State Hospital 2000: 21st Century Survival and Success©

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Introduction

Time is marching down the last few steps of the 20th century. It descends with all the excitement, anxiety and other emotions that typically attend great change. Somewhere upon the same slope of history, State Hospitals are also approaching the new century. Their descent shares the great angst but not the grand expectations. For they have been devalued, deinstitutionalized, down sized, right sized, correctionalized, consolidated and eliminated with little hope of a renaissance or a redeeming contribution to the future. As such, the fate of the State Hospital is uncertain. Is there yet some meaningful role of support they might play in the new century's behavioral health delivery system? Can and should they survive? If so, what role would they play?

Most states and their hospitals are being challenged by increased health care costs, major budget reductions, shifting foci of care to communities, health care reform, managed care, and growing consumerism. Such issues surely portend the nature of change in the coming millennium. The purpose of this article is to better prepare state hospital stakeholders for a fast-paced future of continuing change and challenge. The author is a psychiatrist and the former Superintendent/CEO of one state hospital that strove to survive and succeed despite the challenges and uncertainty of pre-millennial times. The facility’s skilled and caring staff members like those of many other state hospitals were devoted to providing good patient care and improving its quality despite the aforementioned challenges. An abbreviated

30 history of that effort and description of the essential spirit and strategies
31 that drove it are presented and commented on here.
32
33 The Need
34
35 In 1752, Philadelphia's Pennsylvania Hospital became the first in
36 Colonial America to provide care for the mentally ill. The first hospital in
37 America exclusively for the care of the insane was the Public Hospital for
38 the Insane in Williamsburg, Virginia. It opened October 12, 1773. Since
39 that time these institutions and their staffs have played a major role in the
40 development of this country's mental health systems and practices. From
41 their participation in the founding of the American Psychiatric Association
42 through Moral Treatment and three waves of deinstitutionalization, their
43 contributions have been formidable.[1, 2]
44 The State Hospitals (SH) was created to address behavioral health needs
45 of individuals that exceeded the management ability of families and society.
46 When the community's capabilities or tolerance were overwhelmed by too
47 challenging disabilities and dysfunctions, the individuals affected were
48 delivered to a special place. If only by dint of frequency and duration of
49 involvement, these places and their staffs have gained a unique experience,
50 knowledge and skill for the care of such persons. The wisdom and ability
51 that has evolved from over 200 years of ultimate patient responsibility at
52 the most intense end of the service continuum is a unique and too often
53 unappreciated asset. A venerable history, however, does not ensure the
54 future.
55 In any service recipient population, the amount and intensity of
56 services needed by individuals is expected to be normally distributed. Two
57 standard deviations above the "average level of need" there will be a small
58 percentage of *outlyers* who require significantly more service. In the

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59 population of people needing mental health services, the outlyers have
60 historically been the SH's clientele. Even if new medications and treatment
61 technologies reduce the number of highly disabled persons, large systems with
62 limited resources must ultimately accommodate their efforts to some majority
63 of its population and their needs. Consequently, there will still be some
64 minority of outlying individuals who will have special, higher intensity
65 requirements not addressed by the array of services designed for and
66 available to the "average" recipient.

67 Despite treatment advances, there is a curious evolutionary persistence
68 of the outlyer population.[3] In the 1950s, new advances in medications and
69 psychosocial methods stimulated a wave of SH discharges.[4] Many of these
70 patients were relatively long-term and well institutionalized. When liberated
71 from their psychosis, they often retained a well-learned base of obedience to
72 authority from their hospital experience. A generation later outpatient
73 baby-boomers, treated with more potent medication, combined their illnesses
74 with their cohort's inclination for recreational drug use and increased
75 mobility. The result redefined outlyers as *Dually Diagnosed* and *Young Adult*
76 *Chronic Patients*. [5-10] Their behavioral hallmark was noncompliance with
77 traditional services, associated with brief but more frequent use of high
78 cost interventions (i.e. hospitals and emergency rooms) and high intensity
79 services.[6, 9, 11, 12] It took most of the 1980s for many service systems to
80 recognize and respond to the extreme challenge of these "revolving door
81 recidivists."

82 Today there are again newer, more effective medications for treatment
83 and support of community-based care. Unfortunately, some street drugs such
84 as crack and even marijuana have also become more potent. If the current
85 mentally ill population again expresses its illness in a manner influenced by
86 its cohort characteristics, then the demands of Generation X service

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recipients (who recreate with highly aggressive games and music) may again re-invent the outlyer subpopulation as even more violent and aggressive. A community-based system can certainly adapt to this, but the initial response capability is likely to be more rapid and effective from providers who have already had experience working with and adapting to outlyer challenge.

In summary, some amount of relatively high intensity services is likely to be needed for the foreseeable future.[13-15] Unless private and community-based service systems are remotivated to serve this population, and can quickly learn and dramatically expand their scope of service, they are unlikely to sufficiently address the needs of a small but highly in need subpopulation of service outlyer patients.[3, 10, 16] These individuals will require special care of above-average intensity.[17-19] The unique history and experience of SH's equip them with a collective perspicacity and competence that is likely to be useful in adapting to and providing care for such persons. It would appear safe to assume that for the immediate future, there will be a need for the intensity of services currently provided by state hospitals. This is not to say, however, that a SH can or must remain in its current incarnation (or walls) to provide that service. Neither does the existence of such a need guarantee the survival of any particular facility. Those that do survive will deserve it based on the effectiveness and efficiency of their services in response to a legitimate need

The Roles

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood
-Robert Frost

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115 In an enlightened process of service role determination, there is an
116 effort to match customer needs with provider capability. If role is
117 determined primarily on the basis of customer need, with little regard to the
118 provider's abilities, or vice versa, the result will most likely be
119 frustrating and unsatisfactory for both parties. In the mental health service
120 sector, the role of a SH may be influenced by the hospital itself, but it is
121 usually determined by a higher state authority. State Hospitals perform many
122 direct care and latent functions.[16, 20-22] Perceptions of SH capabilities
123 and possibilities can be a critical part of such determinations. However,
124 beyond the recognition of gross service elements (e.g. medication therapy,
125 substance abuse programs) and attributes (e.g. locked doors, 24 hour
126 staffing) the multitude of functions and tremendous potential of state
127 hospitals may not be sufficiently understood. There appears to be a tendency
128 toward one of two fundamental frames of reference regarding the service role
129 of SH's.

130 The first perspective is the *Box View*, in which the SH is essentially
131 seen as a container. It is largely bricks and mortar that hold, control and
132 protect those inside and out In the box perspective, a SH is essentially a
133 high intensity, uni-dimensional *treatment service*, intervention or level of
134 care (LOC) largely for persons in need of containment and control. Certain
135 roles and functions naturally flow from such a perspective. If the box is
136 empty it can be used for new containments or sold to another in need of a
137 container. If partially filled, its contents can be included with that of
138 another box, or simply be poured out. Box vision may well lie behind the
139 selling of SH's and/or their conversion to correctional functionsSuch
140 solutions are straightforward and practical, if not sublime. However, the
141 box view may also produce infelicitous consolidations for patients and
142 downsizings that fail to preserve unique staff resources.

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143 In contrast is the *Base View*. From this perspective the SH is seen as
144 a platform, station or hub. It is a personnel, informational, fiscal and
145 physical resource pool that supports, seeds, connects and coordinates. Its
146 physical construct is less important than its services and programmatic
147 contents.[10] Base vision is sometimes reflected in the consideration of
148 constructive 'safety net' (v.s. 'dumping ground') roles for . It is base
149 perspected whenit is defined as a flexible utility provider that back stops
150 the continuum of care (i.e. there is no other willing/able provider) or
151 provides a standard of care for judging new service providers and
152 possibilities. This perspective is apparent in the entrepreneurial efforts
153 of an increasing number of SH's across the country.[15] (See Appendix 1)
154 From the base perspective, a SH is a high intensity multi-dimensional
155 *treatment resource* for people who need support, rehabilitation and
156 interconnecting.
157 The box, with its containment properties (even with a humane intent
158 added) seems historically reminiscent of leper island colonies and isolated
159 asylums. It may also imply a particular skepticism about service
160 expectations and patient prognosis, (i.e. the prospects for recipients'
161 functional improvement). A base, on the other hand, suggests a more pro-
162 social and optimistic view of human potential. It connotes a harmony with
163 the interconnections, integration and team approaches characteristic of the
164 new age we are entering.
165 All SH's could be expected to have box potential. Effecting such a
166 role is simple and utilitarian. This, and society's anxiety-driven desire to
167 isolate and control those who are different, may explain the appeal of this
168 choice. Base development is less common and could be a more demanding
169 endeavorStill, its potential benefits make it worthy of more frequent
170 consideration.
171

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172 *I took the one less traveled*
173 *And that has made all the difference*
174 *-Robert Frost*
175
176 An Example and Case Study
177
178 **The History.** Georgia Regional Hospital (GRHA) in Atlanta was a 368-bed
179 psychiatric inpatient facility located in the second largest of the counties
180 that form the Metropolitan Atlanta area. Originally planned for a future
181 increase to 500 beds, it had twenty-two, single story, mansard-roofed
182 buildings on a gently rolling campus of 175 acres. There were three ponds, a
183 swimming pool, two tennis courts and a layout for a nine-hole golf course. It
184 was modern and airy compared to Georgia's first state hospital. It was one
185 of ten state hospitals (MH & MR) which were ultimately established in Georgia
186 built in 1842. GRHA served children, substance abusers, the developmentally
187 disabled, geriatric and forensic populations. The majority of services were
188 for acute and chronic mentally ill adults. At its peak (fiscal years 1995
189 and 1996) it managed more than 7000 admissions. . It was one of the busiest,
190 if not *the* busiest, public psychiatric hospitals in the country, for the
191 better part of a decade.[23] , it.
192
193 *Out of the night that covers me*
194 *Black as a pit from pole to pole –*
195 *William Ernest Henley*
196
197 This volume of workload, the growing challenges of homeless, multiply
198 diagnosed young adult chronic patients, and the emergence of crack cocaine as
199 their drug choice, were important in defining the institution's character.
200 The pressures and problems of a limited bed supply were exacerbated by the

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201 increasing service demand and a State policy that disallowed denials of
202 admission based on census alone. In such circumstances change,and creativity
203 were needed just to keep afloat.. The active search for increased
204 effectiveness and efficiency quickly became an organizational way of life.
205 Overcrowding (so called because "crowding" was the norm) and a high
206 readmission rate (recidivism) were important teachers, experienced by GRHA
207 three to five years before these same phenomena reached other facilities in
208 more rural parts of the state. So rapidly did these conditions develop that
209 the State's Division of Mental Health/Mental Retardation and Substance Abuse
210 (The Division) had difficulty appreciating GRHA's peculiar .
211
212 *I thank whatever Gods may be*
213 *For my unconquerable soul.*
214 *-William Ernest Henley*
215
216 This was the context in which the 1990s dawned upon GRHA.Increasing
217 demands for in-patient service and quality needed to be met while hospital
218 resources were shifting into the community There was anxiety and uncertainty
219 about the hospital's fate and how to do more with less. From somewhere in its
220 organizational soul and sincere concern for patients, the hospital determined
221 that despite all the obstacles and limitations, it would achieve and maintain
222 quality in its services. Staff wanted to feel proud of what they did. GRHA
223 wanted to become a world class provider of inpatient psychiatric care for the
224 seriously mentally ill. A commitment to provide even traditional SH services
225 at such a level was considered bold, if not foolhardy, given the existing
226 resource constraints. The challenge was compounded and the vision almost
227 destroyed by the chance events of state hospital life.
228
229 *In the fell clutches of circumstance*

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230 *I have not winced nor cried aloud*
231 *Under the bludgeoning of chance*
232 *My head is bloody, but unbowed*
233 *-William Ernest Henley*
234
235 In April of 1990, a patient was discharged from GRHA and shortly
236 thereafter obtained a handgun, went to a local mall, shot and wounded four
237 persons. One individual was killed.[24] In that tragedy, many presumed that
238 the espoused quality had failed and that the dream of world-class was over.
239 However, weeks of national media scrutiny and special panel investigations
240 found no dramatic failures of quality. GRHA then proceeded to take the next
241 steps toward its vision. While in the glare of the *world's* most critical
242 stare, the hospital decided it could still show its *class* by learning more
243 about the imperfect art of predicting and managing dangerous persons.
244 Instead of running away, it could and should turn toward the most challenging
245 patients of all kinds. Rather than give up and quit, it could dig in and
246 quicken its pace toward quality. And, it did. The notion of achieving
247 world-class quality would grow and guide the organization for the better part
248 of the remaining decade.
249 Model practices and new efficiencies were sorely needed to help the new
250 young adult chronic patients who increasingly challenged service capacities.
251 Consequently, GRHA mustered additional time and energy to increase knowledge
252 (especially about *quality*), to gather resources (especially information), to
253 develop strategic plans, to visit model programs and volunteer for relevant
254 projects. The facility's executives threw themselves into studying the new
255 management methods of Deming, Juran, Crosby, Covey, Senge and others. The
256 manufacturing based principles of CQI and TQM were refined and adapted for
257 the not-for-profit service environment of a SH. The organization began
258 making original efforts to define quality for itself and to hold itself

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259 accountable to standards that exceeded external expectations. It redefined
260 its mission from a process-based description of its services to an outcome-
261 based commitment to achieve certain patient goals. (see Appendix 2).

262 In 1992, GRHA reached something of a pinnacle for the traditional SH.
263 Despite its extra ordinary workload and limited resources it had made
264 remarkable efforts to maintain quality in the face of these challenges. The
265 effort was recognized when it became GA's first SH to be accredited with
266 commendations by the JCAHO. Despite such achievements, creative problem-
267 solving and efficiency the facility was still losing ground to a rising tid
268 of admissions. Analysis revealed a trend of increasing readmissions similar
269 to that occurring all across the nation.[25] A program was developed to
270 identify those with the highest rate of hospital utilization as defined by
271 four or more admissions during the past year. Two hundred patients were
272 identified. Each was offered highly concentrated services during subsequent
273 admissions, with increased efforts to stabilize the patient's condition,
274 provide information and skills for use after discharge, and coordinate after-
275 care programs with community providers. This program demonstrated that the
276 number of *admissions* could be reduced for this population, but only by
277 increasing the *total number* of hospital days. After discharge, patients
278 still returned at about the same frequency established prior to the program.
279 It became clear that the lack of real influence over conditions in the
280 community after discharge for challenging patients such as the chronic and
281 homeless mentally ill seriously limited achievement of the desired patient
282 outcomes.[26] Yet as a traditional State Hospital GRHA was generally
283 constrained to operate within its walls.

284 Toward the end of that year, GRHA also took administrative and clinical
285 responsibility for a small, troubled outpatient methadone program ("Atlanta
286 West") that the Division no longer wished to manage directly. Working with
287 this program began to suggest the utility of operating an outpatient drug

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288 treatment program in conjunction with the inpatient services since many
289 patients were enrolled in programs at both sites.

290 In the closing months of the same year, GRHA's Superintendent was
291 nominated by the Division for appointment by the Governor to a special
292 commission that was to review evaluate and recommend improvements for the
293 entire MHMRSA delivery system.[30] The fulfillment of that charge would
294 ultimately result in a new state law passed by the 1993 legislative session
295 initiating the most sweeping reorganization of Georgia's MHMRSA delivery
296 system in a quarter century.[31, 32]

297 The GRHA Superintendent, as the Commission's only psychiatrist and SH
298 representative, had a unique opportunity for advocacy and access to
299 information. That opportunity was used to influence the development of the
300 reform's guiding principles [27] (see Appendix 3) in clinically appropriate
301 ways. Perhaps the most significant benefit of that representation was the
302 achievement of language that actually broadened the scope of potential SH
303 services beyond the inpatient realm so that they might remain players in the
304 new system.[33] Salvaged from the crisis of reorganization was a small but
305 significant opportunity for survival and success. **The Strategy.** In light of
306 State reorganization and the potential for national health care reform, GRHA
307 refined its vision. A strategy for success in the new environment was
308 developed. It was based on the facility's expertise and experience with the
309 system's most challenging patients because that was thought to be a critical
310 and emerging need for which there were few willing/capable providers. This
311 decision to survive by becoming a specialized provider for such populations
312 was not an easy one., Ultimately it was accepted by as the best method for
313 meaningful (vs. mere) GRHA woulduse the new opportunities of the reform to
314 provide the best possible continuum of care and achieve world class outcomes
315 for those patients who were the most in need and the most challenging.

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The implementation. This decision was so consistent with the core values, caring hearts and professional identity of most staff that upon its acceptance, there was an explosion of effort and confidence. The vision became clearer. Fear and anxiety gave way to the courage of commitment. The remainder of 1993 was a year of repositioning. The seedling outpatient endeavor, the Atlanta West Methadone treatment center was challenged to expand its scope to include programs for abusers of other substances. Another community SA program (Renaissance) was accepted from the Division. The problem of escalating rates of readmission was retackled with the use of comprehensive psycho-education and rehabilitation models imported from California (i.e. Camarillo Modules) and Boston (i.e. Anthony's Rehabilitation methodology).[34-36]

By 1994 GRHA was ready to reorganize its internal service delivery system in accord with its maturing vision and principles. Unit/Service management was removed from traditional, administrative unit managers and delegated to new leadership teams comprised chiefly of senior clinicians representing each of the major behavioral health disciplines. Putting Continuous Quality Improvement (CQI) principles to work, eight primary consumers with relevant disabilities were also hired on entry level manager's salaries to add consumer perspectives to those leadership teams (for the first time in Georgia). This structure was adopted to increase the clinical and consumer staff's direct involvement in planning and achieving improved patient outcomes.

With the assistance of its recently acquired community SA programs, the hospital was able to redeploy some staff to outpatient activities. Using Pareto's Principle and a stronger focus on outcomes (vs. process), it redeployed staff to provide more effective services to its 182 highest recidivist patients.[37] Those relatively few individuals were responsible for a disproportionately high percentage of the hospital's inpatient

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345 utilization (i.e. bed days). Using patient needs assessment and model
346 program reviews, a set of modified Programs of Assertive Community Treatment
347 (PACT) teams was conceptualized and a pilot program implemented around them
348 within three months.[38-42] The pilot was steered by an operations committee
349 that drew membership from several community organizations who's previous
350 involvement had been limited to referring patients for the inpatient services
351 of Georgia Regional. The pilot was staffed by positions formerly assigned to
352 inpatient services. They were freed for this purpose as part of the plan and
353 hope that their efforts would produce a corresponding downsizing of inpatient
354 services. If the program were effective, these beds would no longer be
355 needed. There was now sufficient confidence in staff, strategies, plans and
356 principles to take such calculated risks.
357 Shortly after, GRHA, its affiliated community SA programs and new
358 outreach services were reconceptualized and renamed the Metro Atlanta
359 Psychiatric Care System (MAPCS), a vertically integrated mini-system for care
360 of the seriously and persistently mentally ill. AT their request, MAPCS then
361 relieved the Division of another community SA program ("Ujima").
362 Over the next 2 years as the reform matured, it became evident that
363 resources would increasingly be removed from Georgia's SH's to further
364 develop community-based services. MAPCS proactively elected a self-pruning
365 strategy. It developed a Resource Allocation Plan (RAP) based on an
366 internally developed, workload sensitive methodology for determining minimum
367 or core staffing for each of its units and service types. It performed
368 Georgia's first formal SH cost analysis using a cost distribution
369 methodology. RAP established internal MAPCS staffing ratios and priorities
370 for programs and personnel in the event of downsizing. This combined with
371 other small efficiencies permitted the development of an internally
372 controlled discretionary resource of 'extra-core' staff. With this as
373 capital, MAPCS could look beyond maintenance functions even during a time of

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374 decreasing SH resources. In so doing, it became an entrepreneur and took
375 another step toward world class. This new prospective was shared and
376 encouraged at all levels of the organization. In that spirit, MAPCS
377 volunteered to participate in the state's first managed behavioral health
378 care contract even though it would reduce utilization and increase the
379 external threat of downsizing. The risk was taken because it was an
380 opportunity to learn more about managed care (i.e. the competition) and it
381 was the right thing to do.

382 In 1995, MAPCS advocacy and RAP technology convinced the Division to
383 redefine staffing allotments in its plan for statewide Child and Adolescent
384 (C&A) unit consolidation. The MAPCS ACT program, called The Atlanta-Area
385 Community Consumer Empowerment Support System (ACCESS), received the Mental
386 Health Association of Georgia's Programmatic Achievement Award, and upon
387 completion of its first year of operation accomplished what had seemed
388 impossible just two years before. It did so by exceeding first year goals and
389 reducing its target population's admission and hospital utilization rates by
390 52% and 64% respectively. MAPCS also forswore a chance for a repeat JCAHO
391 commendation with the then unprecedented move (in GA) of having its in- and
392 outpatient programs jointly surveyed. The joint participation of MAPCS (i.e.
393 GRHA, Atlanta West, Renaissance, Ujima and ACCESS) in Georgia's first
394 corporate survey made it the first accredited network of state providers.
395 MAPCS began planning for a local area network (LAN) and other infrastructure
396 improvements to improve coordination, integration and quality. Later that
397 year, MAPCS conceptualized The Fulton Collaborative Crisis Service System
398 (FCCSS), a unique horizontal integration of disparate state, county, non-
399 profit and private crisis providers, to improve crisis services and to
400 compete with managed care. The implementation time frame was six months.
401 MAPCS/C&A unit won another contract to provide after-hours crisis services

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402 for adolescents in the adjacent Cobb and Douglas counties. The service was
403 also initiated with RAP generated extra core staff.
404 Beyond entrepreneurial expansion into partnerships and networks, World-
405 Class aspiration and confidence also spawned a spirit of non-competitive
406 sharing. During this period, private hospital consolidation unexpectedly
407 caused the Morehouse Medical School Psychiatry Residency program to lose its
408 training sites. MAPCS extra core resources, staff and replacement hospital
409 rotations helped the program survive. This maturing munificence was also
410 extended to the division. When it needed more hands and expertise to wrestle
411 with reform implementation, MAPCS donated over 400 hours of loaned manager
412 time to assist with planning and other projects.
413
414 *It matters not how straight the gate*
415 *Nor charged with punishment the scroll*
416 *-William Ernest Henley*
417
418 In 1996 MAPCS development continued, but some displeasure on the part
419 of its superordinate bodies was becoming apparent. When the four FCCSS
420 providers signed a formal letter of intent/agreement, it overcame long-
421 standing governance barriers and created a first of its kind collaborative in
422 Georgia. The Division questioned the relationships and began to express
423 discomfort with the use of the 'MAPCS' name. It was also in this year that
424 the Division halted the MAPCS LAN construction project and called for a major
425 fraud and abuse investigation of it. Despite this, MAPCS maintained
426 sufficient goal focus that FCCSS was awarded and began a $1.2 million dollar
427 crisis service contract for Fulton County (the most populous of GA's
428 counties). Unfortunately, the Division lacked mechanisms for properly
429 implementing the contract and this contributed further to the tension between
430 it and MAPCS. As the world came to GA for the 1996 Atlanta Olympics, MAPCS

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431 continued to demonstrate its values, vision and class by helping to plan,
432 locate and staff (with both professionals and consumer specialists) Atlanta's
433 first 'Friendship Center' style drop-in centers as a volunteer contribution
434 to the Olympic Support Project for the mentally ill. With the end of the
435 Olympics, the earlier investigation resurfaced. At its conclusion, one MAPCS
436 mid-level manager was terminated by the Division because of covert and
437 illegal, self-benefiting hiring practices related to LAN construction.
438 MAPCS was now operating under division-imposed slow-downs and an increasing
439 cloud, but was awarded a new $600,000 competitive contract in Cobb-Douglas
440 counties with its 'Net 200` Plan to collaboratively provide alternate
441 community services that would decrease hospital utilization by severe and
442 persistently mentally ill (SPMI) persons. MAPCS was bridging the
443 hospital/community divide and communitizing itself. This plan also
444 introduced the concept of *Diagonal Integration* (i.e. planned use of natural
445 supports and lay caregivers as providers and extenders in the formal service
446 network). Again, the Division lacked mechanisms for properly implementing the
447 contract.

448 On September 13 (Black Friday), MAPCS came to a dramatic denouement.
449 Its leadership was precipitously purged. The Superintendent was forced to
450 resign. The Deputy Superintendent, Assistant Superintendent and Director of
451 Information Services/QI were all relieved of duty and transferred.

452 **Epilogue.** Black Friday is a reminder that there is danger in
453 disturbing a system's status quo. It recalls the old adage that the highest
454 aspiration of (unenlightened) bureaucracy is mediocrity and conformity. When
455 the Governing Body is a respondent rather than a progenitor of change this
456 adage is even more likely to be accurate. However, it should also be
457 remembered that the dedication to true quality requires continuous
458 improvement and thus change. As such, such a commitment is not for those who
459 are faint of heart, lack integrity or are unwilling to pay the price for

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460 success. To further appreciate those costs, an informal review was made of
461 GRHA's more recent status. In **1999**, Atlanta West, Renaissance and Ujima
462 continued their affiliation as GRHA Community Substance Abuse programs. Two
463 years prior they received a Fulton County Regional Board award to expand
464 their central intake, women's and continuing care services. Friendship/Drop
465 In Centers persist in the Ponce Avenue corridor of Downtown Atlanta. Some are
466 now enhanced with Double Trouble groups. Brook Run (a 325 bed facility
467 located in northern metro Atlanta and one of two state MR/DD institutions)
468 has been closed and residents not placed in the community went largely to the
469 Developmental Learning Center (and ICFMR unit) at GRHA.
470 The Georgia Mental Health Institute (once a 250 bed sister State
471 Hospital serving northern metro Atlanta) has also been closed. Adult and
472 Child patients from its catchment area are now served by GRHA. The C&A Unit
473 at GRHA now serves 47 of Georgia's 159 counties, contracts and consults with
474 other agencies (such as the Georgia Department of Children and Youth
475 Services, whose first Director of Mental Health is a former MAPCS/C&A
476 manager). The Division continues to use RAP based methodology for staffing.
477 The Morehouse Residency survives and its third year residents have added two-
478 month rotations with GRHA's ACCESS service. ACCESS is the benchmark for
479 virtually all other ACT teams in GA. Six of the original eight Consumer
480 Specialists are still employed at GRHA. Their chosen title is the standard
481 moniker for such persons throughout the state. Finally, in May 1998, the
482 still 368 beds of GRHA and its affiliates (Atlanta West, Renaissance, Ujima,
483 ACCESS and FCCSS)were again surveyed jointly and this time received JCAHO
484 Accreditation with Commendation
485
486 **Implications for State Hospitals of the future**
487

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488 Many lessons can be gleaned from the rise and fall of MAPCS. Those
489 selected for discussion here are for stakeholders who are most interested in
490 the fate of a state hospital entering the new century. Even with the
491 elimination of competition, survival requires that certain critical functions
492 be performed well. For a service organization, the most critical function is
493 satisfying a recognized need. Without the need or ability to meet it, there
494 is no reason for a service agency to exist. As such, SH survival first
495 requires the two fundamentals of need and ability. The more successful a
496 facility is in identifying the right need(s) and addressing them well, the
497 more likely it is to survive. The “right” need is not just a real or
498 legitimate need. It is the need that corresponds most felicitously with the
499 abilities, strength and assets of the agency. Doing well means achieving the
500 customer’s desired outcomes in a manner that is so effective, efficient,
501 timely, available, safe respectful and caring that it meets, if not exceeds
502 expectations.[43]
503
504 Based on this logic, the first several steps toward survival and
505 success are:
506 Step 1: Establish a leadership core with competence and integrity
507 Step 2: Identify the hospital’s abilities and assets
508 Step 3: Identify the (right) need(s) to address
509 Step 4: Define and commit to an outcome that will meet or exceed need
510 based expectations
511 Step 5: Develop initial vision and action plan for outcome
512 accomplishment
513 Step 6: Anticipate/Determine obstacles to outcome accomplishment
514
515 These first steps obviously establish a foundation for action which if
516 successful leads to the desired accomplishments. The next steps are:

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517

518 Step 7: Act on the goals/outcomes
519 Step 8: Achieve the goals/outcomes
520

521 The last steps are based upon and a recognition of the fundamental
522 definition of quality as a continuous process of improvement
523

524 Step 9: Review, monitor and evaluate
525 Step 10: Improve some more/again
526

527 The true power of these steps is in their quintessential nature. The
528 challenge is to recall and persistently apply them during unsettling times.
529 Neither the logic nor wisdom of these steps is new. As such, many of the
530 points that could be raised in explication of each would be familiar. The
531 MAPCS experience, however, involved an uncommon emphasis on certain issues
532 and principles within these steps that should be further elucidated.
533

534 **Point of Emphasis #1: Vital Assets**

535 Identifying the hospital's abilities and assets must be approached with
536 hard-nosed practicality. What should be is not always what is. Defining an
537 accurate reality is critical at this step. Values are a subtle but
538 significant part of a reality that is too frequently overlooked as an asset.
539 An accurate understanding of what is important (i.e.- valued) and what not,
540 to the organization and its collective staff is essential for correctly
541 gauging capabilities and limits. In the MAPCS experience, values also
542 provided energy. The organization and its leadership believed in and cared
543 about people, the value of their lives as well as their right to quality
544 care, health, relief and respect. Quality was both a value and a goal.
545 Earlier on, GRHA had developed its own definition of quality so that the term

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546 was not just a vague buzzword. The energy of activation that ignited these
547 values was courage. Leaders were sometimes awed but seldom afraid. The
548 organization was sometimes anxious but rarely scared. This was not just
549 bravery or naiveté. It was primarily a result of the intense focus upon a
550 sincere desired goal that largely precluded fear and other distractions.
551 Thus leaders and staff were freer to think and act. It was also due in large
552 measure to the bolstering provided by other values such as making more
553 information and knowledge available. This decreased the anxiety that
554 generally attends the unknown as did having a clear goal to shoot for,
555 reliable tactics and strategies to fall back on. It also supports the Demming
556 mandate to "drive out fear" [44].

557 Integrity (especially of leaders) was another critical factor. Keeping
558 integrity with declared organizational values provided much needed
559 consistency and predictability in the midst of change and occasional chaos.
560 It should be noted that leaders and organizations without integrity generate
561 too little confidence to be great champions of change. Since there must be
562 change if there is to be improvement and true quality, integrity is also
563 critical.

564 The sustaining power for MAPCS efforts was staff relationships. The
565 strength of those relationships rested not so much in authority as upon
566 demonstrated consistency (and again integrity) with professed values and a
567 commitment to honest and timely communication. Leaders were expected to be
568 able and willing to explain their actions or decisions. Inability or
569 unwillingness to do so was an informal quality check. Staff was respected
570 enough to be considered competent to reasonably handle any news no matter
571 how unpleasant. This eliminated the excuse of not informing staff for fear
572 that they might panic or revolt. They were told what was known, unknown and
573 the risk involved. Both of these required a major investment of leadership
574 time, but paid great dividends in staff understanding, loyalty and support.

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575 As a result, staff were permitted informed consent and constructive dissent.
576 It was the energy of these relationships, shared vision, values and common
577 goals that carried the organization the extra mile when needed.
578 When cooperative interactions produce an enhanced (and desired)
579 combined effect, it is called synergy. Synergy is organizational overdrive,
580 a system's super energy and the requisite power for overcoming obstacles and
581 long-term survival. Synergy (as opposed to fear) is the energy of successful
582 change management. Values, integrity, courage and strong relationships are
583 vital assets and the keys to organizational synergy.
584
585 **Point of Emphasis #2: Outcome Orientation**
586 It is important to train staff to clearly articulate and commit to a
587 desired outcome and think through how they will know when they have achieved
588 it. They should have impressed upon them the power of outcome orientation
589 and be encouraged to concentrate first on the outcome versus the process for
590 getting there. This approach provides more flexibility and options for
591 success. For example, the process goal of *driving* downtown is more limited
592 and vulnerable (to flat tires, insufficient gas, speeding tickets, floods and
593 car theft) than the outcome goal of *being* downtown, which can be accomplished
594 in an infinite number of ways limited only by law, morality, imagination and
595 accepted values.
596 A significant move for MAPCS was a shift from a process-based mission
597 statement to an outcome-based mission commitment. (See Appendix 3).
598 Consider this simplified example:
599 If your most beloved significant other were in the hospital would you
600 want them to get:
601 A) The highest quality care at the best possible price in the most
602 respectful manner or
603 B) Well?

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604

605 This points out that it is one thing to promise a service, even one of
606 highest quality. It is another thing to define and commit to accomplishing
607 the desired outcome of that same service. The latter when sincerely done
608 requires a different level of courage, maturity, confidence and caring.
609 Review your current mission and vision statements in this light.

610 The commitment to patient outcomes led GRHA inexorably to the need for
611 extra hospital support of its patients. Accomplishing such support required
612 bridging hospital/community gaps (which fortunately was permitted by the
613 principals of the State Commission on MH/MR and SA Service Delivery). This
614 in turn necessitated the new spanning structures of MAPCS, ACCESS, FCCSS, and
615 NET 200. The original impetus for these improvements and innovations was not
616 genius, but rather a commitment and focus upon outcomes.

617

618 **Point of Emphasis #3: Action Imperative**

619 At the most fundamental level, any success enjoyed by MAPCS was based
620 upon its commitment to act. It found ways and to act when others would or
621 could not.

622 To be most successful, a SH should not only plan its strategic actions
623 but also its action strategies. One of the previously described benefits of
624 an outcome-oriented approach is its flexibility. Organizations that restrict
625 the array of acceptable efforts loose that advantage and the ability to see
626 wider opportunity (e.g. to a hammer everything seems only in need of
627 pounding). Given total goal commitment, improvement activity should only be
628 limited by the boundaries of what is legal, moral, effective and affordable.
629 To facilitate and guide choices within this larger array, MAPCS evolved
630 philosophies about its approaches. These served as a set of mental pocket
631 tools for handling change. They can also be used as components of an action
632 strategy.

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For example, one of the most fundamental of these philosophies was to 'keep patients first'. In any conflict of goals or values one should act upon the choice that is in the better interest of the patient. Additionally it was understood that an honest mistake in sincere service to a patient would and could most likely be forgiven and corrected.

Such approaches helped to ensure harmonious efforts of empowered and/or decentralized units and teams. MAPCS actions fell principally within three domains. Some of the strategies for each of the domains are provided.

Domain 1: Progenitor Actions

Use Pareto's Principle: The Principle states that in any function, only a "vital few" factors are responsible for most of the problems. This principle can be applied to quality improvement. The majority (80%) of problems {or any outcome, good or bad} are produced by a few (20%) key causes {or critical actions. If one corrects the few key causes or takes those critical actions, one will have a greater probability of success.[37] If 80% of what is achieved comes from 20% of what is done staff should use this to help prioritize actions and outcomes. In any problem or opportunity look first for the (20%) parts that have the biggest (80%) impact. Start there.

Define Quality and Commit to a Methodology of CQI: Practice Continuous Quality Improvement [44-47] One should approach the management of all change and improvement of quality with the guidance of performance improvement principles (e.g., Plan, Do, Check, Act). Walking through the specific steps of a multi-disciplinary treatment planning process encourages completeness and more effective treatment plans. Similarly, subscribing to and following the principles of continuous quality improvement on a routine basis (especially during periods of crisis and/or chaos) incline an organization towards more complete and effective overall planning.[48] Special attention

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662 should be paid to such principles as making data base decisions, utilizing
663 consumer input/involvement and attempting to do it right the first time. It
664 is no accident or coincidence that the JCAHO has made principles of CQI and
665 Performance Improvement a major theme and foundation of its survey process.
666 Use Theories: When managing situations that are new to one's
667 experiences seek relevant theories and technology. Few state hospitals can
668 mount effective arguments about their resources during downsizing because
669 their true costs are rarely known. Theories and technology for determining
670 such costs exist and are commonly used in other fields. Even minimum
671 understanding of more advanced concepts is sometimes helpful as in the land
672 of the blind, a man with one eye is king.
673 Develop and/or Use Pilots: Like a sounding line or a servomechanism,
674 pilot efforts help sharpen abilities and divine the future. They are also
675 less risky than full-blown ventures and consequently easier to sell at all
676 levels.
677
678 **Domain 2: While-in-Waiting Actions**
679
680 Get in Position: When in a completely dark room with a securely locked
681 door (symbolizing the helpless unknown of many change situations), do not sit
682 in the middle of the room and complain. If nothing else, find the best
683 position to be in when the door opens or the light comes on. Remember where
684 you ultimately want to be (mission, vision, and goals) and at least get in
685 position. Neither facing the unknown or insurmountable obstacles is an
686 acceptable cause for inaction. Taking reasonable action can provide purpose.
687 The strength of purpose can often overcome the paralysis of fear.
688 Obtain information. Use information to anticipate specific changes
689 that may have major impact on the organization. Reading is important.
690 However, one must go beyond intra-organizational and system communiqués,

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691 memos, reports and e-mail. Time must be found to nourish and fortify oneself
692 from a larger national literature of related clinical, management, business
693 and research fields. Visits to other similar or analogous facilities and
694 services should also be arranged. Such forays into the private sector are
695 particularly useful as that domain is often several years ahead of the public
696 sector in technology and philosophy. It is important to position key people
697 in information streams (particularly near their headwaters) so that the best
698 information is available early. This also ties in with the use of pilots.

699 Drive out fear. This is Demming's 8th principle.[44] Staff must not be
700 afraid to try or even to fail in the interest of pt care and quality
701 improvement. Prolonged fear stifles creativity, investment, loyalty,
702 respect and drains energy. Ultimately it limits options for the
703 organization, its staff and the patients it serves. Most people run better
704 (and longer) when they run after versus away from something.

705 Raise questions. Don't be afraid to ask questions. Just ask them
706 constructively. New staff should be especially encouraged to ask questions.
707 Itis good for their orientation and for keeping other staff sharp. Sometimes
708 their fresh perspective helps reveal new possibilities. A question may be
709 their first contribution to the organization.

710

711 **Domain 2: Respondent Actions**

712 Find the Opportunity: There is a natural tendency to be distracted or
713 diverted from longer-term goals by crises and other intense change.
714 Effective organizations deal with such change in a manner that respects but
715 minimizes the distraction. Like a martial artist, such organizations use the
716 energy of change to further advance their vision. Some cultures believe
717 that every crisis contains an opportunity. One of the most significant (and
718 most frequently overlooked) aspects of the crisis/change management task is
719 finding an opportunity within them that can benefit the mission.

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720 Manage Loss and Defeat: Always do your best and play to win/succeed.
721 (i.e.- achieve mission and desired outcomes) But if you cannot win, try not
722 to lose (seek a draw or tie). If some loss is unavoidable, lose no more than
723 necessary. Most importantly, keep until the end the things you will need to
724 try and win again.
725
726 VI-In Conclusion
727
728 The current pace of change has quickened and shows no sign of
729 slackening as the 21st century approaches. During a similar period of great
730 uncertainty, rapid change, and major reorganization of behavioral health
731 delivery systems, one state hospital in Georgia strove to affirm quality care
732 by redefining itself. Despite limited support from its superordinate bodies
733 and inadequate resources, it briefly transformed itself into a unique mini-
734 system of care for a challenging population of persons with serious disabling
735 mental illness. Using a deep commitment to patients, quality, outcomes and
736 action, it developed an impressive ability to problem solve, position,
737 partner, compete and rapidly redeploy resources for mission advancement and
738 the improvement of quality outcomes for a challenging patient population.
739 Such ability and achievement will be needed in the new millennium. However,
740 innovation is not without risk and there can be set backs and penalties even
741 with success. The facility failed to sustain its newly defined role or to
742 fully realize its vision (i.e. a lofty quest for world class quality). yet,
743 it succeeded in surviving two sister facilities, transcending mediocrity and
744 in expanding the potential of Georgia State hospitals. Perhaps it also
745 provided a glimpse of 21st Century evolution for such facilities.
746 In the new millennium there will continue to be a small but significant
747 portion of the mentally ill population that needs relatively higher intensity
748 services. SH's should be uniquely qualified by experience to provide such

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749 service. However, the need for high intensity services will not guarantee the
750 survival of any particular state institution and the next century will almost
751 assuredly commence with fewer SH's than the last.[13]

752 Those that do survive are most likely to be variants of two fundamental
753 functional roles. They will either be used as boxes or bases in the new age.
754 The control oriented box perspective with its lack of pro-social or
755 normalizing optimism about patient needs is like the rigid isolative
756 approaches of the past. It will probably pass into a similar extinction (or
757 correctional absorption). The multi-dimensional, flexible, omni-integrated,
758 value grounded action and outcome oriented, quality driven base perspected
759 facility is the other role option. It is like a high yielding investment
760 that may be riskier and more difficult to develop at first, but ultimately
761 more fit for survival ,enhancement of the service system and achievement of
762 improved patient outcomes. Stakeholders who wish to optimize the longer-term
763 contribution of State Hospitals should encourage and support this type of
764 development.

765 In the final analysis, an organization will not long succeed by simply
766 surviving but may survive for a more extended period by succeeding. While
767 survival may arguably be the ultimate goal, it should not be the primary
768 focus. Service organizations and providers should only exist if there is a
769 real need to be provided for. They only deserve to survive if they are
770 effective and efficient in addressing that need. Though not without risk,
771 being first to address a need or doing so in a unique manner can achieve a
772 relative advantage of effectiveness/efficiency since there is at first little
773 competition on the cutting edge. Ultimately, those State Hospitals that are
774 most effective and efficient in the provision of services (and/or elimination
775 of competition) are most likely to succeed and survive. The quality of that
776 future survival and success depends on the vision, values and courage of
777 decision-makers and leaders now.

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778

779 *I am the master of my ship*

780 *I am the captain of my soul*

781 *-William Ernest Henley*

782

783

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783 Appendix #1

784

785 **Examples of Base Perspected State Hospital Activities**

786

STATE	**BRIEF PROGRAM/ACTIVITY DESCRIPTION**
AZ	Re: Arizona State Hospital: On January 11, 1999 in her State of the State Message the Governor declared a major health initiative called Arizona's PATH (Positive Action for Tomorrow's Health) in which the "number one priority is to address the needs of the state mental hospital."
GA	Georgia Regional Hospital: Primary consumers called consumer specialists are employed as members of treatment and unit management teams. West Central Georgia Regional Hospital utilizes ACT teams.
KY	University of Louisville-Central State Hospital- Local CMHC: One of their State Hospitals has developed an accredited Addictive Disease Fellowship. Another has a specialized Geropsychiatric Unit
MA	Medfield State Hospital: PRISM Program- A comprehensive rehabilitation service for every patient at the hospital that spans the needs of the most impaired to those being released for discharge – Uses Lineham's model to teach skills to patients
MO	A Missouri State Hospital: Almost eliminated the use of restraints via the use of Anthony's Cognitive-Behavioral Rehabilitation Program
MT	Montana State Hospital: Is rebuilding its single State Hospital as a smaller and more modern facility tied into the community with the unifying treatment philosophy and

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	principles of Rehabiitative Role Recovery
ND	North Dakota State Hospital: Has developed a specialized sex offender Evaluation and Treatment program for persons civilly committed under a new law allowing civil commitment of such persons
NE	Lincoln Regional Center and Hastings Regional Center: One facility operates a Community Transition Program (CTP) that significantly improves communitization and reduces Hospital Utilization. The other has developed a Neurogeriatric Services Outreach (NGSO) team that supports several nursing homes and their residents.
NJ	A New Jersey State Hospital: Integrated Case Management Services assigns case managers for education, linkage, monitoring and support while in the community for a period of at least 18 months following hospital discharge
OH	Ohio State Hospitals: Community Support Network (CSN) intensive community services for persons discharged from SH care provided by former (over 600) state employees/in patient staff
OR	Oregon State Hospital: Intermediate and long-term child, adolescent, adult, geriatric and forensic hospital
UT	Utah State Hospital: On-campus clubhouse for inpatients that teaches OT and work skills
VA	Southern Virginia Mental Health Institute: Has a Rapid Release Program

787

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787 Appendix #2

788

789 Illustrative Mission Statements

790

791

792 PROCESS ORIENTED

793

794 *To **provide** the highest quality behavioral health services in the most*

795 *affordable manner to the citizens of…*

796

797 OUTCOME ORIENTED

798 *"To improve the quality of life for each consumer we serve by achieving*

799 *with them the relief or control of their symptoms and their successful*

800 *community living in a manner that respects their person and maximizes their*

801 *participation.."*

802 –The Metro Atlanta Psychiatric Care System – 1995

803

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803 Appendix #3

804

805 **Georgia's 14 Principles Of Mental Health Reform**

806

807 **Consumer choice**

808 Of providers and services through input in planning the service system
809 and involvement in developing individualized service plans

810 **Single point of accountability**

811 For fiscal, client service, and administrative issues. To include
812 better coordination of services for consumers moving between hospital and
813 community and more rational and equitable resource allocation to meet
814 individualized needs

815 **Comprehensive System**

816 Easy access to a comprehensive array of services and supports for
817 people with mental illness, mental retardation, and substance abuse problems
818 to live, learn, and work in communities throughout Georgia

819 **Privatization**

820 Increased involvement by the private sector to allow consumer and
821 family choice and increased competition among providers

822 **Local planning**

823 Increased community input and control by empowering consumers and
824 families, as well as providers and elected officials

825 **Adaptive system**

826 A simplified system designed to adapt to the changing needs of
827 consumers and families

828 **Most-in-need**

829 Allocation of limited public funds to ensure that the needs of
830 consumers who are most in need are met at the appropriate service levels

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831 **Prevention**

832 Emphasis on strategies for preventing disabilities that are
833 preventable, balancing the need to direct limited resources at both
834 prevention and intervention activities for those most in need

835 **Quality of service**

836 Provision of the highest-quality services using flexibility in funds
837 and incentives that reinforce quality and efficiency

838 **Separation of functions**

839 Separation of service planning coordinating contracting, and resource
840 allocation from the function of service delivery

841 **Single point of entry**

842 For all consumers and families who enter the service system

843 **Accountability**

844 A system of accountability for public and private providers that
845 focuses on outcome measurement using a reliable management information
846 system

847 **Qualified staff**

848 A system for supporting the quality of staff through continued
849 education and training, incentives, and other recruitment and retention
850 strategies.

851 **Funds to follow the client**

852 Funding flexibility to allow funding to follow the needs of clients
853 rather than the needs of agencies and programs

854

855 (Adapted from Elliott, M.D., Ph.D. Richard L., *Mental Health Reform in*
856 *Georgia, 1992 to 1996.* Psychiatric Services, 1996. **4**(11): p. 1207 with
857 permission of the author and journal.)

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