

A. Treatment and other services to be provided:

For those people who have been at HSH for over two years, the hospital will need to adopt a more assertive treatment approach that focuses on partnering with each person admitted to identify the causes of hospital admission, to determine the treatment priorities, and to mutually commit to eliminating the issues that prevented the person from living and receiving treatment in their preferred community. In most cases, that will also involve the county MH authority, the provider agency/ies and family members/significant others who have been part of the person's pre-hospitalization life. Because there appears to be a significantly better probability of being discharged within twelve months of admission than between months 13 and 24, our subcommittee decided that the first year anniversary within the hospital should trigger a meeting that would result in a major commitment of resources, both from HSH and the county program, aimed at helping refocus treatment approaches and treatment goals.

The following processes are recommended as both necessary for the HSH of 2010, as well as for immediate development/implementation as strategies to effectively plan for those who are targeted for discharge (HSH Length of Stay of 2+ years). Critical to successful implementation will be a dramatic philosophical shift in both hospital and community work to a recovery-oriented philosophy of care premised upon CSP Principles:

- Consumer Centered/Consumer Empowering
- Strengths Based
- Culturally Competent
- Accountable
- Community Based/Natural Supports
- Flexible
- Designed to Meet Special Needs
- Coordinated
- Recovery Oriented

Both community and hospital staff will need to be trained on recovery and resiliency philosophies.

1. Admission Referral Process:

- **Pre-Admission/Acute Care:**

All admissions to acute care for any consumer served within the public mental health system need to be reported to the designated county program representative. Additionally, private pay consumers close to exhausting insurance benefits need to be encouraged to agree to county program services. Active involvement by a county program representative will be essential to anticipate state hospital involvement and/or consider other alternatives. Intensive county program review will need to occur during week two of the inpatient stay, referral and

response from HSH will be necessary during week three to allow a commitment hearing and transfer to HSH during week four. As has been the case for many years, only exceptional clinical circumstances should result in voluntary admission to HSH. Exceptional clinical circumstances would include HSH serving in an integrated capacity along with other community-based and acute care treatment approaches that have been attempted but have not successfully resolved the problems. In all instances, upon scheduling the HSH admission, the county case manager would be identified and given the date for the consumer's initial HSH treatment team meeting.

2. *Post Admission Planning:*

- **Initial Treatment Team Meeting (72 hours):**

The case manager will be need to attend the first planning meeting to address treatment planning from a community perspective and help develop a preliminary discharge plan based upon consumer preferences and available community options. Simultaneously, person-centered planning commences. The use of recovery and resiliency philosophies as a fundamental approach on the parts of both the HSH staff and the county program representatives will be critical to understanding the consumer's history and the development of a wellness recovery plan (Copeland).

- **Master Treatment Team Meeting (day 15):**

History and plan are completed. Comprehensive Treatment Plan is developed and initiated based upon full participation of the consumer. Daily program schedule initiated on Day One is refined based upon the choices of the consumer and an achievable discharge plan. This meeting and all subsequent planning meetings need to insure consumer, consumer-designated family/friends and county case manager involvement. Providers of services/supports would also be included in the planning meetings as needed.

- **One Year Review:**

A thorough review of the previous year and reasons why a consumer remains in the state hospital results in a specific plan detailing the commitment of human and monetary resources from HSH and community to insure discharge in the upcoming months.

3. *Treatment Services:*

Consumers will select program services from a comprehensive array of services that are most geared to personal interests and recovery goals. Programs will be available emphasizing illness management and recovery skills such as wellness recovery planning, crisis management, daily living skills including cooking, cleaning, personal care, budgeting; socialization opportunities to help consumers

develop and obtain self-help and support; and, vocational rehabilitation programs identifying work interests, strengths, goals and real work.

Treatment Services will encompass the six evidence-based practices consistent with those published by Substance Abuse Mental Health Services Administration (SAMHSA) to include the following:

Illness Management and Recovery

The program strongly emphasizes helping people to set and pursue personal goals and to implement action strategies in their everyday lives. The information and skills taught in the program include:

- Recovery strategies
- Wellness Program
- Practical facts about mental illness
- The Stress-Vulnerability Model and strategies for treatment
- Building social support
- Using medication effectively
- Reducing relapses and coping with stress
- Coping with problems and symptoms
- Getting needs met in the mental health system

Medication Management Approaches in Psychiatry

Medication Management focuses on using medication in a systematic and effective way, as part of the overall treatment for severe mental illness. The ultimate goal is to ensure that medications are prescribed in a way that supports a person's recovery efforts. The program includes:

- Guidelines and steps for medication decision making, based on current evidence and outcomes;
- Systematic monitoring and record keeping of medications; and
- Consumer and family member involvement

A uniform statewide medication algorithm is used to sufficiently reduce or control symptoms.

Family Psycho-education

Family Psycho-education involves a partnership among consumers, families and supporters, and practitioners. Through relationship building, education, collaboration, problem solving, and an atmosphere of hope and cooperation, family psycho-education helps consumers and their families and supporters to:

- Learn about mental illness
- Master new ways of managing their mental illness
- Reduce tension and stress within the family
- Provide social support and encouragement to each other
- Focus on the future
- Find ways for families and supporters to help consumers in their recovery

Supported Employment

All consumers will be encouraged to discuss vocational supports, with the predominant goal of securing employment in the community. Site-based employment will be explored along with transitional employment experiences. Individuals approaching discharge will be supported in identifying competitive employment or suitable supports available in the vocational continuum.

The core principles of this vocational program include:

- Eligibility based on consumer choices and preferences
- Supported employment as an integrated treatment
- Continuous follow-along supports
- Help with moving beyond the consumer role and developing new employment-related roles as part of the recovery process

Introduction of a peer specialist training curriculum and consumer worker positions will be established to provide active support to consumers throughout treatment around issues such as admission, commitment hearings, treatment planning, etc.

Co-occurring Disorders: Integrated Dual Diagnosis Treatment

While HSH is not an addictions treatment facility, Integrated Dual Diagnosis services will be provided for any person with co-occurring disorders, mental illness and a substance abuse addiction. This treatment approach helps people recover by offering both mental health and substance abuse services at the same time and in one setting.

This approach includes:

- Individualized treatment, based on a person's current stage of recovery
- Education about the illness
- Case management
- Help with housing
- Money management
- Relationships and social support
- Counseling designed especially for people with co-occurring disorders

A Drug and Alcohol Treatment Specialist will work with all persons with dual diagnosis and encourage involvement in dual diagnosis education and self-help and support groups.

4. *Self-Help Support:*

Consumers admitted to the HSH need to continue or be supported in initiating involvement in self-help and support mechanisms. Self-help resources need to be available and accessible during an extended inpatient stay to facilitate recovery and build hope. Drop-In Centers need to be accessible to consumers in treatment in all levels of the mental health system including HSH. A multi-county supported Drop-in Center program available on the HSH grounds will be established. Center hours would not need to be full-time but consistent and, most importantly, available at a time of day when consumers are most available. Support for the Center could be through direct county funds and/or SMH funds for peer support services. The HSH-based Drop-In Center would provide a vital bridge to community-based consumer support mechanisms in the consumers' local communities.

5. *Specialized Treatment Concerns:*

At least two groups of persons with special needs warrant specific attention in this plan.

- Individuals with Axis II disorders, specifically Borderline Personality disorder, continue to perplex the service delivery system. While a stronger integration of recovery oriented principles at all levels of the mental health system may most ease this challenge, those with self-abuse/mutilating behaviors will still need to be served. HSH needs to assure treatment programs are oriented toward developing individuals' competencies to cope with crisis, change and transitions without resorting to life-threatening responses. Specialized services for those suffering from long-term effects of trauma, sexuality issues and anxiety disorders will be developed.
- Chronic medical diseases such as COPD, diabetes, etc., stemming from a variety of factors, including poor life style choices, i.e., substance use, poor diet, limited access to health care and other resources, are increasing challenges in the mental health system. Additionally, long-term effects of typical and atypical antipsychotic medications are resulting in significant health care challenges. HSH needs to be positioned to provide the best possible specialized psychiatric/comprehensive health care assessment.

6. *Discharge/Transition Planning:*

A standard planning tool for discharge will be a Crisis Plan. Within the Wellness - Recovery model, planning for and anticipating crisis and agreements with individuals

who are available and willing to provide necessary supports is a critical item for inclusion. The time to plan for crisis management is when a person is well.

B. Number of Harrisburg State Hospital beds in 2010 and beyond:

Implementation of a two year length of stay model within HSH will result in the discharge of approximately 147 current consumers who have been hospitalized longer than two years (count as of 4/29/04), as well as the discharge of additional patients who enter the two years or greater LOS group during the 7/1/04 to 6/30/10 interval.

Several assumptions are made in order to project actual beds needed in 2010:

1. A continued average admission rate of 11 per month.
2. Continued average discharge rates of:

- 25 % in 150 days (5 months)
- 50% in 270 days (9 months)
- 60% in 365 days (12 months)
- 75% in 1 ½ years (18 months) - projected
- 100% in two years (24month) - projected

Based upon these lengths of stays assumptions portrayed on the below graph the maximum census will be 138 as of 7/20/10.

Adm/month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
1	11	11	10	9	9	8	8	7	7	6	6	5	5	5	4	4	4	4	3	3	3	2	2	2	0
2		11	11	10	9	9	8	8	7	7	6	6	5	5	5	4	4	4	4	3	3	3	2	2	
3			11	11	10	9	9	8	8	7	7	6	6	5	5	5	4	4	4	4	3	3	3	2	
4				11	11	10	9	9	8	8	7	7	6	6	5	5	5	4	4	4	4	3	3	3	
5					11	11	10	9	9	8	8	7	7	6	6	5	5	5	5	4	4	4	4	3	3
6						11	11	10	9	9	8	8	7	7	6	6	5	5	5	5	4	4	4	4	3
7							11	11	10	9	9	8	8	7	7	6	6	5	5	5	5	4	4	4	4
8								11	11	10	9	9	8	8	7	7	6	6	5	5	5	5	4	4	4
9									11	11	10	9	9	8	8	7	7	6	6	5	5	5	5	4	4
10										11	11	10	9	9	8	8	7	7	6	6	5	5	5	5	4
11											11	11	10	9	9	8	8	7	7	6	6	5	5	5	5
12												11	11	10	9	9	8	8	7	7	6	6	5	5	5
13													11	11	10	9	9	8	8	7	7	6	6	5	5
14														11	11	10	9	9	8	8	7	7	6	6	6
15															11	11	10	9	9	8	8	7	7	6	6
16																11	11	10	9	9	8	8	7	7	7
17																	11	11	10	9	9	8	8	7	7
18																		11	11	10	9	9	8	8	8
19																			11	11	10	9	9	8	8
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21																					11	11	10	9	9
22																						11	11	10	10
23																							11	11	11
24																								11	11

*Current Census is about 270

Max Census = 138

- The census has declined only 2 per year (excluding CHIPPS); in 6 years, census would be 210-12-17=241. (17 CHIPP discharges in FY 03-04)
- To reach a stable census of 140 by 7/2010, 17 CHIPP like discharges will be needed per year.

Other considerations:

1. The HSH census has declined only 2 per year, excluding CHIPP discharges over the last 10 years so, in 6 years or by 2010, HSH would have 270 consumers minus 12 (2 x 6 years) = 258 – yearly CHIPP discharges. If the goal is to reduce the number of beds to the level needed to accommodate admissions and short-term care
2. (< 24 months) then 17 CHIPP- like discharges per year will need to occur to allow HSH to decrease to 138 consumers by 6/30/11:

<i>Month/Year</i>	<i>Projected beds</i>
7/04	251
7/05	232
7/06	213
7/07	194
7/08	175
7/09	156
7/10	137

3. Effect of implementing a 30 days cap on acute care stays, moving state hospital admissions by day 31.
4. Effect of implementing a limit on acute care commitments at 2 per year.
5. Number of 2+ year HSH consumers who may not be discharged by 2010.
6. Individuals aging out of Youth Development Centers (YDC) and maxing out of sentences served in State Correctional Institutions (SCI) requiring inpatient psychiatric services.
7. Impact of system-wide integration of recovery philosophy on the underlying assumptions, C.1. & 2 above.
8. In order to move adequate dollars from the present HSH budget based upon living unit closures, 30 consumers would need to be moved per fiscal year or the movement of the dollars would occur at a slower rate.

In order to provide sufficient extended acute psychiatric inpatient beds for the counties served by the hospital, we estimated that we should have enough beds to serve the number of persons that would be admitted in any one year (approximately 130) plus a cushion of approximately 20% of that number (25) for fluctuations in the admissions numbers, for persons who might be in active transition from the hospital to a community setting or for those who might require treatment at the hospital that would exceed the two year goal. Thus, we believe that at the end of the five years covered by this plan, Harrisburg State Hospital should have no more than one hundred fifty-five (155) beds, a reduction of 117 beds from the current 272 certified beds. If, during the course of the five- year period, the number of counties served by HSH changes (either more counties or fewer counties) due to a reduction in the number of state operated mental hospitals, the projected number of beds required would need to be revised.

HSH would need to continue to operate a minimum of Petry Building (3 living units of 25 – 26 beds each = 75 - 78 total beds) and Eaton Building (3 living units of 26 beds = 78 total beds). Petry and Eaton Buildings would be the preferable buildings to operate due to overall space, design and conduciveness to providing in-building program services. A less favorable alternative would be Petry (75), Slothower Building (30), and Hilltop Building (45). Two centralized treatment units (on the first floor of each of Petry and Eaton Buildings) would allow for seven days per week structured programming and therapeutic activities. The Work Advancement Center would continue to operate in its separate building. Other buildings needed for continued hospital operation include the Chapel, Dietary, Administration, and Maintenance buildings.

Adjusted access to HSH beds in 2010 may be estimated on the basis of 2004 total bed caps:

<i>County</i>	<i>Number of Beds</i>
Cumberland/Perry:	29
Dauphin:	48
Franklin/Fulton:	11
York/Adams:	65
<u>Other:</u>	2
Total:	155

