

SECTION V: Development of Community Treatment and Services

Currently resounding in the mental health community is the concept of real recovery. During the late 1990's through present, advocates, consumers, and families have worked hard to educate professionals and policy makers that recovery is more than wishful thinking; it is reality for many individuals. Advances in medication, in conjunction with treatment and support services have created opportunities for people with serious mental illness to lead successful lives, with family, jobs, homes and most importantly, hope.

There is understanding that changes in our current system must occur to successfully support individuals in recovery, with rehabilitative programs that provide opportunities for reintegration to community rather than people simply "being taken care of." Preparing to facilitate such a major shift in philosophy is no small undertaking. Most stakeholders involved in the mental health system have very little knowledge of and experience with recovery values and principles. Literature available suggests that recovery is a unique and personal experience. Therefore, staff training and flexibility in services/supports need to occur in order to plan successfully.

Representatives from each of the four (4) administrative MH/MR units, along with representatives from Harrisburg State Hospital, providers, families, consumers, and advocates collectively are considering how the current continuum of care should be transformed to promote recovery. Current service structure is based largely on a medical model and will require significant energy and overhaul to offer the foundation for true expansion to recovery oriented supports. In addition to the philosophical shift, services that are basic to a recovery-oriented system will require expansion.

Key areas to be developed are those of peer supports and training opportunities for staff, families, and consumers in recovery philosophy and principles. Psychiatric rehabilitation services are presently being developed in several counties, but will need significant expansion in order to provide opportunities for the majority of individuals who meet criteria for such, based on priority population definitions as outlined by OMHSAS.

Critical to supporting the identified three goals is timely access to community mental health treatment, rehabilitation, and social opportunities. Having appropriate resources within the community to provide quality and timely care will facilitate successful outcomes related to the three SAP goals. At present adult consumers, whether publicly or privately funded, must wait 6 - 8 weeks to see a psychiatric physician. It is critical these services be available much sooner to support the goals of the SAP.

Counties and providers of community services represented in this service planning initiative operate under both significant fiscal constraints and challenging regulations. Review of a variety of data sources, as well as current practices within each county program, suggest that the current system lacks the capacity to support the present level of consumer need. Hence some individuals must "wait" to receive medically necessary treatment services and supports. Concurrently, individuals must also wait for housing, jobs, access to healthcare, case management and other services. In most cases peer support, which can be very helpful, is not built into the existing programs. Stakeholders

note the importance of creating a continuum of care that assists people back into the mainstream of society, as well as proactive treatment and rehabilitative supports that provide intervention prior to the need for more intensive and less integrated support, such as the state hospital.

Therefore the planning initiative needs development from both ends of the spectrum. Effective and available community supports that will decrease each consumer's potential need to use long term care need to be developed/enhanced. Concurrently, services and supports to increase reintegration opportunities for individuals who have received long-term care and treatment within the state hospital system also need to be developed. Additionally, consumers, advocates, and families should continue to encourage legislators and policy makers to pass mental health insurance parity legislation. Full parity would assist in reducing or eliminating the fragmentation in the system.

The following plan is proposed to successfully prepare and support individuals in recovery during the next five years.

<i>Year 1:</i>	Recovery Training, Human resource development concerns, expansion of recovery supports (Peer mentoring programs); expansion of CFST and quality management initiatives; expand current community services as needed to support current capacity concerns; identify funding/insurance for individuals coming from state hospital as appropriate; formalize partnership with state and county correctional institutions to plan for individuals with SMI in recovery.
<i>Year 2:</i>	Expand/Develop Specialized Personal Care Homes (perhaps shared resource between 2 or more counties), supportive living services, vocational opportunities, consumer self-help groups, expand transportation; discharge 30 individuals from HSH, with the closure of one living area.
<i>Year 3:</i>	Development/Expansion CTT/ACT; develop forensic housing opportunities, train judicial system and mental health providers serving forensic population; expand psychiatric rehabilitation services, expand transportation; review year 1 and 2 successes and failures and make appropriate adjustments to service area plan; discharge 30 individuals from HSH, with the closure of a second living area.
<i>Year 4:</i>	Develop regional crisis stabilization unit; expand transportation; discharge 30 individuals from HSH, with the closure of a third living area.
<i>Year 5:</i>	Develop regional LTSR (If still deemed necessary); discharge 30 individuals from HSH, with the closure of a fourth living area.

It is anticipated that positive outcomes will be evidenced as services that promote and support recovery are developed and expanded. Counties anticipate cost savings coming primarily from reduction in expenses associated with inpatient stays and partial hospitalization. Costs saved will be redirected to recovery oriented supports such as psychiatric rehabilitation.

In support of SAP Goal 1 (no person will remain in the state hospital for more than two years), a number of individuals who have received maximum benefit from long-term inpatient care were identified by each of the four administrative units. Supports to assist these individuals to reintegrate to life in the community will be identified and/or developed. Intensive treatment planning for transition will occur for those individuals who are currently in treatment at HSH and those who are admitted in the future in order to assist them to be ready for discharge as quickly as possible. Identification of types of supports that are anticipated should happen at admission, or as soon thereafter as feasible.

Many individuals, due to their years of institutionalization, have become very dependent upon staff to meet their needs. It may take an extended period of time to assist these individuals to become significantly more independent. In the review of the extended stay population at HSH, need assessments were completed. The following types of supports will be needed in order to serve these people in the community:

- Specialized Personal Care Services
- Supportive Living
- Long Term Structured Residence (for a small group of individuals)
- Assertive Community Treatment Teams
- Psychiatric Rehabilitation
- Peer Supports
- Medication
- Representative Payee Programs
- Social Supports (preferably tied to natural supports within the community)
- Vocational supports
- Transportation
- Targeted case management

Most of these services are available within the service area but will need significant expansion to successfully support Goal 1. Adequate funding, based on individual needs, is critical to the success of this plan. Funding streams must support the SAP goals. We believe that early costs to support individuals who have remained in the state hospital for many years will be higher due to the level of daily support they are currently receiving. Additional staff supports must be initially built into a number of programs supporting individuals with long-term hospitalization histories until some community successes are realized. Many of these individuals have received treatment in excess of 10 years (and in some cases longer than 30 years) at the state hospital and HSH has become “home” to them.

Many of these individuals are over 60 years of age and some are eligible or will become eligible for Medicare. There is uncertainty as to how the new Medicare pharmaceutical benefit will impact this group of individuals. Most people in this subgroup are on newer atypical antipsychotic medications, which are covered under HealthChoices and fee for service Medical Assistance, but are not covered under county pharmaceutical formularies. Specific planning needs to be completed during years prior to each person’s discharge to identify insurance eligibility and navigate how to facilitate obtaining prescriptions. If no other options are available to fund needed medications, it

is recommended that each county have the resources and the flexibility to cover psychiatric medications (and, potentially, physical medications). To be truly successful, there needs to be a holistic approach to treatment, with all physical and mental health treatment /support services for the person coordinated.

Issues for Attention:

Efforts will be made to encourage and support independence for each individual. However, this will be an effort-intensive process for some people and the realization of positive outcomes will take time.

Community acceptance for Goal 1 will prove challenging. Each of the counties represented in the planning process has waiting lists for many critical services for individuals who are already living in the community with very marginal success. Wait times for outpatient appointments to visit the psychiatrist are 6 - 8 weeks. The waiting list for residential supports is often measured in years, since the number of individuals who have requested residential support is equal to the current capacity. Waiting lists are present for vocational supports, social rehabilitation and other critical services. We must address infrastructure issues and build capacity for persons already in the community because community stakeholders have already expressed concern over planning for additional individuals coming from state hospitals, increasing competition for currently insufficient community treatment and support resources.

County Administrators have concern over several years of level funding that translates into a real funding decrease. Annual cost of living adjustments (COLA) are critical to build and maintain a fully functional mental health system.

Local communities may also prove unreceptive to the idea of persons with serious mental illness moving into their neighborhoods. The developers of new CHIPP initiatives in recent years have occasionally had to face this concern. The mindset of "Not in my Backyard" (NIMBY) and its insensitivity is alive and well in some south-central Pennsylvania communities.

Some consumers currently served at HSH are resistive to leaving. The state hospital has been a safe haven, with support from caring staff who in some cases have become like family to this group. When the idea of leaving is discussed, it creates significant anxiety, as the concept of successful community living seems difficult or unattainable. Family members may also be resistive to the idea of assisting their loved ones back to a community setting with the many challenges that it presents. Time, education, concern and support for both consumers and families will assist in creating an atmosphere where support for the plan can be realized.

SAP Goal 2 specifies that no person will be involuntarily committed to a community hospital more than twice in one year. During the planning process, a subcommittee work group was assigned to review data regarding involuntary commitments. Data collection systems varied greatly and sources of data differed from county to county. Unfortunately each reporting entity has a portion of the data regarding recidivism, but no

reliable totals could be established from among the different payer and provider sources represented on the committee. Available data reviewed preliminarily suggested that the number of persons involuntarily committed more than twice in one year was very low for the service planning area. When information regarding voluntary readmissions was reviewed, the picture of repeated hospitalizations changed greatly. (See Community Hospitalization Data Table)

Community Hospitalization Data

As reported by hospitals in the 5 county area

COUNTY	SINGLE ADMISSIONS	SINGLE READMISSIONS	MULTIPLE READMISSIONS	TOTAL ADMISSIONS	TOTAL READMISSIONS
REPORTING PERIOD: 12 MONTHS - July 1, 2002 – June 30, 2003					
Cumberland/Perry	702	72	47	821	119
% ^{age} of "Total Admissions"	85.5%	8.8%	5.7%	100%	14.5%
Dauphin	988	174	49	1211	223
% ^{age} of "Total Admissions"	81.6%	14.4%	4%	100%	18.4%
Franklin/Fulton	430	85	33	548	118
% ^{age} of "Total Admissions"	79%	15%	6%	100%	21%
York/Adams	2221	244	111	2576	355
% ^{age} of "Total Admissions"	86.2%	9.5%	4.3%	100%	13.8%

The data reports activity as it occurs within individual hospitals. Counts from each hospital are unduplicated but duplication cannot be determined at this time across hospitals. Therefore some single admissions at one hospital may be a repeat admission for the individual. Likewise, single readmissions to a hospital may actually be multiple readmissions for the individual. Because hospitals are frequently at capacity, it is likely that the number of re-hospitalizations of individuals to multiple hospitals within a year is much higher. While this data does not indicate the absolute number of readmissions by individual, its consistency across the area suggests that the data does serve as a useful gross indicator for reporting system-wide reductions or increases of readmissions as a proportion.

While individuals are rarely involuntarily committed, there are many individuals who are voluntarily readmitted to community hospitals multiple times within a calendar year. There is also no clear link between number of community readmissions and referrals to the state mental hospital. The committee has recommended further study of known recidivists to evaluate the factors and causes for readmission for this group of individuals with the hope that a detailed review of records would yield conclusions that can be generalized for system planning. There was not sufficient time for committee members to complete such a study prior to submission of this plan. Therefore, the committee utilized the experience of members to answer the question - "Why do people need readmitted to a community hospital?" Local Community Support Programs (CSP); service providers, providers of crisis intervention, providers of inpatient treatment, HealthChoices representatives, and county MH representatives were enlisted to provide insight and analysis. The following table provides responses obtained to this question:

Administrative Functions	Diagnostic/Medical Complexities	Life Event/Social Complexities	Other
Short lengths of stay (first and /or previous)	Individuals with dual diagnoses of MH/SA or MH/MR	Abuse issues	Consumers who refuse aftercare
Insufficient outpatient or post inpatient services	Medical condition that contributes to mental illness/crisis admission	Social Isolation/lack of therapeutic supports	Support services not perceived as helpful or culturally relevant
Admissions due to lack of alternatives	Unwillingness to take medication	Homelessness/lack of adequate stable housing	Self referral by consumers who want to be admitted
Emergency Room physicians/departments concerned re: liability	Medication changes	Consumers unable to obtain periodic support after they have "graduated" from the system	Safe haven for consumers from police, parents, stressors,
Insufficient transportation services to outpatient and support services	Medication unavailability	Stress/issues of living	MH system fosters dependency and creates aura of hopelessness for consumers

Agreement was reached among the Stakeholder group that a delivery and support system should be designed that will assure interventions and resources are applied in the first hospital admission to help prevent multiple admissions. In order to successfully support Goal 2, regulations most likely will need to change. Current community inpatient stays are approximately 8-10 days. Many times, adequate post-discharge supports are not available, and supports available vary dependent upon insurance. If the individual hasn't stabilized to the point of comfortably returning home, there are no real options other than the community hospital continuing to provide treatment (and sometimes absorbing the cost of the stay). The subcommittee recommended the development of a second level of community care, an extended acute stay. This would afford the opportunity for individuals to stabilize a bit longer prior to leaving the hospital, and would provide mechanisms for community inpatient units to be paid for needed additional care. Inpatient providers currently must exercise great caution, as they are to provide only short-term care by regulation. They put their licenses at risk when individuals remain in the hospital for extended periods of time.

Additionally, with limited resources, community mental health programs must focus on those who are most in need. Virtually every community-based program operates with a waiting list that requires ongoing triage to determine which consumers qualify as "most in need" of available resources. Unfortunately, it is often not until after inpatient readmission occurs that consumers are triaged as "most in need" of limited services. If resources (staff and fiscal) were readily available, if regulations were more flexible, and if supports could be integrated more quickly - providing a proactive recovery focus to services - the second goal could potentially be impacted very positively. This again speaks to challenges that go beyond the ability of the service area plan group. Policy makers need to be aware of issues that impact the quality of care for all Pennsylvanians. Due to the lack of parity, insurers cover only some types of services and limit the amount of service individuals can have. After these services are exhausted, individuals then either pay expenses out-of-pocket or the cost of services "shifts" to the public dollar. If this paradigm continues, the impact is unknown over the course of the next 5 years. Best practices suggest that intervention strategies early in treatment produce far better outcomes, rather than after several community inpatient hospitalizations.

In determining the community barriers to reaching goal number 2, the stakeholders were quick to surmise that the barriers are inherent in the current system of inpatient psychiatric treatment. The current emphasis on crisis stabilization and short length of stays will continue to be a barrier to reducing re-admissions. Reimbursement for inpatient care is based upon a short-term episodic treatment and separate admissions that meet pre-established medical criteria. The concept of longer inpatient treatment or the provision of other alternative supports on an outpatient basis in order to prevent re-admission is not financially rewarded for those who are privately insured.

The lack of continuity and coordination of care between inpatient providers and the larger community support system for frequently admitted consumers are also barriers to reducing re-admissions.

If sufficient funding were made available to expand the capacity of community-based programs, supports could be integrated more quickly, hence providing a proactive recovery focus to services. The subcommittee made the following recommendations:

- Improve discharge planning during inpatient stay.
- Create “follow-up specialist” position.
- Ensure facilitating agent to confirm that discharged patient gets to the next step with navigating system.
- Train inpatient providers to view inpatient care as part of plan to prevent the next readmission; each admission should not be seen as a separate episode of care.
- Increase awareness and increase participation of case management and natural supports to recognize symptoms and seek help early.
- Increase awareness and use of psychiatric advance directives to reduce readmission the target population.
- Expand/improve case management system.
- Create a targeted/blended case management model.
- Advance the community mobile service concept.
- Social supports are critical, as they offset environmental stressors related to community living that may heighten risk factors and trigger responses that lead to hospitalization.
- Increase post discharge support for public and private consumers (peer mentoring models, professional to consumer models, potentially could be paid position created by HealthChoices).
- Behavioral Health Managed Care Organization could “follow-up” discharged patients. This could be for individuals who do not have targeted case management.
- Create “long-term” acute care at an *intermediate care unit/facility* or as a State Hospital unit, allowing additional time for the therapeutic benefits of medications and therapeutic milieu to be implemented in order to address the factors that lead to repeated inpatient admissions.

Goal 3 advocates that within 5 years the incarceration of target population will be reduced. The subcommittee reviewed statistical information regarding incarcerations of individuals with serious mental illness. Information is presented below:

	Cumberland	Perry	Dauphin	Franklin/Fulton	***York/Adams
Census	330	76	1000	294	2128
SMI	25	4	45		176
Diagnosis					
Non-Violent Misdemeanor	4	0	14		67
Violent Misdemeanor	2	0	19		20
Non-Violent Felony	10	1	5		217
Violent Felony	4	3	7		41

***Note: York Prison has a refugee unit.

The group identified the following gaps in services for individuals with serious mental illness who have committed criminal offenses:

- Forensic case management is not fully operational in all counties.
- Forensic specialized residential programming is not available.
- There is an absence of urgent psychiatric care.
- Arresting officers do not screen arrestees for mental health issues - they simply take the individuals to jail.
- There is a serious limit on the availability on all resources - CRR, supported living, ICM/RC, psychiatric care.
- Discharge procedures for the county prisons are varied and discharges frequently are not coordinated with mental health systems.
- Inmates are sometimes discharged to the community mental health system after maximizing their judicial sentences. This action results in no legal mandate for the consumer to follow through with mental health services.
- Cooperation between the county judges and the mental health system is widely varied.

The group identified the following recommendations to be implemented in the individual counties or joinders to address the gaps in the system:

- Each county should have a dedicated forensic case management program, including probation officers who are dedicated to the seriously mentally ill population.
- Each county should develop a structured diversion program for individuals with mental illness who have committed criminal offenses.
- Each county must expand the availability of supportive services identified in gap number 5 above.
- Each county should develop a collaborative working relationship with the District Attorneys' Office, the Office of the Public Defender, and the Adult Probation Unit.
- Each county should develop a mechanism for discharging inmates with mental illness from incarceration prior to the individual maximizing his or her sentence so the transition to community treatment services can occur as a condition of probation.

It was noted that at present no regional services exist for the forensic population in the Harrisburg State Hospital region, so gaps specific to the service area were not identified. Please refer to the gaps identified above. The group identified the following recommendations to be implemented on a regional basis to help address the gaps in the system:

- The region should develop 40 maximum care community residential rehabilitation beds that are specialized for the forensic population.
- The region should develop a training program for law enforcement and judicial personnel and mental health provider staff members regarding forensic mental health issues.

The group addressed two additional critical components to successfully supporting Goal 3. These components were specific to human resource development and community acceptance.

The most critical component of this plan will be the availability of financial resources for implementation. Mental health workers who have specialized knowledge of forensic issues will be more expensive than other mental health workers. While the training program addressed in Service Area Development recommendation #2 can improve the skills of many of the individuals working in the system, we believe that management staff for these programs must come with previous experience.

Additionally, the group identified the following barriers and included proposed actions to address the barriers:

- The region must address community resistance to the location of residential facilities for forensic clients. This barrier can be addressed through careful planning of the locations in county areas where the least amount of resistance will be experienced. It will be necessary to communicate with the communities that the programs are serving non-violent offenders.
- The counties must address resistance from President Judges to diversion programs. We believe that continued education and collaboration can address this resistance. However, if resistance continues at the President Judge level, the impact of the resistance of the President Judge can be reduced if the counties gain the cooperation of the District Attorneys and the Public Defenders.
- There may be resistance to getting all of the county prisons to agree to a consistent set of pre-release procedures. Certainly, the county offices can work with the local prisons with the same set of recommendations. Additionally, the training recommended in this plan will also help to address any resistance.

The following tables illustrate a recovery crosswalk for both the state hospital consumers and consumers that currently reside within the community. It also includes a budget projection.