Comparative study on psychiatric treatment referens and the formation of systems for the protection of right in the USA, Canada and Japan

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金沢大学

精神医療改革と権利擁護制度形成に関する
アメリカ・カナダ・日本比較研究

（研究課題番号　13610197）

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研究成果報告書

平成16年12月

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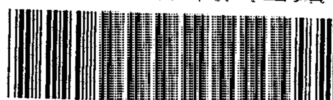
金沢大学附属図書館



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はしがき

この報告書は平成１３年度～平成１５年度の科学研究費補助金を受けて行った研究「精神医療改革と権利擁護制度形成に関するアメリカ・カナダ・日本比較研究」の経過を報告するとともに収集した資料及び得られた知見をまとめたものである。本報告書をまとめるにあたって、平成１４年度、１５年度の二度に渡る実地調査及び資料収集にご協力いただいたアメリカ合衆国ウィスコンシン州マディソン市の精神保健当局各位並びにウィスコンシン大学マディソン校ソーシャルワーク大学院の関係者各位、また国内でインタビュー調査や資料収集にご協力いただいた関係者各位に感謝する。

平成１６年１２月　　研究代表者　　高橋涼子

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研究組織

研究代表者：高橋涼子（金沢大学法学部教授）

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精神医療改革と権利擁護制度形成に関する研究概要

高　橋　涼　子

１．研究の背景

私は平成１０～１１年度科学研究費（奨励研究A）「精神医療における患者の権利擁護システムの整備に関する研究」（交付総額１８０万円）を受け、権利擁護（アドボカシー）制度の政策理念、内容、歴史的背景及び展開状況について、アメリカ合衆国を中心に概要を把握するとともに、日本における精神医療ユーザーの当事者運動や民間の権利擁護機関の実態を把握することを目指した。この研究では、アメリカ合衆国の精神医療政策の柱であった脱施設化と患者の権利擁護に関する法制の関係を明らかにすることはできたが、脱施設化の進行に大きな役割を果たしてきた地域ケアシステムの構築については、充分に研究することができなかった。特に、平成１０年度の科研費で、研究のレビューを受けるため訪れたウィスコンシン大学教員 James J. Mandiberg 氏より、同州の地域ケアシステム PACT（Program of Assertive Community Treatment）の説明を受けその先進性を指摘されるとともに資料の指導を受けることができたが、同科研費研究期間内には、それ以上に発展させることができなかった。しかし、患者・当事者の権利擁護（アドボカシー）が確実に行われるためには、その前提として、治療やケアの主体的選択と日常生活をサポートする地域ケアシステムの存在が必要であり、これなくしては、権利侵害の生起する患者・当事者の日常環境自体が改善されない。

従って、今回申請した、「精神医療改革と権利擁護制度形成に関するアメリカ・カナダ・日本比較研究」においては、地域ケアシステムを主眼に起きつつ、患者の権利擁護と当事者参加について、さらなる研究を行いたいと考えた。特に、①精神医療改革の趨勢である地域ケアシステムの構築と展開を、北米を中心に研究し、精神医療ユーザーの権利擁護を進展させる、地域資源の整備と当事者の活動参加の現状を調査する、②利用者の「主体性」と「選択」を主眼とする社会福祉制度へのシフトが進行中の日本において、精神医療ユーザーを医療・福祉のサービス利用者という対等な当事者として位置づけ、精神医療を施設中心から地域ケアシステム中心へとスムーズに転換していくために必要な、法制度と社会資源の適切な配置および当事者参加の支援について展望を示す、の２つを大きな目的として当研究の科研費申請を行い、平成１３年度～１５年度の研究費補助の決定を受けて研究を開始した。

２．研究計画・方法

平成１３年度にはアメリカ合衆国、カナダの過去３０年間の精神医療改革の展開について、文献でその理念、法制度改革、判例の影響、地域ケアの構築過程などについて研究調査した。特に、従来の研究経過でふれた、ウィスコンシン州の地域ケアシステム PACT（Program of Assertive Community Treatment）に関して、文献調査を進めた。平成１４年度、１５年度はウィスコンシン州の地域ケアシステム及びアドボカシー制度について州都マディソンにて調査を行い、医療従事者、行政担当者、法曹関係者、当事者運動のキーパーソンらへのインタビューから、州全般の制度の概要を明らかにするとともに、アメリカ合衆国の精神医療制度についての資料を収集した。なお、平成１５年度には当初、カナダにおける患者の権利擁護制度と精神医療ユーザーの活動についてオンタリオ州トロントで調査を行う方向で計画を始めたが、当地のＳＡＲＳ問題により断念し、前年度に引き続いてマディソンにて調査を行った。マディソンとトロントは地理的に近く、部分的に情報を得ることはできたが、アメリカ合衆国と同様、州が政策主体として地域の医療や福祉を統括しているカナダは一方でアメリカ合衆国のような市場化の様態は示しておらず、今後、引き続き比較のための資料収集に努める予定である。

以上の調査をもとに日本の精神医療制度改革の経緯及び当事者運動との比較を行い、研究発表の項で呈示したように成果の発表と行った。

なお、権利擁護制度については一定の知見を得ることができたが、アメリカ合衆国の精神医療政策において近年、理念として掲げられて注目されるリカバリー概念とその精神医療政策に対する影響については、調査の進行に伴いその存在を認識したが、その実態について充分な資料収集と分析を行えなかった。本研究の主眼である権利擁護と密接な関わりをもつ当事者の参加を提唱するこの概念を、精神医療改革と権利擁護制度形成の文脈においてどのように評価すべきかについて、追加の資料収集を行った上で判断したいと考えたため、報告書作成の期限延期を申請し、今回、ここに作成するものである。

３．研究の成果及び今後の課題

①. アメリカ合衆国を初めとする欧米諸国の精神医療改革の展開について、クライエントの地域生活の続行を支援する多職種の医療専門職チームによる「訪問型の包括的地域支援サービス」（Assertive Community Treatment ＝ ACT）に注目しつつ、資料収集と文献研究を行った。その上で、アメリカ合衆国において地域精神医療システムの先進地と言われるウィスコンシン州マディ

ソン市にて現地調査を行った。行政担当者、法曹関係者から制度の説明を受け、ACT あるいは PACT（Program of Assertive Community Treatment）といった様々な地域ケアプログラムを提供しているプロバイダー関係者（医療専門職およびコンシューマー）にはその多様な活動についてインタビュー調査するとともに可能な範囲で活動に同行し、サービス提供の一端を実際に見ることができた。この調査によって多様なプログラムをもつ地域ケアシステムと患者の権利擁護（アドボカシー）との連関が確認できた。この正の連関の背景として、a. マディソン市が属するデーン郡の精神保健センターは地域ケア重視の方針のもと予算の約 80 %を配分していること、b. 医療専門職間及び、医療関係者と法律関係者の間の連絡が密であり様々な協力態勢が組みやすいこと、c. 連邦法及び州法に基づく権利擁護制度が根付き、施設内入院者の権利擁護だけでなく PACT のような地域サービスプログラムもクライアントの同意を得る手続きについて州の権利擁護機関から定期的に審査されること、等が確認できた。

②アメリカ合衆国、カナダ、及びヨーロッパ諸国における精神医療改革の主流である脱施設化と地域ケアの構築については、理念の定着は確実であるが、病院からコミュニティへ患者が生活の場を移すにつれ、治療の継続が必要な患者の治療確保が大きな課題として立ち現れていることが明らかになった。施設内の入院患者に関する権利擁護の法制度が整備された一方、各国が地域で生活する患者に対し治療を受けることを強制する法制度をそなえるようになっている。その運用と患者の権利擁護との関連については新たな課題である。ウィスコンシン州に関しては Conditional Release（条件付き退院）制度及びその運用について資料を得ており、今後、さらに研究したいと考えている。

③欧米では精神病院の設立は国や州が主であり、従って脱施設化やその後の社会資源の地域社会への移行は、公的権限による社会資源移動と私的セクターの参入という形態をとる。当事者の権利擁護については病院入院に対してその制度基盤がつくられ、行政の責任が明確化されるとともに、権利擁護団体が実際の権利擁護活動を担うことで、公的セクター、私的セクターそれぞれの医療サービスを監視するとともに、退院後も社会的サポートを必要とする当事者のニーズを政策に反映するようになった。医療における権利擁護（患者アドボカシー）は、施設外部の異なる専門職からの統制と施設内部のチェック機関設置という２つの制度的装置によって権力の乱用の防止が可能になる。なお、こうした制度移行は、当事者からの退院請求に対して家族以外の様々な地域支援の資源を活用できることを前提としている。

④アメリカ合衆国で1990年代から提唱された「リカバリー」は当事者を受け身の治療対象とみなさない、いわば当事者によって提示された社会モデルであり、ウィスコンシン州マディソンを管轄するデーン郡でも、郡の精神医療政策に「リカバリー理念」を導入し当事者の関与を押し進めるプログラムが進行している。ウィスコンシン州の精神医療政策の形成過程において、行政、医療関係者、サービスプロバイダー等さまざまなステークホルダーを召集したて行われたディスカッションや折衝を参与観察し、理念の整理と政策への適用プロセスを分析したJacobsonは、その背景に積極的な当事者運動の蓄積がある一方で、マネイジドケアの導入による社会資源振り分けをめぐる公的・私的セクターのせめぎ合いがあること指摘している（Nora Jacobson, *In Recovery :The Making of Mental Health Policy.* Vanderbilt University Press, 2004）。医療・福祉サービスの市場化と福祉的視点からの社会生活援助、当事者の権利擁護という３点の関係については、より慎重な分析を必要とし、今後の課題である。

⑤以上のような地域ケアの構築、当事者の参加、精神病院や地域のケアシステム内での権利擁護の進展の一方で、アメリカ合衆国ではナーシングホームの入所者に含まれる精神障害者へのケアやその権利擁護が課題となっている。この場合、既存の権利擁護法制によって活動する権利擁護団体は施設内の権利侵害としてこうした事案を取り扱うことが可能であり役割を期待される。また犯罪を犯して収監された人が精神障害の問題を抱えている場合、刑務所の矯正モデルは服役後は自立した生活を独力で営めることが想定されているため、医療福祉サポートを提供できる体制になく、結果的に社会生活を持続できずに再犯率が高くなることも課題となっており、医療関係者、刑事政策担当者、行政等のステークホルダーらによる合議が始まっている。

⑥欧米の精神医療改革の進行に対比して日本では、精神病院の設立・運営は1950年代より民間に依存してきたため、脱施設化に関しては、これら私的セクターに対して理念のみではなく現実的な強力なインセンティブが必要となる。さらに日本では精神医療審査会が権利擁護システムとしての機能を充分に果たしていないと指摘されるが、その原因の１つに、当事者から退院請求があった場合、退院後の地域支援の選択肢が少なく家族の受け入れの可否に頼らざるをえない現状から、実際には家族の意向を相当に考慮せざるをえず、中立的な判断をしにくいこと、さらに家族の負担感の増大や当事者の家族不信を悪化させる可能性さえもつことが明らかになった。当事者の権利擁護に地域資源の整備が緊密な関わりのあることが確認された。

施設処遇中心から地域ケアへの移行を目指す日本で、ACT が注目されるようになり、2004 年度より国立精神・神経センターによるパイロットスタディが行われている。地域ケアシステムの一定の展開を前提として最重度の精神障害者を援助するために推進されるアメリカ合衆国の ACT が、そのような前提の成立していない日本においてどのような役割を果たすか、その動向には今後とも注目したい。

４．資料と論文について

今回の研究で訪れたウィスコンシン州マディソン（デーン郡）の地域精神医療プログラム及びその中でのリカバリー概念の採用、ACT タイプのプログラムの１つであり軽犯罪を犯した精神障害者に対する代替プログラムＣＴＡ（Community Treatment Alternative）について、関係者にインタビューしており、その記録は上記３．の④、⑤、⑥との関連において資料として提示する意義が大きいと思われるので次ページより掲載する。

また、高橋涼子「医療・福祉領域における権利擁護制度の検討（１）」（『金沢法学』第 46 巻第１号、2003 年、pp.137-157）は、こうした資料をもとにこの研究の意義をまとめたものとして、再掲する。

資料：ウィスコンシン州デーン郡の地域精神医療について

地域精神医療プログラムに関するインタビュー記録
(Dane County Mental Health Center, David LeCount 氏　２００３年２月)

<Recovery>

David: What is recovery? Recovery grew out of both psychosocial rehabilitation literature and the consumer movement. So it came out of 2 different levels and it converges, it's converging now I think into a general concept. So the recovery process is one that is, I view it on a continuum - a longitudinal, horizontal continuum. Over here, somebody may be symptom free. That's one understanding of recovery, in other words - 'I've recovered'. 'I no longer have symptoms'. Or I am able to - in this range you might be able to manage your symptoms better. And then over here might be - 'I'm able to live my life and I understand that periodically I may have an episode of a higher level of a acute [?] - that my symptoms might flare up and I will understand that and I will try to do whatever I can to prevent that and I will try to take care of myself. It puts more personal responsibility on the person. That's one understanding of it, but it's a process that each person has to go through. So there's no general understanding of recovery because each person has to understand it from themselves and how they've internalized it. It has to do with many times the acceptance that they have on mental illness. And that they are doing everything they can to manage the mental illness. It has with it a strong message of hope. And hope is something that we, as professionals can provide to the consumers. And hopefully we can be the inspiration in each person's life. It's not giving any messages of, 'because you have this illness, the die has been cast and there's no hope.' 'And you are going to be like this the rest of your life and it's a bio-chemic disturbance and there's nothing you can do about it.' Contrary to that it's very much you can be in control of yourself. And the whole emphasis is, you do not become the illness. Your self is basically in control, and the illness is only a small part of yourself. So that's the difference between it - what each person can do to take care of themselves and to continue to grow and develop, and it has to do with you taking control of your life. And ultimately determining what your own path is going to be. You aren't owned by the illness. You are in control of the illness. And the way you take care of yourself has to do with getting good amounts of sleep, eating the right foods, doing exercise, developing social relationships, yoga, meditation, acupuncture, holistic ways to take

care of yourself to the extent to which...jogging, going for walks, whatever the things that you need to do to keep yourself in balance and in tune. I mean, we know that stress in people's lives exacerbates symptoms. I just reviewed, for example, all of the people that were emergency detained and placed at the Mendota Health Institute last year. And I can tell you, reviewing all the narrative material that I went through that was generated by the hospital, most of the people were there as a result of increased stress in their life. There was a situational reaction. It might have been a domestic dispute, it might have been drinking too much, it might have been a fall-out with a friend, it might have been a loss of a loved one. All had to do, most of it had to do with situational things - somebody not taking their medications, somebody not being able to meet their basic needs for whatever reasons, and feeling a lot of stress in their lives for a lot of different reasons. But recovery would say that you should through the inspiration in others, you should have hope and you should basically plan your life and live your life in a manner that is going to promote your health. And so it is more of a personal responsibility thing as opposed to the medical model that says we are here to take care of you. I like it.
Takahashi: Very hopeful and holistic person image
David: Yes, definitely. I have seen, for example, many times where people have put themselves pretty much at the mercy of everybody that's taking care of them and keep referring to what do I need to do - asking others and/or it's solely the medication and I am going to have good days, I am going to have bad days. But I think, what I like about this, is that is really does put the onus of responsibility on each person and not necessarily and outside expert. And that our role is to give people good information to act as guides or coaches, to respond to helping in any way we can. But, our primary role is to say to each consumer is what do you want and what do you need to live your life? As opposed to I'm going to make the treatment plan and you are going to have to follow it. So you could do the parallels between the 2 systems. You could do a chart over here that says traditional system and the chart over here that says recovery, and you could draw the lines as to the differences between them. And I'm sure that's been done, but I give that as an example of the fact that I think it's a healthier model and it's one that will help people become more fulfilled in their life. And they won't always be projecting onto others - the doctor didn't give me the right medication - that's why I feel bad. Obviously each person can look at how they can take care of themselves, how they can nurture themselves - if they continue to have a really difficult-to-control illness in spite of everything they've done - they can plan for those times in which I am not

going to be able to be responsible for myself and you can actually have a statement signed when somebody else will act in your capacity. In other words you'll have sort of like a guardian to take care of you. It could be a family member, it could be your best friend, it could be whoever. And you could say to the emergency services unit, 'When I am totally floridly psychotic, and incoherent, this person is the one you need to contact and they will respond on behalf of my best wishes, because I know this person, we've talked and we've all agreed on certain things.' So, if I need an inpatient setting I would prefer to go to this hospital rather than that hospital, and if I need increased medications these are the ones that I would prefer, realizing that that may change, but these are my preferences - so somebody else to act on behalf of me if I'm not able to. So that could be a part of recovery. A person is taking responsibility for planning even the most difficult times in their life. So it's a very normalization concept. It's a very functional way to look at people. And I think a lot of our emotional states and everything are influenced by how we view them - even the way our mind works, and even our ability to, you know, studies have indicated that even with psychotherapy, the biochemistry can change in our mind. It's not just the pills that can change our biochemistry. So that's where I think we can put a great deal of emphasis on personally influencing each other. And how much better do people feel when they feel like they're in control. The definition of depression is somebody that has lost control. And so they don't feel that they can influence the events in their life in any way - they feel hopeless, helpless, un-empowered. We want to empower people to take responsibility for their lives. So it's an exciting concept. I'm very excited about it. We have a consumer provided service called SOAR Case Management Services.

Takahashi: I will visit on Friday morning.

David: Good. That's a newer service.

<SOAR>

David: I've worked with the Director, Jen Coberstein since 1998 so we're about 5 and a half years of working together to develop this service. I started out with her by joining her on the street when she was a street worker. She was working with homeless people on the street. So one night I spent an evening with her on State Street. So she made her contacts and we walked up to the homeless shelter and we walked down where everybody else was walking and she would make her contacts with homeless people that she had worked with for a long period of time. And one of the things that I was impressed with is that there were 2 people that were living

in a tent and she had worked with this person who had been on the street since the 1960s - a long time. But he was getting to the point in his life, even though every day he would go to State Street and pan-handle, he had a little office - what he called his office, on State Street, where he would stand and he would try to get people to give him money. And one of the things that he was finding out in his life was that he was having more difficult time figuring out how to get back to his tent each night - so he was starting to get early stages of dementia, and Jen used that as an opportunity to say, I will get you an apartment. And the person that's currently living with you in your tent - I will pay him to help take care of you within your apartment. But you won't have to worry about how to get to your tent - you won't have to worry about the elements as much as you have to now, and life will be more comfortable and better for you because you need somebody to be a caretaker for you. And the 2 of you can still be friends. And that is what a lot of SOAR does - they match people with services and they will pay for natural supports if somebody lives in a building.

They might pay somebody in that building to make sure that the person is taking their medications, or giving their medications at specific times, if that's what the person needs and wants. So I'm having coffee with Jen in a coffee shop and somebody comes in and Jen says come over here and it just happens to be the person she's working with, that she's hired to make sure a person in the same building as he lives in is getting her medication. And they have been friends for many years, and she's set up that arrangement. I've had many people that Jen has taken out of hospital settings where they have not been able to work well at all with the person in the hospital setting because of power struggles and things of that nature where she will go in and say where would you like to live and how can I set something up that will work for you? And then she will match whatever that person says - interests, what they like, what they don't like, she'll take that all into consideration and she will go out and find somebody that meets that criteria and then she will put them together and they both have to agree to it. And then we pay for the person who is taking care of the other person, depending on their degree of need and how much time and energy and effort it takes we'll pay him. So she has developed a lot of flexibility. And she purposely asked for money not for direct services to pay her staff, but money that she can use for other purposes. So last year, she spent over $100,000 just paying to help others with living arrangements - rents, security, deposits, whatever they needed. All of our people pretty much in the public sector, because that's what we are - we are the public sector - we have a

lot of people that are working with people that have situational things in their life. We're working primarily with people who have serious and persistent mental illnesses - long term in most instances. It's our responsibility to make sure there's a full range of services available. So, I'm always interested in creating continuums of care, systems of care - community systems of care where everything is interrelated and people are working together and you're working together with all the related systems. So you're working with law enforcement, the homeless networks the emergency service network, the funding networks, the basic need networks - everybody - the church community, the faith community, all aspects of the community. Now we're only one part of that community and so SOAR is a consumer operated professional service, and they have over 20 staff and they basically go throughout the community in their cars, and they have cellphones and they try to be as immediate as possible. So people can be called at anytime and they'll respond. And Jen - if you're with her, her cellphone is going all the time, so you talk a little bit, and she's on the phone - you talk a little bit, she's on the phone. But she's directing people - well remember what I said, what we discussed last time or she's cueing them but they always know they can call back so they don't take a lot of time, so maybe 2 minutes. And then she's on to somebody else. So she provides a lot of services to a lot of people, she's very cost effective - she works with the highest need, and with people with lesser need. So she's able to define her own continuum in many respects. Whereas a PACT program is pretty prescriptive - it's pretty directive and it's got a lot of staff intensity and roles are pretty clearly defined. Jen is sort of all over the place and she's got a much larger territory and she's got more mobility and she can respond extremely quickly, and she works with helping people get the resources they need. So she's almost like a system that carries her onto herself. So she's got, she works with, her staff work with over 300 people during the course of a year. And it's a relatively new program. The biggest community support program I have is probably around 140 some people. And PACT is about 140 now, so that would be the largest community support program. But I have about 500 people in the community support programs that are PACT-like. The mental health center has 4 of them

<SOAR and PACT>

Takahashi: So now you suggested PACT and SOAR are very different. SOAR is consumer-oriented, and PACT is professional, interdisciplinary staff-oriented. There seems to be much resource that consumers can select in Madison Community

now. There are sufficient resource- do you think so?

David: Well, I don't know if any there are different ways in which people come into the system. One of the ways in which I built SOAR into the system was I connected them with the emergency services unit because as I said a couple of years ago we had 150 people that were being followed by our emergency services unit because they couldn't get into other programs. So I kind of said we need a release valve in the system - we need somebody that can come in and be immediate and helpful as people. Well, when SOAR started they didn't have psychiatry so they could come in and help some of the people but they still had the medication issue and they had to seek out either private psychiatry in the community or mental health center psychiatrists. So now, over time we incorporated psychiatry into the program. So now they can also prescribe in addition to providing case management services and resource connection they have a psychiatrist that prescribes. And that's worked extremely well also. But PACT selects people to come into their program. It's a research model and they have been doing this longitudinally dating back to actually 1969 on the ground of Mendota Mental Health Institute - it was called the state hospital back then. '72 was when they started to branch into the community. Some people reference 1972 as their starting time. But PACT is has always selected their people and they have to meet certain research criteria. So they will make some exceptions to those rules, because I've asked them over the years to take a person in simply because of the needs of that person. But they want to make sure that they have somebody that meets their research criteria and then they do a control group, so that they can compare.

Takahashi: So this is something like recruit system.

David: Yeah, they do their own intake. And right now they are working with younger onset people. And that's been their trend from the start. They started with the people out of the state hospital, so they're long term, older people, probably, that had stayed there for many years that were revolving in and out. Then they went to 18-30, now they're going 15-21. So they've gone down age-wise getting closer to onset. And then what they are trying to demonstrate now is that if you intervene early in somebody's life you're going to have a better outcome. And I think that just makes good common sense. We know that the earlier you can provide treatments to the early onset of the problem, the more you are going to be able to minimize the problems and how people get on with their lives. So it's not an exceptionally brilliant concept but I think the project follows everything they've

done. And they're doing good work, and they're having a lot of impact on the children, youth, family system. My system is primarily for people 18 and up, and they're now working with people as young as 15. So they're helping the children youth family system do what the adult system has done many years ago which is to take people out of institutional settings. The children youth family system has a significant number of people that they are putting in institutions. In this country they call them CCIs - Child Caring Institutions. They aren't hospitals - they're like huge residential treatment centers in which all their needs are met within the facility - so their education, medical needs, total care - food, clothing and shelter; everything is met there and they're very expensive. So what PACT is doing is saying is we want to work with people, and have them in the community and do the same thing that we have done with adults. So they're working by keeping people in the community - they're giving them the services, they're working with the schools, they're working with all the community resources to keep the person intact within the family and the service adjunct to all of that. So they are sort of demonstrating to the schools and to the children youth family system what they hope to do in the adult system and that is basically minimize hospitalization - in this case institutional care for kids. And Janna Fry who is the director of that program is working on trying to develop a sort of like the cottage program out on the grounds of Mendota a mental health institute where people can go for short periods of time, where they can be assessed, evaluated, plans can be made in a safe environment, and people can understand their needs and then they can go back into the community only it would be for a short period of time. Might be for a few weeks versus years in an institutional setting. They stay mainstreamed in the community, basically. And the whole idea is to not have the child have to go through all different kinds of learning experiences and foreign environments but to keep them in their natural environments. So that's exciting. So it's not like people can automatically select that's the program they want to go into, but PACT will primarily get their referrals from youth crisis here at the mental health center. Youth crisis will be aware of the people out there that have children and youth that have special needs that might fit their criteria. And SOAR will get their referrals primarily through the emergency services unit. And they do some jail diversion.
Takahashi: I will go tomorrow.
David: Oh good.

<Crisis Homes>

David Lecount: Crisis homes have been set up through our emergency services unit and that unit is located on that end of the building, right there. It's a part of the mental health center. It started in 1987, and we have about 10 crisis homes. We had as many as 13 at one time - they are certified as adult family homes, and that is something peculiar to us. In other words they have to meet certain standards. They're basically trained by the emergency services unit staff. And there's one person on the staff that's responsible for coordinating the crisis homes.

Takahashi: Is a responsible stuff living together with the client?

David: The crisis homes are natural families that are living in our community that have said they have space for another person and it could be 2 people even at times. It could be a Mom, a Dad, it could be a single person, it could be children living with Mom and Dad, and they are saying we are willing to take somebody into our home, and the emergency services unit is our gatekeeper for inpatients. And well over 50% of them, of the people presenting for inpatient - that unit finds alternatives for them. Crisis homes are one of the alternatives. So anybody that they feel comfortable with, that needs additional time, attention, somebody they can talk to - being in a natural family environment they will place within a crisis home setting. And we actually have expanded a lot of our alternatives in lieu of inpatients. And it could be that people are staying in crisis homes in lieu of going into an inpatient setting in the first place or, they go into the inpatient setting and it shortens the length of time that they stay there so that's an alternative. Now we have a range of other alternatives - we can use any part of the system as an alternative. But even through the emergency services unit we have greatly expanded the ranges well beyond what I define in here even. So it's only been in the last few years that we've developed some of our expanded alternatives. We have a pool now of over, it's 22 staff that we call crisis aides.

Takahashi: Crisis aides?

David: Yes

Takahashi: Including client, mental consumers?

David: Yes. Some of them are consumers. [As a] matter of fact most of them are consumers. So we pay them on an hourly basis for going out and supporting others in the community. So we can hire a Crisis Aide and pay for them to be with someone in their own apartments. So that's another alternative. They can take somebody out for coffee, and just spend time with them. They can recreate together - whatever that person needs, they can help with. And many times they will help them with some resources that they need for example. If they need to

figure out how to connect with another agency or service or something like that they can help with that. And they can provide transportation. Another recent thing that we just started is what we call the recovery house.

Takahashi: Ah, recovery house.

David: Yes, that just opened up within the last couple of weeks.

Takahashi: Ah, very new.

David: Very new. It's for 4 beds. And it's going to be staffed by the Crisis Aides. And the staff will be placed in the recovery house as needed. Right now, it's built. There are 4 people in the recovery house. It's another alternative for people that we don't think would fit well into crisis homes. They may not want somebody to come to their own apartment; they may not have a place to stay. But it's not really for housing purposes solely; it's primarily as a way to support somebody because they need additional support now in their life. So the staff can vary depending on how many people we have there. The daytime, we are going to try to help them structure their lives about various places they can go in the community. But at nighttime they'll all be there. They will, can stay there for a longer period of time than a crisis home. A crisis home's usually around about 3 days. Anywhere from 1 to 3 days. This place, they'll be able to stay longer. And we'll try through practice to see how, all the uses that it will have. So we are going to use it sort of as a pilot program. But it is the most recent thing that we just started in the system. And it's going to be paid for by medical assistance pretty much. Medical assistance acts like an insurance benefit. And once somebody has been found to have a disability, they get what we call a supplemental security income, and medical assistance is like their insurance as a part of it. So most of these people will have medical assistance and we will bill that to the extent to which we can. And so and we can bill it in this instance for people in lieu of them going into an inpatient center. So it will pay $79 a day for somebody that is in the facility. So that's sort of the continuum of what the emergency services unit offers. But the emergency services unit will help people with lots of resources. And they will even follow people we can't get into anything else. They might be the unit that might prescribe the medications - they have psychiatrists. And they will have the person come in for the medications until they can get into another program where they can get case management services and other services that they need. So right now they are following about 85 people like that. About 2 years ago they were following about 150 people like that. But I have expanded some of the other services so now there are fewer people waiting. But we always have people on waiting lists or people

that are under-served. We've never been able to provide the services to the level that it's actually needed. And that's pretty common throughout our entire country. Seldom can you go some place and you find that everybody's getting what they need.

<CTA>

David: CTA was set up for people coming out of jail. And also forensic people for conditional release, and I set the program up through them. And so over time they have become the oversight for conditionally released people throughout our system. It's a small number - it's about 25 people. Most of their people have come out of jail, so you'll have a chance to see them. We've put a little additional money into that program over the last few years and in the state of Wisconsin there's been a heavy emphasis on building prisons and jails. And the decades of the '90s we've put all kinds of people in jail, in prisons. So can we say that suddenly society has gotten worse and people are bad? Or was this just the political bias at that time. My sense is that a lot of it had to do with the political bias. So they put in over 20000 people into prisons throughout the state. And they are spending almost a billion dollars now. And we can't even house them all in the state of Wisconsin, so we send them to other states, too. So we've created a bit of nightmare for us, I think, by locking everybody up. They passed a bill a couple of years ago called Truth and Sentence, meaning you can't release anybody earlier, that sentence is the time that they stay and we can't get them out sooner. So that is another step and what I call meanness.

Takahashi: Meanness?

David: Meanness, another word for being mean to people.

Takahashi: Mean to people?

David: Yes. It's like you are bad, we understand you are bad and we are going to give you the ultimate punishment.

Does everybody need to be there? We are on the forensic side we have resolved that problem because we have basically put that person through a system that determines whether they are competent or not, to adequately assist counsel and understand the charges against them. And if they can stand trial, chances are if they were symptomatic, at the time of the act, they will be found not guilty due to mental disease or defect. They will go not into a prison system but a mental health system. Well, we picked them up at the point that they are conditionally released from that system, so any time they are ready for the community, that's when our system kicks in. Otherwise, they're out at Mendota. And the fact that we have

many fewer people at Mendota during the course of the year - over half of the people at Mendota now are forensic-related. And they serve the entire state, along with another institution to the North of us so there are 2 state hospitals that are providing the forensic services. We're having a change in government right now, so one of the things that I recommended to the new head of the department of health and family services at the state level was that we look at shorter periods of time for the forensic people at the state hospitals and I think that is a concept they will buy. I think right now we have people that are just sitting in the state hospitals that are already stabilized - the only reason why they're there is that nobody has developed conditionally release plans, plus they probably think that they should be further rehabilitated before they come out. Well, we know that institutional settings aren't good places to rehabilitate people. The best place to do it is in the community, where they can learn the responsibilities they need to take care of themselves. And that will do that with support because the state will pay for alternative services for us to be able to do that - especially for those who are at the state hospitals. So we are paying $620 a day for somebody out there now. If they will pay me just a fraction of that cost we'll do it better in the community. And that's one of the proposals that I made. Then people coming out of the prison system - we have a place called Wisconsin Resource Center. They come out of the prison system, they are put in the Wisconsin Resource Center because their symptoms have acted up while they are in prison. I was saying we need to study that group and get them out into the community as well. So we're looking at ways to make inroads into other institutions that we have created. And the idea is to do some of the same things that we've done with psychiatric hospitalization - find alternatives for them in the community, so I am excited about that - I think that holds a great deal of promise.

Takahashi: How about the data of them?

David: Are you talking about the people that are at Mendota now - who are they other than forensic?

Takahashi: Mendota is in the Dane County and patients come therefrom all area of Wisconsin State, I think.

David: Right, and it does serve all of the state. So it serves all 72 counties, and I suppose you could sort of compare the counties to your prefectures - there are set jurisdictions that each county has.

<State hospital and community support programs>

David: I did a review of the people at Mendota actually I was working on this over the weekend - we had, last year, 131 admissions and actually it turned out to be probably about 124 people. This was an increase of about 33% over our prior year, so that's why I did the study. The prior year we had 98 admissions. And then I looked at what were the number of days, and we had 1832 days and last year we had 2014, so I had a net increase of 182 days. And then I looked at average length of stay. In 2001 it was 18.69 days and in 2002 it was 15.37 days so I decreased it by 3.32 days. So there was a 17% decrease in days, albeit a 10% increase in days, and 33% in the number of admissions. And then I went over the records and I went over our service data. So you would be curious to see that I've looked at that and I've cracked on the Mendota account for many years so that's all of our involuntary admissions to Mendota over the years dating back to 1977-2002. In the early years we were able to downsize because we developed functions like the emergency services unit acting as a gatekeeper - it used to be open-ended. Anybody, any physician could recommend somebody going to Mendota and they'd just automatically be placed there. And in 1972 we developed anew process so everybody has to go through a legal process. They can be emergency detained and then go through that legal process out at Mendota. But we started our own community support program modeled after PACT, and we put on additional problematic elements over the years and this is the kind of impact that you see and then sort of a leveling off, and now a little spike-up. One of the reasons for this spike-up is that our population is growing and the services aren't increasing all that much. So in the last decade we've had 60,000 more people come to town. So we're now about 432,000 people. So I think you can say there's been a pretty steady baseline here as far as Mendota is concerned and I'm not concerned that we're losing control or that the system is falling apart - I'm just saying I try to study these things and look at them and say what's influencing it, and you know one of the things I learned is that the typical person that goes to Mendota is almost 40 years old and they're most likely to be a male. We've got as many people between 20 and 40 that go to Mendota as we do between 40 and 60. So 40 is kind of the middle age or the mean. So it's the mean and the median. And about 50% of the people that end up at Mendota probably we haven't had any prior contact with. For the people that we know and are involved in our service delivery system, we've been able to minimize the hospitalization. Most of the people that have been to Mendota have had prior hospitalizations - it's not like it's a new thing in their lives. Albeit there are a few that show up that might be the case, but it's rare. And most

of them are going to have dangerousness either to themselves or others, so that'll be a factor that's in there. Many of them have multiple reasons why they're there. I mean obviously the illness being out of control is one of the main reasons, but they may have alcohol or drugs, which is not as common in your country as it is here. Probably over 50% of the people here will be drug involved. So that's another factor. And that factor can heighten the illness, or it could be that they have taken drugs that have actually created psychosis. That's less likely, but it happens. One of them was even an LSD induced psychosis, something I haven't heard of for years around here. But it used to be a more common thing. They may have physical disabilities - sometimes it might be dementia related, or where they are not as cognoscente or aware of their environment and they become more frustrated and upset to the point where they might hit somebody, and that might lead to an admission to Mendota. Situational reactions, domestic disputes - but it usually has to do with somebody's state of mind getting out of control. It might be a bipolar disorder where the mania is starting to take over and getting out of control in their life so that's why the domestic dispute might have occurred. Frequently I think most, some of the people are here, - I've got 14 people who either came from other counties or other states - in other words they showed up in town and they were mentally ill to the point where we could do an emergency detention. 18 came out of the jail, and we do have mental health services in the jail, which David Delap will probably talk to you about. 19 of the people were connected with our system - 2 were at Yahara House, 12 were in CSPs, 3 were in SOAR and 2 more were in another case management program. A lot of people, 42 of them, were in other systems - they were getting services from the private sector that aren't a part of our system - but one that where they generally bill insurances, and we have what's called health maintenance organizations here in town. They provide their services to people - it's not as extensive as the mental health services that we provide, but they're able to provide medications and talk therapists - those are the 2 things. So we have a number of people coming out of that. We have 13 people that were emergency detained to Mendota from the community hospitals so in other words the person started out in a community hospital on a voluntary admission and maybe they had an altercation and they needed a more secure setting so they ED-ed [emergency detained] them out to Mendota. 5 of them were cognitively impaired - developmentally disabled is what we call it - and while there's only 5, one of them stayed almost a year - that's just way off the wall in our system, but it's because they couldn't find another place for him - that happens rarely, but it does happen.

One came from a nursing home, one came from Badgercurie [?] Healthcare Center which is the County nursing home, 2 came out of our detox unit, so in other words they were admitted to detox for alcohol - generally detoxification - probably had an altercation - weren't able to handle them - they ED-ed them to Mendota. So anyway, I reviewed all that material and then I reviewed what the aftercare dispositions were, and it gives me clues as to where I need to focus and things like that and I have a database - everybody that provides services in our system has to report the units of service to us. Everybody that we contract with I have line item budgets with - so for living arrangements these are all of the providers that I contract with, for let's say the crisis homes - this is my budget, and these are all my funding sources - you don't have to know what all those are - just trust me, we've got a lot of funding sources. Here's a group home that somebody would be living in. The cost for that group home for 8 people is $235,000. Here's the money the county puts in, here's the money the state puts in. And this is another funding source, it's called Community Options Program - and if they meet certain criteria we can bill it, so if we put it in. So I track on this - this is my budget. And then I have a contract with each provider - Goodwill Industries is the entity that provides Northport Group Home. They also provide Offshore, and Jamestown. So they have 3 group homes and I pay for the services. They have to report who's in these group homes - the name of the person, and how many days the person has stayed in the group home, and all that data gets reported to the County and then we track on that data and send it to the state. And they have to report out all different characteristics - age, sex, date of birth, social security number; if the person has a serious and persistent mental illness they have to complete an assessment, a global assessment of their functioning as defined in DSM4 manual. They have to basically point out whether the person has worked or not. There are about 14 different characteristics they report out on that form. So, we collate all that data, and now with computers, we can do it much easier. We can do enquiries - if I want to find out how many people got services in the system last year...As a matter of fact I've just done this - so, around 5,000 had services in our system. Well, how many met the criteria of serious and persistent - mentally ill? Close to 1,700 people would meet those criteria. Those are people where most of my money goes. So we have all different reporting criteria - under living arrangement, CSPs - Community Support Programs that's a separate standard program category that they have to report out of. Inpatient is another standard. Crisis intervention is another. So it goes on and it gives you a line by line - what the break-out on my budget is and

the bottom line is that's the summation of it and here's another way to look at it - these are revenues and the expenditures - so all of this is how much the County put it - the County is about 42% of the budget. State puts in about 23%. And then medical assistance puts in a certain amount through - these are for people in community support programs- they all Medic Aid for their services. We also bill Medic Aid for case management and crisis intervention and stabilization, what I was talking about before with crisis homes. So these are all of our expenditures, 16 million, I mean revenues, and then these are our expenditures, this is how the money is spent. So a lot of money that goes into those PACT type models is that amount - it's the highest amount 27% of my system is PACT models. And living arrangements is second - that's 23% - that used to be as high as 34%, so it's going down as people are getting acclimated to the community - it's becoming a lesser percentage of my budget. Inpatient is about 10% here. And that's for the acute stabilization at Mendota and community hospitals. Case management. Case management is in all of our programs but I targeted here as only for the programs we defined as solely case management. So SOAR is a case management program. Community Intervention Team is a case management program. But people in CSPs, they have case managers. And everything is hung together pretty much by case management services. And if a person is in a core program like a CSP or Yahara House, that case manager is a system case manager too.

Takahashi: I have been to there, my first visit, 4 years ago.

David: Oh, okay.

Takahashi: It is very active consumers' activity. And I heard they are becoming more powerful recently.

David: Yahara house would be almost as comprehensive as a PACT model. It would have the same level of staff intensity but it doesn't have the degree of assertive outreach - it's more where people come there and then they are focused a lot on the internal activities and the work, helping people work - almost 60% of the people work in that program. It's our highest program of work - I think people understand that people going into the program it's almost an expectation so that's why the percentage is so high but they are able to develop a community of caring and hopefully people are able to extend themselves to the broader community after they're in those programs for longer periods of time. So it's very much a comprehensive, integrated, supportive service that's provided through that. But medications are part of psychotherapy - Day services is Yahara House. We have some programs that do solely work. So I have several programs that just do work.

And that'll be defined in my line item budget. And then outreach would be the homeless networks and things like that - we pay for some of the services there, not much. We benefit from a lot of the services they provide because they know our system and they refer to us and we work together and that's strictly a medication line item that I have in the medication services program that I have here at the mental health center. But you can have all this and this chart right here, I could write a book on. This is the Mendota chart and I could easily write a book on this. I can tell you everything that's happened along the way that makes these bars shorter or longer. Only this one here probably has a bar too longer on it. That goes to '96, this goes to 2002. Actually I determined I think from '96 to '86 the average length of stay was 15 days. It got a little bit higher than that in 2001. My data will show it was 18.69 days in 2001. But it got back closer to 15 in 2002. That's nearly 3.7. But, everybody has to report to us and that's how we can evaluate what we're doing. It's one of the ways in which we can see how many - when I write a contract it will be for so many hours of service for example. The emergency services unit - how many hours of crisis intervention will they be providing. And then we also put in the cost per hour, and that's what we reimburse by. So they have to earn their money to get their money. Group homes, it would be a day of service. Hospitals would be a day of service. So each hospital I have a contract with that's buying so many days of service. And hospitals are authorized through the emergency services unit and for the community hospitals we will pay based on the number of days that Crisis has authorized. So Crisis will put on the name of the person, the hospital, the person's date of birth, and whether there's any payment sources. The emergency services unit will keep a copy of the authorization form, another copy goes to the hospital and another copy goes to me. I in turn send it to my accountant. The hospital sends the bill to the accountant at my office. The accountant pays the bill back to the hospital. Crisis doesn't do that. But she checks to see that the episode has been authorized and she checks the number of days that it has been authorized. If they hospital bills one day beyond the amount of time that has been authorized, she won't pay it. She'll just pay for the time that Crisis authorized. So it's a very controlled system, and all aspects of the system are set up that way. If somebody needs a group home, they have to go through centralized referral exchange and that's set up through another organization called Talarian[?]. And they in turn will authorize the service in whatever group home that that person is placed in. And I have the group homes under a separate contract. And the group homes will then report out to me the

name of the person, and the number of days and then we will reimburse them. Generally the way we reimburse is on a 1/12th basis of the contract. But we add up the units and the hours and the days of service and we'll determine whether they are over or under the contract. If they are under the contract, before the end of the year they have to send us a notice saying we need to increase our unit cost to pay for all of the services we provided even though we didn't provide sufficient services to cost out the contract. So we will look at it and make the consideration as to whether we'll do that - in most cases we will. Because we understand they have fixed costs to provide their service, they just might have had - in a group home somebody might have left and there might have been a long period of time before they got somebody else in, so there was a down period, and we'll understand that. So it all works pretty well. There's a lot of work with law enforcement. There's a lot of work with the homeless network. There's a lot of work with all the related systems - drug and alcohol for example, developmental disabilities - they have a separate system. But there are certain individuals where we will determine they need to provide the service, the primary service - we will provide this but they need to provide that, but we work out those arrangements between our respective systems. So there's a lot of give and take within the system. But it's not like we have a model program that's providing services to a few people. It's like, we try to provide something for everybody, and relate it to an entire system of care versus a model program that's doing it for 150 people. In some parts of the country you'll see a program like Yahara House. Well that's it in that community. And if you didn't get access to Yahara House you are getting those kinds of services that you may need. The fact is we have a lot of diversity within the system which is good because it gives people more choice and yet as I said before we're trying to follow more what people want - SOAR comes the closest to meeting that model. So I kind of see SOAR as the 21st century model. And my goal is to get the whole system to be more like SOAR. Now the whole system wouldn't understand that at this point. But that's sort of my agenda. I can say that to you, but if I said that to the entire system there are probably a lot of people who won't want to hear that because that might mean they would have to change. Right now, our funding dictates to us how we do things too. So the fact is if you have a certified community support program like PACT it means you can bill medical assistance for your services. PACT brings in about $600,000 a year in Medic Aid.

Takahashi: That's big money for PACT

David: That's about a third of their program so they are being rewarded with

$600000 by operating the way they do. Medic Aid is not flexible money - you have to provide the service before you can get it and it has to be a certain type of service. And the way you provide the service has to be according to a prescribed model. My funding from the County can be completely flexible. But I provide it within that framework because they have to meet the Medic Aid criteria to provide the service. They get additional money from the state that could be flexible too. But everything sort of flows around how Medic Aid dictates how it should be, and it's all defined in the administrative rule called HSS63. And that lays out how you are going to do the assessments, how case management functions are going to be performed, how admissions are going to occur, how discharges are going to occur - it's very prescriptive. So when you get a chance to see the PACT model, you will see a lot of that type of prescription. SOAR is a little less prescriptive, and it's more flexible. I think flexibility is really critical given the fact that we are talking about recovery and trying to figure out what each person needs. So instead of paying for someone coming to deliver your medications, if the money was flexible you could help pay for their rent. You could help pay for something that may get their car started if they needed to work. You might be able to pay for somebody to come in to be with that person for a period of time while they are experiencing higher levels of anxiety. You might pay for something that would help that person with whatever he is or she is needing at that particular time. So I think flexibility is really critical to recovery.

<Japanese mental health system and PACT model>

Takahashi: Now I would like to talk about your Obihiro studies and how, what do you think about the application of the PACT model in Japan - is it possible or useful for the institution of Japanese Mental Health System? The government say, maybe you know, 700,000 people can go out of the hospital to the community if they have much support in the community.

David: I would agree with that. As I understood it there were about 360000 people that were hospitalized in over 1000 hospitals, 200-400 bed facilities throughout Japan. The hospitals that I visited - I was more impressed with the degree to which I saw institutionalized behavior than the degree to which I saw acute psychosis or symptom otology. That tells me a lot. It tells me that the biggest difficulty that Japan is going to have is dealing with the institutionalized behaviors. These are not people that are socialized like the typical person is in the community. So, they're going to stand out. And my sense in Japan is that you are going to need

to greatly assure the communities of safety and concerns. That the acceptance of the person and the potential for any kind of backlash if things did not go well if somebody, if one incident occurred, or somebody hurt somebody else due to their mental health, it would send the whole movement back. Same thing can happen in our country. The difference is, we have a greater emphasis on legal rights, so even though somebody hurts somebody here, that person still has rights, and the whole group of people with mental illness has rights. So they have the right to at least a restrictive environment for example- that's a big part of our law - and I can tell you I have used that every step of the way in helping to develop this system. They also have the right to due process. In other words we can't just willy-nilly put someone in an institution because we think that's a good place for them. We'd have to prove that that's where that person needs to go, based on attorneys and courts. So it's different here from that respect. I think the PACT community support models are probably a good way to go initially. I mean that's as I said, I think PACT was a good model for us back in the '60s and '70s and '80s. The '90s I would like to see us move more into SOAR like models because I don't necessarily think - we're still dealing with the lag. If we look at the lag concept - there's a cultural lag too but I think to start with you need to do higher cost models. And you start with people that are the highest functioning. And you de-institutionalize those carefully through well thought-out plans and services in place. And you have back-ups on your plan. But first of all you need a place for them to live. One of the things I did not see a lot of is the kind of group home supervised living environments that I developed early on in our system. For those with the highest needs we literally have staffing environments in homes to be there any time of the day that people need them and then you have your community support programs in addition to that. PACT does not necessarily provide for living. So you still need supervised living. And you may need supervised living to start off for somebody that basically could take care of themselves because they are so unsocialized and you are concerned that they are going to present nuisance behaviors in the community if they don't have a place where they can be supervised during the day. You'll have your day care kinds of centers. You'll have a lot of those, work centers and things like that - you have a lot of those - places they can go during the day. But you'll still need a place where they come, get up in the morning and come back to at night. So you'll need supervised housing, you'll need the day centers and the PACT to start with. I don't know - I would always look at this as transitional - in other words any time you place somebody in this supervised environment it's to teach them the behaviors,

they need to learn to live more independently. And then you teach them those skills. Now, in one of the institutional settings I was in, they were using a didactic approach to teach those skills. It was like an academic class. We have learnt, in our experiences, that those skills are not well generalized if taught in an institutionalized setting. The best place to teach those skills is where you are actually doing those skills, in the community. So I don't think spending a lot of time to try to teach somebody how to cook and personal hygiene and dressing and grocery shopping and riding the bus and all those other things and subways etc. You aren't going to teach those in an institutional setting. And if you do, they aren't going to generalize well anyway. So my sense is that that's what you'll be doing in the supervised environments. The CSP workers, the PACT like workers will be monitoring those and setting up those plans. And you'll be working with the person - what do you want to learn? and then how to teach them that. And you might have other consumers over time help with those activities. And so it's other natural support people in the community. They are involved with any community activities where natural supports can come in, or the families. To the extent to which families feel comfortable with that. You know that's a problem too.

Takahashi: Yeah in Japan they're bad burden on families.

David: "Bad families". It's sort of a stereotype and it's a stereotype here too, that families created the problem and you are responsible for it. We have what's called the Alliance for the Mentally Ill. They probably are combating that stigma as much as any organization can. So in Madison there's a lot of diversity here, and a lot of acceptance of diversity. Plus people have rights, and it's understood legally. It's not like you can go down and perpetrate against somebody and we aren't going to hold you responsible - we are. And likewise somebody with a mental illness we are going to hold them responsible if they commit an act. We have a forensic system that deals with it one way, we have a legal system that if they are competent at the time they committed the act they would be handled the same as everybody else. So they would go to jail, the same as anybody else. So you have to figure out philosophically how you are going to deal with all that given your culture, given your ideas, your customs, your beliefs, all those things. And you've got a very professional, gracious, wonderful, people - bright, energetic, just really really a nifty nifty culture - I can't tell you how much I enjoyed it. When I was there I loved the food, and I loved the people and I loved the consumers. Consumers are more placating there than here. I can tell you consumers here - many of them are very assertive. I'm going to be meeting with consumers here tomorrow - I have a special

forum that we meet with on an ongoing basis and I can tell you they are going to tell me the way it is - they are going to tell me what they like, what they don't like and they'll be very forthright in telling me that. I didn't get the same feeling in Japan. It's more like, they just were so appreciative that anybody would give them any attention - it's like I'm not worthy of this. And that could be a part of the culture, it could be the way in which they relate to somebody that comes from some place else that came there in quotes as 'somebody that supposedly knew something about something'. As a special capacity sort of thing it was really nice and I really enjoyed it. And I've enjoyed working with Mariko, I enjoyed working with Mr. Kadoya in Obihiro and I enjoyed meeting a lot of people along the way - Dr Ito and many others that were extremely ingratiating I mean it wasn't only the consumers that were ingratiating, it was everybody and I'm looking forward to returning.

But I think the PACT way is a good way to start. But remember those other services too that I mentioned.

<"Dignity of Risk" >

Takahashi: Thank you. Now, final question. There is the word "dignity of risk".

David: It's a good concept, thank you.

Takahashi: I understand it something like non-paternalistic reliance, confidence to people with mental illness. Is it correct or something you must add it or explain another way.

David: "Dignity of risk" came up in 1984 in a conversation I had with Harriet Shetler who was one of the co-founders for the Alliance for the Mentally Ill. And she said, David, you know, I think a lot of what we are doing in this community could be called the dignity of risk. And by that we mean we're taking responsible risk taking. The most common frequent comment regarding people in institutional settings going to the community is, can we assume that risk. Are these people going to be dangerous to others? Are they going to be dangerous to themselves? Is this a responsible thing for us to do? Yes it is, if we weigh the risk-benefit ratio. For each person we have to assess risk and look at what does this person need to live responsibly in the community and then build it in, realizing that everything that we do in life is risk taking. Your coming here was a risk. Us getting in the car and driving away - that's a risk. Getting up each day, we all take a certain amount of risk, but it's reasonable. And this is called planned risk, where we have a good responsible plan in place. And we realize as a person assumes more responsibility we can rob them of that plan and a person expands their territory and

I believe in the concept of ownership. Everybody has the capacity to grow, and that everybody is attempting to reach a polar level of living and being and every generation is trying to do better than the next generation.

"Dignity of risk" has been mentioned where I've gone whether it be New Zealand, whether it be England, whether it be India, whether it be Japan, wherever I've gone in the United States. Everybody raises the issue - if they don't raise it it's implied in what they are saying. They are talking about risk taking. Now who's the head of the team in this risk taking? Generally it's referred to as the psychiatrist. Well the psychiatrists that I worked with in inpatient settings when I directed inpatient programs - they could very clearly determine whether someone was going to stay or leave. And why did they have that ultimate control? Because if anything happens to this person when that person leaves I'm going to get sued. And that's our culture. When they created that system, and the Counties are responsible and I'm the mental health coordinator, I can be sued. So whenever psychiatrists would tell me that, at this point, I would tell them to join the crowd because you can be sued, I can be sued, they can be sued, anybody can be sued - we're all liable. So it leads us all to assume the dignity of responsible risk. And we're all in this together - we might as well learn how to work with it and manage it. And we've had situations where people have killed themselves - suicide - we're working with a very high risk population - we've had people that have killed others - homicide - that can happen too. It's less likely to happen. We have many more people that are more dangerous to themselves than they are to others. So I always reassure the communities that these people are more likely to be perpetrated against because of their vulnerabilities than they are likely to be perpetrators. So remember that in your communities. The acts that our people commit are usually pretty easy to figure out -they aren't methodical, they aren't well thought through - they're acts that are done due to, in many times, incomprehensible things - due to poor judgment, due to not having all their faculties. So it's very easy to problem-solve and see who's responsible. We have many other people that are committing horrendous acts, but they're clever, and they're well thought out and sometimes they get caught, sometimes they don't. The most dangerous thing in our society is probably driving, while under the influence of alcohol and domestic violence. So does that mean that we are going to lock everybody up because they drink? And are we going to lock husbands and wives and partners up because they fight? Who's going to be left in the real world? And do we lock somebody up because they went mad once in their life? I think we need to protect people when they need to be

protected. And I think we need to be involved with them and I think we need to do everything we possibly can to minimize it - and that's the dignity of risk - it's responsible risk taking. But it's a good concept.

Takahashi: Yes, I like that concept.

David: And I don't think people understand it very well - I think you could sit back and make all the excuses in the world as to why somebody should be in an impatient setting for example. I don't have anybody in an impatient setting that I'm making excuses for them being there. I think everybody has the right to live in the community. And I think our entire system has evolved to that level. We are far from perfect - we have many problems and many times we are not working together and many times we fight -we're always problem solving. And I would say one thing about this community is that when you get people together, chances are people are going to be more willing to problem-solve than to fight. And that's the dignity of risk - where everybody says, yeah, we're in this together - how can we work together. And that's the whole beauty of a community system from my perspective. I think it's important that we develop a system of care that we are actively aware of all the people that we need to be most concerned about. So if a court determines that somebody needs to take medications as prescribed, it not only happens in an impatient setting it happens in the community, I have a whole tracking system set up around all the people that we've committed that are under involuntary orders. It's done through the emergency services unit - it's done through all of the community support programs. Tomorrow when you go to CTA you will see that there's a staff person there that's monitoring all the conditional releases of people. About 24%, almost a quarter of the people, are under some type of court ordered services. They've either been found incompetent - had a guardian appointed and one of the roles of the guardians is overseeing taking the medications as prescribed - they may have committed a criminal act and they have a probation officer and the probation officer is saying as a part of your condition of your release into the community you have to take your medications. We have people under civil commitments and settlement agreements - specifies taking medications as prescribed. And that's how it's set - taking the medications as prescribed as long as the psychiatrist is determining that you need to take their medications. The only way they can adjudicate somebody to do that is, that person has not had sufficient insight to understand the advantages and disadvantages of the medications - they've got a proven history, whereby they have gone off the medications and have de-compensated - so we monitor that very closely. And I

have a tracking system - I've developed a tickler system for the Emergency Services Unit where they are tracking on all of the people to make sure they are taking their medications as prescribed - within each program, that's also tracked, and working in their case plans - that's also tracked. So we land credibility to the courts, and that's our role and that's part of the responsible risk taking too - that's the dignity of risk. It's our system's responsibility to do that. Now, Recovery would say we should not have so many people under these findings - that there's something we're doing that's not affording more people the ability to be more independent and make their own decisions. That we're over-controlling - that that's a coercive part of our system and we should be looking at ways to help people to get beyond court-ordered services. I agree with that. We should be. So it's not perfect, but that's where we're at. In New York City they developed Kendra's law - which was an outpatient commitment for people that have been found to be dangerous to self or others. I talked with some of the reporters there as that all was taking shape because they had a number of incidences that were attributed to mentally ill people. Kendra was a lovely lady that happened to be on a subway station. Malkowitz was the person that pushed her into an oncoming train and killed her. That became Kendra's law. And I can tell you, New York does not have any system by which anybody that is adjudicated under Kendra's law that they're going to be tracked, followed in the community to assure they are taking their medication as prescribed. There's no system. You have to have to have those systems in place. Recently it's been said that in California they've got a law that (and it's not only in California, it's throughout the country) where, if somebody's a sexual perpetrator against kids, for example, that they have to identify themselves to the proper authorities on an annual basis upon release from prison. The idea is for law enforcement to know where that person is at all times - where they're living - that if anything is reported in that neighborhood they would immediately know who's living in that neighborhood that's a previous sex offender, for example -that they could look up then and check on. Well, they found out that there are over 70000 people in California that have perpetrated, sexually, against others that haven't been reported and they don't know where they live. They developed the law but they didn't develop the system - so there's no credibility. Now the fact that it's been reported means that people are going to look at it but they're also going to look at - boy, this is going to take a lot of money to do this.

Takahashi: Money.

David: Yeah. So I think we have, my role and responsibility is then, to fix

responsibility. And that's what I've tried to do. How are we going to do this, how is the responsibility going to be fixed. It doesn't necessarily mean that I'm going to micromanage each piece of the system but at least there's going to be a person there that knows, this is what you're supposed to do. And we have to perform. So we lend the courts credibility, and we lend the community credibility the better we do our job. It doesn't mean that we haven't had mistakes that things haven't fallen apart but those are the challenges regardless of what system you put together, you're going to have to work to make it work - you're going to have to fix the fences all the time. That's the hard work part. I have a meeting tomorrow - it's a system meeting on jail related issues. And I can tell you there are all kinds of things that aren't working there. But we know what are some of the primary areas are and we know what needs to be done to fix it - we know that we will probably have some good problem solving. So when things don't work you get together and try to make them work. Good questions!

Takahashi: Thank you very much

David: Oh, you're very welcome. Dignity of risk - I like that one.

Takahashi: I like it too

David: Yeah, it's a great concept. And thank you for so much - I really appreciate that.

資料：ウィスコンシン州デーン郡の地域精神医療について

CTA (Community Treatment Alternative)プログラムに関するインタビュー記録

(Program Director, Dave DeLap 氏　２００３年２月)

<PACT モデルについて>

The Program of assertive community treatment or the PACT approach to treatment to provide services to folks who'd been diverted from our local jail which is the Dane County Jail and the next slide just explains where we are - we're in Madison, Wisconsin and that's our pretty Capital and that we're part of the Mental Health Center of Dane County, but specifically we're Community Treatment Alternatives and that's my name and email number and fax number and all that stuff. And usually start by paying homage to the mother program which is PACT - program of assertive community treatment. This is actually the back side of this building. There's a street level, but that's not PACT that's like a coffee shop or something and actually their entrance is on the other side of this building but it's just a door and you just go up the elevator. Since PACT is the program that developed this approach to Assertive Community Treatment I always make sure that I am giving credit to them. The PACT programs are called different things sometimes in different parts of the country. Obviously many people know it is PACT. But in many states, they call them ACT teams or Assertive Community Treatment teams. Michigan has a number of assertive community treatment teams, so Michigan calls them ACT teams which I think makes good sense. One of the things that is kind of confusing - here in Wisconsin we call them CSPs or Community Support Programs. CSP is probably not the best name for PACT programs because in other places in the United States, a community support program is any community based program that works with folks with serious and persistent mental illness. Not just PACT programs. So for example, in other states a CSP could include group homes, it could include psychosocial rehabilitation clubhouse models, like Feltham House, it could include just regular case management services. But in Wisconsin, it's really supposed to be an assertive community treatment team. In, I think it's New Hampshire, and Connecticut, that call them Continuous Treatment Teams, or CTT teams. When I was doing some consulting in Georgia they called them Access Teams. In South Dakota they call them Impact Teams. In Florida they call them PACT teams. But fortunately in Texas they don't call them PACT teams. But probably the best thing to refer is

ACT teams - if you say Assertive Community Treatment teams people will be clear on what you are talking about - or PACT-like teams. So this is the Millhouse Center of Dane County. So that's a large Mental Health Center down on West-Washington Avenue. Our crisis intervention team is located in this building.

There are several different programs - we have a large drug and alcohol outpatient treatment program is located in this building. The Child-Adolescent-Family services are located here. A program called the Medication Services Program or MSP for short is located there. MSP is a unit of doctors and nurses who, their primary responsibility is to help people make sure the people have medications and if they're prescribed properly and so for anybody who needs more intensive services it would not be appropriate but for people who primarily only need medications it's where they would go. And so each nurse has about 90 to 100 clients that they work with and so it's again primarily, for folks who only need medications. The Mental Health Center actually runs 5 community support programs or ACT-like programs - I didn't include their pictures on here - I have pictures of them too. There's a program called Blacksmith house that has 65 consumers, a program called Cornerstone, which has 85 consumers. And then a program called Gateway that actually has 2 different teams in the Gateway program, and each team has about 70 consumers.

<CTA>

The thing that distinguishes us from the other assertive treatment teams in Madison is that we're a jail diversion program. So in order to get into CTA you need to meet the standard admission criteria to get into a community support program. The state of Wisconsin certifies community support programs - there are standards that have to be met in order to get your certification and those standards outline the kind of consumer who's appropriate for a CSP and those standards basically say you need to have a serious and persistent mental illness like schizophrenia, schizoaffective disorder or bipolar disorder and you have to have a serious functional impairment stemming from that disorder. So for example there are a lot of people with bipolar disorder and people with schizophrenia who are very high functioning who really don't need intensive services - they get the right meds, they really don't need intensive services. So CSPs or ACT teams are really designated for those folks who have multiple needs and intense needs. So to get into CTA, in addition to meeting the standard CSP admission criteria you need to also be either currently incarcerated in our County jail which is the Dane County

Jail, or have criminal charges pending that might result in incarceration at Dane County Jail.

CTA started in March of 1991 as strictly a jail diversion program, and again the other way to get in was to be currently incarcerated in the Dane County Jail or have charges pending. But then in 1996 we also had a third way to get in and that's for folks who are conditionally released, after pleading, they are not guilty by reason of mental disease or defect. And right now I think about 14 of our 81 consumers are folks who are currently on Conditional Release. And I meant to count this for you but it must be close to another 15 people who, they initially got into the program under conditional release but they completed their NGI commitment – they are not guilty by reason of mental disease or defect commitment and then they've continued with this even though they're no longer on the conditional release. So that was kind of a mouthful - but the idea is we're a specialized ACT team that works mostly with folks that have been diverted from our local jail.

<1. Integrated Services>

These are what I have listed, what I see as the core components of assertive community treatment. And you may have already heard some of this and you'll probably hear more about this when you visit PACT tomorrow. But the first component that I've listed is that the services are comprehensive and they're integrated. Comprehensive means exactly that - basically the program deals with whatever issues the person might have problems with so obviously since all the folks have a serious and persistent mental illness one area that needs to be addressed for the psychiatric needs. Routinely finding housing and keeping housing is an essential component of assertive community treatment so we help people with their residential needs. Finding and keeping employment is a challenge for a lot of our folks with serious mental illness so helping people with their vocational needs is important. Sometimes people need help with activities of daily living. We don't usually get that personal, but sometimes we do have to remind people - you know it's probably what time to take a shower but sometimes people might need a lift to the Laundromat - maybe they don't have laundry facilities in their building and so we can give folks a lift to the Laundromat to do their laundry. We do a lot of giving rides to the grocery store to do shopping - most of our folks live on limited incomes and lots of times they don't live close to the grocery store, and so being able to give somebody a ride to the grocery store where the food's a little cheaper is usually very helpful. Not to mention that I think you

can really do a better job at least as good a job of assessing a person's mental status by talking with them while driving in the car to do something like go grocery shopping. As well as observe how they're do in the store shopping - Are they organized?, Are they disorganized? Are they having a hard time making selections? or Do they make selections easily?. So I think lots of times you can tell more about a person's mental status out in the community doing real world stuff than just sitting in the office asking the person about their thoughts, and that sort of thing. Help people with social recreational activities. A large percentage of our folks are dually diagnosed meaning they have alcohol and drug problems in addition to their mental illness so help the person with that. And then general support services - case management services. Basically what I mean by that is helping people with whatever needs they might have. Now obviously since we are a jail diversion program, a lot of what we do is help people get through court hearings, get to court hearings, support them in that process. Sometimes they get placed on probation or parole and so we help them navigate that probation-parole system. So that's what comprehensive means - it basically means helping people with whatever they might need help with. And the part that a lot of programs that try to emulate PACT and try to be an ACT program, the part that they don't get, is the integrated part of the services and I what I mean by integrated is the ACT team itself, insofar as is possible, tries to provide the service to the person. So for example, again, a large percentage of our folks are dually diagnosed namely they have drug and alcohol treatment problems. Our Mental Health Center has a wonderful and a large outpatient drug and alcohol treatment program. We could just refer all of our clients who have drug and alcohol problems over there and wash our hands of it and say, okay we took care of that problem. We gave it to another part of the Mental Health Center to deal with. That doesn't work well. Integrated means that we do our best here at CTA to try and help the person address their drug and alcohol problems, so for example we have a dual diagnosis group that meets every Thursday morning here at CTA. Our social workers and case managers, when they meet with their consumers individually, we will be asking them how they're doing with their substance use. We do urinalysis here sometimes in a bottle to see if the person is able to stay clean. So we use 'antibuse'

Takahashi: Antibuse?

Dave: ...sometimes for people who have drinking problems that if their liver permits - use that. So in any rate we employ a lot of different modalities right here in order to help the person deal with their substance abuse problem, rather than

just referral to the Mental Health Center and hope that things go well.

I work with a woman who actually, I don't know if you know this, Tim was actually bringing her in for her 'I am held old shot??? that's why he was parked out front before he went to lunch. And she is somebody who is by the way doing beautifully now – she is been employed working 20 hours a week for the last 3 or 4 years, she has 2 children at home now - one is 5 years old and the other is 9 years old, and is also living with her long term partner who is the father of both of the kids. At any rate about 6 or 7 years ago, she developed a problem with crack cocaine and while smoking crack, eventually got to the point where she thought I shouldn't need to take her medications either. So she'd got quite ill, quite psychotic from not taking her meds and smoking crack cocaine, got evicted from her apartment because she became convinced that her father owned the building and therefore didn't need to pay rent, which was a delusion on her part. And before she started smoking crack she was working part time and then through the process of smoking crack she eventually lost the part time job that she had. At any rate it took a long time before she finally got back on her meds and finally started to want to work towards stopping smoking the crack cocaine. But she did and during that process I referred her to one of our drug and alcohol treatment programs over at the Mental Health Center - it was called ROMC, which stands for Recovery Options for Mothers with Children. And they work in much the same way that we do - they go out to people's homes and meet with them in their apartments and really try to connect with people very assertively and we referred her to a drug and alcohol counselor at ROMC who we know quite well and we respect and like very much. And I stayed in pretty good contact with that counselor talking with her usually at least once a week if not once every 2 weeks. So you'd figure the services were pretty well integrated, well maybe you're right. So this woman finally got, after a couple more months of abstinence from cocaine, she told me - she said "Dave, you know, I think I'm doing well enough, I want to go back to work." And I think "Oh, good", this is what I've been after for years. Knowing too that if she was working she'd be focused on, she'd have some of her time structured it would help her maintain her abstinence from the crack cocaine. And so I was very excited and said wonderful - let's get to work on that. And then the next day she went to meet with her drug and alcohol counselor, and the drug and alcohol counselor said, no, no, no, no you don't want to make any big changes like starting a job during your first 6 months of abstinence because a person goes through a lot of emotional and physical

changes during their first 6 months of abstinence so you don't want to make any big changes until you've been abstinent for 6 months. So, clearly these services were not integrated. In this case, even though it's the same Mental Health Center, and we have a good treatment approach and we were communicating, it left it up to the client to try to integrate these different messages. Dave was saying yeah go to work and the drug and alcohol counselor was saying no, you've got to wait 6 months. So, at any rate... So it's a bit of a long story but I think it helps to underscore why it's best that these services are integrated, and integrated means, basically the same team. Now we do still do some referral over to our drug and alcohol unit but it's in conjunction with providing some of those services here at CTA.

<2. Ongoing Services>

So the second important component of assertive community treatment is that services are ongoing. And what ongoing means is that the services are available to people for as long as they need those services. And what that means is that since many of these illnesses are life-long it means the service needs to be available to the person potentially for the rest of their lives. This is probably one of the more controversial aspects of ACT, well one of several, but at least this one is controversial. In part because government entities that fund Assertive Community Treatment understand once you tell them the services are ongoing it means the only a way to get services to more people typically is to expand the number of programs providing the service. You can't just say work with this person for a year and once they're better you move them off to something less intense. I think there's pretty good - I'm very convinced that this is a really essential part of Assertive Community Treatment. Other people are less convinced. But some of the initial PACT research that was done starting in the mid '70s, I think provides pretty good evidence of why these services need to be ongoing. One of the most seminal research pieces published about community mental health was published in the Archives of General Psychiatry in January of 1990 and it's the article by Mary-Anne Test and Len Stein about some of their findings - about ACT. And during that part of the PACT research protocol, but what they did was they took people who were seeking admission to the state hospital to Mendota, and ask them if they were interested in being involved in PACT and if they were, they were randomly assigned either to go in the hospital if they were assigned to the control group, or if they were assigned to the experimental group, to PACT, then they went directly with PACT staff back out into the community. So they actually never went

into the hospital. The folks in the hospital group, in the control group that went into the hospital, would get whatever follow services that you normally would get after being discharged from Mendota back in the '70s here in Madison. And the PACT group would work with the PACT team. But this service was time limited so they followed the PACT group for 14 months and they followed the control group for 14 months and at the end of that 14 months the PACT group looked better than the control group in nearly everything they measured. So they looked at the level of symptomotology, and the PACT group had less symptoms. They looked at the number of days spent in the psychiatric hospital and the PACT group spent less time in the hospital. The PACT group was more likely to live independently - in their own apartments rather than with family or in group homes, the PACT group expresses greater satisfaction with their lives. The PACT group was more likely to be employed. But then they stopped giving the PACT services to the PACT group and followed again the PACT group and the control group for another 14 months. And at the end of that 14 months there wasn't any difference between the PACT group and the control group. Surprise, surprise, surprise - schizophrenia is a chronic, relapsing illness. It really shouldn't have been surprising to them then, and it shouldn't be surprising to us now, that people need services on-and-on going basis. If fact, if you look at that PACT research, which I can give you although you'll probably get it when you're over at PACT but I can give you a copy of that article which at this point is 23 years old. But the research name for PACT is actually Training and Community Living, or TCL. And it really was their expectation or their hope that if they provided intensive training to people after getting out of the hospital or even before going to the hospital, that they could then withdraw that support and people would have been trained how to live in the community. I think in retrospect that was pretty naive, although there are still some people who think that's [to somebody in the office]- it looks big enough! Couldn't figure out why... There is Dylan Abraham and his mother Nancy - Dylan is a PACT client and has been for years - he also now is a consumer aid who helps us out at the Medical Center's Crisis Unit and his mother Nancy both have been very involved in the National Alliance for the Mentally Ill.

Takahashi: NAMI?

Dave: Yeah, NAMI. And Dylan and his Mom, Nancy have done a lot of speaking around the country about Assertive Community Treatment, about mental illness in general. At any rate I heard Nancy talk about this idea that ACT services should be time limited - I heard her talk about it in the following way - she said this idea

that PACT services should be time limited is a little bit like telling those of us who wear glasses - giving us glasses for a year and a half and then taking away the glasses and then when we have problems without having our glasses, well what's your problem? We gave you glasses for a year and a half - why are you having problems now? The point is that people need ongoing services.

<3. Assertive fashion>

3 important components of Assertive Community Treatment is that the services are provided in an assertive fashion. And assertive means several things.

1) One of the things it means is the location of its services. It means, not waiting for the client to come to you in your office but going out in the community. So last year 80% of our face-to-face contacts with our clients was not in the office, it was outside in the community - so in their apartments or in the grocery store or in a café, or at work,...

Takahashi: In the car?

Dave: In the car. Yes, right, a lot of contact in the car. One of the problems with our initial attempts at institutionalization in the United States was that I think we had this view that clients would come to us. And so in the 1950s and 1960s, around the time de-institutionalization started, the federal government gave localities money for community mental health centers. And so there were a lot of community mental health centers built up around the country. But I think a lot of us working in community mental health centers didn't really know how to work with folks with serious and persistent mental illness and so people would get discharged from this state hospital and they'd be given an appointment card to go to the mental health center and when the person didn't show up at the mental health center, the mental health center staff would say oh well, if they didn't show up for their treatment they probably weren't too interested in treatment and we all know that people who aren't interested in treatment can't benefit from it, which isn't true. But that was kind of the thinking - If they didn't care enough to show up they probably aren't going to benefit. And no one went out to see what was going on with those folks and usually what was going on with those folks was that they were needing help - they weren't getting their medications so they got really ill again, and they wound up going back to the state hospital. And we got what's known as the revolving door - so they go to the hospital and get well, and come back out and not get the services that they need and go back in. So part of being assertive is going out to where the client is and not just expecting them to show up in your office.

2) A second part of being assertive is not taking no for an answer when the person is saying no because they are psychotic. So for example if we have a client who's quit taking their medications and they are getting psychotic or they are getting ill and we go to their door and we knock on the door and try to talk to them or offer them medications. If they say "Get the hell out of here - I never want to see you again", we politely smile and say "Well, we'll be back tomorrow." and then we come back tomorrow. I think it's that part of assertive that sometimes gives assertive community treatment a bad name with some of the consumer groups that feel like if somebody tells you "No", that you shouldn't bother them again. But I think that's an absolutely essential part of assertive community treatment that I don't think it's reasonable to expect someone who's acutely psychotic to be able to make good decisions about what their current needs are. So to not go back and check on the welfare of someone who's acutely psychotic, even though they've told you "No" on uncertain terms they don't want to see you again I think it's still irresponsible not to go back and check on them because they could be very very ill.

3) And the third part of assertive has to do with being hopeful - full of hope for people. Debbie Allness who is one of the folks who wrote this PACT manual with Bill Knoedler - she calls it having a can-do attitude. I listened to a lecture by a researcher named John Strauss. John Strauss is a fellow who interviewed people who suffered from schizophrenia over many many years. So he interviewed them when they were in the hospital and not doing well, and he interviewed them when they were out in the community and doing well and so on for a course of many years. And one of the questions he went to ask the people when people got better was what they found to be helpful when they were very ill. And many people talked about the thing being most helpful was someone that believed in them – may be they were even too ill to believe in themselves. And he coined that 'surrogate hope'. So I think it's our responsibility - I think part of being assertive in assertive community treatment is having surrogate hope for people - having a vision that their lives can get better, that they can lead meaningful productive lives in the community. And having that hope and that vision for them even when maybe they're too ill to have it for themselves.

4) And then the last important component of assertive community treatment is that services are normalized. And what I mean by normalized are a lot of practical things. It means living where you want to live. Most clients want to live independently in their own homes or apartments. Most clients don't want to live in group homes. I have never had a client who has come to me and said - Dave,

please find me a group home. I have had clients that are living in group homes say Dave, please help me get out of here I want to live in my own apartment. It means in terms of work - working at a regular job for regular pay. What we used to do for a long time in terms of work is send folks with mental illnesses to sheltered workshops. And sheltered workshops in this country are generally places where folks with developed mental disabilities or mental retardation would go to work and they'd do usually repetitive piecework type things. And they'd get paid based on their production rate and they're typically paid well below minimum wage. And right now in the United States the minimum wage is $5.25. But when you go to a sheltered workshop you can be paid as little as a few pennies an hour based on whatever your production rate is. And again, like with the group homes I've never had a client come to me and said Dave, I really want to work - please send me to a sheltered workshop where I can work for less than the minimum wage. Most people want a regular job where they get paid at least minimum wage, if not better. Most people want to work in a setting where not all their co-workers would necessarily have disabilities. They may or may not have disabilities, but they want to be integrated into the larger community or in other words services should be normalized so that includes work, that includes living situation, it includes where you get your services. It also means that we don't place - the services are highly individualized - try to develop the service that the person needs. So we don't have a lot of groups here at CTA - we do run some groups, we run a drug and alcohol group and we actually we do have an employment group. But what happens with some mental health agencies is that all they do is run groups. So when a client comes to them they don't try to individualize the treatment then instead say, well, we've got this group, we'll put you in here, because this kind of fits you need. So that's what I mean when I say the services should be normalized.

<CTA Staff>

So now we're just going to talk about CTA. So we have 6 social workers here at CTA. All of us have Master's degrees, actually 4 of us have Master's degrees in Social Work, and Tim has a Master's degree in Rehabilitation Psychology and Corinda's Master's degree is in Communications, and 2 nurses. And so those 8 people - the 6 social workers and the 2 nurses are people that provide the direct case management services for 80 clients. So it's about a 1 to 10 client to staff ratio between case manager and client. And the thing that is a sort of somewhat unique about ACT is that even though it is a multi-disciplinary team where we have social

workers, we have rehabilitation psych specialists and nursing, each of those people all do some of the same things. So for example even though our nurses have nursing degrees, they also do case management work, which is much of what you might think social workers normally would do - our social workers don't do nursing things, but our social workers are very knowledgeable about medications and about side effects of medications so that even though they're not packaging meds like the nurses are doing, they should be observing the client to see if they're having side effects from their meds and then reporting those to the psychiatrist or to the nurses. In addition to the 6 social workers and 2 nurses, we have 2 employment specialists and they actually are specialists - they don't carry a caseload - they don't do case management work - they specifically help people find and look for work. I would actually prefer that these people also be generalists. We got some specialized funding to hire our employment specialists through the pathways to the independence research project. I would have actually preferred that they gave that money and allowed us to hire maybe 4 employment specialists and each being half time case managers and employment specialists but that wasn't encouraged for the funding. We actually are running out of that funding and we are right, this month in the process of transitioning to a more of a generalist approach. And that's the way PACT does it and it is better. PACT has 4 or 5 people who are case managers but who are also employment specialists. They have a slightly reduced caseload for their case management but they also provide the vocational services. And I think that's again an even better way to integrate vocational services with the mental health services. So anyway, we've got 2 employment specialists and Kim, our psychiatrist - for a team our size, we probably really should have a full time psychiatrist working 40 hours a week here. We don't have that luxury unfortunately. Kim is 30% FTE which means 12 hours a week. And we really could use more of her time but unfortunately don't have the money to have a full time psychiatrist. And again PACT does much better that Bill Knoedler is full time at PACT. And at least for some period of time in addition to Bill, their full time psychiatrist, they'd had another, I think, up to half time psychiatrist - they are larger. I think PACT is 140-150 clients. So they're not quite twice as big as we are. But the point is if you're going to do this model the staffing requirements are really very laid out here. And we don't quite need quite the intensity that we wish we had. We get pretty close - we actually do better than most places. But still it could be better. And I didn't put Mary on your printout because this gets confusing. I'm just talking about jail diversion here. Mary doesn't actually provide any of the

clinical services here. She's the coordinator for all the folks that have been conditionally released in Dane County. I'm not going to talk about her anymore otherwise it'll get confusing. And Mark, our program secretary, and he is full time. So, at any rate - he is there. So basically it is these 6 people that provide the case management work and then the 2 employment specialists - usually when you're figuring client to staff ratios, you exclude the psychiatrists and you exclude the support - the program secretaries. So including the employment specialists we have about a 1 to 8 client to staff ratio. Which is very good but believe it or not it still doesn't feel like we have enough staff to really adequately meet all the needs of our clients.

<CTA Demographics>

Now most of the rest of these slides are some of the data that I have on particularly the criminal justice end of things, so this is as you can see getting kind of old but I looked to see - we had 58 people who had completed one full year of treatment with CTA as of July 1995. So all this data has to do with those 58 people. And these are the demographics for them. So you can see 80% of those folks were men, or 81% were men, 19% were women. That reflects the jail demographics - in the Dane County Jail about 80% of the inmates were men and about 20% women. In our other community support programs it's about 60-40. So about 60% of the folks in the community support programs are men, and 40% women, so it's a little closer. But as you're probably aware, the gender split in the world, including the states, well at least in the United States is really 50-50. It does appear that in general, men are more severely disabled by illnesses like schizophrenia than women. That's not to say that women can't be severely disabled by it but women who develop schizophrenia typically develop it later on in life, meaning in their early to mid twenties. Men typically develop it in their late teens to early twenties and it does appear those people that have an earlier onset are typically more functionally impaired by the illness, so it's not surprising that in general there are more men than women in Assertive Community Treatment teams. But it's quite a bit different here because of the jail demographics. About 30% or 29% of our consumers are African-American. And we have one fellow at this time who's Native American and the rest, nearly 70% are white. But again, the thing you need to know - in Dane County, only 6% of the population is African-American. So again unfortunately this high figure of African-Americans represents the jail demographics. At any given time in the Dane County jail between 30 and 35% of

the inmates in the Dane County Jail are African-American, which unfortunately I think speaks volumes about institutional racism even in good old liberal Madison, Wisconsin. If you're a black man screaming at your voices on the street corner you've got a better chance of being hauled off to the jail than being hauled off to the hospital. Now as a matter of fact, if you are a white person screaming at your voices on the street corner you still have a pretty good chance of winding up in jail instead of a hospital, but I think it's even worse for those, for our African-American residents. Dually diagnosed, I talked about this for this group of folks about 69% or about 70% of our consumers are dually diagnosed meaning they had substance abuse problems in addition to their mental illness. Alcohol is the primary, in terms of frequency of problems - alcohol is probably the drug that most consumers who have problems with, have problems with alcohol. But followed by Marijuana, followed by crack cocaine and a smattering of folks addicted to heroine and other drugs, but alcohol, pot and cocaine are really probably the biggest trouble. Diagnostically, these figures change slightly over time but usually at any given time about 50% of our consumers suffer from schizophrenia, about 25%, schizoaffective disorder and about 25%, bipolar disorder - the numbers are a little different in this group.

<Arrests Prior to Admission & Arrest Status On Index Change>

So the number of arrests prior to admission to CTA, ranges from one, in other words the arrest that got them into the program, to a high of 69 arrests before admission to CTA. The average number of arrests was 10 and the median was 6.5. and the 5% trim mean was 8.5 I think. 8.6, close. This fellow with 69 arrests was probably a bit of an outlier and that was unusual, but the next most frequent amount was something like 36 the next most frequent was like 35, 33, 32, and I think all of those people had manic depressive illness, or bipolar disorder and you could look at their arrest history and just see when they cycled. We had one fellow that typically got manic in the fall when he was running for president and manic in the spring, and I don't know what he was running for in the spring. But you could just tell what his cycles were because he got arrested for little things like disorderly conduct and basically just being a nuisance when he was manic.

Do you know about the distinctions between misdemeanors and felonies in the United States? A misdemeanor is a more minor crime; a misdemeanor is a crime that is punishable by no more than 1 year in jail. A felony is a more serious crime that is punishable by more than a year incarcerated. Typically when you are

convicted of a misdemeanor, you spend that time in a county jail, and typically when you are convicted of a felony and if you are sentenced to more than a year, you go to prison.

So anyway, what you're charge with is at least a rough indicator of the seriousness of the crime that you've been accused of committing. So as you can see, for these 58 people - 39 or 67% - the index charge - the charge that got them into CTA was a misdemeanor. And typical misdemeanors were things like criminal damage to property, disorderly conduct. Many people, like I said, screaming at their voices on the street corner and they're really loud and really creating a commotion and the police get called and the person doesn't settle down and the police don't know what else to do and they can't really take them to hospital because they're not really being dangerous to themselves or others, but they feel like they need to do something about it so they get arrested for disorderly conduct. Criminal damage to property is a really common charge - we have 3 fellows in the program right now that were charged with breaking down doors. And all 3 of them had the same thought - they thought for sure if they could get behind the door and reason with the person who were sending them the voices into their heads, that maybe they could get the voices to stop. You can see a smaller percentage, only 16% were charged with felonies - those ranged in seriousness from first degree attempted homicide to arson so badly some pretty serious crimes. The percentage of folks that have committed felonies has actually increased - earlier I told you that we started taking folks that were conditionally released after pleading not guilty by reason of mental disease or defect in 1996 and these figures are from 1995, so this is strictly the jail diversion part, but I think the percentage now of our consumers whose index charge was the felony was closer to 30%. And we have people who've committed murder, as a matter of fact, on conditional release in fact you met one of those fellows this morning. And 14% were in jail - half of this 14% actually had new charges, and the other half was in jail strictly on probation holds. I mean all 14% were in jail on probation holds.

When a person is sentenced to probation,... what happens sometimes with folks who were sentenced to probation instead of to jail time or prison time, is that if they weren't getting mental health services they needed, they frequently weren't doing well on probation - they maybe weren't going up to see their probation agents when they were supposed to, or they were using drugs and alcohol or they were just out of control because they weren't taking their meds and their agent didn't know what to do and put them in jail on a probation hold because things weren't going well, and

then referred the person to our program and was willing to drop the whole if the person would work with us. And 2 people, not very many - 3% are of criminal traffic, so one fellow had a drinking while driving charge, and another fellow had a driving after revocation charge. His driver's license had been revoked but he was homeless and he had a car and his car was the only place he had to live so he kept driving it and got caught.

The woman I was telling you about integrated drug and alcohol services- and this was actually after we'd worked with her for 3 or 4 years and she was doing very well - and then she started smoking the crack and quit taking the meds and got psychotic - well back when we first started working with her and this was actually in 1991, she was in jail. What had happened was, she had a job working at an answering service, working for a medical answering service and she was doing okay at that time, but she lost that job so she lost her insurance to pay for her meds, so she quit taking the meds. So she had become acutely ill, and became homeless because she had no place to live, so she went to live with her father who was at the time trying to raise her 5-year-old sister too. And because she was ill she got very loud and out of control and her father asked her to leave. And she refused to leave and was kind of frightening then. So he called the police. When the police came, she still refused to leave. If you refuse to leave a place when the police ask you to leave, that's called criminal trespass, so since she refused to leave, they were going to charge her with criminal trespass. Well, she was ill, and now also frightened because the police were now also trying to arrest her, so she struggled with police, so that's called resisting arrest, so she went to jail but she got a signature bond the next day - because she didn't have a long criminal history and these are minor crimes - these are misdemeanors and so they gave her a signature bond and a court date to come back. Well, she was at the homeless shelter a couple of weeks later and basically the same thing happened again - they didn't have a place for her - they asked her to leave, she wouldn't leave, they called the police, the police came and she still wouldn't leave, so they charged her with criminal trespass. And she struggled with police and she got another resisting arrest and then if you get legal charges while you are out on bail, that's another crime. And that's called bail jumping. So now she's got 5 charges. And she's back in jail, and the judge doesn't want to give her another signature bond, because she's already screwed up. She's missed her appointment with the court from the earlier charges, and now she's got new charges pending. We were aware that all this was happening because she was ill. So we went up to the jail and it actually took about a week of visiting her and

we told her look if you agree to start you meds again and start working with us, we think we can persuade the judge to give you another signature bond so you can get out of jail. And it took about a week, but she finally said, okay, I'll take you meds and so she started a day or two of meds and then she came out into the community with us and we helped her find housing and she looked just 100% better after taking her meds for a few weeks and indeed we went to court about a couple of months after getting her out of jail and they basically gave her time served, meaning they felt like she had spent enough time in jail, she was hooked up with us, things were going okay. So they just said, if we plead guilty we'll just say the time you spent in jail covers your sentence. And then she continued to work with us voluntarily for many years after that. But anyway at that court hearing I asked her afterwards - I said, you know why didn't you show up for that first hearing - what happened and she said 'Oh, well the voices were telling me that they'd taken care of that hearing and that I didn't need to go to court.'

<CTA の有効性の検証～①Incarceration 減少>

58 people have completed one full year of treatment with us - those 58 people spent 2700 days incarcerated in the year before admission - they spent 915 days incarcerated in the year after admissions - that's a 67% reduction in jail days and that's statistically significant at 0.01.

42 people had completed two full years of treatment as of July 1995. They spent 2500 days incarcerated in the two year period, one or two years before admission, and 50 days in jail in the 2 year period, two years after admission, that's a 62% reduction in jail days.

And 31people had completed three full years of treatment with us. They spent almost 3700 days incarcerated and the 3 years before admission but only 990days in the 3 years after admission. That's a 73% reduction in jail days. This is not a controlled study, obviously. This is before and after the data.

It could be that even if the program was doing nothing, people would have spent less time incarcerated after admission than before admission. So what I did, was I looked at the people that had completed 2 full years of treatment with us, and that was 42 people. And I compared the 2nd year before admission compared to the 2nd year after admission, taking out the first year before admission, first year after admission, and even looking at the data that way, there's a 64% reduction in jail days which is also statistically significant at 0.05. And the same thing - 31 people had completed 3 full years so I looked at the 2 year period - 2 and 3 years before

admission versus the 2 and 3 year period after admission and they spent nearly 2800 days incarcerated in the 2 year period 2 and 3 years before admission versus 639 days in the 2 year period, 2 and 3 years after admission and that's a 77% reduction in jail days. Now, one woman accounts for 440 of 639 of these days - one person. I was thinking about doing a 5% trim to mean here in other words you'd take out the worst 2.5% on the bottom and the best 2.5% on the top which would've eliminated this woman's before and after data along with a couple of other folks. That would've got this data to about a 93% reduction in jail days, and I thought, while I'm not even going to make this like because that just looks unbelievable - but it really is unbelievable about how much better people do when they finally get the treatment they need. The other problem with looking at this kind of data is that one person can really skew this so we've got these average number of days before versus after but a better way to see what's happening with the average person is with a frequency chart -so this is that same 32 people, looking at the 2 year period - 2 and 3 years before admission versus 2 and 3 years after admission and this is the percentage of the people who spent this number of days incarcerated during that 2 year period. So you can see in the 2-year period before admission only 39% of folks spent no time in jail. But in the 2 and 3-year period after admission a full 81% spent no time incarcerated. And then in each of these categories you can see that people are spending less time in jail. But this is the figure that interests me is that with treatment really only about 20% of our folks spent any time incarcerated in a 2-year period. PACT did some longitudinal study after this study that they published the Archives of General Psychiatry in 1980. Basically from the late '70s to the early '90s they admitted folks and worked with them on-and-on going basis. And in the PACT 2-year results, 24% of the PACT group and 29% of the control group spent some time incarcerated during their first 2 years of treatment with PACT under the control group. So in other words, that rate of incarceration is really - it's actually higher than our rate of incarceration here but my guess is that there is not really a statistically significant difference because the numbers are so small. But nonetheless, what that tells me is that our clients are really no more criminally inclined than any other person with serious and persistent mental illness in Dane County. It's just that our clients weren't getting assertive community treatment. And once they got assertive community treatment, their rate of arrest and incarceration dropped to the same level as it is with other folks with serious and persistent mental illness. And I've got that 2 year data - no frankly that article talks a lot about their other outcomes but that incarceration data is also in

this 2 year data. You can turn that off while I fumble through this? Throughout the first 2 years the time that patients in both groups spent in these settings - that's actually referring to jail and homelessness. While a significant number of patients spent some time in a penal setting for 7 months through 24 months, that's really a 18 month period, 25% of the training in the community living group or the PACT group and 29% of the Dane group or the control group, spent some time incarcerated. But anyway, the point is even though CTA is only a forensic ACT team, taking only folks out of our jail once our clients get the treatment they probably should have been getting all along, their rate of incarceration really goes down to the same rate as folks with serious and persistent mental illness in our county.

<②Success In Completing Legal Obligation>

In July of '98, 3 years after this first cohort of 58 people had completed one full year of treatment with us, I looked to see how many of those people had completed their legal obligation to be involved with treatment with us. In other words if they were sentenced to probation, had they finished probation, or if they had gotten to us as a condition of bail, had they completed bail and then the charges were dropped. So as you can see, 80% of those 58 people had successfully completed their legal obligation to be involved in treatment. 3% - their obligation continued - what happened is, that's 2 people. One fellow was charged with arson, the other fellow was charged with first-degree attempted homicide. They both ended up pleading not guilty by reason of mental disease or defect. They were given conditional releases but their NGI commitment lasts a long time. One fellow is committed until 2018, and the other guy until 2032 - they're very long commitments but they're conditionally released so they're with us in the community but their legal obligation continues. 14% had their legal commitment revoked. Typically that means they were on probation - they didn't do well, even with our help and they got revoked and sent to prison. In fact the woman who accounted for 440 of the 639 days - she suffers from schizophrenia, is addicted to crack cocaine and prostitutes in order to get money for her habit, she's one of those who got revoked and sent to prison. By the same token, our philosophy of not giving up on people, having surrogate hope, and providing ongoing services, we readmitted her after she got out of prison and worked with her again and that didn't work and she went back to prison. We actually readmitted her about 4 times. And hopefully one of these times we'll find the thing that makes the difference. And 2 people or 3% committed suicide. Suicide is obviously the ultimate failure of a program. And fortunately this rate of

suicide is pretty good. We have had - we started in 1991 so we are now 12 years old as of next month - we have had one other suicide after this, so in our 12-year history we have had 3 suicides. But given that about 10% of folks who suffer from schizophrenia kill themselves within the first decade of diagnosis, our rate of suicide is probably quite a bit lower than you might expect would happen without treatment. It's still - horrible outcome and an unfortunate reality. So those 80% of people who had completed their legal obligation to be involved - that's 46 people.

<③Retention In Treatment With CTA>

I looked to see what was happening with that person one year after completing their legal obligation, and a full 89% - nearly 90% were still engaged in treatment with us a year after they were no longer legally compelled to do so. And I think that's what this kind of treatment should be about. It should be about taking something really bad that happened to someone, in other words winding up in jail, giving them the treatment they should have had all along, giving them a chance to see how their lives could be different, with adequate treatment, so after they're no longer legally compelled to be in treatment, hopefully they'll decide to remain in treatment after they're no longer legally compelled to do so. And this is the thing that I think I am most proud about, about CTA - so many people decide to stay with us, even after they are no longer legally required to do so.

<Collaboration Between Mental Health Providers & Criminal Justice System>

We do a lot to try to make the criminal justice system and the mental health system work collaboratively in this County. We have a system-wide forensic meeting, which is a pretty interesting meeting. The person from the district attorney's office - the district attorney is responsible for charging people and prosecuting people; the Director of the Public Defenders office which is the folks on the other side who are responsible for trying to defend people in court against the district attorney; the Captain of the Jail - Dane County Jail comes to this; people from the Bail Monitoring Program; people from probation and parole; CTA goes; Conditional Release folks go, folks from the Conditional Release Program up at the State, Linda Harris, goes; basically anybody represented from the Madison Police department is there - the corporation council, who is the lawyer responsible for doing the civil commitments in Dane County, and people from our Crisis Intervention Unit - basically anybody who would have anything to do with folks with mental illness getting involved in the criminal justice system come to this

bi-monthly meeting to try to work out problems between the systems. This is highly unique. The other thing to keep in mind - this is all good stuff, and frankly if you have a good assertive community treatment team, you can have really good outcomes for your consumers, even if none of this other stuff is in place. This other stuff helps, but I think the key is having a good assertive community treatment team. In Madison we also have specialized probation and parole agents - we actually have 2 agents who are assigned most of the folks who have mental health issues. Those agents actually sometimes meet the clients here at CTA rather than requiring the clients to go down to their office, which frankly makes it easier for the clients. It's easier for the clients to get here than down to their probation and parole agents' office. We have regular meetings with those mental health probation and parole agents to make sure things are going well. They have the mental health team located in the jail, which you visited yesterday. And all of our staff at CTA have jail clearance so if one of our clients gets arrested we can go up and check with them and see how they're doing. As well as it enables us to screen for potential new clients. I'm going to finish up pretty quick here. This is replicated over and over - there is all kinds of research showing that assertive community treatment is good at helping people stay out of the hospital. This is some data from our early years - 55 people have completed, no, 55 people were in treatment in September '94. No, I take it back. September '94, 55 people completed one full year of treatment. Only 7 of those people needed to be hospitalized for psychiatric reasons during their first year. That's a 13% rate of hospitalization. 37 people that have completed 2 full years of treatment - only 8 of those people needed to be hospitalized during that 2-year period of hospitalization - that's a 22% rate of hospitalization. Those are very low rates of hospitalizations. And not unlike what PACT has been able to do with their clients. So anyway, in addition to helping them stay in the hospital we've been equally successful in helping people stay out of the psychiatric hospitals. This is housing status before and after admission. Before admission, 66% of our consumers were homeless. When I did this we still had a couple of people who were homeless. Right now we don't have anybody who is homeless. Community programs - this means, like group homes. And admissions - 4% of folks were in community programs when I did this, 10% of our folks were in community programs. I think it's lower than that now. Out of our 80 people I think we have 5 people in group homes. So the vast majority of people can live on their own. Again, not many people were living with their parents at admission - only 10% - when I did this 7% were living with their parents.

Right now we don't have a single client living with their parents. We do have one client who lives with his sisters. So the big change is in terms of independent living. Before admission only 21% of our consumers were living independently in apartments, when I did this 77% were living independently in their own apartments. This again was in '94. When I did this figure for last year, I believe it was 84% of our clients were living independently in their own apartments. So in other words I think that the other trap that mental health systems sometimes get into - they think that treatment can only happen in a group home or in a hospital or in an office. Really, most people - the vast majority - 80-90% of folks, really can live independently in their own apartments if they're getting enough of the other supports. And, employment. Typically at any given time about 40% of our folks are engaged in competitive paid employment. Over a 12-month period, typically 60% of our folks are engaged in some sort of paid, competitive employment. Frankly I wish this was much better. Nonetheless, it's much, much better than the national average. Nationally, statistics range from about 5% to 15% of folks with serious and persistent mental illness engaged in some sort of paid competitive employment. So the 40% figure is much much better than that. I also think we can and should do it better.

All right. Enough of that. Do you have questions?

<Questions>

Takahashi: Some questions are given explanation. So I want to confirm - the CTA staff sometimes go to the court for your client to assist them legally?

Dave: Yes. Yes. We almost always offer to take the person to court and then be there as an advocate for the client. Frankly, now that we have a reputation with the Criminal Justice System, that often really helps. Can I tell you a story?

Well,I went with one client to a hearing, and he was being represented by his defense attorney who hadn't met me yet, and the defense attorney was going to meet with the client and the district attorney to talk about a possible plea. And they were going off into this room and I asked the client "Do you want me to come with you?" and he said "Yes, please" and I walked in the room and the district attorney didn't recognize me and she said "I don't think he needs to be in here", and said "who are you?" and I said "I'm Dave Delap from CTA" and she said "Oh, CTA, okay!" So, at least now that sometimes works to the benefits of the client.

Takahashi: So, CTA has a great confidence.

Dave: Now. We didn't in the first several years - nobody knew who we were. And I

think, people were a little, particularly the D.A.s [district attorneys] were a little suspicious of us. But with good results over the years... We get referrals from the District Attorney's office in other words from the prosecuting attorneys sometimes even give us referrals not just the defense attorneys.

Takahashi: I see. Is the newest number of the total participant for CTA?

Dave: 81 now.

Takahashi: Maybe the longest client has been involved in this CTA program for more than 10 years?

Dave: Yes, our second, our first client lasted about 4 years but he did get revoked and got sent to prison. Our very next client is somebody who we've worked with since April of 1991, she's doing very well. And probably about the 10th admission was the woman I was telling you about - so she's been with us now for almost 12 years. So we have, you know I don't have the exact number but my guess is we have at least 30 if not 40 people who we've worked with for 10 years.

Takahashi: Are the participants able to go away and return to CTA again?

Dave: It really is sort of a lifetime commitment to the person. So we have had people leave Madison and then come back and want to get services again, and we make every effort to provide that service again to the person, even if we're full at the time. So we've actually had several people who, things didn't go well and they got revoked and they also got sent to prison and then they got out of prison on parole and we pick them up again. As well as people who just left the area, moved to another town in Wisconsin or another state even, and have come back and have requested readmission and we've re-admitted them.

Takahashi: You have criteria, and pick up the member then provide them the program?

Dave: And there is a problem in that there are vastly more people who could use our services, than we have room for. And it's very important to stay - In order to provide good treatment you really need to keep the client to staff ratio between 1 and 8, and 1 and 10 because if you just keep bringing on people and you don't bring on staff you aren't going to be able to provide the quality of services that people need.

Takahashi: CTA has medication control, and clients' life, good ordinary life support, and for that you are arranging housing or vocation programs. You yourself don't have any housing?

Dave: Right, We don't own any housing. We help people find housing, and we help them find a way to afford that housing. Again, that housing for the 5 people out of the 80 is a group home, so we helped them get that group home and hopefully we'll

help them get out of the group home as quickly as they can. Housing is fairly expensive in Madison. So we help people apply for programs that will help them afford regular housing. There is a program called - it's a federal program administered locally called "Section 8 Certificates", and that's a certificate you can get so that you pay 30% of your income for your rent, and then the government pays the difference between your 30% and what the apartment actually costs. And so we help people get that certificate, and then find a landlord willing to take it, and that sort of thing. So even though we don't own housing, or run housing programs, we help people with housing. On the vocational programs, there are some programs that will really refer people to other vocational programs to work on their vocational issues, but we don't do that - we actually provide the employment vocational service here - that's the integrated part.

Takahashi: And medication, you yourself provide the medication

Dave: Yes.

Takahashi: I saw Mary Joe [a stuff] gave her client - this is today's medication - and tomorrow I'll give you in the office - . This is very directly. So the medication are - Kim arranges the medications?

Dave: The psychiatrist? Yes, can prescribe.

And the level of supervision of people taking meds varies. Some people, when they're not doing well, we will watch them take every dose of medication. So we might watch them in the morning, at night, 7 days a week, 365 days a year. Many people, when they start getting better, really are quite capable of taking their meds without supervision, so we might give them a weeks' supply of medication in a pill box. There's actually a couple of fellows who just get a months' supply of medications and they take their medications entirely on their own. But if they start having trouble, and are maybe forgetting their meds, or are ambivalent about taking their meds, then we can go back to more daily supervision of medications, or twice daily supervision of medications, but it's again, individualized.

Takahashi: I see. The final question is about the funds for this CTA program. This is the program of Dane County Mental Health Center, so the budget comes from the Mental Health Center - it's OK?

Dave: Yes. And the Mental Health Center gets, we basically - most of our money comes through the County. So it's the David Lecount at the County who's responsible for - we negotiate with him and the County then gives us money for the Community Support programs or the CTA - and the other programs that we run. It costs about $8500 per consumer per year for the CTA services. That doesn't

include the medications. Many of our clients have Medic Aid and Medic Aid pays for their medications, which sometimes are also very expensive, but it's about $8500 per client per year for just the CTA services.

The County is really probably the more important thing to think about. David Lecount at the County has a pot of money that comes from the state, and some of that comes from the Federal government and some of that comes from the County - some of that is direct County money, and it's his responsibility then to contract with the Mental Health Center, with other providers in the community to provide the services. It's also his responsibility to pay for the state hospital - for Mendota State Hospital bills and so if we in the community can do a good job of keeping people out of the hospital, it gives him more money to give back to us to help people stay out of the hospital. I think that is probably the most important thing to know about why the Dane County system works as well as it does, and that there is a financial incentive for us to do a good job of keeping people out of the hospital.

Takahashi: Thank you very much.

Dave: You're quite welcome.