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DEVELOPING LOCAL SERVICE STANDARDS FOR MANAGED MENTAL HEALTH SERVICES

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ABSTRACT: Managed care schemes for community mental health services are becoming common. Capitated funding models designed to control costs may create incentives to withhold care. The authors describe a method for creating local standards for minimally appropriate levels of service. The use of such standards can lead to a dialogue with funders and managed care administrators over what constitutes a suitable service package.

Increasingly, states are reorganizing community mental health services under managed care schemes (Center for Vulnerable Populations, 1993). Although there are numerous variations, these schemes typically share at least one of three characteristics: (1) a negotiated plan between the state and provider agencies that specifies service packages for defined populations at prespecified prices (Feldman, 1992); (2) intensive prospective and concurrent service review (Landress & Bernstein, 1993); and (3) agreement by the provider to be at risk for providing services when expenditures exceed payments (Mechanic & Aiken, 1989; Schlesinger, 1989).

Proponents hope that managed mental health care will encourage the creation of a broad spectrum of psychiatric, rehabilitative, and support

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services; enable a more appropriate fit between consumer needs and received services; and increase provider incentives to serve consumers with severe and persistent mental illnesses (Babigian & Marshall, 1989; Santiago & Berren, 1989). However, critics point out that these hypothetical benefits are yet to be demonstrated (Schlesinger, 1989) and warn that the risk-sharing feature of managed care may lead to inadequate care (particularly for consumers with intensive service needs) (Konayagi, Manes, Surles, & Goldman, 1993; Lehman, 1987; Leff, Mulkern, Lieberman, & Raab, 1994) and increased consumer dissatisfaction (Christianson, Lurie, Finch, & Moscovice, 1989; Schlesinger, 1989).

To protect consumers' rights to appropriate service under managed care, incentives to underserve must be counterbalanced by an aggressive quality assurance plan holding the system accountable for inappropriate or inadequate care (Schlesinger, 1989). Key to an effective quality assurance strategy is the development of service standards that delineate the range and types of service appropriate to the clinical needs of consumers (Burns, Smith, Goldman, Barth, & Coulam, 1989; Konayagi et al., 1992; Schlesinger, 1989). (This strategy has been endorsed by a national coalition of advocates, provider agencies, consumers and families (Konayagi et al., 1992; p. 541).) Such standards should be developed independent of managed care utilization and cost control mechanisms and be viewed as legitimate by consumers, providers, and funders.

In this paper, we describe a pilot project to initiate development of standards in a system moving toward capitated, managed mental health care. We describe strengths and weaknesses of our methods, identify principles and techniques generalizable to other local systems, and discuss some of the technical and political challenges to creating service standards for community mental health systems.

THE RECOMMENDED SERVICE LEVELS (RSL) PROJECT

The project was conducted in the second half of 1993 by a team of agency- and university-based researchers in close collaboration with King County, Washington, mental health agencies. Team leaders had prior experience creating and testing methods for linking consumer level of need to standards of care (Uehara, Smukler, & Newman, 1994). These initial efforts at standards development were prompted by state legislation that consolidated major responsibility for managing mental health resources at the regional level (State of Washington, 1989). More recent initiatives to capitate regional mental health services (State of Washington, 1993), along with concern about the fate of publicly funded mental health services

under pending state health care reform, underscored the need to develop service standards independent of cost-containment-driven funding mechanisms. For example, while the pilot project was being planned, analysts suggested Washington's intent to capitate Medicaid mental health services may substantially increase the county's financial liability to finance services beyond the available funds (Mauer and Kero, 1993). At the same time, the state's methods for establishing reimbursement rates and limits, based on historical service utilization, may substantially underestimate the service needs of King County's caseload (Community Psychiatric Clinic, 1993a). The RSL pilot project described below anticipated the need for methods that more systematically link level of service with consumer need under such managed care schemes.

The RSL project was developed to create and test a preliminary set of local standards for minimum, appropriate service for consumers at several levels of need. Financial support for the project came from the County Mental Health Division. At the time, the Division was actively planning prepaid mental health services for Medicaid-eligible county residents within the framework of Washington state's Medicaid waiver for capitated mental health services. The project was implemented independently of the Division's method for developing criteria for service payment under the planned managed care contract.

The RSL method incorporated five elements: (1) a vision for an iterative process of local standards development and refinement, of which the project would begin the first cycle; (2) a project organization designed to systematically tap the diversity of clinical expertise available in the service network and to identify and resolve conflicting judgments; (3) tools and technical support work to translate clinical input into a schema for classification of consumers by needed level of service; (4) a planned decision-making process (Toseland & Rivas, 1984) that identified critical decision points and the project team work products required to support informed decision-making; and, (5) wide dissemination of a formal report of the conclusions.

By the term "local standards" we mean norms for levels of service resource use which are perceived by the service providers, consumers, and funders in a local service system as appropriate to achieve desired outcomes for clinically meaningful groups of consumers. Standards conceived in this way are expected to function in the service delivery setting as a general guide to the minimum appropriate service benefit package, not as a prohibition against variation in individual service planning for clinically sound reasons not accounted for in the standards.

Viable development of local standards based on service provider input requires an iterative process. An initial consensus on local standards is

established based on the recommendations of service providers. (For a discussion of the strengths and weaknesses of this "deductive" approach to delineating consumer groups see Uehara, 1994.) Data are then collected on assessed need of consumers receiving service, the type and volume of services received, and outcomes. Results of data analysis are fed back to the clinician participants to guide a more refined consensus for another cycle. In each cycle (standard-setting, data collection on service use, analysis, and feedback) the expert judgment of service providers is challenged and sharpened by the empirical evidence of the effects of implementing the recommended standards.

The RSL pilot was planned as the first step, standard-setting, in the first cycle and was executed in five stages:

1. Organizing the participants.
2. Developing RSLs, based on service providers' recommendations for specification of consumer groups and the minimum, appropriate level of service to achieve acceptable outcomes for the respective groups.
3. Selecting an assessment instrument that is effective in categorizing consumer groups by level of service need.
4. Creating an algorithm (decision rules) for using level-of-functioning and other assessment data to classify a consumer as appropriate for one of the RSLs.
5. Testing the validity of the RSLs in a sample of the consumers receiving county-funded services.

METHOD

Stage 1: Organizing the Participants

Team leaders assisted representatives of 14 adult mental health agencies to meet as a supervisory body for the project—the Oversight Committee. Three agency types were represented: (1) community mental health centers serving primarily the suburban and small town areas of the county; (2) a network of community mental health centers that contracted jointly to serve the central city; and (3) members of a Cross Cultural Alliance (typically small agencies or programs serving historically underserved populations including ethnic and sexual minorities, physically disabled, elderly, and deaf or hard of hearing). The 14 agencies had previously worked together to develop two innovations in the county system: (1) eligibility criteria that improved access to services for underserved populations; and

(2) a level-of-functioning tool that was perceived to appropriately assess service needs of these populations.

A clinical expert panel, whose members were designated by the Oversight Committee participants, met separately to develop the specifications for service levels and criteria for eligibility. The panel was composed of a cross section of program managers, supervisors and experienced case managers from all the participating agencies. To preserve the diversity of input based on experience with intensive inner city caseloads and special populations, respectively, members of the panel from the central city network and the Cross Cultural Alliance met in separate work groups before each of the panel meetings. Following each panel meeting, the project staff synthesized a product for review and formal action, typically approval with comment, by the Oversight Committee.

Stage 2: Developing Service Levels and Eligibility Criteria

While agency representatives were being organized, project team leaders identified and reviewed service level schemes under development at other sites in the country. The review suggested two principles that were incorporated into the pilot project: (1) the consumer's history of functioning impairment should be used in criteria for service level eligibility in addition to current level of functioning; and (2) service level schemes should delineate a minimal number of clearly demarcated service levels for optimum feasibility.

The expert panel was then assisted to differentiate profiles of consumer groups distinguished by need for level of service on three dimensions: (1) principal goals (i.e., symptom reduction, basic skill building, maintenance, or rehabilitation); (2) required intensity of resource commitment (as indicated by the average weekly range of service hours) for a 90-day treatment plan period; and (3) required extent of continuity of care and supervision (as indicated by presence/absence of case management and 24-hour supervision). Using these parameters, the panel ultimately delineated the eight levels of service shown in Figure 1.

The panel subsequently established minimal criteria for consumer eligibility for each of the eight RSLs, using as a general guide current level of functioning difficulty in the areas covered by a level-of-functioning assessment tool with which participants had experience, the Problem Severity Summary (Community Psychiatric Clinic, 1992). Panel members ultimately identified current level of difficulty experienced in four general domains as essential for making eligibility decisions: (1) psychiatric symptoms, (2) independent community functioning, (3) physical functioning and self care, and (4) maladaptive and dangerous behavior. Two criteria not related to current functioning (history of functioning impairment and

FIGURE 1
Parameters of the Recommended Service Levels

Recommended Service Level	Care[a]	Service Hours[b]	Parameters: Goals — Symptom Reduction	Maintenance	Rehabilitation	Basic Skill Building
1. Brief Intervention/Crisis		≥15 hrs/yr	X			
2. Medication Maintenance		≥15 hrs/yr		X		
3. Monitoring	C	16-35 hrs/yr		X		
4. Rehabilitation	C	1-5 hrs/wk	X	X	X	
5. Supervised Living	C/S	1-5 hrs/wk	X	X	X	
6. Intensive Community Support	C/S	3-7 hrs/wk	X			X
7. Aggressive Community Support	C/S	5-12 hrs/wk	X			X
8. Inpatient	S	N/A	X			

Note: From Uehara, 1994.

[a]Care Continuity/Supervision C - Case management is provided
S - 24-hour supervision is provided

[b]Service Hours are standardized and expressed in terms of the cost equivalent of one face-to-face service contact hour. Case management and direct service hours in residential facilities are included.

duration of time since onset of functioning impairment) were also included to differentiate consumers in service levels 2 (medication maintenance) and 3 (monitoring) (Figure 2).

Stage 3: Selecting a Level-of-Functioning Assessment Instrument

Following identification of the domains of functioning critical for determining eligibility for an RSL, the Oversight Committee accepted the project team recommendation to use the Revised Problem Severity Summary (RPSS; Community Psychiatric Clinic, 1994a) as the assessment instrument. Factors favoring the selection of this instrument included: (1) simplicity and cost-efficiency—a brief assessment format easily learned by bachelor's degree-level case managers with minimal training; (2) adequate interrater reliability; (3) demonstrated sensitivity to the full range of consumers to be served (i.e., from high functioning to severely impaired within both majority culture and historically underserved and special need populations); and, (4) a sense of local ownership among clinical staffs resulting from participation in its development.

FIGURE 2
Criteria for Entry to Recommended Service Levels

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Criteria for Entry to Recommended Service Levels

Criterion Type	1 Brief Intervention/ Crisis	2 Medication Maintenance	3 Monitoring	4 Rehabilitation	5 Supervised Living	6 Intensive Community Support	7 Aggressive Community Support	8 Inpatient
Functioning Impairment Criteria:	Slight symptoms AND Slight community functioning impairment AND GAF ≥70	No symptom or community functioning impairment for at least one year	Slight community functioning impairment	At least marked symptom or community functioning impairment	At least marked symptom or community functioning impairment AND At least severe self-care, cognitive, physical, health, or medical care needs AND Low dangerousness and maladaptive behavior	At least severe community functioning or extreme symptoms impairment in two or more areas OR all of the following: At least marked symptom or community functioning impairment AND At least marked self-care, cognitive, physical, health, or medical care needs AND At least marked dangerousness or maladaptive behavior	At least severe community functioning impairment AND one of the following: Extreme self-care, cognitive, physical, health, or medical care needs OR At least severe dangerousness or maladaptive behavior	Extreme dangerous behavior
Persistence (Duration)	Duration ≥ 1 year from onset	Duration ≥ 1 year from onset	Duration ≥ 1 year from onset					
Other		A treatment plan specifies management of psychiatric medication at maintenance levels	History of functioning impairment meeting criteria for level 4 or higher services					

NOTE: From Uehara, 1994

The RPSS was created through collaboration of three of the authors with the clinical expert groups described earlier. Case managers in the field were also systematically involved, in order to develop items to address the issues of special need populations. The RPSS is comprised of 22 single-item scales designed to assess level of functioning and broad symptom areas for an adult population with severe and persistent mental illness. An earlier version, the Problem Severity Summary, was already in use routinely for determining eligibility for county-funded services and had demonstrated adequate inter-rater reliability and concurrent validity for most scales for both mainstream and special need populations (Community Psychiatric Clinic, 1992).

Stage 4: Creating an Algorithm

The criteria for classifying consumers into groups (Figure 2) were formulated as an algorithm (a set of systematic decision rules). The algorithm uses decision tree logic, beginning at the "Inpatient" level, and queries whether the consumer has a rating of extreme dangerousness on the level-of-functioning instrument. If the answer is "yes," the consumer is classified as belonging in this level. If the answer is "no," the next set of queries refers to the eligibility criteria for the "Aggressive Community Support" RSL, and so forth. The algorithm was then computerized and tested for its ability to inclusively and accurately classify all of the consumers in a sample.

Stage 5: Testing the RSLs

The major field test question was, "Are the classifications of consumers into service levels, based on RSL criteria, valid?" The primary focus of the field test was to explore the concurrent criterion validity of the RSLs by examining the relationship between consumer RSL classification and ratings on seven risk factors reported in the literature to be associated with intensity of service need. The team hypothesized a linear, positive relationship between intensity of RSL placement, number of psychiatric hospitalizations in the previous year (Drake & Wallach, 1992; Pablo, Kadleo, & Arboleda-Florez, 1986), homelessness (Calsyn & Morse, 1991; Sangiuneti & Brooks, 1991), number of jail episodes in the previous year (Michaels, Zoloth, Alcabes, Braslow, & Safyer, 1992), number of residential changes in the previous year (Appleby & Desai, 1987, Caton & Goldstein, 1984), instability of medication regimen (Drake & Wallach, 1992; Feldmann & Paynter, 1988; Joyce, 1985), and experiencing of life stressors (Dohrenwend & Dohrenwend, 1974; Ensel & Lin, 1991; Lin, Dean, & Ensel, 1986; Mueller, Edwards, & Yarvis, 1978; Schwartz & Myers, 1977).

A secondary focus was to explore the extent of disparity between the expert panel and case manager perceptions of service need. Case managers

in the pilot study were provided with the description of each RSL but were unaware of the algorithm used to classify a consumer into an RSL. Case managers were asked to make their own best judgment of the "minimum appropriate" RSL for each of their consumers based on their assessment. Our logic was that greater levels of disparity between algorithm-generated classifications and case manager judgments would indicate greater degrees of system change difficulties in implementing RSLs (Leff et al., 1994). Thus, we compared each consumer's RSL generated by the algorithm with the case manager's independent choice of RSL for the consumer.

Sampling. These issues were investigated in a field test of the RSLs conducted to estimate the utility of the schema in classifying the service-level-needs of a county-wide sample of adult consumers with severe and persistent mental illness. A random sample was selected for 17% (928 cases) of the adults enrolled and receiving services in the county system as of December 1, 1993 (see Community Psychiatric Clinic, 1994a, for the details of the sampling and data collection).

Training. Following sample selection, case managers participating in the field test (N=369) received training to complete the assessment package. Two-hour sessions were conducted for small groups of approximately 15 case managers. Training was conducted by one of the authors and two experienced master's-level clinical trainers. The training was standardized by use of a manual for trainers and case managers. The manual included an explanation of the purposes of the field test, clinical guidelines for completion of the assessment forms, instructions for selecting an RSL based on the assessment results, and procedures for transmitting completed assessments to the project team.

Trainees completed practice assessments for a written case description. The ratings were shared with their training group on each assessment item. The group compared its ratings and discussed interpretation issues for each item that resulted in highly disparate ratings. This discussion clarifies how raters interpret the assessment items and subsequently improves interrater reliability (see Newman and Sorenson, 1988, for the training methodology).

Data Collection Procedures. Immediately after the training, the project team provided to each service agency a list of the agency's service consumers who appeared in the sample. For each of their cases, case managers provided RPSS scores and information about previous service history. Case managers also provided data about the presence of a set of risk factors for high utilization of services (psychiatric hospitalizations, homelessness, jail episodes, residential changes, unstable medication regime,

severe stressor episodes, and lack of proficiency in English). Typically, the task required 30 minutes. Case managers were also asked to record suggestions for improving any aspect of the assessment package. Assessments were completed during a 5 week period. Additional sociodemographic data for each consumer in the sample was extracted from the county information system.

Pilot Results. The pilot results are briefly summarized below. A report giving a full presentation of results is available from the first author (Community Psychiatric Clinic, 1994a). The age, ethnicity, and gender composition of the sample was shown to be comparable to that of the county caseload as a whole (Community Psychiatric Clinic, 1994a). The percentage of cases in the sample classified by the algorithm into the eight service levels were: Brief, 1%; Medication Maintenance, 2%; Monitoring, 9%; Rehabilitation, 43%; Supervised Living, 5%; Intensive Community Support Services, 28%; Aggressive Community Support Services, 10%; and Inpatient, 1%. Within each RSL, the distribution of the cases was very similar in terms of age, ethnicity and gender.

As a preliminary to answering the validity question, data on interrater reliability were examined for separate special population and mainstream agency subsamples. The interrater reliability was acceptable for 19 of the 21 RPSS items, ranging from at least moderate (Intraclass Correlation Coefficient of .40) to high (Intraclass Correlation Coefficient of .79) in one of the subsamples. To improve reliability, changes were made to the instrument which were suggested by case managers during the pilot (Community Psychiatric Clinic, 1994b), although data have not yet been available for evaluating the magnitude of the improvement.

We then examined the validity of RSL classifications. Risk factor data, collected as part of the assessment, was not used in the algorithm. We compared the algorithm classification to the consumers' risk factors as a way of testing the algorithm's predictive validity. As hypothesized, there was a positive and significant relationship between intensity of RSL and seriousness of risk factors. The range of association indexed by Cramer's V was .12 to .32 ($p \leq .001$; Uehara, 1994).

Finally, we examined the extent of disparity between classifications of consumers' level of service need by use of the algorithm versus classification by the case managers. The case managers' judgments were exactly the same as the algorithm classification in 30% of the cases (see Leff, Mulvern, Lieberman and Rabb, 1994, for similar findings). A large proportion (69%) of the case managers' RSL choices fell within one RSL of the algorithm classification. In cases of disagreement, it was more likely for case managers to recommend a lower RSL than the algorithm (47% of the

cases) than the reverse (23% of the cases). These findings suggest that case manager perceptions of consumer needs are generally, though not always exactly, aligned with RSL classifications. Successful implementation of RSLs in the field would require dialogue with case managers to increase the "fit" between case manager and expert panel perception of need. Ideally, such a dialogue would result in ongoing education of the case managers, refinement of the RSL classification scheme based on case manager insights, and greater congruence between RSL classification scheme and case manager perceptions.

The highest proportion of matching recommendations occurred for the four RSLs of Medication Maintenance (29%), Monitoring (39%), Rehabilitation CSS (38%), and Aggressive CSS (38%). Case managers tended to recommend a service level higher than the algorithm when the algorithm classified the consumers at the least intensive RSLs of Brief Intervention, Medication Maintenance, and Monitoring. Case managers tended to recommend a service level lower than the algorithm for all other service levels (Community Psychiatric Clinic, 1994a). We speculate that one source of disagreement between case managers and the algorithm's representation of the clinical expert panel's criteria was the case manager's historical experience of service use driven by fee-for-service reimbursement incentives. We further speculate that the match would improve dramatically if the case managers had had positive experiences in accessing packages of services prescribed by the RSL algorithm.

DISCUSSION AND CONCLUSIONS

Strengths and Weaknesses of the RSL Method

The field test demonstrated the promise in the RSL method. Clinical judgment across a complex, county-wide system was structured and expressed as a standard for the minimum service levels which should be made available in response to assessed consumer need. The method performed well enough to encourage both the correction of defects, many of which were remedied immediately, and the completion of the first cycle of development.

Three problems of the RSL approach still await resolution: (1) failure to involve consumers in specifying the initial RSLs; (2) productively managing the tension between the RSLs (a proxy measure of service quality in lieu of outcome data) and other explicit or implicit criteria established by the funder to determine eligibility for mental health managed care benefit packages; and, (3) validation of the RSLs via outcome data.

Involving Consumers. The public credibility and the effectiveness of local standards will be improved if consumers are fully engaged in their creation and refinement. The failure to get consumer input raises both a professional practice concern and unanswered questions about the acceptability of the RSLs to consumers. The issue of good professional practice is important from two perspectives. First, consumer input into individual service planning is the cornerstone of the emerging methodologies for quality management in human services which envision the service consumer as the "primary customer" and the satisfaction of consumers with their service experience as the basic data for determining the quality of services (Martin, 1993). Second, involvement of consumers is a practice value at both micro and macro level, as partners in the design and delivery of humans services (Swift & Levin, 1987; Tower, 1994; Weick, 1983). The benefits of this value extend beyond just the short-term improvement in clinical impact that may result in individual cases. We embrace a commitment to facilitate maximum empowerment of consumers as an organized group, including their prerogative to identify their priorities for outcomes, to define appropriate services, and to participate in service management.

Finally, evaluators of one demonstration of service levels found that at least some of the gaps between the services prescribed and the services provided were associated with the consumer's recorded rejection of the prescribed services (Leff et al., 1994). These findings suggest the importance of the consumer voice in identifying acceptable services at the planning phase in order to improve the acceptance rate in the service delivery phase.

The Function of RSLs in Quality Management. The strategy of the RSL method—to develop local standards for quality service independent of funding allocation decisions—will heighten tension between the managed care organizations (MCOs) which administer the service system and the participants involved in creating local standards (typically service providers eager to continue their contracts with the same MCOs). The tension arises because the funders of service and MCOs are accountable not only for service quality, but also for cost containment and expanded access (Boyle & Callahan, 1993). The result is that developers of local standards may often be confronted with funded service levels lower than the service levels they judge minimally appropriate in order to produce desired outcomes.

In these circumstances, local standards can still serve two functions. First, within the spirit of a managed care contract, local standards can be used as a clinical decision pathway for prompting and documenting requests for authorization of exceptional care for those consumer groups

which will otherwise be most underserved. Second, local standards are a potential foundation for negotiating changes in contracts leading to increased service funding levels. This use of local standards seems more likely if the poor outcomes at the funded (as opposed to recommended) service levels can be demonstrated to have politically intolerable consequences (i.e., cost shifting to other public services including public safety/corrections, school, health, and hospital budgets).

To the extent that state and local mental health authorities are accountable for the performance of the managed care systems implemented in the public sector, including those operated by MCOs, they may be interested in a program of clinical audits using local RSLs. Concurrent and retrospective audits are among the methods used to determine the adequacy of the service benefit packages delivered to plan enrollees. Using RSL-like standards as a tool in adequacy-of-care audits offers two advantages: (1) a method for standardizing the reviews and (2) the ability to use automation in the review process, thus freeing skilled clinical reviewers to concentrate their efforts on systemic problems resulting in exceptions.

Conversely, the absence of explicitly stated standards created independently of resource allocation methods invites breakdown in clinical communication and a tendency toward debate and, ultimately, litigation centering on conflicting claims to clinical knowledge of medical necessity and achievable outcomes for classes of consumers. Funders and MCOs may view RSL-like methods as a positive means of systematically overcoming the wide variations in clinical perception, practice patterns and quality which distract from the promotion of effective care (Berlant, 1992; Gottlieb, 1989).

Validation and Refinement of RSLs. Critical RSL development work still needs to be accomplished in order to produce a fully dependable tool for operational quality management in routine field settings. Three additional validation projects await the availability of data on actual assessments, service utilization, and outcomes in the operating environment. The first is to determine that RPSS scores are sensitive to change over time.

The second analysis project is to determine that the utilization of service at the minimum levels specified by RSLs is associated with positive outcomes. Conducting this analysis will be challenging given the expectation that the system will typically provide less service as a standard benefit than is prescribed by the RSL for a given consumer. The critical task will be to capitalize on the natural variation in level of service received by consumers at a given RSL level of need. We hypothesize a positive linear relationship between the percentage of prescribed RSL service level received by a consumer above the standard benefit and the extent of

positive outcome experienced. Outcome measure dimensions for which data may be available in the county information system include: employment status, living conditions, hospital and jail use, assessed symptomatology and functioning. To the extent that consumer groups receiving higher proportions of RSL-specified services experience more positive outcomes, the first cycle of RSL development is completed satisfactorily.

The third project involves improving the validity of RSLs by refinements based on identifying subgroups of consumers who received RSL-specified services but failed to experience a positive outcome. There may be characteristics shared by members of these subgroups which will be predictive of their poor outcomes. Discriminant analysis can be useful as an empirical technique for determining the distinguishing characteristics of these subgroups. An expert panel will then be asked to review the subgroup compositions and to recommend whether the RSLs should be modified to include alternative service levels for the subgroups.

Conclusions

The RSL project experience suggests that RSL-like methods for local standards development are feasible innovations for other systems. Local standards can be developed and refined to make the practice wisdom available in a system publicly accountable.

A critical function of the RSL method is its independence from funding allocation methods which are substantially driven by the press for cost containment as well as increased access to service. The establishment of standards for outcome-related service use independent of service resource allocation creates the basis for a dialogue between providers, consumers, and other advocates, on the one hand, and those accountable for service funding on the other. Schlesinger (1989) points out that, because such standards may under some circumstances favor excessive service use, their interaction with financial pressures "may strike the right balance in providing care" (Wennberg, 1984, p. 101). In this sense the RSLs offer the potential for a system of checks and balances.

There are, however, disconcerting possible consequences of publicly and explicitly stated expectations for minimum benefit packages. Comparing the costs of providing explicitly stated minimum benefit packages using RSL-like standards to the expected funding allocation would force all the participants to examine the realities of what can be provided with existing resources. In the light of cost projections based on adequacy-of-care standards, public mental health services for persons with serious and persistent mental illness may not appear profitable to MCOs. If so, we may lose some certainty about managed care as the vehicle for improving the

performance of public mental health services but gain in our understanding of responsible public policy.

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