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Factors Related to the Responsiveness of State Mental Health Authorities to Parents with Mental Illness

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Abstract

The majority of adults with serious mental illness living in the community are parents, many of whom may be receiving services from State Mental Health Authorities. Innovative intervention approaches are available to improve outcomes for these parents and their children. An understanding of factors related to SMHA responsiveness to clients who are parents suggests strategies for policy and program development. Quantitative analyses of SMHA- and state-level data, and qualitative interviews of administrators, service providers, and consumers underscore the importance of organizational structure and philosophy, an advocacy presence, and available funding to SMHA efforts on behalf of parents and their families.

Keywords

State Mental Health Authority; Systems change; Parental mental illness

Introduction

The majority of State Mental Health Authorities (SMHAs) are unaware of the parenting status of the adult clients receiving public sector mental health services (Nicholson, Geller, Fisher, & Dion, 1993). Findings from a national survey of SMHA Directors regarding programs and policies for mothers with mental illness indicate only 31 percent of SMHAs collected data on the parenting status of female clients, 20 percent had policies regarding pregnancy and parenting for women receiving services, and none had visitation policies for hospitalized mothers and their children (Nicholson et al.). Neglect of the parenting role may result in missed opportunities for promoting rehabilitation and recovery of adult clients, and may increase barriers to services for parents and children. Attention to the goals of adult clients with mental illness who are parents may contribute to positive outcomes for entire families. Knowledge

regarding factors related to the responsiveness of SMHAs to the issues of clients who are parents could inform efforts of those in other states and systems interested in facilitating change to meet the needs of families living with mental illness.

Women and men living in the community who met criteria for serious and persistent mental illness in the previous 12 months are as likely or more likely to be parents than individuals not meeting criteria for any psychiatric disorder (Nicholson, Biebel, Williams, & Katz-Leavy, in press). In analyses of National Comorbidity Survey data, 68 percent of women meeting criteria for psychiatric disorder over their lifetime are mothers, and 55 percent of men meeting lifetime criteria are fathers, compared to 62 percent of women without psychiatric disorder who are mothers and 53 percent of men who are fathers (Nicholson et al., in press). Other studies corroborate the finding that adults with mental illness have the same fertility and pregnancy rates as those without psychiatric diagnoses (Apfel & Handel, 1993; Oyserman, Mowbray, & Zemencuk, 1994). Several studies drawing from state mental health case management records indicate that significant numbers of adults receiving public sector mental health services are parents. Analyses of New York State Office of Mental Health data suggest that almost half of women younger than 35 receiving intensive case management services are mothers (Blanch, Nicholson, & Purcell, 1994). Approximately nine percent of women receiving Massachusetts Department of Mental Health case management services in the early 1990s were caring for dependent children (White, Nicholson, Fisher, & Geller, 1995). These studies using public sector mental health service data may underestimate the rates of parenting among individuals with mental illness given the stringent eligibility requirements of SMHAs regarding functional impairment, illness duration, and severity (Nicholson et al., in press). In the only published study of fathers with mental illness, approximately 21 percent of male clients receiving services in a Massachusetts Department of Mental Health case management site were known by their clinicians to be fathers (Nicholson, Nason, Calabresi, & Yando, 1999).

Children receiving public sector mental health services are likely to have parents with their own psychiatric issues. Data from the SAMHSA National Evaluation of the Comprehensive Communities Mental Health Services for Children and their Families Program sites indicate that 45 percent of children with serious emotional disturbance have a history of family mental illness and 20 percent have a history of psychiatric hospitalization (Center for Mental Health Services, 1999). While there are no national data available on the number of children in the general population who have a parent or parents with mental illness, the numbers are likely to be in the millions, as women and men with mental illness bear children at the same rate as those without mental illness (Caton, Cournos, & Dominguez, 1999; Mowbray, Oyserman, & Ross, 1995b; Nicholson et al., in press; White et al., 1995).

Families living with parental mental illness have the generic needs of all families, as well as service needs specific to living with mental illness (Nicholson & Henry, in press). Mowbray and colleagues (2000) found that mothers worry about paying off debts, transportation, clothing, food, social activities, rent and utilities, and medical needs. In addition, a large number of women reported experiencing stressful life events including psychiatric crises, major money crises, the death of a close friend or relative, or periods of separation from their children (Mowbray et al., 2000). Marital discord is also common for parents with mental illness (Downey & Coyne, 1990; Quinton, Rutter, & Liddle, 1984). Mothers with mental illness, while acknowledging the challenges, identify motherhood as a primary motivating factor for treatment (Mowbray, Oyserman, & Ross, 1995a). Mothers say that not being able to parent their children compromises their well-being and impedes their progress toward recovery (Blanch et al., 1994; Nicholson, 1996).

An emerging evidence base and the identification of promising practices offer SMHAs solutions to the problem of unmet service needs for parents with mental illness and their

families (Hinden, Biebel, Nicholson, Henry, & Stier, 2002). Solutions do not always require the development of specialized services or the expenditure of new money. Exemplary models have been identified, many of which employ well-known psychosocial rehabilitation strategies to improve parenting skills, and access and modify existing resources (Nicholson & Henry, in press). Recommendations have been made to expand on well-documented, tested, and widely-used models, such as Assertive Community Treatment or Family Psychoeducation, to include a focus on the adult client's goals as parent and family members' need for information about mental illness. Guidelines for practice have been developed in other countries (Australian Infant, Child, Adolescent and Family Mental Health Association, 2003).

Innovative interventions are being tested in the field, and are available for adoption by SMHAs and adaptation by service providers. Beardslee and colleagues developed a psychoeducational intervention to educate parents about the potential impact of their illness on children, ages eight to 15, and to enhance communication between parents and children about mental illness (Beardslee et al., 1996, 1997a, 1997b). Longitudinal follow-up indicates that parents and children report improved knowledge and communication about mental illness; parents report increased marital support and understanding of each other's feelings; and children are reported to be functioning better (Beardslee et al., 1997b). This intervention is currently being tested in various community settings (Podorefsky, McDonald-Dowdell, & Beardslee, 2001). Nicholson and colleagues (2001), in partnership with parents with mental illness, their family members and service providers, developed a rehabilitation approach to improving the skills of parents with mental illness either individually or in groups. Components of this intervention are currently being tested in several settings, including with special populations, e.g., homeless mothers (Weinreb & Nicholson, presentation). The "Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma" curriculum, developed by the Institute for Health and Recovery in Cambridge, MA, involves both one-on-one mentoring and intensive skill building, as well as a group intervention (Moore, Buchan, Finkelstein, & Thomas, 2002).

Research on the development of mental health policy in general reveals that it is not a linear process, but rather an interaction of a multiplicity of decision points, ideologies, technologies, and incentives (financial and otherwise), with political, economic and organizational frameworks of care (Rocheffort, 1989). In addition, mental health policy must be considered in the context of the policy structure of the United States, the policy-making process, and changing conceptions of mental health and illness (Miller, 1991).

Factors related to SMHA performance in general have been studied in previous research, and are potentially related to SMHA "responsiveness" to adult clients who are parents and their families, that is, the development of policies and programs for parents with mental illness. Torrey and Wolfe (1986), in their controversial ranking of SMHAs, identify indicators of "best" public mental health systems performance reflecting fiscal characteristics and organizational structure, including: flexible fiscal systems, decentralization of authority to states or counties, and good leadership within the SMHA and by the governor and legislature. These authors also highlight the importance of a strong advocacy presence, the significance of which is underscored in later research by Geller and colleagues (1998). The presence of empowered consumers in the public mental health system can be influential in SMHAs policies and practices. States with larger populations were found to have SMHAs with greater consumer involvement (Geller et al.).

Analyzing the same data as Torrey and Wolfe, Hudson (1987) identifies additional variables significant in determining a state's mental health performance, including population characteristics. States with greater population densities, that is, more urban than rural, had higher-rated community mental health systems (Hudson). States with greater population densities had increased socioeconomic development, facilitated by economies of scale that

allow for more cost-effective community programming. In contrast, rural communities struggled to meet the minimum needs of a geographically dispersed population. SMHAs in smaller states may be better able than those in larger states, however, to maintain a higher degree of accountability for lesser costs, as they have closer contact with providers (Frank & Gaynor, 1994).

In addition, some research suggests that behavioral managed care has the potential to address the needs of the unserved and underserved better (McGovern, Lyons, & Pomp, 1990). However, behavioral managed care systems often ignore many of the primary concerns faced by public mental health service consumers (VanLeit, 1996), and may not have the necessary social commitment to serve traditionally underserved populations (Ross, 2000). Scallet (1996) warns that the most vulnerable populations will be ill-served by a behavioral managed care system.

Parental mental illness is a significant issue for SMHAs addressing the mental health service needs of adults and children in the public sector. Innovative interventions and modifications to well-established treatment approaches offer solutions. An understanding of the factors contributing to SMHA “responsiveness” to clients who are parents or their children would suggest strategies for policy and program development in other states and systems committed to improving the lives of families living with parental mental illness. The objectives of this study are three-fold: (1) to determine the “responsiveness” of SMHAs to the issues of parents with mental illness and their families, i.e., the extent to which SMHAs have relevant policies and programs; (2) to determine the relationship between selected state characteristics and SMHA “responsiveness;” and (3) to explore factors and strategies contributing to SMHA developments related to parental mental illness.

Methods

This study was conducted in three phases to address the three study objectives. In Phase 1, primary survey data were collected and analyzed to explore SMHA responses to the needs of adult clients as parents. In Phase 2, secondary quantitative data were analyzed to determine the relationship between selected state characteristics and SMHA development of policies and programs specific to parents with mental illness. Phase 3 involved a qualitative case study component to elaborate factors and strategies related to SMHA developments.

In Phase 1, SMHA Directors in all 50 states and the District of Columbia (N=51) were surveyed regarding policies and programs for parents with mental illness using a 142-item questionnaire developed as part of a SAMHSA-funded project. Survey items were reviewed by eight experts in the field, including researchers, SMHA policy makers, providers and consumers, for feedback on validity and ease of administration, prior to its distribution to SMHAs. From this survey, 25 questions were selected to reflect information on SMHA activities in three broad categories: the identification of adult clients as parents and assessment of clients’ parental functioning (five items); specific programs and services designed for SMHA clients who are parents (10 items); and specific policies and written guidelines for SMHA clients who are parents (10 items). Program and policy activities were examined across 10 service types including: acute inpatient; continuing inpatient; emergency mental health; community residential; community rehabilitation; employment/vocational; clubhouse; day treatment; outpatient; and other. The SMHA Director or Commissioner, or his or her designee, typically the director of adult mental health services, completed the survey. Response rate for the survey was 100 percent. The survey was reviewed and approved by the University of Massachusetts Medical School (UMMS) Institutional Review Board (IRB).

Data for the quantitative component of Phase 2 were obtained from the National Association of State Mental Health Program Directors Research Institute, Inc.(NRI) and United States Census Bureau (USCB) databases, and the United States Advisory Commission on Intergovernmental Relations' Index of Fiscal Comfort (IFC). The NRI database includes information provided by SMHAs about the fiscal characteristics, organizational structure, policies, and service offerings in the states and the District of Columbia. The USCB database contains demographic and economic information gathered at county, state, and national levels regarding population characteristics, expenditures, and growth. The United States Advisory Commission on Intergovernmental Relations Index of Fiscal Comfort is a measure of states' capacities to raise revenue relative to the cost of delivering services (Tannenwald, 1999).

In Phase 3, four states were selected for case studies using data generated from Phase 1. These states represented a range of SMHA responsiveness to the parental role of adult clients. Selected states varied in size from mid-sized to large, and all had county-run mental health systems. Original SMHA survey respondents identified an initial set of stakeholders for interviewing; a snowball sampling strategy was used to generate the larger sample for the qualitative component of the study. Stakeholders from each state included two administrators/policy-makers, two consumers/advocates, and two service providers involved with the issues of parents with mental illness and their families. Telephone interviews were conducted with six stakeholders from each state using a semi-structured protocol. A total of 25 stakeholders were interviewed, as one state yielded three consumer/advocate respondents. Interviews were audio-taped and lasted approximately one hour. Respondents were paid \$50 for participating, if allowed to accept compensation by their agencies or organizations. The UMMS IRB approved the semi-structured protocol and consent form; completed consent forms were received from all respondents.

Results from Phase 1 and 2, examination of the on-line databases, review of the literature and previous research, and existing interview instruments informed the development of the semi-structured protocol. Questions were clustered into three categories reflecting (1) the process of responding to the needs of parents and their families (e.g., "Describe your role in the public sector mental health system or services in your state."); (2) interests, influences, and obstacles to responding (e.g., "What made it difficult to generate interest in the issue of parents with mental illness?"); and (3) the potential for greater response (e.g., "To what extent do you think your state's efforts with regards to parents with mental illness can be replicated?").

Measures

Dependent variables.—The dependent variables for Phase 1 and Phase 2 analyses are *SMHA responsiveness* and *breadth of responsiveness*. *SMHA responsiveness* is a dichotomous variable (responsive vs. non-responsive) created from survey responses. SMHAs providing "Yes" responses to at least one of the 25 questions regarding parents, programs and policies were designated as responsive. SMHAs with "No" responses to all 25 questions were designated as non-responsive. *Breadth of responsiveness* is a continuous dependent variable; a summary score was created by adding strength and diversity scores. Strength scores reflected the number of affirmative responses. SMHAs were given a diversity score of zero if there were no affirmative responses, 100 if all affirmative responses appeared in only one category of questions, 200 if affirmative responses appeared in any two categories of questions, and 300 if affirmative responses appeared in each of the three categories of questions. Diversity scores were weighted more heavily than strength scores because responsiveness across several domains demonstrates a greater incorporation of the issues of parents at multiple levels. The resulting *breadth of responsiveness* scores were transposed to reflect their rank within the 51 subject slots (i.e., 51 states) with higher scores representing greater responsiveness by SMHAs to parental mental illness.

Independent variables.—For Phase 2 analyses, 11 independent variables, theorized to be influential with respect to program and policy development, were generated from data in the NRI and USCB databases and the IFC, and grouped into five categories: fiscal characteristics, organizational structure, advocacy presence, population characteristics and managed care. (see Table 1) Fiscal characteristics are measured by three continuous independent variables: *per capita mental health expenditures*, *per capita income*, and *fiscal comfort*. Characteristics of SMHA organizational structure are reflected in three independent variables: *organizational layer* (continuous), *independent SMHA* (dichotomous), and *SMHA services* (dichotomous). Advocacy presence is represented by two dichotomous independent variables: *voluntary consumer involvement* and *mandated consumer involvement*. Two continuous independent variables measure state-level demographic characteristics: *population per square mile* and *estimated population*. One dichotomous independent variable, *managed care*, reflects the presence of managed behavioral health services in each state. For one of the subjects, data were Winsorized to control for extreme outlying values on per capita mental health expenditures and population per square mile.

Analyses

Responses to each of the 25 SMHA survey questions were examined through descriptive statistics in Phase 1. Descriptive statistics were calculated for responses to individual questions, as well as for items grouped into the three categories of questions. Survey data were internally cross-checked for consistency and analyzed for links between response patterns and respondents.

Relationships among independent and dependent variables were analyzed using multivariate techniques to address Phase 2 research goals. Characteristics contributing to *SMHA responsiveness* were modeled using regression techniques – logistic regression for the dichotomous dependent variable and multiple regression for the continuous dependent variable. For non-dichotomous independent variables, the modal category was used as the reference category.

For the Phase 3 state case study component, qualitative data from interview transcripts were content analyzed after coding for themes derived from the interview protocol and the results of analyses conducted in the first phase of the project. A hierarchical map of relationships among factors was used to identify major themes. Themes were summarized and compared across states and across type of stakeholders, to elaborate factors and strategies related to SMHA developments.

Results

SMHA Responsiveness

Fifty-three percent (n=27) of the SMHAs were responsive to the parental role of adult clients, i.e., answered “Yes” to at least one of the 25 questions regarding the identification of adult clients as parents and assessment of clients’ parental functioning, specific programs and services designed for SMHA clients who are parents, and specific policies and written guidelines for SMHA clients who are parents. The number of affirmative responses ranged from two to 16, with the majority of SMHAs reporting six or less affirmative responses. SMHAs were most likely to identify adult clients as parents and/or assess clients’ parental functioning (n=25); next likely to have specific programs and services for clients who are parents (n=14); and least likely to have specific policies and written guidelines for clients who are parents (n=4).

State Characteristics Related to SMHA Responsiveness

None of the independent variables in the logistic regression models were significant predictors of SMHA responsiveness. In multiple regression models, two variables from the organizational structure category, *independent SMHA* and *SMHA services*, were identified as significant positive predictors of *breadth of responsiveness*. (see Table 2) Fiscal characteristics, the variable *organizational layer* within the organizational structure category, advocacy presence, population characteristics, and managed care were not identified as significant predictors of *breadth of responsiveness*.

Factors and Strategies Contributing to Development

Stakeholders identified 33 factors or strategies contributing to the development of policies and programs for parents with mental illness and their families within SMHAs. These cluster into eight theme categories.

Collaborate.—Identify and collaborate with key stakeholders, particularly those in leadership positions, from other agencies and systems. One mental health provider noted, “Coordinate locally. People may not have money but may have resources and can be partners with you.”

Focus on families and children.—Embrace a family-centered orientation in which both adult and child clients are viewed as family members. According to one policy-maker, “Counties that have embraced (thinking about families) have moved towards very family-oriented, family-friendly services. This lends itself to thinking about parenting.”

Have a vision.—Articulate a vision of the challenges facing parents with mental illness and the solutions. In some states, considerable change has resulted from the dedication and commitment of one visionary person, dedicated to serving families. One policy-maker suggested, “You have to have a person who can organize the thoughts and put them on the table and talk about what you want to do to get a clean, coherent picture of what it is all about.”

Collect and use prevalence data.—Prevalence data regarding the number of families living with parental mental illness are useful in making policy, planning and development decisions, and advocating for change. As one policy-maker noted, “The first step is knowing your population, and knowing who you need to serve.”

Collect and use personal experiential data.—The personal stories of individuals affected by parental mental illness are very powerful in demonstrating need and recommending solutions. A provider related, “What really opened my eyes was actually being in a room with people who were in that situation, parents who had a mental illness and hearing their stories. It was very compelling to me and I knew it would be compelling to others as well. That information, those testimonies, were very, very, very powerful.”

Be open to innovation.—Individuals, agencies or systems that have been willing to embrace new issues, service delivery models or treatment strategies are more responsive to the needs of parents with mental illness and their families. One policy-maker suggested, “We had buy-in from the top and support from the very beginning. There was a very clear statement to everybody in our organization that (serving families) is how we are going to do business.”

Adopt multiple approaches.—Interest in and efforts to respond to the challenges of parental illness can come from both inside and outside the mental health system, and benefit from the support of “top-down” and “bottom-up” approaches within agencies and organizations. According to one consumer, “It’s not just top-down or bottom-up. It’s a

combined effort of local need advocating strong and hard and people at the top saying this is important and you need to respond to it.”

Access funding available for prevention initiatives.—Funding targeted to early intervention and prevention service for infants, young children and their parents has been useful in developing services and supports for families living with parental mental illness. A policy-maker noted, “The adult system doesn’t have a funding stream like Early and Periodic Screening, Diagnostic, and Treatment. There are no prevention dollars available for adults.”

Discussion

Results suggest that approximately half of SMHAs are responsive to the parental role of adult clients in some way. These SMHAs are identifying the parental status of adult clients, assessing parental functioning, offering specific programs or services for parents or providing specific guidelines or written policies for parents. Almost half are not ostensibly responding to the needs of parents with mental illness even though the prevalence of parenthood is high, the risk to children and families is significant, and parenting is an issue identified as important to mental health consumers. SMHAs may be genuinely unaware of the prevalence of adult clients who are parents. Especially given the high rates of custody loss, many SMHA clients who are parents may not be the primary caregivers for their children. Issues concerning parenting have traditionally been the responsibility of other systems or agencies such as child welfare or public health, or, within an SMHA, the purview of the children’s mental health division. Finally, most SMHAs have service delivery and funding mechanisms designed to serve individual clients rather than families. SMHAs may not have the mandate or the resources to meet the needs of the children of adult SMHA clients, or conversely, to address the issues of parents of child SMHA clients with serious emotional disturbance, many of whom are living with mental illness themselves.

Interestingly, fiscal variables were identified only in relation to supporting early intervention and prevention programs. And while a lack of financial resources is frequently cited as a barrier to serving SMHA clients, results suggest that the availability of funding is just one of many factors that are important when developing new programs and policies.

Organizational structure of an SMHA, specifically whether a SMHA was independent and whether a SMHA administers only mental health services, was also identified as significant in relation to program and policy development for parents with mental illness. It may be the case that independent SMHAs not located within other agencies may be more autonomous, and be able to develop their own agendas better without having to include the priorities and interests of other departments located under the same umbrella agency. Independent SMHAs may also be more capable of establishing their own areas of interest, and may have an easier time developing new initiatives and priorities if they are not part of a larger agency that needs to be involved in the decision-making process. SMHAs that administer only mental health services may be better able to concentrate their efforts on specific populations of interest within the mental health arena, e.g., parents with mental illness.

Responsive SMHAs appear to embrace a particular organizational philosophy, or way of doing business that facilitates serving parents with mental illness and their children. This organizational philosophy involves working collaboratively within and across agencies and service systems, moving away from more traditional ideas about delivering and designing mental health services for individual “identified clients” and focusing on the needs of families and children, and a willingness to design and implement innovative services and policies. These concepts support Hasenfeld’s (1983) notion that flexible internal structures are critical to adopting novel organizational goals. These strategies are potentially enhanced by SMHAs with

organizational structures that are independent, and administer only mental health services, as autonomy and the ability to have a more narrow focus contribute to a more innovative and collaborative organizational philosophy and the flexibility to make change. High-level support (usually at the county level) from systems, agencies and boards was crucial to the ability to be responsive to parents with mental illness and their children.

Advocacy and the role of advocates are important in SMHAs' efforts to be responsive to the parental role of adult clients. Strategies used by advocates focused on what information was effective in making change happen (i.e., collecting and using personal experiences and prevalence data) as well as how to use this information within service systems (i.e., adopting multiple approaches). Stories of mental illness, whether of being a parent with a mental illness, being the child of a parent with mental illness, or working with parents with mental illness and their families, were powerful and effective in generating interest in parental mental illness. Prevalence data lend validity to the stories of consumers, family members and advocates, and prevent the dismissal of parental mental illness as a rare and uncommon occurrence. These data convey that parental mental illness is not something that affects only a small number of adults and their children; the prevalence is great and the issue is pervasive. Advocates then used these experiences and data to tackle the mental health system with both top-down and bottom-up approaches, while also working from within and outside of the mental health system. This decreases the reliance on one individual, and encourages involvement of persons from different systems, and from different levels within systems, in facilitating change. These types of advocacy may differ from the advocacy efforts often seen in SMHAs including consumer involvement in policy making, advisory boards and statewide planning efforts. The data suggest that how advocates choose to move forward with an issue, as well as their relationships relative to an SMHA matter when promoting systems change.

Some methodological limitations should be considered when reviewing these findings. First, the lack of previous research on parents with mental illness, as well as the dichotomous nature of the response categories for many of the survey questions, limit the sophistication of the methodology. Second, the identity of the SMHA survey respondents could be a confounding variable, as individuals in different administrative positions may vary in their knowledge of how the SMHA responds to the needs of adult clients who are parents and their families. Third, the reliability and validity of the SMHA survey have not been demonstrated. Therefore, how well the survey questions capture how a particular SMHA responds to parents with mental illness is unknown. Fourth, the selection of independent variables is limited by the NRI database. Since NRI is the only nationwide database committed to issues concerning SMHAs, data available for analysis are determined by NRI. However, data from the NRI and USCB databases and the Index of Fiscal Comfort (Tannenwald, 1999) are widely used, and researchers have accepted their reliability and validity. Fifth, the reliability and validity of the semi-structured protocol for the qualitative component of the study are also unknown. As there were no existing protocols to explore factors and strategies contributing to SMHA development related to parental mental illness, questions were generated through review of previous research, the literature and existing interview instruments. Finally, linear statistical models may be ill-suited to address complex, multiply-determined relationships such as program and policy decision-making. Setting mental health priorities is often an irrational and illogical process, influenced by a variety of factors including the values of the times, cultural forces and interest groups (Callahan, 1994). SMHAs are extremely complex entities; decisions regarding policy and program development may not be based on a step-wise, rational model.

Conclusion

Parenthood is extremely prevalent among adults with serious mental illness. There are many opportunities for SMHAs to attend to the needs of both adults and children living with parental

mental illness. Findings from this study suggest that over half of SMHAs respond in some way to the needs of these families. Quantitative analyses indicate that organizational structure, specifically autonomous structure and providing only mental health services are positively related to SMHA responsiveness. Stakeholders suggest a variety of factors and strategies related to change including organizational philosophy, advocacy presence, and funding. These results should encourage SMHA administrators and providers interested in strategies that facilitate systems change.

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Table 1
Independent Variables Theorized to be Influential to Program and Policy Development

Category	Variable	Data Source	Definition	SMHA/State
Fiscal characteristics	Per capita expenditures	NRI	SMHA expenditures for mental health – per capita	Mean: \$52 Min-Max: \$13-\$132
	Per capita income	USCB	1997 state personal income per capita, in 1992 dollars	Mean: \$21,835 Min-Max: \$16,21-\$32,177
	Fiscal comfort	IFC	1996 index of state fiscal comfort	Mean: 103 Min-Max: 65 – 150
Organizational structure	Organizational layer	NRI	Number of formal organizational layers existing between the SMHA Director and the Governor	Zero: 11 (21.6%) One: 28 (54.9%) Two: 11 (21.6%) Three: 1 (2.0%)
	Independent SMHA	NRI	SMHA is not part of another State agency	14 (27.5%)
	SMHA services	NRI	SMHA administers only mental health services	9 (17.6%)
Advocacy presence	Voluntary consumer involvement	NRI	State has consumer involvement in SMHA for policy-making activities including development/ promulgation of rules/regulations, statewide/regional-planning efforts, or SMHA advisory/ governing boards	46 (90.2%)
	Mandated consumer involvement	NRI	SMHA has statutory or regulatory mandates for consumer participation in policy making, or resource allocation	17 (33.3%)
Population characteristics	Population per square mile	USCB	1990 state population per square mile	183, 1–1043
	Population estimates	USCB	1998 state population estimates	Mean: 5,346,879, Min-Max: 479,602-33,145,121
Managed care	Presence of managed care	NRI	State involved in providing managed behavioral health services	29 (56.9%)

Table 2

Standardized and Unstandardized Regression Coefficients for Significant Predictor Variables of SMHA Responsiveness to the Parental Role of Adult Clients

Variables	Constant	B	SE B	ß	p
Independent SMHA	23.149	11.89	4.11	.381	.006
SMHA services		10.39	4.81	.285	.036