

FINANCING MENTAL HEALTH REFORM IN KANSAS

Robert H. Lee and Ronna Chamberlain*

ABSTRACT. This paper examines the impact of the Kansas Mental Health Reform Act of 1990 on the mental health care system, on the budget of the state, and on the budgets of the Community Mental Health Centers. Both the successes and the failures of Mental Health Reform suggest that coordination of institutional and financial arrangements are needed to improve the outcomes of care. From a budgetary perspective, Mental Health Reform demonstrates the central role of Medicare and Medicaid in financing services for vulnerable populations. The reform also demonstrates that shifting costs to Medicare and Medicaid is a component of prudent financial management by the states.

INTRODUCTION

This paper examines the impact of mental health reform in Kansas on the mental health care system, on the budget of the state, and on the budgets of Community Mental Health Centers. Our examination demonstrates how complex decentralization of authority and rationalization of incentives can be in an environment that involves multiple levels of government.

The Kansas Mental Health Reform Act of 1990 responded to a 1987 report showing that the financing system was incongruent with the state's policy objectives in three fundamental ways. First, although the state sought to facilitate independent living in the community, 93 percent of its funds went to state hospitals, private psychiatric hospitals, and long term care facilities. Second, access to hospital and community services was

* *Robert H. Lee, Ph.D., is Professor, Department of Health Services Administration, University of Kansas. His teaching and research interests are in health economics. Ronna Chamberlain, Ph.D., is the Director of the School of Social Welfare, University of Kansas. His research interests focus on mental health.*

confusing and poorly coordinated. Third, although the state sought to control spending on mental health services, incentives for doing so were weak. In making these changes, Kansas joined a number of other states (*e.g.*, Vermont, Ohio, Iowa, Texas, and Oregon) that were trying to change the financing and delivery of mental health services.

These states confronted complex financing systems. Total spending for substance abuse and mental health services totaled \$54 billion in 1990 (Frank, McGuire, Regier, Manderscheid and Woodward, 1994). Of this, 41 percent came from a variety of private sources (including private insurers, out-of-pocket spending by patients, and philanthropy); 22 percent came from a variety of federal sources (Medicare, Medicaid, the Veterans Administration, and other sources); 32 percent came from state sources (Medicaid and other); and 5 percent came from local sources.

The complexity of the financing system is compounded by the wide range of organizations that provide mental health services. Public (for the most part, state) hospitals and private specialty hospitals have long played central roles in the delivery of mental health services. In part because of advances in therapy and in part because of a search for new markets, psychiatric units in short-term general hospitals have captured an increasing share of inpatient mental health services. Long term care facilities serve many residents with dementia and schizophrenia. An even more diverse array of providers delivers services in the community: Community Mental Health Centers, private psychiatrists, other physicians (especially primary care physicians), psychologists, and social workers in a variety of human services agencies.

The complexities of mental health financing and delivery look quite familiar to observers of health care in the United States. To such an observer three notions that are central to current efforts to reform mental health services will also be familiar. First, improved coordination of care may improve the outcomes of care and reduce costs. Second, changes in the mix of services may improve the outcomes of care and reduce costs. And, third, changes in incentives will be needed to realize these goals. Precisely these ideas underlie the nation's shift to managed care.

Despite many similarities, mental health financing and delivery are different in three important ways. First, state governments have a pivotal role in the financing and delivery of mental health services. States are the principal funding sources for public mental hospitals, disburse federal and state grants

to local mental health care providers, and participate in structuring Medicaid. As Frank and Gaynor note, this gives states considerable latitude in defining the implicit and explicit contracts that underlie most public funding of mental health services (Frank and Gaynor, 1994). Second, especially for those with severe and persistent mental illness [SPMI], the ability of patients and their families to coordinate services is often compromised. Because diminution of cognitive function is a common consequence of SPMI, patients may not be able to coordinate care and may actively resist the efforts of family members to act on their behalf. This often makes coordination of care even more difficult than for other chronic illnesses and places increased demands on formal coordination mechanisms. Third, there have been repeated public sector attempts to improve the management of mental health services and to change the mix of services. This contrasts sharply with the record for other parts of the medical care system, where, despite longstanding recognition of the shortcomings of the acute medical care system, public efforts to change the system have been tentative at best.

At least four postwar rounds of reform have sought to increase the role of community services and improve the coordination of services. Anchoring the first round of reform was the National Mental Health Act of 1946, which initiated a program of small grants to states. These grants were designed to expand community-based treatment programs and coordinate community services with institutional services. The second phase of reform had quite different effects. The expansion of Community Mental Health Centers in the early 1960s was designed to foster coordination of comprehensive mental health services within defined catchment areas. Although the infusion of federal money further encouraged expansion of community-based treatment, states were not involved, as the grants went directly to Community Mental Health Centers. With the leverage of the states reduced, coordination of state hospital and community services did not improve for the most part. Moreover, little of the expanded capacity benefitted SPMI patients. Instead, serving more vocal and less severely impaired clients evolved as the primary mission of Community Mental Health Centers.

The third round of reform began in the early 1980s, as passage of patients' rights bills made involuntary hospitalization more difficult, as dissatisfaction with existing community services for SPMI patients became more acute, and as model community programs demonstrated that SPMI patients could do well in the community (Stein and Test, 1978). These concerns prompted the creation of the Community Support Program, which

was designed to expand services for the severely mentally ill in community settings. Initially the National Institute of Mental Health defined the components of a comprehensive program, established coordinators in each state, and funded a series of demonstration grants. Later Public Law 99-660 required states to develop plans for community-based mental health services in order to continue to receive Alcohol, Drug Abuse, and Mental Health Administration block grants. As a further incentive for expansion of community-based services for SPMI patients, Medicare and Medicaid began reimbursement for case management and partial hospital services.

Despite these advances, a fundamental barrier to the expansion of community care remained. State hospital services continued to be “free” for community-based mental health providers, and incentives to overuse these inpatient services still shaped patterns of care.

Although largely funded by the federal government, the third round of reform ultimately reinforced incentives for renewed state activism. Direct federal funding of Centers largely ceased, as states became disbursement agents for both federal and state grants. This gave the states increased leverage. The concomitant changes in Medicare and Medicaid gave the states a powerful incentive to use that leverage. By shifting to a largely community-based system, states could rely on increased federal support.

The current round of mental health reform emphasizes case management and delegation of responsibility. Case management emphasizes outreach to a targeted group of individuals at high risk of hospital admission, assistance with management of symptoms in the community, and facilitation of independent living in the community (Stein and Test, 1980). Delegation of responsibility to a central mental health authority makes one organization accountable for clinical, financial, and administrative management of services for all mental health services, including the SPMI population (Goldman, Morrissey and Ridgely, 1994). Delegation is designed to complement case management by creating incentives for the accountable organization to coordinate the varied providers of services. The Mental Health Reform Act gave Community Mental Health Centers the funds and the responsibility for managing the care of Kansans with SPMI.

KANSAS BEFORE REFORM

Kansas had four state mental hospitals as reform began.⁽¹⁾ The three large hospitals were responsible for patients within their catchment areas.

Osawatomie State Hospital, with 371 licensed beds, was about 50 miles south of Kansas City. Topeka State Hospital, with 348 licensed beds, was about 60 miles west of Kansas City. Larned State Hospital, with 535 licensed beds, was about 275 miles southwest of Kansas City. Rainbow Crisis Center, with 59 licensed beds, was a specialized facility for children in Kansas City, Kansas.

The locations of the state mental hospitals mirrored the concentration of the population in the eastern half of the state (*i.e.*, in area served by Osawatomie, Rainbow, and Topeka). Western Kansas was (and is) sparsely populated even by comparison with most other rural areas. Of the 50 counties in the Larned Catchment area, just nine had populations over 10,000 (Kansas Hospital Association, 1994). As a result, some patients had to travel vast distances to secure medical and social services. Mental Health Reform began with the recognition that serving the SPMI population in the community posed special challenges in much of Kansas.

As of 1989, twenty-seven Community Mental Health Centers covered the state. Some centers served vast areas. For example, the catchment area of High Plains Mental Health Center encompassed 20 counties and 20,000 square miles. In addition, many Centers were quite small. In 1989 nearly half had budgets of less than \$1,000,000.

As a result, the capabilities of the centers varied greatly. For example, emergency and screening services were quite limited: only 14 percent of the Centers reported having hospital liaison personnel in 1990 and only 41 percent reported having crisis line personnel (Chamberlain, et al., 1995). A number of Centers lacked important components of the Community Support Program. For example, only 32 percent reported having personnel working to enhance the vocational skills of clients. Services for children and adolescents varied even more than services for adults. For example, all of the Centers had case managers for SPMI clients, but only 45 percent had case managers for children and adolescents. There was general agreement that meaningful reductions in institutional services would require expansion of Center resources.

As Table 1 shows, Community Mental Health Centers had fairly typical financing structures before reform. The state supplied roughly a third of Center revenues via grants and its share of Medicaid. Although smaller than the 41 percent share of funds from state sources that Frank and Gaynor report for all states, this still afforded the state considerable influence (Frank

and Gaynor, 1994). Medicare was not a major revenue source. At 52.5 percent, the share of revenue from private and local government sources was more than double the national average (20 percent according to Frank and Gaynor (1994). The increased reliance on private payments reflected the position of many rural Centers as principal providers of mental health services.

TABLE 1
1989 Revenue for Kansas Community Mental Health

Source	As % of Total Revenue
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Total Revenue (\$56,177,485)	
Medicaid	17.0
Medicare	2.2
Private Insurance	20.8
Consumers' Direct Payments	8.7
Grants	25.5
County Support	18.1
Other Local Revenue	4.8
Other Revenue	2.9

Source: Kansas Department of Social and Rehabilitation Services (1990).

THE GOALS AND STRUCTURE OF REFORM

The Mental Health Reform Act sought to contain the state's costs of caring for the severely mentally ill, to shift funds from institutional to community-based care, to deliver services for the severely mentally ill in settings as unrestrictive as possible, to allow adults with severe and persistent mental illness to live as independently and productively as possible, to allow children with serious emotional disturbances to live as independently and productively as possible, and to clarify the roles and responsibilities of mental health and social service agencies. Aside from cost control, these were precisely the goals that have motivated most of the reforms of the last 50 years.

Containment of the state's costs had two components. First, there was reason to believe that community-based treatment might offer comparable or superior outcomes with somewhat lower costs than institution-based treatment (Knapp and Beecham, 1990; Weisbrod, Stein and Test, 1980). Second, there was reason to believe that much of the costs of community-based care could be shifted to the federal government. Medicare and Medicaid imposed fewer restrictions on reimbursement for outpatient services than on inpatient services. In addition, Community Mental Health Centers could generate "soft match" funds for Medicaid services. Under a soft match, Medicaid matching funds could come from sources other than the state (*e.g.*, from county taxes). So, even if reform did not reduce total costs, it would almost surely reduce the state's share of costs.

Despite these multiple goals, the structure of Mental Health Reform was relatively simple. By October 1, 1991, each Community Mental Health Center was directed to prepare a coordinated plan to address the service needs of adults with severe and persistent mental illness, of severely emotionally disturbed children and adolescents, and of other individuals at risk of requiring institutional care in the Center's catchment area. Then, on a phased basis, each Center was to contract with the Department of Social and Rehabilitation Services to provide screening, evaluation, and treatment services for members of those target populations. Screening was required for all state hospital admissions, including court-ordered evaluations, and each Center was given a quota of days in its state hospital. Treatment was defined broadly, including essentially all the services required for members of the target populations to function outside inpatient institutions. After signing the contract, Community Mental Health Centers received Mental Health Reform grant funds. The formulas for awarding grant funds were reached via negotiations between representatives of the state and representatives of Community Mental Health Centers in each of the three catchment areas. In principle, the Secretary of Social and Rehabilitation Services could cancel or refuse to renew a contract for failure to meet the terms of the contract, but a Center's grant was not explicitly based on volume or outcome measures.

Mental Health Reform was initiated on a phased basis in the three state mental hospital catchment areas. Reform began in the Osawatimie catchment on July 1, 1991 and was to be completed by June 30, 1994. Reform began in the Topeka catchment on July 1, 1992, and was to be completed by June 30, 1996. Reform began in the Larned catchment on July 1, 1993, and was to be completed by June 30, 1997. Associated with this

was a requirement for the phased closure of 60-90 state hospital beds in Osawatomie, Topeka, and Larned State Hospitals.

THE OUTCOMES OF REFORM

The growth of state hospital spending slowed after reform. Between fiscal year 1990 and 1994, state hospital budgets increased by only 9 percent, less than the rate of inflation. The budget for Osawatomie State Hospital, the first hospital affected by reform, increased by only 3.5 percent between 1990 and 1994. Licensed beds fell by 10 percent, and the average daily census fell by 21 percent. Again, the changes were most dramatic at Osawatomie. There licensed beds fell by 17 percent and the average daily census fell by 38 percent.

An even more fundamental change occurred in hospital services. Hospitals increasingly became acute care facilities rather than long-term care facilities. Admissions rose by 11 percent, and the average length of stay fell nearly 30 percent, from 104 days to 74 days.⁽²⁾ What is most striking about this shift is that it took place almost entirely in Osawatomie and Larned State Hospitals. There was little change at Topeka State Hospital, and Rainbow Crisis Center was already functioning as an acute care hospital. Further reductions in admissions and lengths of stay are almost surely feasible. For example, two of the large counties in the Kansas City area realized 49 percent reductions in admissions as the average length of stay fell by 36 percent. These counties had resources that others did not: a head start in reform, large population bases and large budgets, small service areas, well-established 24-hour crisis lines, large emergency and diversion units, and local psychiatric facilities for crisis stabilization. Nevertheless, expansion of these services elsewhere should permit further reductions in hospital use.

The immediate budgetary effects of this reduction in hospital use have not been trivial, but the long term budgetary impact promises to be much larger. Continued reductions in the state mental hospital patient census and the closure of Topeka State Hospital should allow a reduction in state spending for mental hospital services. The reduction is likely to be less than the Topeka State Hospital budget (\$23.6 million in fiscal year 1994), but could be substantial. Consolidation will sharply reduce overhead expenses, and Topeka State Hospital was the least efficient of the state hospitals.⁽³⁾

The savings from this change in the mission of state mental hospitals could fail to materialize if Mental Health Reform simply shifted services from

state hospitals to complementary service systems. There is little evidence to date that this has been the case. After Mental Health Reform began, court-ordered involuntary commitments fell, Medicaid-sponsored admissions to psychiatric units of community hospitals fell slightly, the adult homeless population did not increase,⁽⁴⁾ the adolescent and child homeless population may have increased modestly, and the number of Medicaid beneficiaries in nursing facilities for mental health did not change (Chamberlain, et al., 1995).

For adults at least, cost shifting to other institutional providers does not appear to have been a major factor in the reduction in patient days in the state mental hospitals.

As Table 2 shows, Mental Health Reform changed the amounts and sources of funds for Community Mental Health Centers. The most obvious change, of course, was that total spending increased sharply. Predictably, about a quarter of the increase was a direct result of Mental Health Reform grants, so the state role in financing the Centers expanded. Less predictably, nearly a third of this expansion was financed with federal funds.

Because of expansion of services and because of more aggressive pursuit of Medicaid revenues, total Medicaid funds increased by \$10,737,904. This 112 percent increase enlarged Medicaid's share of total revenue slightly. For two reasons this does not represent a sustainable strategy. First, the state plans to move nearly all Medicaid beneficiaries into managed care plans and anticipates setting up a managed behavioral health carve-out. This would dampen the incentives for Centers to expand services. Second, if Medicaid is transformed into a block grant, as current Congressional proposals envision, increased spending for beneficiaries would no longer increase the flow of federal funds into Kansas. This would sharply reduce incentives to shift the source of funds from general state revenues to Medicaid.

Expanded services for the SPMI population dramatically increased revenue from services for Medicare beneficiaries. As a result, Medicare revenues rose by \$7,998,083, and the Medicare revenue share increased sharply. This is likely to be a sustainable strategy. Current Congressional proposals to change Medicare would have little impact on these revenues.

In contrast to the growing importance of public insurance, private insurance revenues fell slightly. This reflects two factors (Sharfstein and Stoline, 1992). The proportion of the population with private insurance coverage has been slowly falling, and coverage for behavioral services has increasingly become more restrictive. In short, the trends in Table 2 illustrate

the process of shifting health care costs to consumers and to government payers.

Direct Consumer Payments, Other Grants, County Support, and Other Local Revenue increased more slowly than overall revenue. The dramatic increase in Other Revenue largely reflects improvements in the accounting system, in that it now captures net revenue from programs affiliated with the Centers. Community Mental Health Centers had almost complete discretion in their uses of Mental Health Reform grants. Nonetheless, resources for the services targeted by reform increased sharply. Between 1990 and 1994 the number of full-time equivalent [FTE] personnel providing emergency and diversion services increased by 52.3 percent (Chamberlain, et al., 1995). The largest increases were in hospital liaison and intensive diversion, the services targeted by reform. In fiscal year 1994 these personnel screened 6,146 patients who

TABLE 2
1994 revenue for Kansas Community Mental Health Centers

Sources of Funds	As % of Total Revenue	% Change between 1989 and 1994
Total Revenue (\$106,587,385)	100.0	89.7
Medicaid	19.0	112.6
Medicare	8.7	650.8
Private Insurance	10.3	-6.1
Consumers' Direct Payments	6.6	43.2
Mental Health Reform Grants	10.8	NA
Grants	19.9	48.0
County Support	13.0	35.6
Other Local Revenue	3.0	16.8
Other Revenue	8.8	486.8

Source: Kansas Department of Social and Rehabilitation Services (1995).

were referred for state hospital admission and diverted 67 percent of them to community services. Between 1990 and 1994, FTEs in the Community Sup-

port Program increased by 74.2 percent, and FTEs in Community-Based Services for Children increased by 174.9 percent.

This expansion of services appears to have expanded opportunities for SPMI patients. Chamberlain *et al.* show that 73 percent of those being served by the Community Support Program were severely ill; only 7 percent resided in nursing homes; 70 percent lived independently with supportive services; 86 percent avoided hospitalization during the previous quarter; 50 percent engaged in organized activities (*e.g.*, sports or church) more than once per week; 56 percent engaged in some form of vocational activity; and 26 percent engaged in competitive vocational activity (Chamberlain, et al., 1995).

Despite these positive outcomes, a cautionary note is in order. Interviews with clients and Center personnel suggest that significant numbers of SPMI clients were not receiving appropriate services. Program data show that 34 percent of those eligible for the Community Support Program received very minimal services, and interviews suggest that lack of Center resources was the main reason for this failure to access services (Chamberlain, et al., 1995). In addition, continued development of Mental Health Reform in the Topeka and Larned Catchment Areas will increase the number of SPMI clients living in the community. So, either significant gains in productivity or significant increases in resources will be needed to serve this population adequately.

Although Reform increased community-based services for children significantly, the results were much less satisfactory than for adults. Inpatient days in state mental hospitals for children and adolescents with serious emotional disturbances fell by 31 percent after 1991, primarily as a result of reductions in length of stay. Unfortunately, bed-days in emergency shelters rose 209 percent and bed-days in group homes rose 432 percent. Shifts of responsibility from state mental hospitals to community agencies appear to have taken place. Three main factors appear to account for these more mixed results. First, many children and adolescents affected by reform did not fit a “mental illness” model very well and required a varied list of interventions. There were even questions about whether Community Mental Health Centers were best suited to take the lead in providing services. Second, many Community Mental Health Centers were not well prepared to serve severely emotionally disturbed children and adolescents. No history of program building comparable to the Community Support Program preceded the expansion of services for children, and many Centers began with very

limited resources and experience in serving children. As a result, Mental Health Reform funds were not adequate to build the needed capacity. Third, in contrast to the situation for adults, few fee-for-service incentives reinforced expansion of services for children and adolescents. Only a minority of this population was eligible for Medicaid, few were eligible for Medicare, many private health insurance plans offered very limited coverage for the services needed, and many children were uninsured. Compared with adults, children and adolescents were doubly disadvantaged: greater efforts to coordinate and expand services were needed, yet incentives to do so were more modest.

IMPLICATIONS

In many respects Mental Health Reform has been a success in Kansas. It has shifted the locus of care from institutions to the community for many patients. It has enhanced specialized community services, improved coordination of care between the state hospitals and Mental Health Centers, and appears to have improved the outcomes of care for adults with severe and persistent mental illness.

Mental Health Reform has also set the stage for closure of Topeka State Hospital. Its budget was \$23.6 million in 1994, almost exactly twice the total amount of Mental Health Reform Grants. Closure, combined with continued reductions in hospital days for dients in the other two catchment areas, should allow the state to improve outcomes somewhat for the SPMI population with a modest reduction in the mental health budget or improve outcomes significantly for the SPMI population with no change in the mental health budget.

In other respects Mental Health Reform has not succeeded. A significant number of adults with severe and persistent mental illness still lack access to community services. Concerns about equity remain unresolved, as access to housing and other services for adults continues to vary widely in different areas of the state. Finally, expansion of community services for seriously emotionally disturbed children and adolescents does not appear to have offset fully reductions in state hospital services that Mental Health Reform initiated.

Both the successes and failures of Mental Health Reform suggest that coordination of institutional and financial arrangements are needed to improve the outcomes of care. For SPMI clients, Community Mental Health Centers had clear responsibility, faced a system of incentives that unambiguously

rewarded expansion of services, and had access to enough resources to serve the majority of clients. Mental Health Reform grants continued the expansion of the capacity of the Centers that Community Support Program grants had begun. In addition, fee-for-service Medicare and Medicaid revenues strongly reinforced the incentives inherent in Mental Health Reform. For children and adolescents, in contrast, Community Mental Health Centers lacked clear responsibility, faced a system of incentives that rewarded expansion of services much less, and did not have enough resources to serve the majority of clients. Other state and local agencies were charged with meeting the needs of children and adolescents. No federal program comparable to the Community Support Program had built capacity. Finally, incentives to expand services to children and adolescents were not strongly reinforced by fee-for-service revenues from public and private insurance plans.

Two important components of this system are likely to change. The shift of Medicaid to a managed care framework (and possibly a block grant framework) will dampen incentives to expand services. Completion of Mental Health Reform seems likely to reduce the visibility of SPMI clients in Community Mental Health Centers and in the Legislature. History suggests that other claims on resources will eventually divert resources from the Centers and from SPMI clients. Even maintenance of the progress to date is far from assured.

From a budgetary perspective, Mental Health Reform demonstrates two principles. First, it demonstrates the central role federally financed entitlements in financing services for vulnerable populations. Second, it also shows that the current structure of those entitlements makes shifting costs to federal sources a part of prudent financial management by the states. In an environment of federal budget cuts, this sort of gamesmanship seems unlikely to be tenable.

Mental Health Reform represented a substantial investment for Kansas. That investment, however, was more than matched by increases in Medicare and Medicaid funds. Mental Health Reform Grants increased by \$11.5 million between 1989 and 1994. Medicare and Medicaid funds for Community Mental Health Centers increased by \$18.7 million between 1989 and 1994. Unlike Mental Health Reform funds, expansion of Medicare and Medicaid revenues was directly conditioned on delivery of services to beneficiaries. Medicare and Medicaid funds made expansion of community-based services for the SPMI population both possible and financially attractive. It is, therefore, somewhat troubling to anticipate the

consequences of a Medicaid system that emphasizes block grants to states and capitation for providers of behavioral services.

On the other hand, it is difficult to envision the long-term survival of current Medicaid financing arrangements. In a wealthy state like Kansas, the state government nominally contributes just over 40 percent of Medicaid spending. In fact, because Community Mental Health Centers can use their own funds to match federal Medicaid dollars, the effective state matching rate is well under 40 percent. The incentive to provide services in the community is even stronger because both Medicare and Medicaid sharply limit reimbursements for inpatient mental health services. As a result, the incentives to reduce state mental hospital services are likely to be substantial (especially for a state with much lower matching requirements), whether or not community services are available. Indeed, the mixed experience of Kansas in providing services to children and adolescents suggests that this scenario is quite likely.

NOTES

1. Topeka State Hospital was closed in 1997.
2. The increase in admissions was entirely due to a dramatic increase in admissions at Larned State Hospital. Admissions fell at the other hospitals.
3. In 1994 the cost per discharge at Topeka State Hospital was \$33,372. The average for the other hospitals was \$20,268. Topeka State Hospital's average cost per discharge was 20 percent higher than the cost per discharge at Larned State Hospital, the next most expensive facility.
4. Data on homelessness is of less than ideal quality. There is no data on the number of mentally ill homeless persons in Kansas or even an inventory of shelters. A survey of 31 shelters identified by Community Mental Health Centers produced a diverse collection of data that was not easy to analyze.

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