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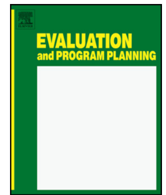

A menu with prices: Annual per person costs of programs addressing community integration

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ABSTRACT

Information on costs of programs addressing community integration for persons with serious mental illness in the United States, essential for program planning and evaluation, is largely lacking. To address this knowledge gap, community integration programs identified through directories and snowball sampling were sent an online survey addressing program costs and organizational attributes. 64 Responses were received for which annual per person costs (APPC) could be computed. Programs were categorized by type of services provided. Program types differed in median APPCs, though median APPCs identified were consistent with the ranges identified in the limited literature available. Multiple regression was used to identify organizational variables underlying APPCs such as psychosocial rehabilitation program type, provision of EBPs, number of volunteers, and percentage of budget spent on direct care staff, though effects sizes were moderate at best. This study adds tentative prices to the menu of community integration programs, and the implications of these findings for choosing, designing and evaluating programs addressing community integration are discussed.

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1. Introduction

The promotion of recovery and quality of life for persons with serious mental illness (SMI) is a major focus of national and local mental health system transformation efforts (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). One facet of recovery and quality of life is enhancing community integration (Corrigan et al., 2002; Kaplan, Salzer, & Brusilovskiy, 2012; Minnes et al., 2003; Yanos, Barrow, & Tsemberis, 2004). Nevertheless, guidance on costs and organizational characteristics of programs addressing community integration that can be used for choosing and designing such programs is scarce. As Yanos and colleagues (2004) note: "the process by which programs should be designed and implemented to best facilitate community integration remains at issue." (p. 134).

Caffray and Chatterji (2009) describe two purposes for collecting program cost data. The first is to provide data for economic evaluation. The second is to provide information for program administrators to use for purposes related to planning and operations. The main purpose of our study was the second – to meet the need for guidance and support in designing, implementing, operating, and justifying programs addressing community integration by providing programs administrators and developers with some parameters for deciding what programs to implement and for comparing the costs of their programs with others. The information that the costs of a program are within the range of costs for other programs of the same type can be useful in corroborating a program design and in budget negotiations. The information collected can also be used for program evaluation by providing ranges of representative program costs for considering the relative efficiency of programs evaluated. Given this perspective, we used an approach that favored breadth over depth in collecting cost-related information.

The concept of community integration emerged out of the "Normalization Movement" which sought to create services and environments that enable people with disabilities "to function in ways considered to be within the acceptable norms of his/her society" (Wolfensberger, 1970, p. 67). Community integration has a legal foundation in Title II of the Americans with Disabilities Act

Abbreviations: ADV, advocacy; DIC, drop-in center; PR, prison re-entry; PSR, psychosocial rehabilitation; SS, social support; WR, wellness and recovery.

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(ADA, 1990) that "requires governments to give people with disabilities an equal opportunity to benefit from all programs, services, and activities (e.g., education, employment, voting, transportation, recreation, etc.)," and the Supreme Court's Olmstead Decision ("Olmstead vs. L.C.," 1999) that confinement of those who could otherwise live in the community in institutions is a violation of the ADA. Reflecting these theoretical, legal and policy advances, community integration has been defined as "the opportunity to live in the community, and be valued for one's uniquenesses and abilities, like everyone else" (Salzer, 2006, p.1), which includes the right to live, study, work, and recreate alongside and in the same manner as people without disabilities (Racino, 1995), though the specific ways programs choose to concretize and pursue such goals may vary. Regardless, the promotion of community integration is viewed as being at the core of psychiatric rehabilitation for persons with SMI (Salzer, 2006). This includes the development of new programs, such as supported employment, supported education, supported housing, and peer supports, as well as efforts to reduce prejudice and discrimination.

Programs that address community integration differ in the range and types of services they provide and can be categorized on that basis. For example, Yates and colleagues (2011) categorized programs addressing community integration as drop-in centers, mutual support, and education/advocacy/training. In choosing and designing programs to address community integration, planners, policy makers and other stakeholders should consider program types that have been implemented, their costs, and organizational features; in particular whether they provide EBPs and consumer directed care so that critical questions about feasibility, effectiveness, and values orientation can be answered. These questions include: How much do services of a particular type cost? Should program developers plan for the program to deliver EBPs? And do programs respect consumers' rights to be involved in their own care?

Understanding the costs of program types addressing community integration is particularly important for choosing and designing programs. Ignoring program costs is, as Garber (2008) has noted, like trying to choose from a "menu without prices." There are three types of costs that are commonly estimated for any type of health or human services program: the overall annual program cost, the annual per participant cost (APPC), and the cost per visit (Brown, Shepherd, Wituk, & Meissen, 2007; Dickey, Beecham, Latimer, & Leff, 1999). We focus on APPC because in our data set per program units of service varied more widely than numbers of persons served. Unit of service costs can vary more widely than APPCs because different programs measure service in different units (e.g., attendance versus visits), creating problems in comparing costs, and because some programs may not keep accurate records of amounts of services provided since they do not charge for care on a fee for service basis (Dickey, Latimer, Powers, Gonzalez, & Goldfinger, 1997; Rosenheck, Neale, & Frisman, 1995).

In designing programs, it can be useful to identify actionable organizational attributes – those under the control of planners and other stakeholders – associated with APPCs. These attributes may point to areas for such things as improving quality or reducing costs. A number of program cost studies were reviewed to develop a "best practice" list of cost-related actionable organizational attributes, which informed development of the survey (Brown et al., 2007; Dickey et al., 1997; Fenton, Hoch, Herrell, Mosher, & Dixon, 2002; Larimer et al., 2009; McCrone et al., 2009; Meehan, Stedman, Roberston, Drake, & King, 2011; Rosenheck & Neale, 1998; Rosenheck et al., 1995; Schmidt-Posner & Jerrell, 1998; Yates et al., 2011). Additionally, this study also considered program type, provision of EBPs (added to the study after completion of our first research report), and provision of consumer directed services. The full list of actionable organizational attributes used in this study is shown in Table 1. This study seeks to identify a range of costs for each respective program type explored, as well as explore the influence of measured organizational attributes on program costs.

Table 1
Actionable organizational variables and variable coding.

Variable name	How coded
Program types	Wellness and recovery Social support Drop-in center Prison reentry Advocacy
Provision of one or more EBPs	Y/N
Provision of consumer directed care	Y/N
Number full time equivalent (FTE) staff	Total no. of FTE
Percentage total costs that is direct care	Direct care costs/total costs
Percentage total cost that is administrative	Admin cost/total cost
Use of volunteers	Y/N
Total number of volunteers employed	No. of self-disclosed volunteers
Benefits provided to staff	Proportion of staff receiving benefits
Proportion of population served with psychiatric diagnoses	Percentage of population served with psychiatric diagnoses
Hours in work week	Hours in work week
Months/year in operation	Months/year in operation

2. Methods

The study methodology consisted of the six major activities described below.

2.1. Survey development

An on-line survey was developed following best practices for on-line surveys (Caffray & Chatterji, 2009), in order to produce information useful to program planners, policy makers, and other stakeholders. The survey was pilot-tested with several program providers and revised per their suggestions. One suggestion, in the interest of increasing response rate, was to limit the survey to questions respondents could easily answer. The survey was password protected, and programs were provided with a unique username and password to complete the survey.

2.2. Identification of sampling frame

We considered programs as fostering community integration if they focused on psychological or behavioral changes to encourage or support persons with mental illness in living arrangements not designated in-patient or community residential facilities, spending time in activities with persons that are not mental health consumers or staff, and using community goods, services and recreational opportunities.

We were unable to find a single inventory of programs that foster community integration in the United States. Consequently, three distinct strategies were used by research assistants to identify programs in the diverse areas of community integration: examination of national inventories of mental health programs, examination of inventories maintained by state departments of mental health and other organizations, and follow-up of individuals recruited at relevant conferences, listed on academic web sites, or referred by others (i.e. snowballing –Sudman & Kalton, 1986). Specific sources used included directories from the National Alliance on Mental Illness (NAMI), Mental Health America (MHA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and state departments of mental health, as well as the

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