AND PROBLEM

Contemporary understanding of mental illness is a complex product of developments in physical medicine and the evolution of scientific understanding of human behavior. In addition, efforts to provide services for the mentally ill have been shaped by broad social events such as wars, depressions, and political movements. In the present section, the ISP is located as a contemporary manifestation of such converging influences.

### Search for the humanity of the mentally ill person

Individual Service Planning was not invented by the plaintiffs in the federal consent decree which affected Massachusetts' Northampton State Hospital. Instead, this kind of planning in mental health services is a contemporary approach to well-precedented concerns with understanding the mentally ill subject (diagnosis) and his/her service needs (treatment). The ISP is a product of a long history of efforts to understand and treat the mentally ill and reflects both our knowledge and our experience about etiology and treatment.

Mental illness has been refractory to scientific study, in spite of some promising early beginnings. Hippocrates, who held that mental disorders (as well as physical problems) were really within the body, challenged the then prevalent belief that mental illness was really a sign of possession by demons (Strider, 1975). Prevailing treatment, which involved exorcism of the demons, was often cruel and painful. Hippocrates laid the foundation for a scientific approach to mental illness through his concern with biological causation and naturalistic treatment, and his use of the case history as a method for studying disease (Strider, 1975).

Early physicians believed that disorders were imbalances within the body's system, and that the system could be adjusted through exercise, diet, and blood-letting. The Greek physician, Asclepiades, living a century before Christ, used Hippocrates' case method to distinguish the symptoms of hallucinations and delusions and to study the role of environmental factors in mental disorders (Strider, 1975). When Celsus, a Roman, organized the Hippocratic theories of disease into groups of disease states, he concluded that mental disorders influenced the entire functioning of a person, rather than affecting only a single organ (Strider, 1975).

With the advent of the Dark Ages, however, the Hippocratic concepts faded and demonic possession was once again revived as an explanation for mental problems; the resultant treatment plans were severe and barbaric. The Renaissance, however, brought a renewed interest in order and classification, with continuous challenges to demonology. Philippe Pinel (1745-1826) demonstrated to his society that humane methods of treatment could effect change in the mentally disturbed, and he pioneered the removal of chains and the cessation of beatings (Strider, 1980).

### American attempts to address the problems of the mentally ill

The treatment of the mental patient in the United States, well documented by writers such as Deutsch (1949), Rothman (1971), and Talbott (1978), parallels that in Europe. Early care in the home, almshouses, or jails was replaced in the 19th century by institutional care at the urging of reformers like Dorothea Dix. Etiological formulation of demonology gave way to the conception that mental illness derived from "animal natures taking hold" (Deutsch, 1949, p. 47). Confinement and punishment gave way to "moral treatment"--that new, humane, family model begun by Pinel (Talbott, 1978).

While the concentration of mentally ill subjects in institutions occasioned some progress in the classification or categorization of mental illness (note Kraepelin), that progress was not reflected in their treatment. Indeed, the size of the ever-expanding institutional population interfered with the realization of the personal caring called for by moral treatment. Under institutional care the family was removed from its responsibility, but the institutions were not able to provide that same kind of personal, individualized care which the family formerly had offered. Institutional care gradually came to be seen as one of the problems of the mentally ill, rather than one of the solutions to their problems.

The large institutions both sequestered the mentally ill and insulated the public from encounter with their circumstances. During the twentieth century the original purpose of "asylum" became perverted as large numbers of immigrants, paupers, eccentrics, vagrants, and mentally retarded were shipped off involuntarily to be cared for in these same "asylums" (Golann & Fremouw, 1976). The mental hospitals further deteriorated through lack of funds and an inability to attract competent staff.

Renewed interest in the problems of mental illness surfaced in the wake of World War I and World War II, when surprising numbers of young men were rejected from the armed forces or were seen as psychological casualties. These developments, which made conspicuous the prevalence of mental illness, stimulated further efforts to understand and treat these conditions. The mental health movement developed after World War I; after World War II, the National Institute of Mental Health was founded. Concern for the mentally ill, which began with the family, had progressively extended to the local community, to the state, and finally to the federal level of government.

> At the beginning of World War II, psychiatry was given the assignment of screening out all those young men who appeared psychologically unfit for military service. Huge numbers were rejected on the reasonable assumption that those with obvious neurotic symptoms or personality defects would break under the stress of adjustment to military life and to combat or become troublemakers and hence impose a tremendous drain on effective troop strength and morale. . . . As the war progressed, the problem of neuro-psychiatric casualties, their handling, and discharge loomed large. It came to public attention as these men returned home, some to be hospitalized and others to make their own adjustments in civilian life. Compounding the problem was the fact that returnees who had successfully survived combat often displayed symptoms of anxiety neurosis during the letdown period. (Joint Commission, 1961, p. 10).

New theories and new methods of treatment came into vogue. Short-term therapies, psychoactive medication, involvement of the patient in his own treatment--all of these forces came to bear on the problems of the mentally ill. But not enough patients benefitted from advances in the care and treatment of the mentally ill, and an upward spiral in admissions to state facilities continued. That upward trend continued even with new service efforts and an understanding that mental illness existed in a social context and was not confined to the individual alone.

## Contemporary redefinitions of the problems of mental illness; legislative initiatives and judicial shaping

It is noteworthy that orientations toward the problem of understanding and addressing mental illness found expression in law over the ages. This codification accelerated dramatically during the 1960s, perhaps as an aspect of a general shift toward a more legalistic society.

As a result of widespread public and professional dissatisfaction with hospital based mental health services, new directions were sought through community mental health legislation enacted in the 1960s. These initiatives created alternatives to the long-term care facilities in the form of out-patient services and attempted to ensure the accessibility of service to a broad population.

The Community Mental Health Center Movement was the outgrowth of an earlier initiative, the National Mental Health Act (P.L. 79-847), passed in 1946, which authorized the United States Public Health Service to provide financial assistance and leadership for research on the causes of mental disorders, the training of professional personnel, and assistance to the states for the establishment of clinics, hospitals, and treatment centers for the diagnosis, prevention, and treatment of mental disorders (Arnhoff, Rubinstein, & Speisman, 1969). The National Institute of Mental Health, formally established in 1949, was to develop into the major federal instrumentality for far-reaching and extensive program development in the areas of mental illness and mental health (Divic & Dinoff, 1978). The Mental Health Study Act of 1955 (P.L. 84-182) directed the establishment of the Joint Commission on Mental Illness and Mental Health, and its report of a six-year study of the nation's mental health needs provided recommendations that stimulated the development of community mental health programs (Joint Commission, 1961). "Deinstitutionalization" as a concept was born with the Commission's suggestion that state hospital beds be reduced to a maximum of 1,000 per institution, that community hospitals be used for short-term mental health treatment, and that full-time mental health clinics be established in communities to offer comprehensive and geographically accessible treatment services (Joint Commission, 1961).

Deinstitutionalization was defined as "a process involving two elements: (1) the eschewal of traditional institutional settings, primarily state hospitals, for the care of the mentally ill, and (2) the concurrent expansion of community-based services for the treatment of these individuals" (Bachrach, 1979, p. 1).

Deinstitutionalization was seen as a way of building on the advances which had been made since 1953 in patient care through the use of medication--advances which made it possible to maintain patients in their communities who otherwise might have needed long-term hospital care (Bachrach, 1979). Psychopharmacology made possible the discharge of many individuals, some of whom had been hospitalized for years. The United States public mental hospital population dropped from 559,000 in 1959 to approximately 150,000 in 1980 (Department of Health & Human Services, 1981, p. 2). Deinstitutionalization was expected to maximize the potential of those no longer needing placement in settings now regarded as restrictive and dehumanizing (Goffman, 1961).

In 1963, President Kennedy proposed a federal community mental health centers' program which largely reflected the Joint Commission's report. This program was described as a "national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill. . ." (Kennedy, 1963, p. 2). The subsequent Community Mental Health Centers Act of 1963 signalled the official opening of the era of community care for the mentally ill (Department of Health & Human Services, 1981). It accelerated the movement of the mentally ill into the community and stated the principle that mentally disturbed persons were entitled to live in dignity, as autonomously as they were able, in an environment that was not restrictive but was suitable to their needs (General Accounting Office, 1977).

A number of important legal decisions at this time, particularly Wyatt versus Stickey, Alabama, 1971, made it increasingly difficult to commit persons involuntarily to mental institutions, at the same time affirming a patient's right to treatment in the least restrictive environment (Golann, 1976).

In essence, these developments reflected a shift from medical to legal determination of mental hospitalization (Talbott, 1981) as well as a changing philosophy about patient care. Whenever possible, treatment had to be offered where patients would be more likely to see themselves as participating members of society rather than as expatriates, and where they would consequently be more involved in their own treatment (Bachrach, 1979). States rapidly changed their commitment procedures, recognizing the individual's right to counsel at commitment hearings, and establishing the "danger to self or others" as the test for involuntary hospitalization (Department of Health & Human Services, 1981).

With Medicare and Medicaid programs in 1965 and Supplementary Security Income (SSI) for mental as well as physical disabilities in 1974, some state expenses for mental patients were transferred to the federal government.

In 1966, Massachusetts enacted its own version of the federal government's Mental Health Centers Act (Acts, Extra Session, 1966--Chapter 735); yet until 1977 there remained few community alternatives to the state hospital in the Commonwealth (Okin, 1980). However, on December 15, 1976, a landmark suit was brought against the Commonwealth by nine plaintiffs, at that time patients at Northampton State Hospital, on behalf of themselves and other similarly situated (Civil Action No. 76-4423-4, Consent Decree, 1978). The suit claimed violation of constitutional and statutory rights to be treated in more appropriate, less restrictive alternatives suitable to the clients' needs. On October 17, 1977 that suit was certified as a class action suit and, on December 8, 1978, a Consent Decree was signed between the plaintiffs and the defendants. The suit thus never actually reached litigation because agreement was reached through the mechanism of a "consent decree" which was to be monitored by the federal court.

Substantially, that consent decree ordered that Northampton State Hospital drastically reduce its patient population and develop community alternative treatment programs (Commonwealth of Massachusetts, 1978). It enabled the DMH to commit vast sums of money to expand the community mental health system in the part of the Commonwealth served by Northampton State Hospital. Thus the DMH had the rationale and the monies to carry out a plan of communitization--a plan it had conceived of several years earlier to place most of its chronic mental patients into the community (Okin, 1980). The Consent Decree, calling for service in the least restrictive environment, not only required the establishment of community-based programs but required procedures for connecting the hospitalized clients with those programs. The Individual Service Plan (ISP) was adopted as the major means for assessing the service needs of the patient and developing an individualized program of treatment. The massive scope and functions of the ISP are spelled out clearly in the Consent Decree:

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 non-residential 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 non-residential 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 treatment goals and timetables for the attainment of those 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 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 both parties by June 1, 1979, which will be substantially similar to those 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 the 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 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 of Mental Health for Area Offices and residential and nonresidential programs to insure the proper delivery of services and in accordance with the Department's regulations. A complete copy of the resident's or client's records will be kept at a single, appropriate location and updated regularly (Consent Decree, 1978, pp. 20-22).

## Treatment philosophy of the ISP in historical perspective

The Individual Service Plan as a device expresses a fundamental belief in the psychosocial treatability of most mentally ill patients by promoting connections between the strengths and needs of the afflicted individual and community resources. This conception comes out of a long history of approaches to understanding and treating the mentally ill client. Approaches to treatment have undergone substantial evolution that in general parallel the expanding view of the problems of mental illness. In overview, the shift in orientation was from a pre-scientific to a physical-medicine-scientific approach, to a social-medical model, to a social-scientific-rehabilitative model. Chart I, following, offers a schematic overview of the succession of approaches used to understand and deal with mental disorders.

## CHART I

### Historical Overview of Approaches to Understanding and Treating Mental Illness

| PERIOD | BELIEF SYSTEM | ASSESSMENT TOOL | CLASSIFICATION & TREATMENT |
|---|---|---|---|
| Pre-Scientific | Mental disturbance seen as expression of the inexplicable or not understood (eg. demons, witchcraft, excess of bodily humors) | Naturalistic observation | Broad categorization.<br>Emphasis on identification and containment.<br>Treatment: management of negative behavior. Nature of treatment based on prevailing theoretical belief about causation. |
| Beginnings of Science: Moral Treatment | Biological causation of mental disturbance.<br>Medical model. | Kraepelin's Assessment Tool:<br>- disease model<br>- characteristics and natural histories<br>- classify individual into group<br>- patient as object | Focus on precise descriptions.<br>Classification & treatment of group, not individual; "Moral treatment offered to all, not individualized to patient.<br>Care in asylums, hospitals, institutions. |
| Meyer's Humanism and its Influence | Patient viewed as total physical, psychological, social being. | Meyer's Assessment Tool:<br>- clinical and developmental case history of individual | Concern with explanation and prediction of behavior or individual.<br>Emphasis on individual differences.<br>Hospital-based treatment. |
| Social Psychiatry | Inclusion of other disciplines: anthropology, sociology, psychiatry, non-medical helpers.<br>Importance of personal experience, and uniqueness of individual within social context.<br>Still based on medical model. | Psychosocial diagnostic evaluation. | Hospital-based treatment with psychosocial approach.<br>Extra-hospital approach to meet individual needs. |
| Social-Science-Rehabilitative Model | Mental illness does not pervade every part of a person's behavior.<br>Mental problems seen as inefficient, unsatisfactory behaviors.<br>Behavior responds to environmental factors, social pressures, expectations; behavior changeable.<br>Certain physiological and psychological predisposition. | Individual Service Planning (ISP)<br>DSM III | Concern with psychiatric rehabilitation, social functioning, social supports.<br>Community-based care - alternatives to institutional treatment,<br>- psychoactive medications<br>- legal provisions for most appropriate, least restrictive setting. |

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The foregoing chart identifies orientations that overlap each other, while differing in salience. The period prior to Emil Kraepelin (1855-1926) and Eugen Bleuler (1857-1939) is seen as "pre-scientific," in that severe mental disturbance at that time was looked upon as an expression of whatever was misunderstood or inexplicable in man's behavior in society. The emphasis was on identification and containment. An individual with strange behaviors was categorized as being influenced by demons, having an excess of bodily humors, or was considered to be a witch. Categorization was broad, and treatment took the form of manging the person: controlling, limiting, and repressing what was considered strange and negative. The focus of attention was on the broad categories, and thus it was nomothetic in approach.

Kraepelin (and later Bleuler, who sharpened Kraepelin's distinctions) placed these strange behaviors into a disease model, similar to Thomas Sydenham's (1624-1689) clinical disease approach, where there had to be characteristic symptoms and natural histories attached to an understanding of the concept. The focus of attention was placed on precise descriptions; it led to care in hospitals and institutions, as this seemed to be the only method for handling (or "treating") such a chronic disease state.

From 1910 to 1950 medicalization of mental illness was elaborated. An acceptance of the Kraepelin-Bleuler viewpoint fostered a continuous search for biological causation. The record for therapeutic success was dismal, however (Bachrach, 1976; Haven, 1973; Shershow, 1978). Whatever was "de trop" as a theory for biological causation was carried over into treatment, from total removal of a patient's teeth to complete castration (Shershow, 1978). Cures rarely materialized; merely leaving a hospital was considered an achievement. Eighty percent of patients admitted to public mental hospitals during this period were never discharged (Shershow, 1978, p. 103). Assessment tools continued to be general; mental illness was considered to be an endogenous disease and was studied the way that any other disease state was studied. The patient was treated as an object (it was not the patient's "fault" that he/she had the disease); concern was with the disease process only.

During this period, the predominance of the objective-descriptive Kraepelinian approach was tempered by the influence of Adolf Meyer's (1866-1950) emphasis on individual differences, and his advocacy of a clinical and developmental case history approach. Meyer's approach is more idiographic in its concern with the explanation and prediction of behavior in the single or unique case based on extensive knowledge of the history and biography of the person. The assessment tool was essentially a medical/physical model, however, and continued to emphasize treatment within a hospital setting (Lowry, 1946).

By World War II, the hospital-centered approach fell into disrepute. Two developments converged to create a community treatment model and shifted the locus of attention from a disease state in individuals to the treatment process for those individuals. The first development was the discovery of rauwolfia (used now primarily for hypertension, see Goldberg & Egelston, 1978, p. 234) and other psychoactive medication. Effective treatment was provided through these drugs for the acute symptoms of mental disturbances; a greater percentage of patients were able to leave the hospitals as a result. The second development was the influence of the social science and psychological perspectives which expanded the physical/medicine medical view of mental illness (Erikson, 1959; Freud, 1949; Goffman, 1961; Hollingshead, 1958; Laing, 1967; Parsons, 1964; Szasz, 1961).

The convergence of these two developments was called social psychiatry: a psychosocial approach to the hospital milieu, as well as a movement concerned with the extra-hospital programming to support the individual needs of a patient population. The treatment tool for this approach is exemplified in the Individual Service Plan. The treatment approach and the assessment instrument are an extension of the Meyerian school, stressing the importance of personal experience and the uniqueness of the individual in his/her social context. It contrasts to the Kraepelinian school which emphasizes categorizing disease states. The rehabilitation model stresses the positives in a person rather than looking only at the "disease," or deficits. The model was born during the decade of the 1970's--a decade which will probably be remembered in the United States as the years of the civil rights for the handicapped. (Note especially Public Law 93-112, the Rehabilitation Act of 1973, establishing the Individual Written Rehabilitation Plan, IWRP; and Public Law 94-142, the 1975 Education for All Handicapped Children Act, establishing the Individual Education Plan, IEP.)

Massachusetts' Individual Service Plan, modeled after the IWRP and the IEP, expressed the principles of psychiatric rehabilitation and the federal laws which were established to ensure individualization and end stereotyped programming for handicapped persons. The ISP grew out of a reaction against a medical model of psychiatric treatment which stressed insight development and remission of symptoms, but which could not counteract a hospital recidivism rate which exceeded seventy percent within three years after discharge (Anthony, 1979, p. 207). The medical model appeared only to label a client and to categorize symptoms. It seemed to have little to do with predicting and affecting a client's rehabilitation potential (Anthony & Margules, 1974).

The psychiatric rehabilitation approach and the psychoeducational approach, with their concomitant assessment tools (whether called the Individual Written Rehabilitation Plan, the Individual Education Plan, or Individual Service Plan), stress improving skills and modifying the environment so that clients can function more effectively in the least restrictive service environment. The new psychiatric approach appears to be guided by the following principles:

> 1. Mental illness does not pervade every part of a person's behavior. Some decisions can be made rationally. Treatment should enhance the client's capacities to make rational decisions.
>
> 2. Human behavior can be changed through shaping.
>
> 3. Human behvior responds to the presence or absence of specific environmental factors, to social pressures, and to expectations (Freedman, et al [Eds.], 1975, p. 2342).

The tool to assess behavior and to plan treatment strategies organizes a list of strengths and weaknesses in a form that is meant to be understood by client and professional alike. The attempt is to break down the "mystique" often built up by professionals to make use of the "magic" of treatment. Patients thus can become partners in their own treatment, with the thought that this can be more powerful than any "magic." The mechanism assumes that a client's physical, intellectual, and emotional capacities are all related; that these capacities must be assessed in terms of the environment in which the person is to live; and that there should be specific goals of treatment which are measurable and are outlined for each individual.

> The goals of a rehabilitation approach should be to provide the disabled person with the physical, intellectual, and emotional skills needed to live, learn, and work in the community with the least amount of support from agents of the helping professions (Anthony, 1977, p. 660).

The ISP and other similar assessment tools reduce the emphasis given to individual pathology in favor of concern with individual and community resources. Individual service planning fits well with the philosophy of the community mental health center movement in its optimism, its broad spectrum of coverage and inclusiveness, and its rehabilitative orientation. Designed to improve opportunities and services for the most severely disabled clients, the ISP tactic has the potential of serving as a dynamic change-agent for both the caregiver and the client.

The ongoing competition among alternative orientations to mental illness finds expression in the Diagnostic & Statistical Manuals (see Chart II) which codify the diagnoses for mental illness. In the most recent reformulation (Diagnostic & Statistical Manual III, 1980) there appears to be a neo-Kraepelinian revival. The Diagnostic and Statistical Manual III (DSM III) takes a precise, descriptive approach to psychopathology, acknowledging, however, the influences of the social and environmental pressures through its various axes. It is an attempt to define mental illness on the basis of a symptoms-syndrome model. It applies operational criteria to the syndrome and sees mental illness, like other illnesses, as having causes and delineations. The conviction is that in the absence of etiological knowledge, perhaps the best way to proceed is to define the clinical uniqueness of the individual in his/her social context.

The current belief is that diagnosis is important for clinical practice, and that clinicians and researchers must have a common language with which to communicate. With the publication of this current manual, the American Psychiatric Association (APA) states that planning a treatment program requires accurate assessment; comparing the efficacy of treatment modalities is possible only if patient groups are described using clearly defined diagnostic terms (DSM III, 1980, p. 1).

DSM I was published by the APA in 1952 as the first official manual of mental disorders in the USA to contain a glossary of descriptions of diagnostic categories. The term "reaction" was used in DSM I to reflect Adolf Meyer's view that "mental disorders represented reactions of the personality to psychological, social, and biological factors" (DSM III, 1980, p. 1). DSM II, published in 1968, eliminated the term "reaction" and used diagnostic terminology which did not imply a basic theoretical framework for understanding mental disorders (DSM III, 1980, p. 2).

DSM III, begun in 1975 and published five years later after extensive field trials, conceptualized mental disorders in a descriptive manner (DSM III, 1980, pp. 1-12). The manual is generally atheoretical with regard to etiology, attempting to describe the manifestations of a particular disorder rather than how that disorder developed. Specific diagnostic criteria are offered as guides to define content and boundaries of each diagnostic category. And, there is a multiaxial system to ensure that information which may be of value in planning treatment or predicting outcome is included (physical conditions; psychosocial stressors; highest level of adaptive functioning within the past year).

## CHART 2

### Comparison of Diagnostic and Statistical Manuals I, II, and III

| DSM I | DSM II | DSM III |
|---|---|---|
| First official manual of mental disorders with descriptions of diagnostic categories. | Classification of mental disorders based on International Classification of Diseases (ICD-8). | Multi-axial evaluation system. |
| Based on Adolf Meyer's psychobiological view. | No implication of particular theoretical framework for understanding non-organic mental disorders. | Comprehensive descriptions of manifestations. |
| Mental disorders reflect reactions of personality to:<br>- psychosocial factors<br>- social factors<br>- biological factors | | No descriptions of etiological possibilities for disorder. |
| No explicit criteria for defining content and boundaries of diagnostic categories. | No explicit criteria for defining content and boundaries of diagnostic categories. | Specific diagnostic criteria as guide for each diagnosis. |
| | | Hierarchical organization of diagnostic classes. |

* All primarily for clinical use, secondarily for research and administrative use.

The DSM III approach may permit homogeneous groups to be brought together clinically and to be examined for response to treatment. Psychogenic causation might be found in the theories about deprivation in early childhood experiences, family interaction, or communications defects and/or social deprivation. Treatments might be found to be biological or non-biological--individual or group psychotherapy, or milieu therapy. But DSM III expresses an objective-descriptive orientation toward mental disorders.

And so the bias resurfaces: diagnosis depends upon presenting symptoms. There is in DSM III an underemphasis on psychotherapy and the Meyerian humanistic values. And, even though treatment may still continue to be influenced by social and environmental factors, those factors are relegated to axes in the diagnostic diagram; thus they are given less emphasis in the understanding of causation.

# CHAPTER II

## STUDY AIMS AND METHODS

### Study opportunities presented by the ISP

Mental illness has remained a perplexing enigma--an elusive, refractory state in which the afflicted are impaired in dealing with the realities of life. Historical material in Chapter I indicates that efforts to solve the riddle of mental illness have usually taken the form of analogues, in which some theoretical model that has been found useful for understanding another problem is offered as relevant to the problem of mental illness. The history of ways of thinking about and responding to mental illness (diagnosis and treatment), therefore, is a history of the successive importation of paradigms from other fields. Mental illness has thus been approached from perspectives offered by religion, philosophy, astronomy, medicine, psychology, education, the law, communications theory, and rehabilitation.

Not only have ideas about mental illness changed, so too has the allocation of responsibility for doing something about it--from the family to social agents, such as philosophers, theologians, medical doctors, and social scientists. The number of disciplines presently concerned with mental illness may be an index of both the multidimensionality of the problem and of our limited understanding of it.

How a society understands its mentally ill and provides care and treatment thus becomes in itself a kind of projective test. The orientation toward mental illness evident today appears to combine a humanistic commitment with a logical-positivist social-scientific approach which sustains an optimistic view about the understandability of mental illness and its treatability.

These paradigms, advanced for understanding mental illness, have brought with them their own networks of treatment planning strategies. If the difficulties were caused by an excess of bile or bodily humors, then it would be important to rid the body of those excesses through blood-letting, diet, exercise. If, on the other hand, the mental problems are a result of evil (whether caused by inner or outer forces), then whatever contemporary method of eradicating that evil should be used. An assessment tool is unnecessary with a religious or philosophical approach. The answers are relatively simple and grounded in the theories of the particular time.

Answers become more complicated when the theories are medical, and one has to note the etiology, the symptom pattern, the results of psychological testing, and one is expected to develop a treatment plan based on those "facts." When the explanation becomes a combination of both medical and social influences, as is true in our current approach, then assessment tools to organize study of both domains become almost mandatory.

The ISP becomes a way of looking at the individual within a modern paradigm: psychiatric rehabilitation. It is the current method of adapting diagnosis to treatment, of taking more fully into account the patient and his/her environment. It looks at the strengths and needs of the person, and then measures these against the environment: personal-psychology against the medical, social, vocational, educational spheres impacting upon that individual.

As a newly mandated provision, the ISP occasions a number of questions. Among these questions, the writer's curiosity falls into two different areas: On the one hand, one wonders how an imposed requirement will find expression in a complex delivery network. That is, a number of specific questions could be raised about how this requirement will be implemented, and what may mediate its variable implementation. On the other hand, it is easy to see the possibility that the participation by helpers, families, and clients to meet the ISP requirement may affect each of them variously. That is, how does the ISP impact upon the participants?

ISP implementation

Services mandated by legislative or administrative directives may relate variously to the true needs of an actual client group. The model of services entertained in the mandate is likely to find quite differing expression in the work of service providers. For example, Weatherley and Lipsky (1977) studied the effects of the actions of service personnel on Massachusetts' Special Education Law, Chapter 766, in three school districts during the first year of the law's implementation. They concluded that those persons ultimately responsible for the law's implementation often distorted and constrained that innovative legislation by virtue of their need to deal with excessive demand placed upon them and the reality of resource limitation. Procedures became routine, goals were modified, services rationed, priorities asserted, and clients limited. What had been a simple procedure involving teacher, specialist, child, and sometimes parent became elaborate, with formal requirements imposed upon an interdisciplinary team. Workload increased, documentation became detailed and conflicting requirements (such as accountability and equal treatment for all, together with fiscal constraint and economy) seemed like nightmares to those who were meant to carry out the law.

Earlier studies support Weatherley and Lipsky's work,[1] raising questions about IEPs as legalistic, time-consuming and thus not cost-effective, which overburdens staff with a tyranny of paper work and fosters the development of easily achievable goals. Engler's 1978 report clearly supports the Weatherley and Lipsky dictim that it is important to pay heed to the voices "on the line" where the words of regulations and policies get translated

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[1] A representative sample of published studies on IEP development includes Alper, 1979, who studied 165 IEPs from 13 California school districts, finding that both long-term and short-term objectives were poorly written and specified, and that once plans were implemented teachers were able to achieve or exceed goal criteria in all areas except communication skills. This raises the question of whether goals are truly understood, and whether or not implementors will make goal statements that are easy to reach in order to support their jobs. Marver and David, 1979, supported this finding, noting that there was considerable variability in how IEP requirements were met nationwide. Nadler and Shore, 1980, interviewing 175 students, teachers, administrators, parents, and support personnel in California, concluded that neither students nor classroom teachers were involved meaningfully in the IEP process, and that an IEP plan rarely led to improvement in service. The development of the plan ended the process. Piper's study (1978) of the first-hand experience of a panel of teachers, special education counselors, and special education teachers emphasized the need for in-service training in order to develop appropriate plans. Reisman and Macy's 1978 study of IEPs in 54 urban areas in the southeast found that the major shortcoming in IEP documentation was a statement of annual goals and short-term objectives. Schenck and Levy's 1980 study of 300 IEP programs and corresponding psychoeducational assessments showed lacks in documentation throughout the plans, as well as a shocking uninvolvement of parents, students, and classroom teachers in the development of the plans. Stearns' 1980 study based on interviews with administrators, teachers, and parents from 22 local education agencies in 9 states noted that the decisions about what services and placements handicapped children received was based largely on what was available and not on what was ideal.

into process. If the professionals are so deluged with paperwork, inadequately trained, and unsupported by teams of clerical and secretarial workers to assist in the process, then Engler saw no individualization, no treatment, and, essentially, no plan.

It is reasonable to expect that the multiple shaping influences identified by Weatherley, Lipsky and others for the IEP would mediate the way the ISP regulation will be put into practice. That is, the yield of the ISP requirement will probably be contingent upon:

1. the capacity of a staff to undertake the time-consuming additional requirements;
2. staff's willingness and interest in involving themselves in the process;
3. the knowledge and informational base available to the persons charged with contributing to an ISP;
4. the helper's experience-based appraisal of costs and gains in participating in ISP development;
5. the availability of resources and the limits of such resources (this, in spite of the fact that the regulation's intent is to advance an ideal plan, regardless of resources);
6. community acceptance of the chronic patient and the treatment modules;
7. the preparation, support, and endorsement the helper receives from colleagues, supervisors, and support staff.

From previous work on IEPs certain general predictions of ISPs would be justified. Within the first few years of initiating the requirement, its implementation would show evidences of becoming routinized; its coverage may be more limited than the requirement intends;

the time intervals within which it is supposed to be completed will not have been met; the documentation increasingly will be brief and incomplete; helpers will develop discriminating appraisals of the general merits of the ISP, in that the same helper will find some ISPs useful and some ISPs a waste of time; the level of compliance will be a function of the extent of active monitoring and whether or not compliance becomes consequential.

Implicit in the ISP is an optimistic view of the world: something positive and constructive can be accomplished for every human being. The ISP, therefore, could become a way of asking the helper to think positively about the mentally disturbed person and to find something to do for and with that person. This consideration suggests that the ISP may constitute a contemporary solution to the problem of supporting an engagement of a helper group for work with society's "misfits." However, ISP conceptions may also invite in the helper a too optimistic view, and thus ISPs could contribute to "burnout" in the helper group. If experience proves that the progressive goals inherent in the ISP are beyond the reach for many, one wonders whether it will survive or be replaced by another belief system.

## ISP as a dynamic

Whether or not the approach is too optimistic, the ISP may indeed have some constructive value. Research on the analogous IEP noted that there were definite advantages to what some were terming a legalistic nightmare. These included the fact that more children were served through the new system than previous systems (U.S. Department of Health, Education, and Welfare, 1979), that teachers were experiencing a greater degree of job satisfaction because they could see the results of their planning (National Education Association, 1978), and that teachers found the IEP process an aid in analyzing their teaching, planning lessons, and motivating students (Schipper & Wilson, 1978). Armstrong, 1978, reporting on the monitoring of 100 IEPs in a rural south Georgia school system, indicated that significant gains in reading and math resulted for children who received special programs as a result of their IEPs.

ISPs have the possibility of improving clients' success rates in adjusting to their mental disorder. They can provide a clarity of focus and of diagnosis which can lead to more approprate treatment choices of service entities. They can promote choices and responsibilities for both the client and the provider. Writing something down forces specificity, examination, and commitment. A piece of the client and the helper becomes part of the process because each is required to think about the problem and examine alternatives. Even if enthusiasts are expecting that this paradigm will do more than any other, and those enthusiasts are disappointed (as history suggests is expectable), the ISP itself can force "ownership" of treatment choices for both client and helper. And this can be an important step toward ending alienation of the "misfits" from the society where they must live.

Along with constructive influences, the ISP requirement may have negative effects on helpers and clients. A mandated requirement would appear to reduce the scope and authority of the staff member by directing how part of his/her time is used. Beyond constituting somewhat of an interference, ISP work may compete with other responsibilities and requirements. Therefore, along with the potential for engaging and mobilizing the worker, ISP work could also become an avenue toward despair. If the resources within the clients are limited and the resources in the community are constrained by economics, development of an ISP may be seen as futile. Similarly, while the client and the family may have a better sense of participation from the ISP, it may also provide an occasion for their further mystification or intimidation by the professionals, or even for their scapegoating as a way of tension release. No mandated requirement can erase the fundamental tensions of encountering a basic mental disturbance, and encountering our presently limited ability to effect its course.

Dr. Patricia Gillespie-Silver's summary of a concept paper on in-service training for IEP development (1980) emphasized some points for effective IEP development which make excellent sense for the analogous ISP. She builds her argument on the principle that long-lasting change can only occur if it is initiated by all involved and when it has the support of all administrative layers and structures within the administrative hierarchy. What Dr. Gillespie-Silver sees as necessary for IEP success holds true for the ISP (Gillespie-Silver, 1980, p. 3):

1. step by step procedures for establishing inter and intra-agency channels of communication;
2. integral involvement and ownership for all participants in the process;
3. administrative support at all levels;
4. relevant and on-going in-service training in the spirit and history of the law, due-process, and skills related to the components of the process.

Considerations of the ISP requirement in the context of social, organizational, and psychological forces suggests that a substantial disparity may obtain between a mandated service arrangement on the one hand, and its probably varied implementation and influence on the other. Far from suggesting that program planning is futile, this disparity itself constitutes a challenge for further planning.

### Specification of study aims

The ISP redefines the relationship between the mental health service provider and the mental health patient. It shifts the locale in which their transactions occur by redefining treatment of the problems using a social-functioning model rather than a medical-illness model. It no longer concentrates on disease state, causation and description but speaks rather to client strengths and weaknesses and the supports necessary to maintain the client in the community. Instead of viewing the client as a passive recipient of "treatments," the ISP approach appears to make an implicit statement that the acquisition of new and relevant skills can inspire hope and confidence in the client and in the service provider. The ISP thus encourages mutual client and provider involvement in all aspects of the assessment and treatment program.

### Study questions

The first experimental question was investigated by study of a sample of subjects who had received an ISP and an apparently comparable sample of subjects who had not. Examined were perceived differences between the sample group and the control group in treatments offered and treatments used by clients, and in their locus of control.

The second question was addressed by study of the service providers' level of understanding of the Individual Service Plan process, their perceptions of its effects on their clients and on their own service provision, and their suggestions for changes in the process.

The third question was investigated by collecting clients' and family members' understanding of and satisfaction with the treatment planning process, and their suggestions for changes in that process.

Definitions of key terms are presented in Appendix I.

## Hypotheses

The decision was made to examine some hypothesized effects of the ISP on clients and on the family members or significant others of the client, and to explore service providers' appraisals of the ISP. The hypotheses taken for study are:

Hypothesis I: Clients for whom an ISP has been developed will have a greater knowledge of their problem areas and treatments offered to them than clients who have had no ISP.

Hypothesis II: Clients for whom an ISP has been developed will report using a greater range of services than clients who do not have an ISP.

Hypothesis III: Clients for whom an ISP has been developed will evidence more internal locus of control than clients who have had no ISP.

Hypothesis IV: Clients for whom an ISP has been developed will manifest a higher level of social ability than clients who have had no ISP.

Hypothesis V: Clients' responsiveness to the ISP will vary with their understanding of that experience and with their level of disability.

Hypothesis VI: "Significant others" of clients who have had an ISP may evidence greater involvement with the client, greater knowledge of that client's needs and problems, greater knowledge of their service plans, service personnel, and unmet needs than "significant others" of clients who have not had an ISP.

Hypothesis VII: Service providers' appraisals of the ISP may vary with their understanding of the ISP process.

### Overview of study plan

The basic plan adopted for this study was an ex post facto comparison between ISP clients and non-ISP clients and their families. In addition, service providers' observations and experience with the ISP planning instrument were collected.

After identifying eligible clients who had received an ISP, an attempt was made to select a comparable sample from the larger group of clients who lacked an ISP. The service experiences and functioning of clients falling in two apparently comparable groups was then examined for evidence about some effects of the ISP. Clients in both groups were asked to identify a significant other; those named were recruited to the study in order to learn about some possible effects of the ISP on relatives. Finally, a sample of service providers who had had experience with the ISP was studied.

### Samples

The contrast samples for the study were drawn from the population of clients served by the Westfield Community Support Services agency (WCSS), located in Westfield, Massachusetts. At the time of the study, this agency had a contract with the Department of Mental Health to provide assessment, treatment planning, and case-management services to all severely mentally disabled clients in the Westfield catchment area.

The geographical catchment area of WCSS consisted of portions of two counties (Hampden and Hampshire) and included eleven cities and towns. Generally it was semi-rural, with three population centers which made up about eighty-five percent of the total population of about 102,000 (Massachusetts' State Census, 1975). Of the total population fewer than 300 were Black, and about 1700 were Hispanic. About 1100 had incomes below the poverty level. There were a number of mental health service agencies in the area which provided a spectrum of services, ranging from traditional out-patient clinics to residential, day-hospital, vocational, and specialized educational treatments. Most of these agencies had contracts with the Department of Mental Health to provide services to DMH clients. WCSS itself had specific contracts to provide residential, day-treatment, and out-patient therapy services, as well as the assessment and case-management services previously mentioned.

During the time of the study, the monthly census of active clients for the WCSS ranged between 150 and 210. ISPs had been completed for about twenty-five of these clients. The remaining active clients were available for selection to comprise the matched comparison group for this ISP study.

Twenty-three clients with completed ISPs were recruited to the research and were studied. The characteristics of this study sample were examined in order to define the characteristics of the control sample sought from the residual client population. By selection, an attempt was made to duplicate in the control group the distributions found in the study sample of the variables of _age_, _sex_, _psychiatric diagnosis_, and _total number of hospitalizations_. In composing the control group, an effort was made also to draw clients served by staff working with the study sample in order to provide the basis for certain comparative judgments between the groups.

## Instrumentation

The following instruments were used in the collection of the research data and are available in Appendix II:

Participant Consent Form
Schedule for Review of Case Records (SRCR)
Client Experience Survey (CES)
Scale to Measure Internal vs. External Control (Rotter, 1966)
Structured Interview for Service Providers (SISP)
Relatives' Experience Survey (RES)
Global Assessment Scale (Endicott, Spitzer, & Gibbon, 1976)

Appraisals of the properties of these instruments will be presented in the next section.

## Schedule for Review of Case Records

The case records at WCSS contained information about client name, age, sex, marital status, address, religion, race, entitlements, wages, employment, insurances, family members, legal competency, psychiatric diagnoses, medical diagnoses, number of hospitalizations, education. As noted previously, the primary parameters for composing the study sample and control groups were age, sex, psychiatric diagnoses and total number of psychiatric hospitalizations.

## Client Experience Survey

This questionnaire was administered to clients by their service coordinators. It was believed that the return rate for such a questionnaire would be higher if it were administered orally to clients by someone who was perceived of as an advocate and who knew them well. It was also thought that some clients might be too confused or mentally disturbed to use a self administered questionnaire but could be expected to accomplish this task with help from a person who was supportive of them. Clients' rights were fully protected. A statement was read to them prior to the administration of the questionnaire. This statement explained that all information given by them was confidential, that each participant would be given a code number and thus would remain anonymous, that any information given would not affect their treatment by the agency, and that they could withdraw from the research at any point. All participants signed the Participant Consent Form.

The CES was designed to measure clients' knowledge of their problem areas, understanding of their service plans, and level of satisfaction with the process to develop those plans. The same questionnaire was administered to the study group and the control group. However, clients who had an ISP received a short, extra section to complete which gave information about their knowledge of the ISP process.

### Scale to Measure Internal versus External Control (I-E Scale), Rotter, 1966

J. B. Rotter was concerned about "social learning" when he developed his I-E scale (Rotter, 1954). He was particularly interested in the effects of perceived internal versus external control of reinforcement. The potential for any behavior to occur in a given situation was seen by Rotter as a function of the person's expectancy that a given behavior would secure the available reinforcement, and the value of that available reinforcement. In a particular situation the individual, though desirous of a particular goal, may believe that there is no behavior in his repetoire which would allow him to be effective in securing that goal. The person might then be described as anticipating no contingency between any effort on his part and the end results in a situation. This is a description of Rotter's "internal-external expectancy" (Rotter, 1966). In Rotter's theory, the control construct is considered a generalized expectancy, operating across a large number of situations, which relate to whether or not the individual possesses or lacks power over what happens to him/her. Individuals are labeled "externals" when they are said to have a generalized expectancy that reinforcements are not under their control across varied situations. In laymen's terms, these persons see themselves more as victims than agents of their own fate. People vary along a "locus of control" dimension with the end points labeled as <u>internal</u> and <u>external</u> (Rotter, 1966). "Generalized expectancies" were similar, according to Rotter (1966) to notions of alienation, competence, field-dependence, and ego-strength.

Development of the scale is documented in Rotter's 1966 monograph. The scale is a twenty-nine item, forced-choice questionnaire, where six of the items are "fillers" and twenty-three offer choices between internal and external belief statements. The scale is self-administered and can be completed in about fifteen minutes. It is relatively short and easy to comprehend. Scoring for the test is computed simply by summing the number of <u>external</u> beliefs endorsed.

There has been considerable research on Rotter's scale, some of the findings of which were reviewed in articles by Lefcourt (1966) and by Rotter himself (1966). The test-retest reliability of the I-E scale was seen as consistent and acceptable in this research, varying between .49 and .83 for varying samples and time periods (Rotter, 1966). In 1981, Robert Lange re-examined the dimensionality and reliability of the I-E scale, using 277 Australian students, and found that the scale itself, and its two factor structure, was stable over a considerable period of time. Numerous laboratory and survey studies give evidence for the test's construct validity (Lefcourt, 1966; Berndt, 1978).

The I-E scale was administered for this study by service coordinators to their clients. The service coordinators were thus available to answer simple questions if clients appeared confused.

One of the principles inherent in the ISP is a belief that when clients are involved in planning their own treatment they will be confronted with the need to deal with making decisions. The psychological reality of this confrontation may be an increased sense of control and autonomy. It may also be the opposite. The Rotter scale was used to measure the client's sense of autonomy and control.

## Structured Interview for Service Providers

The SISP was developed by this investigator to gather information about service providers' experience with the ISP process and their judgments about its helpfulness. The information was gathered through a structured interview conducted by the primary investigator of this project and a master's level social worker trained specifically to carry out such an interview.

It is important to note that the majority of service providers in the Westfield area had had experience both with clients who had had ISPs and clients who had not had ISPs. This fact enabled the investigator to collect informed judgments about the function of the ISP in order to learn whether the ISP was seen only as a management tool or was experienced as an essential part of a dynamic treatment process.

Because the SISP was a structured interview, the parts of each interview requiring a judgment decision were audiotaped. These audiotapes were then rated independently by two separate reviewers. Agreement in ratings was unanimous.

## Relative Experience Survey

The RES was mailed to relatives whose names and addresses were given by clients themselves when they were interviewed for the Client Experience Survey. A cover letter, along with a stamped, self-addressed envelope and a final return date was sent out. Two weeks after the final return date, a second cover letter, questionnaire, and stamped, addressed envelope was sent out with a second return date requested. The cover letters included an explanation of the research project and guaranteed the anonymity of all participants.

The RES was meant to gather information about relatives' understanding of their family member's mental problems, the services offered to help with those problems, and the satisfaction that the relative had with the services offered and with treatment planning in general. A final question requested suggestions for changes in the treatment planning process.

### Global Assessment Scale (GAS)

The GAS is a standardized procedure for measuring the overall severity of psychiatric disturbance. It was developed in 1976 by psychologists Endicott, Spitzer and their associates at New York Psychiatric Institute.

The GAS is a rating scale for evaluating the overall functioning of a subject during a specified time period (usually one week) on a continuum from psychological or psychiatric sickness to health. The scale values range from 1, which represents hypothetically the sickest individual, to 100, the hypothetically healthiest. The scale is divided into ten equal segments (1-10; 11-20, etc.), and the characteristics of each ten point interval are anchored by definitions. The scale is not linked to psychiatric nomenclature but focuses heavily on behaviorally observable phenomena. Ratings are independent of a clinician's view of prognosis. The directions are quite specific that each rating pertains only to a client's functioning during the previous week or ten days.

The researchers who developed this scale studied the inter-rater reliability of the GAS by using raters of varying backgrounds, subjects from different populations (including non-patients), and data from live interviews as well as written material. Under most circumstances, the precision with which ratings were made was relatively high and consistent (Endicott, et al, 1976). The index of precision, the standard error of measurement, was between 5 and 6, indicating acceptably small error for a 100 point rating scale. The interclass correlation coefficient of reliability over five studies reported by Endicott and her associates ranged from .69 to .91, essentially as a function of the variability in overall severity of disability in the subject samples. The five studies reported by Endicott encompassed the range of populations to which measures of overall severity of illness were likely to be applied. The GAS was seen as having good reliability for its intended use.

The key issue with such a scale as the GAS is validity. The evidence presented by Endicott in her 1976 article was of three kinds: correlations with other independently rated measures of overall severity, relationship to rehospitalization, and sensitivity to change.

At both admission to hospital and six months later, when most patients were in the community, GAS ratings by research personnel showed moderate correlations in the expected direction with measures of overall severity of two kinds: seven-point rating scales and total scores derived from a multidimensional rating procedure. Correlations for the therapists' GAS ratings were generally lower. However, as Endicott and her associates stated that the GAS was developed to improve on other global procedures, very high correlations were neither desired nor expected.

Of interest in Endicott's report was that former psychiatric patients seen in the community with a GAS score below 40 given by a research interviewer were found to have a substantially higher probability of being rehospitalized than patients with higher GAS scores. This information suggests that the GAS scale could be useful in identifying former in-patients who are at high risk for readmission, and thus could be an important adjunct to measures used in an ISP.

The GAS is an easily accomplished, inexpensive, and non-time consuming technique which can be used to make overall assessments of the impact of services on clients. After training, it requires less than a minute of a clinician's time to arrive at a rating after a meeting with a client. Service providers who had had no experience with the GAS were trained and then all were asked to complete one GAS for each of their clients in the study and control groups.

### Data processing

Data for the project were collected on nominal, ordinal, as well as interval scales. For comparing the study with the control group, the information was organized initially by frequency distributions and inspected. Chi Square was then used to calculate probability for the observed differences between groups in the classificatory data, and Pearson Product Moment Correlations for the relevant interval data were abstracted. For comparing the groups on variables measured by ranks, the Mann Whitney U Test was calculated.

# CHAPTER III

## FINDINGS

### Comparability of the two samples

Because of the comparative study plan, the comparability of the two groups intended to be equivalent (except for the presence or absence of an ISP) was investigated initially. The two groups were found to have virtually identical means for age (33.48 and 33.17 years, SD = 10.6 and 10.9 years), and were, in fact, identical in terms of numbers of hospitalizations (4.56, SD = 3.40 and 3.59).

Table 1 shows frequency distributions for the two groups on other descriptive variables. What is remarkable is how close the two groups are descriptively on all variables except housing. The groups were identical in distribution across the diagnostic categories and were similar in problems identified by clients, in reports of services suggested and used. However, significantly more study group subjects were currently living in either DMH supervised housing or in the State hospital, while significantly more contrast group subjects were living with family members. In addition, study group subjects reported significantly more frequently ($\underline{p} < .01$) that

## TABLE 1

Frequency Distribution for Two Samples on Descriptive Variables

| Variables | Study Group | Control Group |
|---|---|---|
| Sex | | |
| Male | 9 | 14 |
| Female | 14 | 9 |
| Diagnostic Category | | |
| Bipolar Disorder | 3 | 3 |
| Personality Disorder | 3 | 3 |
| Schizophrenia, Chronic | 9 | 9 |
| Schizophrenia, Paranoid | 4 | 4 |
| Schizoaffective Disorder | 3 | 3 |
| Schizophrenia, Residual Type | 1 | 1 |
| Current Living Situation | | |
| Alone | 3 | 5 |
| With Any Family Member* | 2 | 12 |
| DMH Supervised Arrangement** | 6 | 0 |
| Northampton State Hospital** | 11 | 6 |
| Other | 1 | 0 |
| Problems Identified by Client | | |
| Housing | 9 | 5 |
| Employment | 9 | 9 |
| Physical Health | 7 | 3 |
| Mental | 16 | 11 |
| Other | 3 | 5 |
| Client Report of Services Offered | | |
| Medication | 20 | 21 |
| Day Treatment | 11 | 6 |
| Supervised Living Arrangement* | 15 | 3 |
| Sheltered Employment | 8 | 8 |
| Out-patient Therapy | 11 | 11 |
| Service Coordination | 13 | 10 |
| Client Report of Services Used | | |
| Medication | 18 | 17 |
| Day Treatment | 7 | 3 |
| Supervised Living Arrangement | 7 | 1 |
| Sheltered Employment | 5 | 4 |
| Out-patient Therapy | 9 | 11 |
| Service Coordination | 13 | 9 |

* $p < .01$

** Combined frequencies $p < .01$ by $X^2$

supervised living was suggested to them as a service. Supervised living arrangements are often discussed in an ISP meeting and are often recommended as part of an ISP. Indeed, a subject's need for help with supervised housing arrangements may occasion his/her selection for an ISP. This one difference in housing arrangements between the two groups is thus believed to reflect an artifact of the ISP itself rather than reflecting underlying differences between the two groups.

Because of the high degree of similarity between the two groups on all variables that are independent of the ISP process, it seems reasonable to accept these as equivalent groups; the study conditions sought here were apparently realized.

### Comparison of groups

In the hope of learning whether the provision or lack of provision of an ISP has an effect on two equivalent groups, data about their current functioning were collected. In order to appraise their contemporary level of adaptation or disability, Global Assessment scores were collected for each subject; and, in order to appraise their sense of autonomy, the Rotter I-E instrument was used.[1]

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[1] Investigation revealed that the Global Assessment ratings were not correlated with the Rotter scores. Even allowing for considerable error variance in the Global Assessment scores, the scores are believed at least crudely to reflect real differences among subjects in

Shown in Table 2 are the results for the two groups of these indices of current functioning. As will be seen, the scores were found to be descriptively very close and yielded no evidence that the groups differed significantly. On a group comparative basis, that is, these data provide no evidence of measurable client benefit from the ISP. From examination of the comparability of the two groups, it is apparent that differences in living arrangements between the two groups obtained, and it is possible that those living arrangements may have some differential benefits for clients. However, there is no evidence that any such difference found expression in their rated level of disability or their locus of control.

TABLE 2

Means and Standard Deviations of Scores on Level of Disability and Locus of Control

| Group | Global Assessment Scale | | Rotter I-E Scale | |
|---|---|---|---|---|
| | Mean | Standard Deviation | Mean | Standard Deviation |
| Study Group | 42.30 | 16.67 | 10.38 | 3.38 |
| Control Group | 47.35 | 15.53 | 9.77 | 3.74 |

---

their current functioning. The more standardized Rotter scores similarly are believed to reflect differences among subjects in that domain. The independence between these two measures, though unexpected, is believed to derive from the lack of overlap between these two areas rather than to measurement error.

The ISP as a variable

Examined next were data bearing on some of the possible effects of the ISP.

One group was sampled because they were known to have had an Individual Service Plan, and provision was made in this research to look into these clients' appraisals of that experience. These data were expected to provide the basis for a check of the potential differential effect of the ISP within the Study Group. That is, it was thought that within the sample of subjects who had had an ISP, the experience might emerge with different salience or valence that might mediate its influence on their functioning.

Ratings were made of the clients' understanding of the ISP: they were asked when the ISP had been formulated; their reactions to it were elicited and coded on a three-point scale from negative to positive; their descriptions of the ISP meeting and their accounts of who participated in it were also sought, along with their suggestions for improving the ISP process. Finally, clients were asked how helpful the ISP process had been: their responses were coded on a four-point scale.

The accounts offered by the twenty-three clients who had had an ISP confirmed the indications in the group comparative data that the ISP was a noteworthy experience for most subjects. The ISPs could be dated by only ten of the twenty-three subjects. Nine of these reported that the ISP had occurred more than a year previously. Thirteen of the subjects could not remember when the ISP occurred or gave no answer to the question. Similarly, only eleven subjects could name any participant in the ISP, so that slightly more than half of the respondents had no effective memory of the experience.

Clients' understanding of the ISP was probed through an invitation for them to state the purpose of the ISP and give a description of it. While some subjects were able to offer observations about the purpose of an ISP, indicating an awareness of the provision, few were able to describe its specifics.

Only three subjects provided reasonable descriptions, while fifteen offered no response to the inquiry. Only a minority of the respondents demonstrated a working grasp of the ISP process. Table 3 summarizes these data.

> Good understanding was assigned to such responses as "The ISP is a way of helping me work with my problems, at the same time helping me adjust to living in society and becoming more independent."
>
> Some understanding was assigned to such responses as "A plan for clients' needs that they need to work on so they can live better."
>
> Slight understanding was assigned to statements such as "Send me to Day Treatment."

TABLE 3

Ratings of Clients' Understanding of Purpose of ISP and Description of ISP Events

| Level of Understanding | Purpose of ISP | Description of ISP Events |
|---|---|---|
| Good Understanding | 6 | 1 |
| Some Understanding | 3 | 2 |
| Slight Understanding | 10 | 5 |
| No Understanding/ No Answer | 6 | 15 |

In spite of the limited understanding shown by the respondents, they were moderately positive in their appraisal of the ISP, as shown in Table 4.

TABLE 4

Clients' Ratings of the ISP

| Valence | Overall Evaluation of ISP | Degree of Helpfulness of ISP |
|---|---|---|
| Positive | 8 | 11 |
| Neutral | 3 | 1 |
| Negative | 1 | 2 |
| No Answer | 11 | 9 |

In view of the apparently limited grasp of the ISP displayed by most subjects, the dominantly favorable evaluations they offered probably represent some effort to meet their sense of what was expected. At least it is difficult to believe that a process beyond the memory and descriptive capacity of most subjects could have been so dominantly rated favorably. That interpretation is consistent with the finding that only six of the twenty-three respondents could offer even one suggestion to improve the ISP process.

The content of the suggestions made to improve the ISP indicate that only one subject had a clear understanding of the process and was able to clarify it descriptively: "I think the amount of time given the client to accomplish his/her goals should be lengthened, thus alleviating the pressure factor. Also, some sort of second choice should be discussed so that the client will feel satisfied if she/he does not meet his/her first choice." The remaining five subjects so personalized their responses that it was difficult to judge their grasp of the total ISP process:

> "More contact with my family."
> "More people on the staff."
> "A talk with the doctor."
> "Starting Day Treatment."
> "Correct it. They did darn good for me and
> I'm proud."

The foregoing data failed to support any belief in the widespread significance of the ISP as an aspect of the client's service experience. However, some clients clearly related to aspects of the ISP and demonstrated an appreciation of it. In order to learn whether the ISP might have differential within-sample implications for these subjects, an attempt was made to discriminate those clients showing fuller understanding and those showing more limited understanding of the experience. Toward this end, the data were reanalyzed and summarized by subject in the form of index scores. Use was made of the natural breaking point in the resulting distribution to distinguish those showing best overall understanding from those showing more limited or no understanding of the ISP process.

Index scores were derived by summarizaing six items on the Client Experience Survey. These were the following:

Level of understanding of the ISP
Ability to identify any participant in the ISP meeting
Capacity to describe an ISP meeting
Offering any suggestions for improving the ISP
Offering an overall appraisal of the ISP
Commenting on the helpfulness of the ISP

A simple presence or absence categorization was used on the aforementioned items (0=absence; 1=presence), except for the level of understanding of the ISP and the capacity to describe an ISP. Those items were scored on a 0-3 scale from no response to good response. Intermediate ratings were given as follows:

1 = subjects who offered any statement that showed an attempt to relate to the question
2 = a relevant but highly personalized response, such as stating only a specific service offered to them
3 = more adequate descriptions which showed reasonable understanding of the ISP

The obtained index scores spanned almost the entire theoretical range of 0-10 as shown in Table 5.

TABLE 5

Distribution of Scores Reflecting Subjects' Familiarity with the ISP

| Score | Frequency |
|---|---|
| 0 | 2 |
| 1 | 4 |
| 2 | 4 |
| 3 | 2 |
| 4 | 4 |
| 5 | 0 |
| 6 | 2 |
| 7 | 3 |
| 8 | 1 |
| 9 | 1 |

*n* = 23

The seven subjects with distinguishably higher index scores (6-9) were identified as demonstrating a relatively good grasp of the ISP, while the remaining sixteen subjects with lower scores (0-4) were identified as evidencing a poor grasp.

The two groups were then compared in order to learn whether client-centered variables might help to explain some of the findings, particularly the lack of group-wide effects of the ISP on clients. Should the clients with the greatest grasp of the ISP show higher levels of social functioning and internal locus of control, some possible differential effects of the ISP might be identified.

On most variables, the two groups were found to be similar: the groups did not differ in composition by sex, age, number of hospitalizations, current living situation, problems seen by client, or services suggested to them. Descriptively, however, diagnosis differed prominantly. Among those most knowledgeable about the ISP, the diagnoses of Schizophrenia, paranoid type, Schizoaffective Schizophrenia, and Schizophrenia, residual type were most represented. These diagnoses accounted for 85.7 percent of that group, while only 12.5 percent of those subjects showing poor understanding were represented in those diagnostic categories. Conversely, 87.5 percent of the group showing poor understanding had been diagnosed as Schizophrenia, chronic-undifferentiated type, Bipolar Disorder, and Personality Disorder, while only 14.2 percent of those most knowledgeable about the ISP were so categorized.

While it is possible that the vigilance associated with paranoid states and the social withdrawal associated with chronic schizophrenia might explain some of the variability in subjects' grasp of the ISP, other diagnostic differences between the two groups do not appear to be related to the variable.

Surprisingly, high understanding was not associated with higher levels of social functioning, as rated on the Global Assessment Scale. In fact, the ratings of the more knowledgeable subjects ($\bar{X}$ = 38.57) was descriptively below that of the remaining subjects ($\bar{X}$ = 43.93). Those showing better grasp of the ISP revealed more internal locus of control (or a generalized expectancy that an individual has power over what happens to him/her), as measured by the Rotter I-E Scale ($\bar{X}$ = 9.55 for subjects with better understanding; $\bar{X}$ = 10.78 for subjects with poorer understanding). However, these differences were not statistically significant. Therefore, there is no reason to believe that knowledge of the ISP is associated with locus of control.

### The ISP and service efforts

The study included provision to learn whether or not the ISP was seen by service providers as strengthening their service efforts. Seventeen service providers, whose work made them familiar with study and contrast group subjects, were interviewed by the researcher and a specially trained master's level social worker. The instrument used was a structured interview, the purpose of which was to answer the question: Is there reason to believe that service providers at various levels of expertise found the ISP a useful tool to strengthen their work with clients?

The initial inquiry of these service providers was to determine how well each understood the ISP process. Each provider was asked to describe the ISP process in his/her own words. Since this segment of the interview was audio-taped (with the provider's permission), it was possible to have these responses rated independently by two master's level social work judges who showed independent unanimity in their ratings. Six components of the ISP were used as criteria for appraising the providers' descriptions:

1. Range of assessments for each individual client.
2. List of client's strengths and needs.
3. Service plan must meet client's needs while building on strengths, using existing services or requesting new services for the client.
4. Service plan must see that providers commit to serving the client.
5. Client should be involved in service plan development.
6. Time segments should be built into the plan and these should include an annual review.

Service providers who included all six components in their descriptions (n = 8) were rated as having excellent knowledge of the process. Providers who included five or four of the six components were rated as adequate in their understanding of the ISP process (n = 9). No respondent failed to mention less than four of the components. Interestingly, level of professional training did not seem to make much difference in the measured level of understanding of the ISP process, as noted in Table 6.

TABLE 6

Service Providers' Understanding of the ISP Process

| | Excellent | Adequate | Total |
|---|---|---|---|
| Ph.D. or Master's Level Clinicians | 4 | 4 | 8 |
| Program Directors | 2 | | 2 |
| Residential Manager | | 1 | 1 |
| BA Case Managers | 2 | 1 | 3 |
| Paraprofessional Workers | | 3 | 3 |
| Totals | 8 | 9 | 17 |

The foregoing data indicate that every service provider had a working familiarity with the ISP. Consequently, the data bearing on the contribution an ISP might make toward their work were examined next.

Service providers were asked next whether they had found ISPs helpful to them in their work with clients. As would be expected in response to an open question, the service providers used their own words and developed somewhat different themes but there was some underlying convergence in the judgments expressed.

Two of the respondents expressed enthusiasm. Both of these were paraprofessional support workers. The remaining fifteen service providers advanced qualified views, typically acknowledging both some advantages and costs of the ISP provision. The overall valence of the majority of respondents was neutral or moderately positive.

Recurrent negative themes in the comments of the service providers were as follows:

The ISP is static while clients' needs change rapidly
The ISP is time-consuming and expensive
The ISP imposes additional paper work on providers
The ISP points to service needs for clients beyond current resources

Positive themes were noted also:

The ISP collects useful background information about clients
The ISP promotes reexamination of long-term clients
The ISP helps to identify clients' needs
ISPs contribute to goal specification in service planning
ISPs can coordinate the work of different service personnel

The themes found in the providers' unstructured responses to the opening question in the structured interview reemerged in their later suggestions about how the ISP process might be improved. Only three respondents failed to advance some suggestions for change or revision of the ISP process and only two suggested that it be discontinued. Noteworthy were the following suggestions:

Simplify and reduce the demands on service providers to prepare and to participate in ISPs
Have less frequent ISP meetings
Narrow the range of participants in the process
Focus the ISP on shorter-range and/or more limited goals
Make goals more flexible to accomodate to the changing needs of clients
Simplify the format for the ISP document
Standardize the ISP throughout all the DMH areas

In the hope of learning more about the service providers' appraisals of the ISP, the providers were asked to identify the parts they noted as most and least helpful. In the free responses to this open question, a number of components were seen as helpful:

| | |
|---|---|
| Coordinating providers around treatment plans | (5) |
| The achievement of a comprehensive assessment | (4) |
| Development of program-specific treatment plans | (3) |
| Allocating responsibility for services | (2) |
| Mobilizing and inviting accountability of providers | (2) |
| The annual review | (1) |

Features seen as least helpful were as follows:

Problems in the format for identifying service goals (5)
Inconsistent components (3)
Lack of client participation (2)
Miscellaneous (e.g., static plan limited to existing resources; too ambitious; burdensome procedures) (4)
No answer (3)

Service providers were divided equally between those who reported no change in clients connected with the ISP and those who saw either slight or intermediate positive change. No respondent reported a great deal of positive change but also no respondent reported any negative effect on clients.

As shown in Table 7, service providers were divided evenly between those who thought the ISP made a modest positive contribution to the client's functioning and those who saw it as having no influence.

TABLE 7

Service Providers' Ratings of ISP Benefits to Clients and Service Providers

| | Changes in Clients as a result of ISP | Effects of ISP on Providers' Work |
|---|---|---|
| Positive | 8 | 11 |
| No change | 8 | 2 |
| Negative | 1 | 4 |

Descriptively, the respondents more frequently saw the ISP as contributing positively to their own work. And, while three service providers thought that the ISP interfered slightly with their work, no negative consequences for clients were reported. When asked if their work with ISP clients differed from their work with other clients, ten providers reported no difference, while seven reported some slight to moderate influence.

In the hope of learning more about the basis for variability in providers' appraisals of the ISP provision, the data were examined for interrelationships. Considered first were the responses of providers according to their overall understanding of the ISP process. No association was found between the service providers' rated level of understanding and their views of the helpfulness of the ISP to their clinical work, their estimate of changes in clients as a result of the ISP, or their appraisals of the effect of the ISP on their work with clients. Neither was there an association found between the level of understanding of the service providers and the cumulative frequencies reflecting their appraisals of all the foregoing variables.

Examined next were associations between service providers' responses and service provider characteristics. Service providers were divided by level of education (nine credentialed professionals versus eight other). No association was found between educational qualifications and rated level of understanding of the ISP, views about the helpfulness of the ISP in their work, judgments about changes in clients as a result of an ISP, or reports about the effects of the ISP on their work.

In looking across the data already examined, one notes that the majority of service providers stated that the ISP makes only a modest contribution to the well-being of clients. And, client data indicates that clients show little understanding of the ISP provision. Similarly, the ISP does not appear to have any measurable effect on subjects' locus of control or on the Global Assessment ratings assigned to each group. Therefore, it seems reasonable to view the ISP as offering no conspicuous immediate benefits to clients. And that formulation is congruent with the views expressed by service providers about the very limited impact of the ISP on clients.

### Responses of family members

Examined next were the family members' responses to a mailed questionnaire. Of the forty-six clients interviewed, forty (or 86 percent) agreed to permit the researcher to contact a "significant other" and willingly gave the name and address of that person. Two subjects in the ISP group and four subjects in the control group refused the request. All subjects who accepted the request named a family member as their "significant other." The overall response rate from the identified sample of forty relatives was 63 percent (ISP group, $\underline{n}$ = 14, 60.8 percent; control group, $\underline{n}$ = 15, 65.2 percent).

Table 8 indicates the distribution of responses from relatives to questions about whether or not there was regular contact with the client, knowledge of the client's problems, awareness of the services offered, and involvement of family members in service planning efforts for the client. Table 9 speaks to families' level of satisfaction with services offered to their relative.

No clear differences were found between the groups in the relatives' perspectives on services. While descriptively Table 8 indicates that non-ISP families showed a greater understanding of service plans, these individuals also expressed less awareness of client problem areas. And, while in greater contact with the client, the majority of both groups were not involved actively in service planning for their family member.

Descriptively Table 9 shows that there is a substantial variability of satisfaction expressed by both ISP and non-ISP families. Slightly more ISP families express a higher level of satisfaction than non-ISP families, however.

### TABLE 8

Family Members' Perspectives on Services

| | ISP Families ($n$=14) | | Non-ISP Families ($n$=15) | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| Regular Contact with Client | 13 | 1 | 15 | 0 |
| Knowledge of Client's Problems | 12 | 2 | 9 | 6 |
| Knowledge of Service Plans for Client | 6 | 8 | 10 | 5 |
| Involvement in Service Planning for Client | 2 | 12 | 2 | 15 |

### TABLE 9

Family Members' Satisfaction with Mental Health Services

| | ISP Families ($n$=14) | Non-ISP Families ($n$=15) |
|---|---|---|
| Highly Satisfied | 5 | 2 |
| Moderately Satisfied | 1 | 2 |
| Slightly Satisfied | 1 | 3 |
| Neutral | 3 | 3 |
| Slightly Dissatisfied | 1 | 1 |
| Moderately Dissatisfied | 1 | 2 |
| Highly Dissatisfied | 2 | 2 |

Noteworthy is that the majority of family members from both the study and the contrast groups answered the questionnaire somewhat perfunctorily. They appeared to use the occasion, however, to express at length their deep concerns about their mentally ill family member's problems, their wishes for specific treatment modalities for that family member, and their hopes to be more involved in the treatment planning process. Typical responses included comments as follows:

> "I have been in the dark for years about my daughter's problems even though she is supposed to be getting help from various agencies. I don't think they help her and all I can do is give her the love she needs."
>
> "My son is once again losing a staff member to whom he has become very attached. What is the matter with mental health services that they can't encourage staff to stay?"
>
> "Whatever plan is developed for my daughter *must* have continuity. This is rarely the case."
>
> "There are too many waiting lists for the few programs which exist."
>
> "There should be more research into mental health problems."
>
> "Programs are not individualized enough. Since my son is not motivated to attend the one day program offered to him, he just sits home withdrawing into himself."

The above comments emphasize the interest and the emotional involvement of those family members who took the time to respond to the questionnaire. Yet it is surprising that so few of them were involved in any way in the service planning efforts. Two of the four family members who were involved in service planning expressed high satisfaction with mental health services, while the remaining two indicated more moderate satisfaction. Importantly, however, not one was dissatisfied with service planning. Information such as this should be of interest to program planners who often need the political support of clients' family members in their service development efforts.

The foregoing data offer no evidence that the ISP is seen as a noteworthy influence on either the mental health client or his/her relative. Service providers' views support this finding, as their ratings indicate that the ISP offers no appreciable impact on their clients and makes only a modest contribution to their work. This contribution is cited by service providers as one which offers a conceptual framework through which a client's problems can be viewed in order to formulate an appropriate treatment plan. This framework may, in the long run, be of benefit to clients and their family members through fostering more thoughtful and organized work on the part of service providers.

# CHAPTER IV

## DISCUSSION

### Summary of major findings

1. The present project failed to reveal evidence that clients who had received an ISP benefitted from that experience in the areas examined. Clients who had received an ISP evidenced no greater knowledge of their problems and described no wider range of services available than clients without ISPs. Neither did clients with ISPs report using a greater range of services than other clients. The locus of control of clients was not systematically connected with the ISP nor did a rating of the clients' level of disability show such a connection.

2. There was no evidence that the ISP was associated with differences in the involvement of "significant others" with the client. The relatives of clients who had had an ISP evidenced no greater involvement with the client, or greater knowledge of his/her needs and problems, or of the services used by the client.

3. Service providers demonstrated substantial knowledge of the ISP procedures and variable appraisal of its influence on themselves and on their clients. The

service providers advanced qualified endorsement of the ISP primarily as a contribution to their own work.

## Appraisal of major findings

These findings derive from an exploratory study with small samples of respondents and restricted measurement of the variables taken for examination. Accordingly, it is reasonable initially to examine the plausability that the present study may have failed to detect real differences associated with the ISP. In the sample size used here only sharp differences between groups would emerge. While some of the minor descriptive differences between groups might achieve statistical significance were they to emerge consistently with larger samples, those differences would not be socially significant. For practical purposes the contribution of the ISP should be demonstrable in the sample size used here.

The two indices of impact of the ISP on the clients, Global Assessment scores and a measurement of the internal-external locus of control certainly do not exhaust the potential manifestations of the influence of the ISP on subjects. It is logically not possible to rule out the prospect that the ISP could have a direct influence on clients not measured here. However, the likelihood of that seems highly questionable in view of the very limited grasp of the ISP revealed in the study of these subjects.

That is, it is hard to imagine how the ISP could be a noteworthy influence on clients who could scarcely remember it or describe it.

The lack of evidence that the ISP constituted an influence on family members of the clients is even clearer. The absence of difference between the views of family members in the ISP or non-ISP group is consonant with the wide-spread non-participation of all family members in the ISP process.

The most interesting evidence about the influence of the ISP emerged in the service providers' examination of its contribution to their own work. Service providers showed good working grasp of the ISP and a constructively critical appraisal of its yield. It is possible that the modestly positive appraisal advanced by service providers may have under-represented its contribution to their work. The ISP was an imposed, time-consuming, additional responsibility added to an already burdened staff group. That the service providers tended to identify assets in this requirement seems more plausibly to reflect their appreciation of the benefits it brought along with its liabilities than reactive to the circumstances of the research and the measurement effort. The investigator lacked any authority over the service provider response. Indeed, the research more easily could have served as a safe vehicle for the expression of dissatisfaction with the provision were that the prevailing sentiment. Consequently, the moderately favorable valence in the providers' responses seems to reflect, at the very least, a qualified endorsement of the principles of the ISP.

No associations were found between the service providers' education-role and appraisals of the ISP. This finding suggests that the ISP relates broadly to a range of service providers rather than addressing particularly the agenda of an identifiable sub-group of them. In combination these findings justify the view that the ISP may constitute a general modestly constructive support for the work of staff at various levels.

### Sampling limitations

Unexamined in the present project is the potential contribution of the ISP to administrators, program analysts, and others charged with oversight of a complex service network. For example, personnel charged with the development of new services which might be identified by a review of a series of ISPs were not included in the study sample. Hence, the limited positive evidence supporting one function of the ISP is not to be taken as a comprehensive appraisal of all of its functions in mental health care.

It must be recognized, too, that the version of the ISP examined here occurred in the context of a sample of service providers and expressed only one construction among many possible constructions of ISP procedures. Therefore it is useful to consider the service provider population of which these staff members may be representative. In their educational backgrounds, experience and commitment, the service providers studied here appear to be similar to mental health personnel in many public facilities. While their work and views probably do not represent those that might be found in the very few advantaged training centers or facilities with major research missions, they do appear to represent workers in many of the publicly financed facilities charged with the provision of service to seriously mentally disturbed individuals.

The version of the ISP under examination is clearly not the only construction of ISP procedures. In fact, certain procedures followed by the respondents during the study period subsequently have undergone some revision. Specifically, subsequent to the data collection, revisions were made in the forms for organizing the ISP and the responsibility for developing the initial assessments was assigned to a team who could specialize in this work. Nevertheless, basic organizing principles, philosophy, and mission have been consistent enough to justify generalizations from the present study experience to other ISP programs.

Implications for policy makers

The present project was conducted with exploratory and descriptive aims. In view of the evolving and changing character of the ISP program, this limited level of research seems appropriate. Because one of the major contributions of such preliminary inquiry is to contribute to program development, it is reasonable to consider what clues were found here that might inform and strengthen the implementation of individual service planning. An obvious concern raised by the evidence collected here is whether more effective means might be found for involving both clients and their families constructively in the process. Perhaps some simplification in the explanation offered about ISPs to these participants would aid in their relating to the experience. And, perhaps service providers might underscore more actively in their subsequent work with clients the plans as eminating from the ISP meetings in which they and the clients took part. Perhaps smaller group meetings and an informal atmosphere would foster the clients' connection with the experience. Individual service planning may properly be thought of as a process rather than as an event and there is reason to expand as far as feasible all supports for the clients' participation in developing and using all relevant services. Viewed in this way, the clients' sense of command over his/her fate is probably more important than his/her knowledge of the details of an ISP, but an ISP may well serve to support the client's developing autonomy.

The comparability of the study and control groups in internal locus of control may be interpreted as negative evidence about the ISP or as positive evidence about the efficacy of service providers for expanding the client's autonomy. This formulation seems plausible in view of the service providers' report that their work on behalf of clients is independent of the ISP.

### Implications for service provision

The clearest effect of the ISP was on the service provider. This finding invites curiosity about the basis for the modestly positive reception service providers extended to this provision. What explains the qualified but nonetheless appreciative appraisal advanced by the service providers? One explanation for this derives from the view that service providers are a self-selected, caretaking population, who, in the main, bring seriousness of purpose and dedication to their work. They confront in mental illness refractory, somewhat unpredictable conditions over which we have, at best, limited influence.

That therapeutic zeal may be confounded by the course of a disability is thought to contribute to the high prevalence of burn-out among service providers. The ISP appears both to support the helper's wish to provide effective services and to focus that on practical targets. The ISP may help to bridge the gap between a general impetus to help and the opportunities for action in the real social world. It is certainly clear that the ISP shifts the focus of attention from the general (mental illness) to the specific (a particular client and his/her unique circumstances). The ISP thus has the potential for demystifying mental illness and for helping to reveal the underlying humanity of the person who falls in such a category. It reactivates the Meyerian perspective concerned with appreciating the humanness of the mentally disturbed. By focusing on planning and service provision, the ISP implicitly sustains a general optimism that constructive work is possible with psychologically damaged individuals.

It is probably no accident that the ISP has emerged recently as a manifestation of the evolving social-science-rehabilitative model. In its underlying assumptions, the ISP is entirely coherent with the philosophical posture under which care to the mentally disturbed currently is offered. In part the reception the ISP enjoys may derive from its consonance with other organizing and direction-giving views in the mental health field. One of the acknowledged contributions of the ISP to the work of service providers was that of coordinating and focusing the efforts of many people who were involved in service to a particular client. When provided under a strict medical model, mental health care would not need or perhaps benefit from such a provision. So the ISP appears to be not only a product of a revised model for service but, in addition, to have been mandated by the socialization of mental health care.

### Implications for further research

One of the findings from the present project was that clients, their family members, and service providers are recruitable to studies of their experiences and are effective informants about these experiences. Hence efforts to learn more about service efforts and their effects can count on receptive participation by respondents. It is thus possible to recommend that additional studies of service efforts and service transactions be undertaken.

This project used a cross-sectional study strategy. Another study might benefit from a longitudinal strategy that would collect information from patients, their families, and service providers at several points in time in order to trace converging processes of caregiving, support, and readaptation. A case study approach might reveal more about the place of individual service planning and other influences in the patient's career.

The here unstudied consequences of individual service planning for program and resource development certainly invite examination. At an exploratory level, it would appear easy to collect some of the experiences of administrators in tapping ISP data for their planning efforts. Or, more systematic study might examine the content of a series of ISPs in order to identify needed but absent service resources and report such findings to the responsible administrative staff.

As alternative versions and procedures for implementing ISP provisions evolve, opportunities for comparative study of the yield of different approaches will be available. On theoretical grounds, the effects of different approaches to the ISP on the client's autonomy appear particularly inviting as a study topic.

### Concluding observations

Mental health personnel sometimes have been charged with fadism and conceptual or methodological promiscuity. Those charges probably index the clash between the lofty goals and the limited capacity or power of workers in the field. New provisions, such as the ISP, clearly are vulnerable to distorted over- or under-appraisal as hopes and realities contend. The limited efficacy of the ISP as a contribution to care demonstrated in this research will disappoint those who look to new procedures with the expectation that they may provide magical solutions. The ISP apparently falls far short of fulfilling any such hope. As the field of mental health matures, it should be possible increasingly to acknowledge and appreciate useful additions that contribute anything to the mental health field. If viewed in these realistic terms, there seems to be reason to develop and pursue the instrument studied here with an expectation that it may be a useful addition to the armamentarium of the service provider and possibly, with some modifications, to the clients and their families. The clues encountered in this exploratory inquiry invite efforts to extend versions of individual service planning efforts, to study them, to learn from the experience, and thereby to contribute to patient care. This investigation hopes that the present project will contribute to those efforts.

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# APPENDIXES

# APPENDIX I

## Definitions

# APPENDIX I

1. AREA - a specific geographic locale outlined by the Comprehensive Mental Health and Mental Retardation Services Act of 1966, meant to provide mental health and retardation services to a certain number of persons.
2. AREA DIRECTOR - the chief administrative Department of Mental Health staff person in each specific catchment area.
3. ASSESSMENT - the process of testing, information-gathering, and the making of a diagnostic judgment to determine a client's mental health and related needs.
4. CAPABLE IN FACT - not having been determined by a Primary Clinician to be incapable of making informed decisions regarding the conduct of one's personal and financial affairs.
5. CLIENT - a person of any age who is receiving or is in need of mental health services provided by the Department of Mental Health.
6. COMMISSIONER - the chief administrative officer of the Department of Mental Health.

7. CONTRACTOR - a program which receives funds either directly or indirectly through a contract with the Department of Mental Health to provide services, such as Day Treatment, sheltered workshop, residences.
8. DEPARTMENT OF MENTAL HEALTH - (DMH) an executive body, created by Chapter 735, the Comprehensive Mental Health and Mental Retardation Services Act of 1966, to provide services to the citizens of Massachusetts.
9. INCAPABLE IN FACT - used to describe a client who is not under guardianship but for whom it has been determined, as a result of a comprehensive assessment, that the conditions for appointment of a guardian exist. This client is considered unable to handle his/her own personal affairs.
10. INDIVIDUAL SERVICE PLANNING - regulations of the DMH promulgated in the western part of the state and meant to ensure that all mental health clients receive a comprehensive assessment and linkages to appropriate mental health treatment resources.
11. NORMALIZATION - the utilization of treatments (psychological, rehabilitative, behavioral) and/or living sites which are as culturally typical as possible,

in order to establish and/or maintain personal behaviors and characteristics which are as culturally typical as possible.

12. PRIMARY CLINICIAN - a qualified clinician who is a licensed psychiatrist, psychologist, clinical social worker with a Master's degree in social work, or a Registered Nurse who has had two years experience in a mental health setting.

13. QUALIFIED CLINICIAN - an individual, licensed or accredited in his/her profession as certified to provide mental health services. Examples are a licensed psychiatrist, psychologist, licensed social worker, or licensed registered nurse.

14. SERVICE COORDINATOR - a client's case manager; the qualified clinician who is responsible for developing and monitoring the client's service plan.

# APPENDIX II

## Data Collection Instruments

# SCHEDULE FOR REVIEW OF CASE RECORDS

NAME ______________________________ ID# ____________

AGE __________________ SEX __________________

PSYCHIATRIC DIAGNOSIS ________________________________

TOTAL NUMBER OF PSYCHIATRIC HOSPITALIZATIONS ____________

EDUCATION ______________________________

SOURCE OF INCOME ______________________________________

SERVICE COORDINATOR'S NAME ____________________________

SERVICES OFFERED ______________________________________

______________________________________

______________________________________

# CONSENT FORM

You are being asked to participate in a study about the Individual Service Plan (ISP) of the Department of Mental Health.

We will conduct this study by giving questionnaires to clients of the Westfield Area who have had ISPs and to clients who have not had ISPs.

As part of the study we will need to know what your service plan is and also to talk with some of the people who offer you service. We will also need to contact someone who knows you well and whom you authorize us to contact in order to find out if they understand your service plan.

If you agree to participate in our study, you will be given two questionnaires by your Service Coordinator who will help you to complete them.

Your confidentiality will be protected by our coding the information and filing it under lock and key. Your name will not appear anywhere in the study and any information you give us on the questionnaires will not be identified with you. No information will be given out without your permission, and all information will be destroyed when the study is completed.

No one will gain any financial benefits from this study. The purpose is to find out how satisfied people are with the ISP process.

Your decision to participate will not affect your relationship with the Department of Mental Health or with any of its agencies. If you agree to participate, you are free to withdraw at any time.

If you have any questions, please feel free to ask them. Your cooperation is entirely voluntary. By participating you will know that you have contributed to further understanding of how to help people to solve their problems.

Thank you.

____________________________
Date

____________________________
Signature of Participant

____________________________
Witness

If you wish a copy of the final report of this study, please check here __________

# DIRECTIONS - ISP STUDY

You will be given a Consent Form and two Questionnaires for your client to complete. The Consent Form must be signed by the client prior to administration of the questionnaires. The questionnaires do not have to be completed in one sitting. If you find that your client is easily distracted or upset, it might be best to finish the questionnaire at a later date. However, it is very important that all forms be returned to your Team Leader before July 15, 1983.

## CONSENT FORM

Please read the Consent Form to your client and then ask him/her to sign it. Then, sign the form yourself as "witness," and see that it is dated.

## CLIENT EXPERIENCE SURVEY (CES)

This is a one-page, two-sided form which should be self-explanatory. If you judge that your client can handle the CES by him/herself, please remain with him/her anyway to answer any questions and to look over the form after it is completed to see that all of the questions have been answered.

Should you judge that your client is unable to answer the form alone, please read the questions directly and write down your client's answers.

The open-ended questins are quite important and special attention should be paid to them in order to facilitate answers.

ROTTER'S INTERNAL-EXTERNAL SCALE (I-E Scale)

Please explain to your client that this is a second short questionnaire which is part of the same study, and that it is also meant to help the researcher make the ISP better.

Ask your client to underline the letter (a or b) next to the statement with which he/she agrees most. The client's choice should be spontaneous and not from careful thought. Therefore this questionnaire should take only a few minutes.

If your client cannot read or you judge that he/she cannot handle the questionnaire alone, please read aloud the questions and mark down the answers.

A typical question is:

a. There are certain people who are just no good.
b. There is some good in everybody.

Your client should underline either a. or b.

RETURN THE FORMS TO YOUR TEAM LEADER BEFORE JULY 15, 1983

Thank you very much for your help!

## CLIENT EXPERIENCE SURVEY

Name ______________

1. Current living situation (please check one)

_____Alone
_____With my parents (or brothers or sisters)
_____With my own family (wife or husband or children)
_____Nursing or rest home
_____Department of Mental Health supervised arrangement
_____Other (please specify)___________________________

2. What is the PRIMARY reason you are being seen at Westfield Area Community Support Services (WACSS)?

_____I have problems
_____My family told me to go
_____My doctor suggested it
_____I don't know
_____Other (please specify) ___________________________

3. People being served at WACSS have various kinds of problems. Which of the following do you have? (Check all that apply)

_____Housing
_____Employment
_____Physical health problems
_____Mental problems
_____Other (please specify) ___________________________

4. Which services have been suggested to help you with your problems? (Check all that apply)

_____Medication
_____Day treatment
_____Supervised living arrangement
_____Sheltered employment
_____Out-patient therapy
_____Service coordinator
_____Other (please specify) ___________________________

5. Who suggested these services?

_____Staff person at WACSS
_____Family member
_____Psychiatrist who is not at WACSS
_____Family doctor
_____Other (please specify) ___________________________

6. Of the services offered to you, which do you use?

____Medication
____Day treatment
____Supervised living arrangement
____Sheltered employment
____Out-patient therapy
____Service Coordinator
____Other (please speciify) ______________________

7. Please write in the space below your understanding of what an ISP is:

______________________________________________

______________________________________________

______________________________________________

8. Please write here the name and address of someone close to you whom you will let us contact for their understanding of the Individual Service Plan:

Name: ______________________________
Address: ___________________________
___________________________

IF YOU HAVE NOT HAD AN ISP, YOU ARE FINISHED.

IF YOU HAVE HAD AN ISP, PLEASE CONTINUE.

9. How long ago was your ISP meeting?

____Within the last 3 months
____6 months to 1 year ago
____More than 1 year ago
____Don't remember

10. Some people are pleased with their ISP meetings; some people are not. In general, what was your reaction?

____Positive feeling
____Negative feeling
____Indifferent feeling
____Confused feeling
____Other (please specify) ______________________

11. How helpful has your ISP been for you?

____Quite helpful
____Somewhat helpful
____Not helpful
____Useless
____Other (please specify) ______________________________

12. Who participated in your ISP meeting?

____You
____Family member
____Service coordinator
____Legal advocate
____Other(s) (please specify) ___________________________

13. Please write here in your own words what you recall happened at your ISP meeting.

____________________________________________________________

____________________________________________________________

____________________________________________________________

14. What do you think would improve the ISP process?

____________________________________________________________

____________________________________________________________

____________________________________________________________

THANK YOU FOR YOUR HELP

Name ____________

I-E Scale

1. a. Many of the unhappy things in people's lives are partly due to bad luck.

   b. People's misfortunes result from the mistakes they make.

2. a. One of the major reasons why we have wars is because people don't take enough interest in politics.

   b. There will always be wars, no matter how hard people try to prevent them.

3. a. In the long run people get the respect they deserve in this world.

   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

4. a. The idea that life is unfair to people is nonsense.

   b. Most people don't realize the extent to which life has been influenced by accidental happenings.

5. a. Without the right breaks one cannot be an effective leader.

   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

6. a. No matter how hard you try, some people just don't like you.

   b. People who cannot get others to like them don't understand how to get along with others.

7. a. I have often found that what is going to happen will happen.

   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

8. a. In the case of the competent worker, there is rarely if ever such a thing as an unfair evaluation.

   b. Many times evaluations tend to be so related to actual work that competence is not recognized.

9. a. Becoming a success is a matter of hard work. Luck has little or nothing to do with it.

   b. Getting a good job depends mainly on being in the right place at the right time.

10. a. The average citizen can have an influence in government decisions.

    b. This world is run by the few people in power, and there is not much the little guy can do about it.

11. a. When I make plans, I am almost certain that I can make them work.

    b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

12. a. There are certain people who are just no good.

    b. There is some good in everybody.

13. a. In my case getting what I want has little or nothing to do with luck.

    b. Many times we might just as well decide what to do by flipping a coin.

14. a. Who gets to be boss often depends on who was lucky enough to be in the right place first.

    b. Getting people to do the right thing depends upon ability; luck has little or nothing to do with it.

15. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand nor control.

    b. By taking an active part in political and social affairs the people can control world events.

16. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.

    b. There is really no such thing as "luck."

17. a. It is hard to know whether or not a person really likes you.

    b. How many friends you have depends on how nice a person you are.

18. a. In the long run the bad things that happen to us are balanced by the good ones.

    b. Most misfortunes are the result of lack of ability ignorance, laziness, or all three.

19. a. With enough effort we can wipe out political corruption.

    b. It is difficult for people to have much control over the things politicians do in office.

20. a. Sometimes I can't understand how supervisors arrive at the promotions they give.

    b. There is a direct connection between how hard someone works and the promotions a person gets.

21. a. Many times I feel I have little influence over the things that happen to me.

    b. It is impossible for me to believe that chance or luck plays an important role in my life.

22. a. People are lonely because they don't try to be friendly.

    b. There's not much use in trying too hard to please people. If they like you, they like you.

23. a. What happens to me is my own doing.

    b. Sometimes I feel that I don't have enough control over the direction my life is taking.

24. a. Most of the time I can't understand why politicians behave the way they do.

    b. In the long run the people are responsible for bad government on a national as on a local level.

September 23, 1983

Dear

Attached is a brief questionnaire which I hope you will take a few minutes to complete. It is part of my Doctoral Dissertation research.

Your name was selected as a friend or relative of who is included in my study and who has given me permission to contact you. The questionnaire you will answer is designed to tell us about the level of satisfaction that you as a friend or relative have with the planning of mental health services.

The information you give will be used only for this study. A code number will be assigned and your name will not be used. Your decision whether to participate will not adversely affect your friend or relative's treatment. But I hope very much that you will decide to participate, as I need your help in my effort to learn more about how to improve tretment planning for mental health clients.

A self-addressed, stamped envelope is provided for your convenience. I would very much appreciate your returning the questionnaire to me by October 15, 1983.

THANK YOU FOR YOUR HELP.

Barbara Miller, Researcher

October 24, 1983

Dear

Just about one month ago, I sent you a brief questionnaire which I hoped you would complete and return to me. Perhaps you just did not have the time then. I hope you won't mind my sending you another questionnaire with the request that you take those very few moments to complete it and send it back to me in the self-addressed, stamped envelope I have enclosed.

This questionnaire is part of my doctoral research. Your name was given to me by who is included in the study and who gave me permission to contact you. In this study I am interested in learning about how satisfied people are with mental health service planning.

Your name will not be used in this study. In fact you will be assigned a code number. The information you give will be used only for this study. It is entirely confidential. Your decision whether or not to participate will in no way affect your relative's or friend's mental health services.

I hope that you will decide to participate in this study. I need your help!

Won't you return my questionnaire by November 10, 1983?

THANK YOU VERY MUCH!

Sincerely yours,

Barbara Miller, Researcher

You have been selected as a family member or friend of

PLEASE CIRCLE

1. Are you in regular contact with this person? YES NO
2. Do you know the name of his/her Service Coordinator? YES NO
3. Do you have regular contact with the Service Coordinator? YES NO
4. Do you feel you know what your family member or friend's problems are? If YES, please summarize problems below. YES NO

5. Do you know what treatment plan has been suggested for your family member or friend? YES NO
6. Do you know what a formal INDIVIDUAL SERVICE PLAN is? YES NO
7. Have you ever been part of an INDIVIDUAL SERVICE PLAN meeting? YES NO
8. Do you have a copy of your relative's or friend's service plan? YES NO
9. What services has your relative or friend been offered? CIRCLE all services offered.
    1. Medication
    2. Out-patient Therapy
    3. Day Treatment
    4. Supervised Housing
    5. Sheltered Employment
    6. A Volunteer
    7. Other (please specify)

10. Do you think that your relative or friend should have been offered other services? CIRCLE the services you feel he/she should have been offered.

    1. Medication
    2. Out-patient Therapy
    3. Day Treatment
    4. Supervised Housing
    5. Sheltered Employment
    6. A Volunteer
    7. Other (please specify)

11. Are you satisfied with the services your family member or friend is receiving? PLEASE CIRCLE ONLY ONE STATEMENT.

    1. Very Satisfied
    2. Somewhat Satisfied
    3. A Little Satisfied
    4. Neutral
    5. Very Dissatisfied
    6. Somewhat Dissatisfied
    7. A Little Dissatisfied
    8. Other (please specify)

12. Do you have any suggestins to make treatment planning better for your family member or friend? If so, please tell us here.

## STRUCTURED INTERVIEW FOR SERVICE PROVIDERS (SISP)

1. Name ____________________________________________

2. Agency __________________________________________

3. Position ________________________________________

4. Have you been part of an ISP process? 1. Yes ___; 2. No _____

5. Will you describe the ISP process for me?
    1. Shows good understanding ____
    2. Shows some understanding ____
    3. Shows poor understanding ____
    4. Shows no understanding ____
    5. Other ____

6. In the main, do you feel that the ISP process has been helpful to you in your work with clients? Please explain your answer ...
    1. Very helpful ____
    2. Somewhat helpful ____
    3. Not so helpful ____
    4. Not helpful at all ____
    5. Other ____

7. Has the ISP process been helpful to clients: Please explain your answer...
    1. Very helpful ____
    2. Somewhat helpful ____
    3. Not so helpful ____
    4. Not helpful at all ____
    5. Other ____

8. Please specify the most helpful part of the ISP process as you see it.

9. Please specify the least helpful part of the ISP process as you see it.

10. Have you noticed any changes in clients as a result of an ISP?

    1. A great deal of positive change ____
    2. Some reasonable positive change ____
    3. Very little positive change ____
    4. No change ____
    5. Very little negative change ____
    6. Some negative change ____
    7. A great deal of negative change ____
    8. Other ____

11. Has the ISP process affected your work with clients?

    1. Greatly, in a positive way ____
    2. Somewhat, positively ____
    3. A small amount, positively ____
    4. No change ____
    5. A little negative change ____
    6. Great negative change ____
    7. Other ____

12. Is your work with ISP clients any different from your work with other clients?

    1. A great deal ____
    2. Somewhat ____
    3. Very little ____
    4. Not at all ____
    5. Other ____

13. Do you have any suggestions for changes in the ISP process?

# Global Assessment Scale (GAS) 3/1/78

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Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30), should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g., 35, 58, 62). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

Name of Patient ____________________ ID No. __________________

Group Code __________ Admission Date ___________________

Date of Rating ________ Rater ___________ GAS Rating: ________

100 Superior functioning in a wide range of activities,
life's problems never seem to get out of hand, is
sought out by others because of his warmth and
91 integrity. No Symptoms.

90 Good functioning in all areas, many interests,
socially effective, generally satisfied with life.
There may or may not be transient symptoms and
"everyday" worries that only occasionally get
81 out of hand.

80 No more than slight impairment in functioning,
varying degrees of "everyday" worries and problems
that sometimes get out of hand. Minimal symptoms
71 may or may not be present.

70 Some mild symptoms (e.g., depressive mood and mild
insomnia) OR some difficulty in several areas of
functioning, but generaly functioning pretty well,
has some meaningful interpersonal relationships and
61 most untrained people would not consider him "sick."

60 Moderate symptoms OR generally functioning with some
difficulty (e.g., few friends and flat affect, de-
pressed mood and pathological self-doubt, euphoric
mood and pressure of speech, moderately severe
51 antisocial behavior).

50 Any serious symptomatology or impairment in func-
tioning that most clinicians would think obviously
requires treatment or attention (e.g., suicidal
preoccupation or gesture, severe obsessional
rituals, frequent anxiety attacks, serious anti-
social behavior, compulsive drinking, mild but
41 definite manic syndrome).

40 Major impairment in several areas, such as work,
family relations, judgment, thinking or mood (e.g.,
depressed woman avoids friends, neglects family,
unable to do housework), OR some impairment in
reality testing or communicatin (e.g., speech is
at times obscure, illogical or irrelevant), OR
31 single suicide attempt.

30 Unable to function in almost all areas (e.g., stays
in bed all day) OR behavior is considerably influ-
enced by either delusions or hallucinations OR
serious impairment in communication (e.g., some-
times incoherent or unresponsive) or judgment
21 (e.g., acts grossly inappropriately).

20 Needs some supervision to prevent hurting self or
others, or to maintain minimal personal hygiene
(e.g., repeated suicide attempts, frequently
violent, manic excitement, smears feces), OR gross
impairment in communication (e.g., largely in-
11 coherent or mute).

10 Needs constant supervision for several days to pre-
vent hurting self or others (e.g., requires an
intensive care unit with special observation by
staff), makes no attempt to maintain minimal per-
sonal hygiene, or serious suicide act with clear
1 intent and expectation of death.

The Global Assessment Scale is a single rating scale for evaluating the overall functioning of a patient or subject at a specified time period on a continuum of psychological or psychiatric health-sickness.* The time period that is assessed is generally the last week prior to an evaluation, although for special studies a longer time period, such as one month, may be more appropriate.

The range of scale values is from 1, which represents the hypothetically sickest possible individual, to 100, the hypothetically healthiest. The scale is divided into ten equal interval ranges beginning with 1-10, 11-20, and ending with 81-90 and 91-100. The defining characteristics of each 10 point range comprise the scale. The two highest ranges, 81-90 and 91-100, are for those fortunate individuals who not only are without significant symptomatology, but exhibit many traits often referred to as "positive mental health," such as, superior functioning, wide range of interests, social effectiveness, warmth and integrity. The next range, 71-80, is for individuals with no or only minimal symptomatology but who do not possess the positive mental health features noted above. Although some individuals rated in the three highest ranges may seek some form of assistance for psychological problems, the vast majority of individuals in psychological or psychiatric treatment will be given rating in the range from 1 to 70. Most outpatients will be in the four ranges from 31 to 70, and most inpatients on admission will be in the four ranges from 1 to 40.

Because the scale covers the entire range of severity it can be used in any situation or study where an overall assessment of severity of illness or degree of health is needed. In most studies only a portion of the scale will be actually used. For example, community studies will rarely have individuals in the lowest ranges, whereas studies involving newly admitted psychiatric

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*The original ideas for a single rating scale of 1 to 100 for the health-sickness continuum with defined anchor points is embodied in Luborsky's Health Sickness Rating Scale. The Global Assessment Scale differs from it in the larger number of defined ranges, the avoidance of diagnostic considerations in defining anchoring points, and the use of brief clinical descriptions in the anchoring definitions.

patients will rarely have individuals in the highest levels. However, following a course of treatment, many individuals who may have been rated in a very low range on admission may be sufficiently recovered at follow-up to warrant a rating in one of the highest ranges. This is particularly true of patients with affective disorders whose functioning between episodes may be normal or even superior. It is also true that many patients given a diagnosis of schizophrenia during a period of personality disorganization, eventually recover and may later function at a relatively high level.

Since the ratings are for overall functioning during a specific time period, it is important that the rating be based on functioning and symptomatology during that time period and not be influenced by considerations of prognosis, previous diagnosis, or of the presumed nature of the underlying disorder. In a similar fashion, the rating should not be influenced by whether or not the patient is receiving medication or some other form of help.

The information needed to make the rating can come from any source: direct interview of the patient, a reliable informant, or a case record. Little information may be needed to make a rating at the low end of the scale. For example, knowledge that the individual made a serious suicidal attempt which almost resulted in his death is sufficient by itself to warrant rating a patient in the 1-10 range. On the other hand, before an individual can be given a very high rating it is necessary to not only determine the absence of symptomatology and any serious impairment in functioning, but also to ascertain the presence of signs of "positive mental health."

In making a rating one first selects the lowest range which describes the functioning during the one week time period. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "marked impairment in several areas" (range 31-40). Then the defining characteristics of the two adjacent ranges are examined to determine whether the subject is closer to one or the other. For example, a subject in the range 31-40 who is much closer to the 21-30 range than the 41-50 range should be given a specific rating of 31, 32, or 33. A subject who seemed to be equally distant from the two adjoining ranges would be given a rating of 34, 35, 36, or 37.

## GAS INSTRUCTIONS AND EXAMPLES

The GAS rating covers three major dimensions of psychopathology:

(1) Impairment in daily functioning;

(2) Reality testing;

(3) Potential for suicide or violence.

In making the rating one should take into account both the degree of pathology and the urgency of the need for treatment.

## SCORES 81 AND ABOVE:

This range describes overall functioning at a superior level. It is for those fortunate individuals who, during the period under study, are differentiated from most of us ordinary folks by a number of extraordinary positive qualities. Evidence should be present that the individual is functioning at a "superior" level in the areas of work, social and leisure activities and in interpersonal relationships. The high level of functioning is seen by the individual's involvement in a greater range of activities than the average individual, and involvement in depth in at least one social activity. They are often viewed by the other members of the community as leaders and may be sought out by others for advice. These individuals are successful in their work situations, but are not "workaholics." Their interpersonal relationships, within and outside of the family, are superior. They are empathic and understanding of other people's problems and willing to devote time and energy to problems that are of no immediate, personal benefit to themselves.

91-100: Superior functioning in a wide range of activities; life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity. No symptoms.

This range is reserved for the above described individuals who continue to function in this superior manner, whatever the stresses of daily living.

81-90: Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "everyday" worries that occasionally get out of hand.

This range includes those superior individuals who may have occasional transient symptoms and "everyday worries" that get minimally out of hand. An example of this would be the successful businessman, functioning in a superior manner as described above, who has several sleepless nights and/or mild symptoms of anxiety associated with a potential "take-over" bid, or symptoms of depression when confronted with the death of a loved one, but who rapidly resumes his "superior" functioning.

SCORES 61-80:

This range describes the ordinary adequate functioning of most individuals who are not currently ill and have no more than mild symptoms or slight impairment.

71-80: No more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

These individuals may be involved in many activities outside their work and family setting, and have a wide range of friends and interests, but there may be evidence that this functioning is at a cost in other areas, for instance in family relationships. Individuals who function at a superior level, but who display personality traits that are minimally disturbing to others should be rated here. Individuals in this range may have symptoms such as anxiety, depression or irritability in response to problems they encounter, but these symptoms are at a minimal level and do not persist. Such individuals rarely seek professional psychiatric help for problems, which they handle themselves or within the circle of their family and friends. These individuals are not considered ill by their peers.

61-70: Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick."

This range includes some otherwise healthy individuals who may seek out professional advice for specific problems. Symptoms, when they occur, tend to be subjective and unnoticed by their friends and family, until they are specifically complained about, e.g., the college student who is plagued by self-doubt despite an A average and good interpersonal relationships. Meaningful interpersonal relationships exist within and outside of the family. Stress producing situations lead to a level of symptoms acceptable to others as "normal." Mild personality disorders may exist, but would not be considered "pathological" by the average person, e.g., the passive-aggressive person who may drive his employer wild, but does enough work to avoid being fired and gets along pretty well with his family.

SCORES 31-60:

Scores below 60 should be reserved for those individuals whose impairment or need for treatment is apparent to people who know them well. The 31 to 60 range includes many patients who have not returned to their previous healthy level of functioning after an illness.

51-60: Moderate symptoms OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

This range describes many patients who are stabilized on medication. Examples are:

1. A chronic schizophrenic, maintained on phenothiazines, who is socially isolated and has a flat affect, but displays no psychotic symptoms and is able to continue working and maintain contact with his family.

2. A very mild "high" in a lithium-stabilized "manic." His behavior causes some tension in his family and at work, but is not severe enough to require hospitalization. The patient is somewhat grandiose, staying up late at night making plans, but with no pressured speech or hyperactivity.

This range also includes many patients who come for outpatient treatment. Examples are:

1. A recently divorced woman who is mildly depressed, having some difficulty handling her children and anxious about having to return to work, but with help is managing to cope with household responsibilities and go job hunting.

2. A reluctant teenager, brought in by her family. She often skips school to smoke pot and goes on shoplifting expeditions with friends, but is managing to pass her courses and to avoid major blow-ups at home.

41-50: Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention, (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

This range includes many patients who seek outpatient treatment, and some hospitalized patients. Examples are:

1. A patient with a full depressive syndrome who is managing to continue working and seeks treatment because he is frightened by thoughts of suicide.

2. A patient with the full manic syndrome who is immensely annoying to others, but has enough judgment to stay out of trouble, and is not sick enough to be involuntarily hospitalized.

3. A currently hospitalized patient who has been depressed and delusional, and is now much improved, enjoying weekends at home, no longer delusional, but still has low energy, impaired concentration, some insomnia, and is not yet ready to contemplate going back to work.

A rating below 41 should be given to anyone who has made a serious suicide attempt, regardless of his functioning prior to the attempt. The rater must use his own clinical judgment to determine how close to death the patient was and how likely he is to try again, taking into account the weapon, the degree of premeditation, the likelihood that the attempt would have been discovered, etc.

31-40: Major impairment in several areas, such as work, family relations, judgment, thinking or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), OR single suicide attempt.

The 31-50 range would include the following examples:

1. A severely depressed man who has recently stopped going to work because his concentration is so poor that he feels he can no longer do the work. He is not suicidal.

2. A housewife with the full manic syndrome who is brought to the hospital by her irate husband after giving all her clothes away to the Salvation Army and buying a new $500 wardrobe.

3. A young woman who has been functioning very well in all areas, but after receiving a "Dear Jane" letter from her boy friend takes 10 seconals in a suicide attempt, writes a "farewell" letter and is discovered fortuitously by a friend. After recovery she appears still depressed but no longer suicidal.

4. Ex-patient who holds a job, functions apparently normally, but has a fixed delusion for many years that she is employed by the CIA to foil Communist attempts to poison the water supply. She does not talk spontaneously about the delusion, but when asked states that she is "waiting for the proper circumstances" to act on it.

SCORES 30 AND BELOW:

21-30: Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication, (e.g., sometimes incoherent or unresponsive) or judgment (e.g., acts grossly inappropriately).

This range includes patients who may need to be protected from the possibilities for self-harm which exist outside of the hospital, but do not need continuous supervision. Examples are:

1. A chronically depressed woman who made careful suicide plans, taking a room alone in a motel for the weekend, and beginning to swallow one by one a bottle of 50 nembutal. She took about 20 of the pills, became nauseous and vomited them, then called her husband to come and get her because she could neither continue living nor kill herself.

2. A manic patient with flight of ideas and extreme hyperactivity who climbs onto the lunch table at a midtown restaurant, removes his clothes and exhorts fellow diners to do likewise because clothes are a barrier to communication.

3. A severely depressed man who leaves home and seeks asylum in a church because he believes that his family are all dead and the people living in his house are actually imposters.

4. A chronically ill, unemployable man who lives with his mother and spends almost all of his time in his bedroom drinking beer.

<u>11-20</u>: <u>Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (e.g., largely incoherent or mute</u>).

Examples are:

1. A patient is brought into hospital with a history of repeated suicide attempts. The family are progressively uncertain that they can control the suicidal activity and are concerned that one of the gestures may become successful. The immediate precipitating action was when the patient went into the kitchen and got the bread knife to cut her wrists and when she was restrained, tried to use the bread knife on her daughter.

2. A manic man is picked up by the police after 5 days with no sleep during which he has spent day and night wandering through a dangerous Black ghetto preaching a gospel of white supremacy and has twice been attacked and beaten by the neighborhood teenagers.

3. A disheveled woman is brought into the Emergency Room by the police when she is found wandering into heavy traffic. She is almost incoherent but mumbles that she must go where the voice of God tells her to go.

1-10: Needs constant supervision for several days to prevent hurting self or others, or makes no attempt to maintain minimal personal hygiene (e.g., requires an intensive care unit with special observation by staff), OR serious suicide act with clear intent and expectation of death.

Examples are:

1. A depressed patient is brought to the ER unconscious after a drug overdose. Three days later on the psychiatric ward he is discovered by the nurse attempting to hang himself in the bathroom. The following day he is discovered trying to slash his wrists with the sharp point of a broken plastic spoon.

2. A manic patient in constant frenzied activity, shouting incoherently, banging himself against walls of the seclusion room and assaulting anyone who enters.

3. A priest who believes that he has to repeat the Crucifixion of Christ for his own salvation is discovered to have nailed himself to a cross by putting nails through both his ankles and one wrist. On admission, he states that he is dying and asks for a glass of water, then becomes mute and lies on his bed in a totally unresponsive manner. He is incontinent of urine and feces and refuses to eat.

4. A teenager writes a suicide note to his parents, then drives his convertible into a stone wall, and survives with only minor injuries.

# APPENDIX III

## Individual Service Plan Regulations

## 104 CMR: DEPARTMENT OF MENTAL HEALTH

## Appendix III

## 104 CMR 16.00: INDIVIDUAL SERVICE PLANNING

Section

### 16.01: Scope and Purposes

(1) Scope. This chapter, 104 CMR 16.00, applies to all mental health services operated by the Department or receiving Departmental Financial Assistance within the Department of Mental Health Region I.

(2) Purposes. The purposes of this chapter, 104 CMR 16.00 are:

(a) to set forth the standards by which an individual may request and receive mental health services;
(b) to set forth the standards by which an individual is determined to need a comprehensive assessment;
(c) to set forth the standards by which an individual, as a result of a comprehensive assessment, is determined to need Service Coordination and an Individual Service Plan (ISP);

(d) to set forth the standards by which an individual receives a program specific treatment plan for each mental health service provided;
(e) to set forth the standards by which every Individual Service Plan and its component program specific treatment plans are monitored and reviewed on a periodic basis;
(f) to set forth the standards by which an individual may appeal the provision or denial of mental health services;
(g) to ensure that the Department provide, purchase, arrange, monitor, and coordinate services which are, to the maximum extent possible, adequate, appropriate, consistent with the client's needs and least restrictive of the client's freedom;
(h) to ensure that mental health services are planned and provided in an individual, rational, and fair manner with fullest possible participation of the client;
(i) to set forth the requirements for the establishment of procedures for individual service planning and development.

(3) Interpretation. The intent and meaning of all words, phrases and provisions of these regulations and the determination of compliance with these regulations shall be solely within the authority of the Department.

(a) The requirements set forth in these regulations are intended to be consistent with all licensing requirements for qualified clinicians and shall be so interpreted;
(b) This Chapter, 104 CMR 16.00 shall be interpreted to permit in exceptional circumstances variations from specific requirements for individual service planning in accordance with procedures established under 104 CMR 16.00 (2) (d) 7.;

1. There shall be no variations which:
(a) restrict the client's right as specified in this chapter to be represented by an attorney or advocate;

(b) restrict the client's right as specified in this chapter to be given a copy of the client's Individual Service Plan;
(c) restrict the client's right as specified in this chapter to participate to the fullest extent possible in the individual service planning process;
(d) restrict the client's right as specified in this chapter to appeal;
(e) are not consistent with all statutory and constitutional rights and privileges; and
(f) are not in the best interest of the client;

2. Each variation, except those agreed to by the client or legal guardian, if any, shall be reported in writing within five days by the primary clinician to the Area Director. Included in such report shall be a specific description of the variation and the exceptional circumstances which justify the need for the variation.

## 16.01: Components of Service Planning: General Provisions

Service planning for all individuals requesting or receiving mental health services subject to this chapter shall include one or more of the following components depending on the assessed needs of the individual:

(1) Initial Screening.
(a) Each individual, upon request for mental health services, shall receive an initial screening in accordance with 104 CMR 16.03;
(b) As a result of the initial screening, if the individual is determined to need mental health services he or she shall be referred to the appropriate mental health program unless the individual is determined on the basis of the initial screening to need a comprehensive assessment as provided for in 104 CMR 16.04.

(2) Comprehensive Assessment.
(a) An individual shall receive, with consent, a comprehensive assessment if needed as determined either by an initial screening or by the program specific treatment planning process provided for in 104 CMR 16.07;
(b) As a result of the comprehensive assessment, the individual shall be referred to the appropriate mental health program unless the individual on the basis of the comprehensive assessment is determined to need Service Coordination.

(3) Service Coordination and Individual Service Plan
(a) A service coordinator shall be appointed for each person who is found on the basis of the comprehensive assessment by a primary clinician to need an Individual Service Plan as provided for in 104 CMR 16.05;
(b) The service coordinator shall assist the primary clinician in ensuring that an Individual Service Plan is fully developed and carried out in accordance with 104 CMR 16.05 through 16.09.

(4) Program Specific Treatment Plans.
(a) Each individual in a mental health program shall have a program specific treatment plan formulated and carried out in accordance with 104 CMR 16.07;
(b) If determined to need a comprehensive assessment as a result of the program specific treatment planning process provided for in 104 CMR 16.07, an individual shall be referred for a comprehensive assessment.

## 16.03: Initial Screening

(1) General Provisions.
(a) All individuals requesting mental health services shall receive an initial screening at a program or site designated under 104 CMR 16.10 (2) (a);
(b) The initial screening shall be conducted within five days of such request and shall determine whether:

1. the individual needs mental health services;
2. the individual needs a comprehensive assessment;

3. the individual needs interim services;
4. the individual is in the correct area of meaningful tie.

(2) Components of the Initial Screening.

(a) The initial screening shall consist of, at a minimum, a personal interview by a qualified clinician to gather information in the following areas:

1. Identifying data;
2. Reasons for requesting mental health services, including present level of functioning;
3. History of mental health treatment;
4. Medical history;
5. Personal and family history, including history of mental illness.

(b) Indicators which shall be considered by the qualified clinician as strongly suggestive of an individual's need for a comprehensive assessment include whether:

1. The individual has been hospitalized at least sixty days within the previous twelve months in a mental health in-patient unit; or
2. The individual has chronic or severe emotional problems which might result in either hospitalization, severe limitations or decompensation in functioning in major areas of life, such as holding down a job consistent with a person's level of training and skills, relating to other people, or managing the activities of daily living; or
3. A comprehensive assessment report is necessary for treatment planning, whether or not the client is likely to need Service Coordination or
4. The individual is likely to need Service Coordination in accordance with 104 CMR 16.04 (2) (e).

(3) Results of the Initial Screening.

(a) If the individual is determined to need mental health services and to need a comprehensive assessment, he/she shall be referred for a comprehensive assessment within five days of such determination in accordance with procedures established under 104 CMR 16.10 (2) (d) 3;

(b) If the individual is determined to need mental health services but not a comprehensive assessment he/she shall, with consent, be referred to the appropriate mental health program(s) within five days of such determination in accordance with procedures established under 104 CMR 16.10 (2) (d) 2. Subject to the requirements of any applicable contract with the Department, the Service Provider may:

1. accept the client and then the client shall receive a program specific treatment plan in accordance with 104 CMR 16.07; or
2. reject the client and the service provider shall, in every case, inform the qualified clinician who performed the initial screening within five days of such rejection. The qualified clinician shall refer the client to another mental health program, if appropriate, in accordance with procedures established under 104 CMR 16.10 (2) (d) 2.;

(c) If the individual is determined to need interim services, he/she shall, with consent, be referred to such services in accordance with procedures established under 104 CMR 16.10 (2) (d) 6. Subject to the requirements of any applicable contract with the Department, the service provider may:

1. accept the client and then the client shall receive a program specific treatment plan, if appropriate, in accordance with 104 CMR 16.07; or
2. reject the client and the service provider shall, in every case, inform the qualified clinician who performed the initial screening within five days of such rejection. The qualified clinician shall refer the client to other interim services, if appropriate, in accordance with procedures established under 104 CMR 16.10 (2) (d) 6.;

(d) If the individual is determined not to need mental health services, he/she shall be informed of:

1. the availability of assistance in obtaining other services in accordance with procedures established under 104 CMR 16.10 (2) (d) 9.; and
2. the right to appeal the denial of services;

(e) If necessary the individual shall be referred to the correct area of meaningful tie in accordance with procedures established under 104 CMR 16.10 (2) (d) 2.

## 16.04: Comprehensive Assessment.

(1) General Provisions.

(a) All individuals referred for a comprehensive assessment shall be interviewed for a comprehensive assessment at a program or site designated under 104 CMR 16.10 (2) (b);

(b) If the client is referred for a comprehensive assessment, he/she shall be assessed at the direction of a primary clinician in accordance with procedures established under 104 CMR 16.10 (2) (d) 4.;

(c) The primary clinician directing the comprehensive assessment shall also be the primary clinician for purposes of Service Coordination for clients with an ISP unless unusual circumstances prevail in accordance with procedures established under 104 CMR 16.10 (2) (e) 1.;

(d) The primary clinician may include other persons in the assessment process as appropriate to ensure its comprehensive quality in accordance with procedures established under 104 CMR 16.10 (2) (d) 5.;

(e) The primary clinician shall include a service coordinator in the assessment process as appropriate in accordance with procedures established under 104 CMR 16.10 (2) (e) 2.;

(f) The comprehensive assessment shall determine the actual needs of the client rather than basing need on the availability of specific services;

(g) Within 5 days of referral for a comprehensive assessment, the primary clinician shall initiate the comprehensive assessment process with the client's consent;

(h) Within 30 days of the initiation of the assessment, the primary clinician shall be responsible for:

1. completing the comprehensive assessment;
2. preparing an assessment report which contains the findings of the needs identified by the comprehensive assessment; and
3. referring the client to interim services, if needed;

(i) Inability to complete the comprehensive assessment within thirty days shall be allowed if;

1. the client fails to keep an appointment for assessment; or
2. the need to obtain outside assessments delays the timely completion of the comprehensive assessment; and
3. the extension does not exceed the number of days incurred by the delay.

(2) Methodology and Purpose of the Comprehensive Assessment.

(a) To initiate the comprehensive assessment the client shall be personally interviewed by the primary clinician to confirm that the client needs a comprehensive assessment based on the indicators for a comprehensive assessment under 104 CMR 16.03 (2) (b):

1. if confirmed that the client needs a comprehensive assessment, the primary clinician shall proceed with directing the assessment; or
2. if determined that the client does not need a comprehensive assessment, he/she shall, with consent, be referred for services in accordance with procedures established under 104 CMR 16.10 (2) (d) 2.;

(b) In order to assess a client, both primary and secondary sources may be utilized. The comprehensive assessment shall consist of, at a minimum, the personal interview. Appropriate assessment methods include:

1. personal interview, and group interview;
2. observation;
3. testing and utilization of other standardized diagnostic measures;
4. analysis of reliable previously generated case history, record, tests and other

assessments, which are accessible under 104 CMR 16.03 (9);

5. use of information from family, friends and other associates as appropriate.

(c) Assessments should take into consideration, as appropriate, past and present conditions, strengths and weaknesses, and other existing service plans for the individual;

(d) The assessment shall be conducted in order to form a profile of the client's identifiable mental, emotional, social and behavioral patterns analyzed within a psychodynamic framework;

(e) Indicators which shall be considered by the primary clinician as strongly suggestive of an individual's need for Service Coordination include whether:

1. the client's assessed strengths and weaknesses indicate more than one service need which would then require Service Coordination; or
2. the assessment reflects a past history of psychiatric care showing use of multiple mental health services with the indication of little or no continuity of care; or
3. an area has sufficient linkages among services to ensure that even without a service coordinator, services are consistent and communication is adequate to meet the client's needs; or
4. for any other reason an individual is determined to need Service Coordination.

(f) The primary clinician shall conduct an exit interview with the client upon completion of the comprehensive assessment. This exit interview shall include at a minimum:

1. a summary of the findings of the assessment;
2. an explanation of the client's rights, including the right to appeal;
3. the offer to provide the client with a copy of the assessment report, if requested; and
4. an explanation of the ISP process if the client has been determined, as a result of the comprehensive assessment, to need Service Coordination.

(3) Areas of Assessment. Assessment shall be conducted in the following areas:

(a) Mental Health Status: including at least:

1. cognitive functioning, including attention, memory, information processing, problem solving;
2. affect, attitudes, self-image, emotional stability;
3. interpersonal relations, social adjustment, interests.

(b) Social Setting: including an evaluation of the client's neighborhood, community, family, and key support persons in the client's life;

(c) Health: including an evaluation of the client's medical and dental condition;

(d) Daily Living Skills: including identification of skill level in the following areas, as appropriate:

1. personal care and grooming, nutrition and food preparation, domestic skills;
2. health maintenance, hazard recognition and avoidance, following a prescribed treatment program of medication;
4. communication skills, functional reading, use of telephone, asking assistance.

(e) Vocational Skills: including history or evaluation, as appropriate, of vocational and occupational readiness skills and interests, employment record, and the client's current Individualized Written Rehabilitation Program (IWRP), if any;

(f) Education and Training: including history or evaluation, as appropriate, of the client's educational background or schooling, current education plan or Individual Education Plan (IEP), if any;

(g) Legal Status: consistent with the standards set forth in 104 CMR 16.03 (10) including but not limit to identification of:

1. where the client is under 18 years of age, parent or legal guardian;

2. where the client is under court-appointed guardianship, the court and time of appointment of the guardian, the whereabouts of the person named as guardian, and the scope of the guardian's authority;
3. where the client is receiving any Social Security of Supplemental Security or Veteran's Administration Benefits which are subject to the control of a representative payee, the specific agency and office with responsibility the representative payee named;
4. where the client is a beneficiary of a trust, the court, if any, with responsibility for overseeing the operation of the trust and whereabouts of the trustee;
5. whether the client is capable in fact, as defined in 104 CMR 16.02 (10);
6. the need of the client for guardianship, conservatorship, representative payee or other protective services.

(h) Resource Availability: including identification of actual or potential public and private resources which are available to or for the client or to which the client may be entitled under any local, state or federal law or regulations including:

1. income maintenance programs, such as Supplemental Security Income, Social Security Disability Insurance Benefits (Disabled Worker or "adult child" benefits), Workman' Compensation, Unemployment Compensation, Veterans' Administration Benefits, Veterans' Services Benefits, and General Relief;
2. health care benefits, such as Medicaid, Medicare, individual, group, or family health insurance;
3. housing assistance, such as public housing eligibility, rental assistance, subsidized housing;
4. education/vocational services, such as special education, vocational rehabilitation services, employment counseling and placement services, special training and placement;

5. Social Services, including those under Title XX and those administered by private social service agencies and state and local agencies such as the Department of Public Health, the Department of Public Welfare, the Department of Social Services, the Department of Elder Affairs, and the Massachusetts Rehabilitation Commission for the Blind.

(4) Content of the Assessment Report. Within 30 days of the initiation of the comprehensive assessment unless an exception specified in 104 16.04 (1) (i) applies, the primary clinician shall be responsible for the preparation of the assessment report which shall include:

(a) identification of the client's strengths and weaknesses in each area of assessment;
(b) an analysis of the major findings of the comprehensive assessment, expressed as a clinical diagnosis which establishes a profile of the client;
(c) the client's needs, in terms of assessed strength and weaknesses without reference to existing resources;
(d) a statement of recommended long-range goals and treatment objectives, stated in specific and measurable terms with timelines, if feasible;
(e) present and recommended services, programs and service providers to meet each of the identified needs and recommended long-range goals and short-term treatment objectives;
(f) recommended timing for commencement of each service or date each service commenced;
(g) whether the client is capable in fact; and
(h) whether the client needs Service Coordination and an Individual Service Plan.

(5) Results of the Comprehensive Assessment.

(a) If it is determined by the primary clinician that the client needs Service Coordination;

1. a service coordinator shall be appointed, during or as a result of a comprehensive assessment in accordance with procedures established under 104 16.10 (2) (e) 2.; and
2. an Individual Service Plan shall be developed for the client, with the client's consent, in accordance with 104 CMR 16.05;

(b) If it is determined by the primary clinician that the client does not need Service Coordination, he/she shall, with consent, be referred for services in accordance with procedures established under 104 CMR 16.10 (2) (d) 2. Subject to the requirements of any applicable contract with the Department, the Service Provider may:

1. accept the client and then the client shall receive a program specific treatment plan in accordance with 104 CMR 16.07; or
2. reject the client and the service provider shall, in every case, inform the primary clinician who directed the comprehensive assessment within five days of such rejection. The primary clinician shall refer the client to another mental health program, if appropriate, in accordance with procedures established under 104 CMR 16.10 (2) (d) 2.;

(c) If it is determined during or as a result of a comprehensive assessment that the client needs interim services he/she shall, with consent, be referred to such services in accordance with procedures established under 104 CMR 16.10 (2) (d) 6. Subject to the requirements of any applicable contract with the department, the service provider may:

1. accept the client and then the client shall receive a program specific treatment plan, if appropriate, in accordance with 104 CMR 16.07; or

2. reject the client and the service provider shall, in every case, inform the primary clinician who directed the comprehensive assessment within five days of such rejection. The primary clinician shall refer the client to other interim services, if appropriate, in accordance with procedures established under 104 CMR 16.10 (2) (d) 6.

## 16.05: Individual Service Plan Development.

(1) General Provisions.

(a) The Individual Service Plan (ISP) shall identify services, programs and service providers based on:

1. the client's needs as identified in the comprehensive assessment; and
2. the availability of specific services;

(b) If needed services are not available, the ISP shall detail those available interim services which are:

1. to the maximum extent possible, adequate, appropriate consistent with the client's needs and least restrictive of the client's freedom; and
2. assigned according to the priority and need criteria under 104 CMR 16.06 (2) (b);

(c) The ISP shall be developed with the fullest possible participation of the client and his/her representative and legal guardian, if any;

(d) The ISP shall reflect goals and objectives of attaining the most self-fulfilling, age appropriate and independent style of living possible for the client;

(e) The ISP shall contain goals and objectives which are measurable, so as to permit meaningful evaluation of the progress toward attaining those goals and objectives;

(f) The ISP shall be written in language which can be easily understood by a lay person;

(g) The ISP shall be developed with fullest possible coordination with the IEP or other special service plans involving the client, if any;

(h) In developing the ISP, the primary clinician shall resolve all differences among service providers.

(2) Convening the Individual Service Plan Meeting.

(a) Within ten days of the completion of the assessment report, the primary clinician or designee shall convene an Individual Service Plan Meeting, with the client's consent. The primary clinician may appoint the service coordinator to perform this function;

(b) If difficulty in getting the parties together prevents the convening of the ISP Meeting within ten days of the completion of the assessment report then the meeting shall be convened within thirty days of completion of the assessment report, but no later than that;

(c) The following persons shall be invited by the primary clinician to attend the Individual Service Plan Meeting;

1. the client;
2. his/her designated representative, if any;
3. if the client is an adult, his/her legal guardian, if any;
4. if the client is under eighteen years old, his/her parent(s) or legal guardian, unless an exception specified in 104 CMR 15.03 (12) applies;
5. the service coordinator;
6. potential and present service providers; and
7. with client's consent, any other person who, in the judgment of the primary clinician, will contribute to the Individual Service Plan Meeting.

(3) Content of the Individual Service Plan Meeting.

The Individual Service Plan Meeting shall include an explanation and discussion of:

(a) The client's needs in terms of assessed strengths and weaknesses;

(b) Recommended long-range goals and treatment objectives;

(c) Potential and present service providers;

(d) Recommended dates for commencement of each service or date each service commenced;

(e) Completion and implementation of the ISP process and the development of its component program specific treatment plans;
(f) The means to ensure that services are provided in a coordinated and complementary manner; and
(g) The means for monitoring the effectiveness of services to be provided.

(4) Preparation and Distribution of the Individual Service Plan.
(a) Within ten days of the Individual Service Plan Meeting, the primary clinician or designee shall prepare and distribute the Individual Service Plan. The primary clinician may appoint the service coordinator to perform this function;
(b) The assessment report or relevant sections thereof and the Individual Service Plan shall be distributed to each service provider;
(c) The Individual Service Plan shall be distributed to the following persons:

1. the client;
2. his/her designated representative, if any;
3. if the client is an adult, his/her legal guardian, if any;
4. if the client is under the age of eighteen, his/her parent(s) or legal guardian, unless an exception specified in 104 CMR 15.03 (12) applies; and
5. the Area Director;

(d) Within 15 days of distribution of the Individual Service Plan, the client shall be contacted by the service coordinator concerning acceptance of the ISP, if there has not been acceptance prior to that date.

(5) Content of the Individual Service Plan. The Individual Service Plan shall include:
(a) The client's needs in terms of assessed strengths and weaknesses;
(b) Long-range goals and short-term treatment objectives, stated in specific and measurable term with timelines, if feasible;

(c) Available services, programs and service providers which are, to the maximum extent possible, adequate, appropriate consistent with the client's needs and least restrictive of the client's freedom;

(d) Dates for commencement of each service or date each service commenced;

(e) A description of means to ensure that services are provided in a coordinated and complementary manner;

(f) A description of the means for monitoring the effectiveness of services to be provided;

(g) A statement:

1. of the availability to the client of financial assistance and services from federal, state and local agencies;
2. as to whether the client, if legally competent, is capable in fact;
3. that if the client or client's guardian, if any, or service provider does not object to the Individual Service Plan within thirty days of receipt, he/she shall be deemed to have accepted the ISP, so that the services may be initiated in accordance with the ISP;
4. that upon acceptance of the ISP, services will begin according to the timetable in the ISP or as soon as practicable thereafter;
5. as to the availability of the primary clinician or designee to explain the Individual Service Plan; and
6. that the client or client's guardian, if any, has the right to appeal findings or recommendations in the Individual Service Plan within 30 days of receipt, in accordance with the appeals standards and procedures set forth in 104 CMR 16.11.

(6) The Individual Service Plan: Acceptance by the Client and Service Provider.

(a) Services shall be initiated with the agreement of both the client and the service provider(s);

(b) If the client or client's guardian, if any, does not object to the Individual Service Plan within thirty days of receipt, he/she shall be deemed to have accepted the ISP;

(c) If the service provider(s) does not object to the Individual Service Plan within thirty days of receipt, it shall be deemed to have accepted the ISP.

(7) The Individual Service Plan: Rejection or Partial Rejection by the Client.

(a) If the client or client's guardian, if any, reject some or all of the services identified in the Individual Service Plan, the service coordinator shall inform him/her of the right to meet with the primary clinician or designee within seven days of his/her rejection to discuss the plan and to suggest modifications or, in the alternative to appeal the Individual Service Plan under 104 CMR 16.11;

(b) If proposed modifications are suggested at the meeting between the primary clinician or designee and the client or client's guardian, if any, the primary clinician shall approve the proposed modifications and then present them to the service provider(s) for approval, as appropriate. If the matter is not resolved to the client's or guardian satisfaction, the service coordinator shall again inform the client of his/her right to appeal under 104 CMR 16.11;

(c) A client who rejects the ISP may, nevertheless, agree to accept some or all of the identified services pending the outcome of a meeting with the service coordinator or an appeal.

(8) The Individual Service Plan: Rejection or Partial Rejection by the Service Provider(s).

(a) If the service provider(s) does not accept the client and/or the Individual Service Plan, the service provider shall so inform the service coordinator in writing within thirty days of receipt of the Individual Service Plan;

(b) The service provider(s) must specify the reasons for partial or total rejection, and process modifications, if appropriate;

(c) The primary clinician may accept modifications proposed by the service provider and then present them to the client or client's guardian, if any, for approval;
(d) The service provider(s) may request a trial placement for a specified period of time in lieu of rejection of the client and/or Individual Service Plan.

## 16.06: Initiation of Services.

(1) General Provisions.
(a) The Area Director or designee shall be responsible for ensuring that adequate and appropriate service including interim services, are provided, purchased, or arranged, unless rejected or appealed by the client;
(b) The Area Director or designee shall ensure that services are provided, purchased, or arranged by;

1. providing the service at or through a facility operated by the Department;
2. contracting with a public or private agency licensed or approved by the Department or another agency of the Commonwealth;
3. arranging with another public or private agency for the provision of the service;

(c) Services shall be provided, purchased, or arranged;

1. with client's consent;
2. in accordance with priority of need criteria under 104 CMR 16.06 (2) (b); and
3. upon acceptance of the client and by the service provider.

(2) Determining Priority of Need.
(a) If the number of clients in need of a particular service exceeds the capacity of existing service providers, the Area Director or designee shall recommend services according to the severity of the client's need. The qualified clinician, conducting the initial screening or the primary clinician directing the comprehensive assessment may be the Area Director's designee(s) for the purpose of assigning priority of need.

(b) Priority of need determinations shall be based on the following criteria:

1. First Priority: A client whose current circumstances pose a substantial risk to the personal safety or physical or mental health of the client or others;
2. Second Priority: A client whose current placement is not adequate as defined in 104 CMR 15.02 (1);
3. Third Priority: A client whose current placement is not most appropriate and least restrictive as defined in 104 CMR 15.02 (4) and (26);
4. Fourth Priority: A client for whom any placement or alternative placement is desirable or necessary for any other reason.

(3) Determination of Availability of Services.

(a) Availability shall be determined on the basis of a review of all appropriate services within the area of meaningful tie;

(b) If no placements are available within the area of meaningful tie but are available outside the area, then the Area Director or designee shall, with the consent of the client and acceptance by the service provider, undertake to arrange for service outside the area.

(4) Non-Availability of Services. If a recommended service is unavailable or does not exist, then the Area Director or designee shall:

(a) Make a realistic projection as to when the service may become available;

(b) Recommend an available interim service which is, to be maximum extent possible, adequate, appropriate, consistent with the client's needs and least restrictive of the client's freedom; and

(c) Maintain a waiting list for services in accordance with procedures established under 104 CMR 16.10 (2) (d) 8.

## 16.07: Program Specific Treatment Planning and Periodic Review.

(1) General Provisions.

(a) Each program shall, within thirty days after initiation of service, develop a program specific treatment plan for each client;

1. if the client attends the program part-time, the program specific treatment plan shall be developed within thirty attendance days and no later than forty-five calendar days following initiation of service;

(b) If in the process of program specific treatment planning it is determined that the client needs a comprehensive assessment or additional evaluations which are beyond the program's capability to perform, the program director or designee shall immediately refer the client for such comprehensive assessment or additional evaluations in accordance with 104 CMR 16.10 (2) (d) (4) and (5);

(c) Where the client has an ISP, the program specific treatment plan shall be consistent with the ISP and the client's other program specific treatment plan. Upon completion a copy of the program specific treatment plan shall be sent to the primary clinician or designee;

(d) The program specific treatment plan shall be developed with the fullest possible participation of the client and his/her designated representative and guardian, if any;

(e) The program specific treatment plan shall reflect goals and objectives of attaining the most self-fulling, age-appropriate and independent style of living possible for the client;

(f) The program specific treatment plan shall contain goals and objectives which are measurable, so as to permit meaningful evaluation;

(g) The program specific treatment plan shall be written in language which can be easily understood by a lay person;

(h) The program director or designee shall convene and conduct a periodic review of the program specific treatment plan at least once within three months, then within six months after initiation of service and than at least annually thereafter in accordance with procedures established under 104 CMR 16.10 (2) (e) 4.;

(i) The client, or client's guardian, if any, shall be informed of the opportunity to discuss informally any part of the program specific treatment plan with the program director or designee;
(j) The program director shall provide a copy of the program specific treatment plan to the client or client's guardian, if any, upon request;
(k) The program director shall provide a written report of the periodic review to the client or client's guardian, if any, upon request;
(l) The client, or client's guardian, if any, may appeal provisions of the program specific treatment plan in accordance with the appeals procedure set forth in 104 CMR 16.11.

(2) Content of Program Specific Treatment Plan.
(a) The program specific treatment plan shall be based on the findings of the initial screening and comprehensive or other assessments and shall include the following:
1. a statement of the client's strengths and weaknesses;
2. the client's needs in terms of strengths and weaknesses;
3. long-range goals and short-term treatment objectives stated in specific and measurable terms with timelines;
4. specific treatment modalities to be utilized;
5. provisions for review of the program specific treatment plan with the program director or designee in accordance with procedures establilshed in 104 CMR 16.10 (2) (e) 4.

(3) Coordination of Program Specific Treatment Plans for Clients with an ISP.
(a) For a client with an ISP, the program director or designee shall:
1. develop the program specific treatment plan and implement services within the program's capability that are sufficient in type, intensity and frequency to achieve goals and objectives identified in the ISP;

2. immediately notify the primary clinician or designee if he/she determines a need for additional evaluations which are beyond the program's capability to perform and requests that the primary clinician or designee arrange for these evaluations;
3. immediately notify the service coordinator if he/she determines that the client's needs are not consistent with those identified in the ISP.

(b) The primary clinician shall be responsible for:

1. ensuring that each service provider formulate a program specific treatment plan in accordance with the standards for program specific treatment plans set out in 104 CMR 16.07;
2. ensuring that goals and objectives in each program specific treatment plan are as consistent as possible with the comprehensive assessment, the ISP and other program specific treatment plans;
3. monitoring the adequacy and appropriateness of services rendered to clients. Such monitoring shall consider, at a minimum, the consistency of the services rendered with the goals and objectives of the Individual Service Plan and the program specific treatment plans;
4. attending periodic reviews of program specific treatment plans with the program director or designee, as appropriate;
5. coordinating services provided to the client including the arrangement and provision of technical assistance and, with the client's consent, the sharing of information concerning the client among service providers.

(c) The service coordinator shall:

1. monitor the implementation of the Individual Service Plan in accordance with 104 CMR 16.05; and
2. assist the primary clinician in carrying out coordinating responsibilities identified in 104 CMR 16.07 (3) (b).

## 16.08: Annual Review for Clients with an Individual Service Plan.

(1) General Provisions.

(a) A review of the ISP and component program specific treatment plans shall be conducted at least annually;

(b) The purpose of the annual ISP review is to review the Individual Service Plan and its component program specific treatment plans to ensure that:

1. services continue to be to the maximum extent possible, adequate, appropriate consistent with the client's needs and least restrictive of the client's freedom;
2. program specific treatment plans are consistent with the ISP.

(c) A review of the ISP shall be held three months after initiation of services if the primary clinician or designee finds inconsistencies in the treatment plans or lack of coordination between service providers which cannot be resolved without a meeting;

(d) The review shall be conducted with the fullest possible participation of the client and his/her representative and legal guardian, if any.

(2) Convening the Annual ISP Review Meeting.

(a) The Primary clinician or designee shall convene and conduct the annual review of the ISP and component program specific treatment plans. The primary clinician may appoint the service coordinator to perform this function;

(b) At least fifteen days in advance of the annual ISP review meeting, the primary clinician or designee shall invite the following persons to attend the meeting:

1. the client;
2. his/her designated representative, if any;
3. if the client is an adult, his/her legal guardian, if any;
4. if the client is under eighteen years old, his/her parent(s) or legal guardian, unless an exception specified in 104 CMR 15.03 (12) applies;
5. the service coordinator;

6. a representative of each of the client's service providers;
7. with client's consent, any other person who, in the judgment of the primary clinician, will contribute to the Individual Service Plan Meeting.

(3) <u>Content of the ISP Review Meeting</u>. The annual review of the ISP shall include:

(a) A determination whether there has been any change in the clinical, social, training, educational and personal needs of the client;

(b) A determination as to whether the client needs another comprehensive assessment or additional evaluations;

(c) A determination whether the services being provided to the client continue to be consistent with the client's needs and ISP;

(d) A review of progress towards attainment of goals and objectives stated in the current ISP and component program specific treatment plans and a reaffirmation, modification or deletion of each goal and objective together with the reasons for these actions;

(e) A determination whether any change in the client's circumstances necessitates a modification of the client's priority of need for services not currently provided;

(f) A determination whether there has been any change in the client's personal and financial entitlements and resources; provided however, that services shall not be restricted in quality or quantity on the basis of the client's ability to pay for the services;

(g) A determination whether there has been any change in the legal status of the client, or in the necessity or advisability of having a guardian or conservator appointed or removed;

(h) A determination whether there has been any change in the availability of services formerly determined to be needed but not then available.

(4) Annual ISP Review Report. Within ten days after the annual ISP review meeting, the primary clinician or designee shall prepare and give, upon request, to the client, his/her designate representative and legal guardian, if any, and any other participants in the review, a written report of the review, which shall include need for another comprehensive assessment or additional evaluations, recommendations and any proposed modifications made in goals, objectives, services, or means for monitoring and coordinating services. The primary clinician may appoint the service coordinator to perform this function.

16.09: Modifications or Terminations of the ISP or Program Specific Treatment Plan.

(1) General Provisions.

(a) Requests for modification or terminations of an ISP, Service Coordination, program specific treatment plan or services, or for a change in service provider may be initiated by the client, his/her designated representative, if any, his/her legal guardian, if any, his/her service provider, his/her primary clinician or service coordinator, if any, or may be initiated pursuant to a periodic review;

(b) Modifications or terminations shall be made in an ISP, Service Coordination, program specific treatment plan, services or service provider whenever it is determined at the periodic review or at any other time that such a change will permit the client to receive more appropriate or adequate or less restrictive treatment consistent with the client's needs;

(c) No termination or significant modification to an ISP, Service Coordination, program specific treatment plan, services or services providers shall be made without the approval of the client or client's guardian, if any, and the service provider(s) involved, unless the primary clinician or program director determines that the modification or termination is required to avoid a serious or immediate threat to the health, mental health or safety of the individual or others;

(d) The primary clinician, if any, shall:
  1. approve modifications in the ISP or terminate Service Coordination;
  2. be informed by the service provider of any significant proposed terminations or modifications in the program specific treatment plan; and
  3. advise the Area Director concerning the desirability of a client initiated transfer under 104 CMR 16.09 (2).

(e) Modifications and terminations shall be reviewed and approved within thirty days in accordance with procedures established under 104 CMR 16.10 (2) (e) 5.;

(f) The client for whom a modification or termination is proposed, the client's representative, if any, of the client's legal guardian, if any, may reject and appeal a proposed or denied modification or termination pursuant to 104 CMR 16.11. No modification or termination under appeal may be made pending a hearing on the appeal without the consent of the client or client's guardian, if any, unless the primary clinician or program director determines that the modification or termination is required to avoid a serious or immediate threat to the health, mental health or safety of the individual or others.

(2) Client Initiated Transfer. The client may at any time initiate a request to the Area Director or designee for a transfer to a more appropriate, less restrictive setting. The Area Director or designee shall grant or reject the request within 30 days in accordance with procedures established under 104 CMR 16.10 (2) (e) 6. The primary clinician, if any, may be the Area Director's designee. The request for a transfer may be denied only if:

(a) The current setting is the most appropriate and least restrictive consistent with the client's needs; or

(b) Services are not available elsewhere, provided that the request will be granted as soon as a more appropriate, less restrictive setting can be developed or found.

## <u>16.10: Procedures for Individual Service Planning and Development</u>.

(1) <u>Establishment and Approval of Procedures</u>.

(a) It is the responsibility of the Area Director to establish procedures for Individual service planning and development;

(b) The procedures must be in writing and on file at the Area Office;

(c) The procedures must be approved by the Commissioner or his/her designee;

(d) All modifications or changes in procedures must be approved by the Commissioner or his/her designee.

(2) <u>Content of the Written Procedures</u>. The written procedures shall include at least the following:

(a) Designation by Area Director of programs or other sites where clinical services are provided in the Area to perform initial screening for persons requesting or receiving mental health services;

1. prior to designation, the Area Director must ensure that the service provider responsible for the program or site has has agreed to the designation;

(b) Designation by Area Director of programs or other sites where clinical services are provided in the Area to perform comprehensive assessments or other functions requiring the participation of qualified clinicians:

1. prior to designation, the Area Director must ensure that the service provider responsible for the program or site has agreed to the designation;
2. programs or other sites designated by the Area Director shall be approved by the Commissioner or designee;
3. the Area Director shall not designate his/her Area Office to perform comprehensive assessments unless he/she believes that alternative program or sites cannot adequately or properly provide comprehensive assessment services to all Area clients. If the Area Director believes that there is no alternative, the designation of the Area Office must be justified to and approved by the Commissioner or designee.

(c) A procedure to inform individuals as appropriate:

1. of the right to request an initial screening or comprehensive assessment;
2. of the authority of the Department to require necessary and relevant information about the individual's needs, income, and resources;
3. of the availability of assistance from the Area Office in obtaining information necessary to determine need for mental health services;
4. of the authority of the Department or program to charge for services;
5. of their rights to appeal in accordance with 104 CMR 16.11.

(d) A procedure to ensure that:

1. all programs refer persons requesting mental health services to an appropriate site or program for initial screening designated under 104 CMR 16.10 (2) (a);
2. all persons determined to need mental health services are referred to and accepted for service planning and/or services in the correct area of meaningful tie, as defined in 104 CMR 15.02 (7);
3. all persons determined to need a comprehensive assessment, as a result of initial screening or during or as a result of program specific treatment planning are referred for a comprehensive assessment at an apropriate site or program designated under 104 CMR 16.10 (2) (b);
4. the assessments assigned to serve as the basis for the comprehensive assessment and the development of the ISP are necessary and sufficient to meet those purposes;
5. all persons determined to need additional evaluations during or as a result of the comprehensive assessment or program specific treatment planning are referred for additional evaluations;
6. clients are referred to, accepted for and receive interim services pending completion of the comprehensive assessment of ISP, if necessary;

7. variations in individual service planning allowed by 104 CMR 16.01 (3) (b) are appropriately monitored;
8. the Area's services development procedures respond to lack of services identified that are needed and not available and that a waiting list for services is maintained;
9. individuals requesting or receiving mental health services are, as appropriate, informed of the availability of assistance in obtaining other services and assisted in obtaining other services.

(e) A procedure and provisions for:

1. designating a primary clinician;
2. designating a service coordinator;
3. delineating the relationship between the Area Office, primary clinician, other qualified clinicians, service coordinator, service provider and/or program director, and others involved in the individual service planning process;
4. the regular periodic review by the program director or designee of program specific treatment plans including participation and content of the review;
5. initiating, reviewing, approving and implementing modifications or terminations in Individual Service Plan, Service Coordination program specific treatment plans, services, service providers;
6. determining the advisability of a client initiated transfer and implementing the transfer, if accepted.

## 16.11: Client Appeals.

(1) General Provisions.

(a) This part contains the standards and procedures for appeals by individuals of major individual service planning and implementation decisions;

(b) Disagreements among components of the Department (including the Regional Services Administrator, Area Director, program director, qualified clinicians, service coordinators, and facility head) concerning program placement or area of meaningful tie are to be resolved using Departmental guidelines, rather than the client appeals regulations;

(c) To the maximum extent possible, disagreements shall be resolved with the program director prior to utilizing this appeals mechanism;
(d) Individuals shall be informed of their rights to appeal in accordance with procedures established under 104 CMR 16.10 (2) (c) 5.

(2) Subject Matter of an Appeal. The following issues may be appealed:
(a) Whether the decision that the individual needs mental health services, a comprehensive assessment, Service Coordination, or an Individual Service Plan has a reasonable basis;
(b) Whether the Department's identification of the individual's area of meaningful tie is correct according to 104 CMR 15.02 (7);
(c) Whether the assessments assigned by the Department to serve as the basis for the development of the ISP are necessary and sufficient to meet that purpose;
(d) Whether the service goals and objectives and timelines stated in the ISP or program specific treatment plan are reasonably related to client needs identified in the initial screening, or the comprehensive assessment or program specific treatment plan;
(e) Whether the recommended services identified in the comprehensive assessment are adequate, appropriate and least restrictive consistent with the client's needs'
(f) Whether the actual services identified in the initial screening, ISP or program specific treatment plan are to the maximum extent possible, adequate, appropriate, consistent with the client's needs and least restrictive of the client's freedom;
(g) Whether the findings of the Department with regard to the individual's legal competency, capability in fact, and need for guardianship or other protective services are consistent with the standards set forth in 104 CMR 15.03 (10);

(h) Whether a significant modification or termination of an ISP, Service Coordination, program specific treatment plan or services or change in service provider has a reasonable basis;
(i) Whether the appropriate procedures and timetables as set forth in 104 CMR 16.00 for developing the ISP and program specific treatment plan are being or have been followed;
(j) Whether the Individual Service Plan is being implemented in accordance with 104 CMR 16.05.

(3) Initiation of the Appeal.
(a) An appeal may be initiated by any of the following individuals:
1. the individual requesting or receiving mental health services;
2. the parent of the client, if the client is under 18 years of age;
3. the legal guardian of the client;
4. an individual designated by the client as his/her representative;
5. if the client is legally incompetent and incapable in fact of designating a representative, an individual designated by the client's legal guardian as his/her representative;
6. the individual designated by the Department as the client's advocate;
7. an attorney appointed by a court.

(b) An appeal is initiated by notifying the Area Director of any action or inaction which is a proper subject of appeal under 104 CMR 16.11 (2);
(c) An appeal must be initiated within 30 days of the action or inaction being appealed. The Area Director may, however, accept an appeal after 30 days for good cause. If the Area Director refuses to accept a late appeal he/she shall state his/her reasons for doing so in writing and notify the client. Within ten days of the receipt of those reasons, the client may request review of that decision by the Regional Services Administrator who shall act within 15 days. Failure of the Regional Services Administrator to act within 15 days shall constitute a denial of the request. The decision of the Regional Services Administrator shall be final.

(4) The Appeal Process.

(a) Informal Conference.

1. The Area Director or designee shall hold an informal conference with at least the primary clinician or designee, if any, the client, the program director, if appropriate, and the appealing party (if other than the client) within 30 days of notification of the appeal for the purpose of resolving the issues being appealed. To the extent that resolution satisfactory to all persons is not achieved, the Area Director or designee shall clarify issues for further appeal and shall determine the agreement, if any, of the parties as to the material facts of the case;
2. Except to the extent that statements of the parties are reduced to an agreed statement of facts, all statements of the parties made during the informal conference shall be considered as offers in compromise, and shall be inadmissible in any subsequent hearing or court proceedings under this Part.

(b) Fair Hearing.

1. If all issues under appeal are not resolved at the informal conference held under 104 CMR 16.11 (4) (a), the appealing party may petition the Regional Services Administrator within 30 days of the termination of the informal conference for a fair hearing. Within 45 days of such petition, the Department shall hold a fair hearing on the appeal in a manner consistent with M.G.L. c.30A and 104 CMR 16.11 (4) (b);
2. While the appeal is pending, the parties may agree to implement any part of the ISP or program specific treatment plan of other matter under appeal without prejudice;
3. The fair hearing shall be conducted by an impartial hearing officer designated by the Regional Services Administrator. The hearing officer may be an employee of the Department; provided however, that no person shall be designated as a hearing officer in a particular appeal who is subject to the supervision or direction

of any office of the Department within the Area, or of any facility within the Area, in which the client is currently served or is proposed to be served;

4. The client shall have the right to be represented at the hearing;
   a. the client shall have the right to be represented by an individual chosen by the client at the client's own expense;
   b. if the client is unrepresented at the hearing but needs assistance, or if for any other reason the Regional Services Administrator determines the appointment to be in the client's best interest, the Regional Services Administrator shall designate a client advocate to assist the client in the appeal;
5. The client other appealing party, and the Department shall have the right to present any evidence relevant to the issues under appeal, and shall have the right to call and examine witnesses;
6. The client or other appealing party shall have the right consistent with 104 CMR 15.03(9), or 104 CMR 2.07, as applicable, to examine all records held by the Department pertaining to the client and all records upon which the ISP or program specific treatment plan decisions are made;
7. The fair hearing shall not be open to the public provided that the hearing officer may allow other persons to attend if he/she deems such attendance to be in the best interest of the client;
8. The hearing officer shall render a written decision with 30 days of the close of the hearing:
   a. the decision shall include a concise statement of the facts found, a summary of the evidence relied upon, the decision and the reasons for so deciding and a notice of the client's rights to petition the Regional Services Administrator for a re-hearing and/or to appeal the decision to the Superior Court under M.G.L. c.30A;

  b. the decision shall be mailed to the client and to all parties appealing and their designated representatives;
  c. the hearing officer shall arrange to have the decision explained to the client, to the extent feasible;
  d. except to the extent that the decision is subject to an order for rehearing by the Regional Services Administrator, the decision of the hearing officer is the final decision of the Department on all issues.

(c) <u>Rehearing</u>.

1. Within 14 days of receipt of the decision of the hearing officer by the client, any party may petition the Regional Services Administrator to order a re-hearing on one or more of the following grounds:
   a. that new evidence was discovered by the appealing party subsequent to the hearing, and that the new evidence is such that it would be likely to materially affect the issues being appealed; or
   b. that the hearing was conducted in a manner inconsistent with 104 CMR 16.11 (4) (b) or which was prejudicially unfair to the client or other appealing party;
   c. that the decision is based on inappropriate standards or contains other errors of law; or
   d. that the decision is unsupported by any substantial evidence.
2. The failure of the Regional Services Administrator to grant or deny a petition to order a re-hearing within 15 days of the submission of the petition shall be considered a denial of the petition;
3. Upon order for a re-hearing by the Regional Services Administrator, a hearing shall be conducted and a decision rendered anew, in accordance with 104 CMR 16.11 (4) (b).

(d) Judicial Review. A client aggrieved by a final decision of the Department may, within 30 days of receipt of the decision or a decision after a re-hearing, seek judicial review of the decision, in accordance with the standards and procedures contained in M.G.L. c.30A, s.14.

(5) Standard and Burden of Proof.

(a) The standard of proof on all issues shall be preponderance of the evidence;

(b) Burden of Proof.

1. The burden of proof on the issue of need for mental health services shall be on the person arguing for a change in status regarding services or person appealing on his or her behalf;
2. The burden of proof on the issue of area of meaningful tie, necessity and sufficiency of assessments, sufficiency of goals and objectives, and legal competency and need for guardianship shall be on the Department;
3. The burden of proof on issues relating to programs or program placement shall be on the party advocating the more restrictive alternative.