

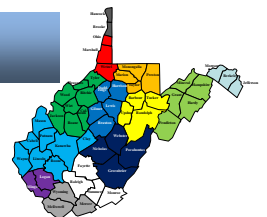


CROSSROADS

Creating a system of care for adults with mental illness or co-occurring disorders



West Virginia's Comprehensive Community Mental Health Centers



Introduction

West Virginia's system of care for adults with mental illness and adults with co-occurring mental illness and substance abuse issues is at a **crossroads**. There is opportunity to assure better results in the lives of people with mental illness or co-occurring disorders in terms of their ability to live, work, love, and learn in the community. This document suggests ways to maximize that opportunity.

“Crossroads” is more than a philosophy. It is more than a plan. It is a recommendation for assuring wise investment in the future – investment in the lives of West Virginians who need not be confined to hospitals, jails, and prisons.

“It goes without saying that the excess costs of untreated mental illness in the disability system, in prisons and on the streets are part of the mental health care crisis. We are spending too much on mental illness in all the wrong places. And the consequences for consumers are worse than the costs for taxpayers.”

Michael F. Hogan, Ph.D.,
“Spending Too Much on
Mental Illness in all the
Wrong Places,” *Psychiatric
Services*, October 2002

The opportunity for that investment has never been as great as it is now. There is commitment of West Virginia's three branches of government to support a community-based system of care. There is commitment of West Virginia's statutory comprehensive mental health centers to provide that community-based system of care. There is a strong desire among West Virginia's mental health consumers, their families, and advocates to experience the outcomes a strong community-based system of care can facilitate.

“Crossroads” suggests that statutory comprehensive mental health centers be given the responsibility to provide a comprehensive system of care for adults with mental illness or co-occurring disorders. The document utilizes recent Court orders in the *Hartley* case, goals of the New Freedom Commission, recommendations of the West Virginia Mental

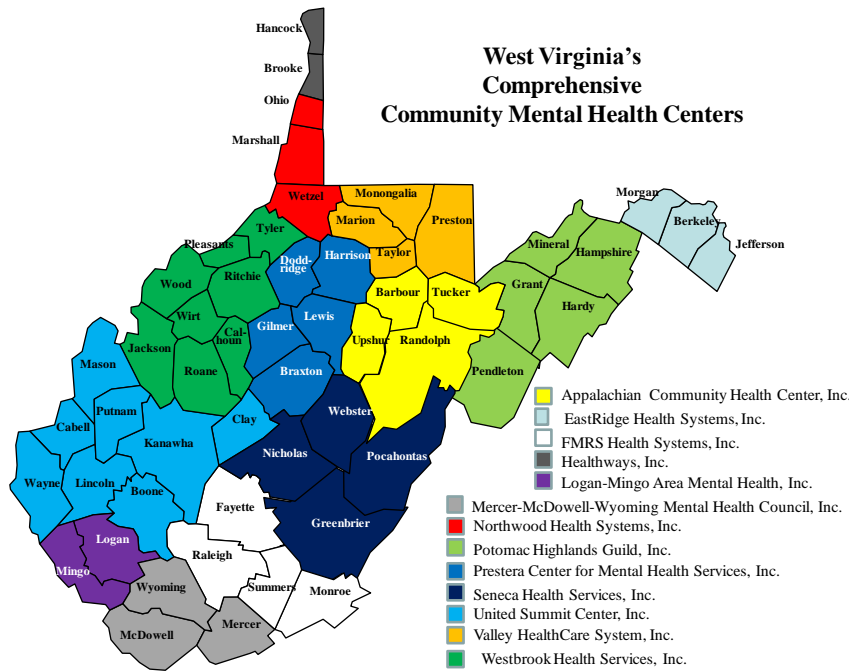
Health Planning Council, information on Evidence-Based Practices published by the Federal Substance Abuse and Mental Health Services Administration, and the experiences of comprehensive community mental health centers to outline the features of a system of care.



Comprehensive Community Mental Health Centers

West Virginia law (§27-2A-1) requires the establishment of “comprehensive community mental health centers.” Among additional provisions in that section of the Code, comprehensive community mental health centers are to have a written plan for the provision of diagnostic, treatment, supportive, and aftercare services and written policies and procedures for implementing these services. That section of the Code also requires that the state’s share of the costs of such services be provided from funds appropriated for this purpose within the budget of the department of health, now the Department of Health and Human Resources. The Code specifies that “No person who can be treated as an outpatient at a community mental health center shall be admitted involuntarily into a state hospital.”

West Virginia currently has 13 comprehensive community mental health centers. They are located throughout the State and include all the counties of the State. They are: Appalachian Community Health Center, Inc., EastRidge Health Systems, Inc., FMRS Health Systems, Inc., Healthways, Inc., Logan-Mingo Area Mental Health, Inc., Mercer-McDowell-Wyoming Mental Health Council, Inc., Northwood Health Systems, Inc., Potomac Highlands Guild, Inc., Prestera Center For Mental Health Services, Inc., Seneca Health Services, Inc., United Summit Center, Inc., Valley HealthCare Systems, Inc., and Westbrook Health Services, Inc. Each Center has a defined “catchment area” of adjacent counties it serves, as shown on the map of the State.



Comprehensive community mental health centers are licensed by the Office of Health Facilities Licensure and Certification (OHFLAC) of the Department of Health and Human Resources. Partial fiscal support, utilizing Federal grants and State general revenue funds, is provided through Grant Agreements (contracts) with the Bureau for

Behavioral Health and Health Facilities (BHFF), which requires Statements of Work (SOW), describing the services the comprehensive center will provide. Additional funding is provided via reimbursement from Medicaid, other insurance, and fee-for-service. Medicaid is currently the largest source of reimbursement for the centers. Reimbursement for services is contingent on



prospective review (authorization for services) and retrospective review (assurances that the provider delivered the service for which it was reimbursed).

To meet the requirement of West Virginia Code 27-2A-1 that “No person who can be treated as an outpatient at a community mental health center shall be admitted involuntarily into a state hospital,” comprehensive community mental health centers must be enabled and funded through a fee for service system to provide a continuum of care. That continuum of care would include Psychiatric Inpatient Services provided by Mildred Mitchell-Bateman Hospital and William R. Sharpe, Jr. Hospitals, Crisis Stabilization, Assertive Community Treatment, Mobile Crisis Units, Intensive Outpatient Addiction programs, Emergency Walk-in Services, Residential programs, Day Treatment Programs, Outpatient and Support services.

This continuum of care – or system of care – can best be effectuated if comprehensive community mental health centers are recognized as gatekeepers for publicly-funded mental health services. Center staff must be involved in assessments which may lead to a commitment to involuntary treatment and enabled to link the appropriate service for the individual who is committed for involuntary treatment. An appropriate service may be inpatient services at a local hospital or other community services, such as Crisis Stabilization or a combination of services.

Each comprehensive community mental health center must establish its own programs and services, based on community needs, individuals served, and resources. Some services are available as “core services” and others are special projects or demonstrations of services. Core services and special projects require a SOW. SOWs are to meet guidelines established by the BHHF as standards for services to be provided. Grant Agreements and SOWs are reviewed and approved by BHHF staff and by Grants Management in the office of the Secretary of Health and Human Resources.



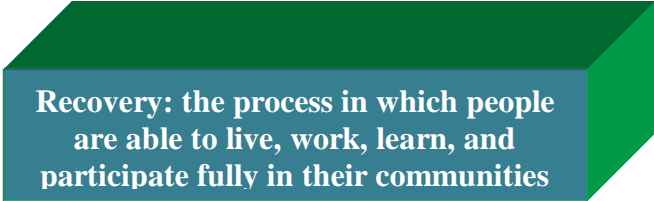
Population of Focus

This document focuses on adults with a mental illness or a co-occurring mental illness with abuse of or dependence on alcohol or other drugs. These individuals have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV-TR)¹, that has resulted in functional impairments which substantially interfere with or limits one or more major life activities. Diagnosis may be of a mental illness **or** mental illness in combination with substance abuse or dependence.

It is important to note that this definition meets the criteria for admission to a treatment program or service. *It does not define an individual for a lifetime.* Indeed, with treatment and supports, most people with mental illness or a co-occurring mental illness and substance abuse can and do live successfully in many roles: father, mother, employee, employer, church member, library patron, club member, wife, husband, etc. The key – and a significant message in this document – is available treatment and supports which enable **recovery**.

Recovery “refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery.”²

The New Freedom Commission noted, “Too often, today’s (mental health) system simply manages symptoms and accepts long-term disability” and “State-of-the-art treatments, based on decades of research, are not being transferred from research to community settings. In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs.”³



Recovery: the process in which people are able to live, work, learn, and participate fully in their communities

It is recommended that the comprehensive community mental health centers be enabled to provide recovery-oriented services for individuals with mental illness or co-occurring disorders which provide necessary treatment and supports for full community integration.

Daniel Fisher, M.D. of the National Empowerment Center⁴ has depicted an “Empowerment Model of Development and Recovery” which demonstrates both hope and hopelessness.

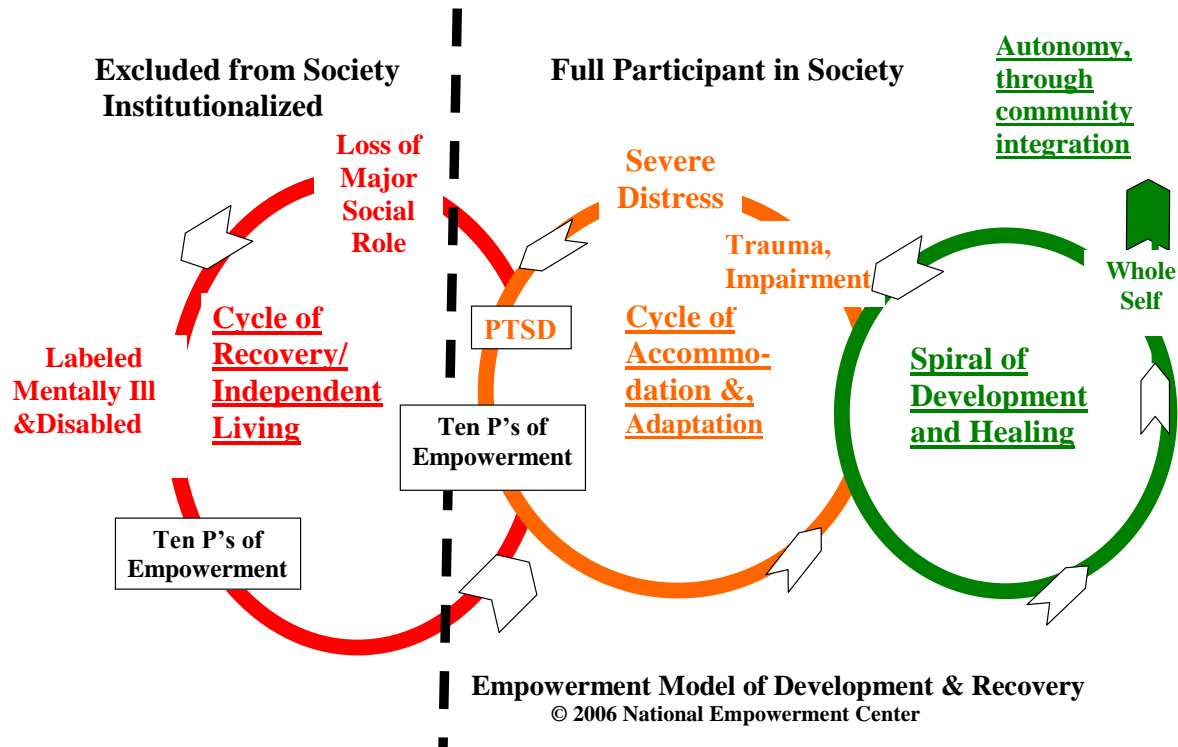
¹ American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*. (4th Edition, Text Revision.) Washington, DC: American Psychiatric Association.

² New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

³ New Freedom Commission on Mental Health.



Obviously, there is hope for people with mental illness if services are provided and an individual is enabled to live in a spiral of development and healing. The absence of services may limit an individual's ability to move from being excluded from society – institutionalized.



There are other important elements in this diagram. Note that the “Ten P’s of Empowerment” are in two places. Thus, an empowering system of care needs to be practiced at the institutional (inpatient) level of care as well as the point at which a person returns to the community. Also, note the location of “PTSD” – Post Traumatic Stress Disorder. An individual returning to the community lives with the effects of institutionalization – no matter how long the inpatient stay or the environment of the inpatient setting.

A further explanation of the Empowerment Model of Development and Recovery offers these salient points:

- People are labeled with mental illness through a combination of severe emotional distress and insufficient social supports / resources / coping skills to maintain the major social role expected of them during that phase in their life.
- The degree of interruption in a person’s social role is more important in affixing the label mental illness to someone than his or her diagnosis.

⁴ See www.Power2u.org for more information on National Empowerment Center.



- Recovery is possible through a combination of supports needed to (re)establish a major social role and the self-management skills needed to take control of the major decisions affecting one's life.
- This combination of social supports and self-management helps the person regain membership in society and regain the sense of being a whole person.⁵

Patricia Deegan, Ph.D.⁶, in a movie titled "Inside / Outside" explains four "stages" individuals who are hospitalized go through: (1) inside / inside, (2) inside / outside, (3) outside / inside and (4) outside / outside. In the first, an individual becomes used to routine and internalizes messages of hopelessness and chronicity. The institution gets "inside" the person. In the second, possibilities for a life outside the institution are seen and the hospitalized person plans to work toward recovery and a meaningful life outside the institution. In the third stage, the individual may seek ways to stay in the protective environment of the hospital or look to professionals to make decisions, but also starts to find her or his own voice. In the "outside / outside" phase, there is a sense of self direction and self knowledge and individuals discover a new and valued sense of self in and through relationships with others.

Decades ago, the effects of institutionalization were recorded through an experiment conducted by a psychology professor and his class.⁷ Individuals with no history of mental illness presented with a single symptom to a mental health crisis program. Nearly all were hospitalized. Once in the hospital, staff treated them as if they had a mental illness. Rosenhan noted the effect of context: people were in the hospital, so they must be ill.

To best serve this population, hospitalization (institutionalization) should be limited, supports to avert or ameliorate a crisis should be provided, and supports to assist in recovery must be available.

There are many examples for accomplishing these objectives. The New Freedom Commission reported on six model programs. The National Registry of Evidence-based Programs and Practices lists practices that are effective in achieving these goals.⁸ The West Virginia Mental Health Planning Council reviews programs and services funded by the Community Mental Health Block Grant and describes effective services.⁹

An executive director of a West Virginia comprehensive community mental health center outlined services which were shown to reduce reliance on and excessive use of involuntary

⁵ Ralph, Ruth O. "Review of Recovery Literature 2000." National Technical Assistance Center for State Mental Health Planning; National Association for State Mental Health Program Directors. 2000.

⁶ For information concerning Patricia Deegan and Patricia Deegan, Ph.D. & Associates, LLC, see <http://www.patdeegan.com/>.

⁷ American Association for the Advance of Science. Rosenhan, David L. "On Being Sane in Insane Places," *Science*, Vol. 179 (Jan. 1973), 250-258.

⁸ See <http://www.nrepp.samhsa.gov/index.asp>

⁹ See <http://www.wvmhpc.org>



inpatient treatment.¹⁰ The dissertation asserts a continuum of services – Psychiatric Inpatient, Crisis Stabilization, Assertive Community Treatment, Mobile Crisis, Intensive Outpatient Addiction programs, Emergency “walk in and 24-hour telephone” access, and Transitional Homes – contribute to a decrease in involuntary commitment rates.

¹⁰ Williams, Robert D. “A Study on the Effect of an Integrated Continuum of Intensive Crisis Intervention Services (ICICIS), including Assertive Community Treatment (ACT) on Civil Commitments in North Central West Virginia. Dissertation submitted to the College of Human Resources and Education of West Virginia University. 2005.



Operationalizing the Opportunity

A recent Agreed Order was signed in *Hartley*, identifying resources which must be developed over a three year period.¹¹ These resources include:

- Residences for individuals being discharged from State-operated hospitals
 - Year one: \$5.35 million for three group homes, 39 residential slots, and three day treatment centers
 - Year two: a total of \$5 million for two group homes, 52 residential slots, and two day treatment centers
 - Year three: a total of \$5 million for two group homes, 52 residential slots, and two day treatment centers
- Crisis stabilization services
 - Crisis stabilization beds in Bluefield, Princeton, Beckley, Charleston, Huntington, and Parkersburg
 - Reimbursement for charity care consumers and enrollees in Mountain Health Choices Basic Plan for crisis stabilization services
 - Development of a policy regarding Community Mental Health Center role as gatekeeper in the probable cause stage of involuntary treatment
 - Use of crisis stabilization beds in the community as alternative to inpatient hospitalization (voluntary or involuntary) and as “step down” from inpatient care
 - Collaboration between providers, prosecuting attorneys, defense attorneys, mental hygiene commissioners and the Bureau for Behavioral Health and Health Facilities to develop a method to utilize crisis services in lieu of hospitalization

The Agreed Order includes additional measures designed to increase coordination of services for individuals with mental illness or co-occurring mental illness and substance abuse and enhance the availability of community-based services for such individuals.

In addition, a portion of a settlement with Eli Lilly will provide for slightly more than \$14 million for use in enhancing mental health services.

Additional resources offer an opportunity implement 21st century approaches to services.

The additional resources identified in *Hartley* and the Eli Lilly settlement offers opportunity to implement a 21st century approach to serving

people with mental illness or co-occurring mental illness and substance abuse. There are examples across the country and in West Virginia on these 21st century approaches. The key is to develop a system of care for adults with mental illness or co-occurring mental illness and substance abuse that supports and facilitates these approaches.

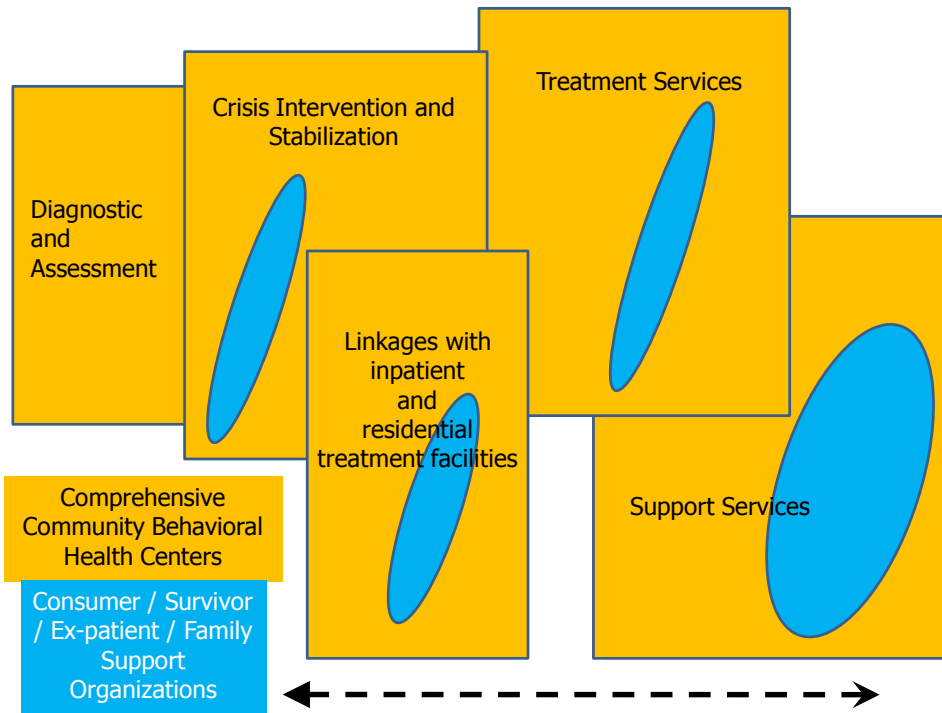
Community Mental Health Centers are expected to provide five (5) core services, defined in the Grant Agreement between the centers and the Department of Health and Human Resources:

¹¹ E.H., et al. v. Matin, et al. Civil Action No 81-Misc-585



- ◇ Diagnostic and assessment services;
- ◇ Crisis services;
- ◇ Linkages with inpatient and residential treatment facilities;
- ◇ Treatment services; and
- ◇ Support services.

The system of care recommended by the New Freedom Commission, the discussion in Williams’ dissertation, and description of Evidence-Based Practices can be diagrammed in many ways. The following diagram is offered as an example of a system of care for adults with mental illness or co-occurring mental illness and substance abuse issues:



There are several elements in this diagram. First, note that it includes Comprehensive Community Mental Health Centers and consumer / survivor / ex-patient / family support organizations. Licensed, organized comprehensive mental health centers and services are

necessary for a comprehensive system of care, but evidence shows that people will be better integrated into the community if consumer-supported and managed and family supported services are available.

The five “core services” are not separated – they are linked, indicating a comprehensive system and continuity of care. Comprehensive community mental health centers are the focus of service provision, but the diagram indicates collaboration with consumer-operated and family support organizations. The two-way arrow at the bottom of the diagram indicates individuals may receive services at any point in the continuum.



Ralph¹² lists several examples from the literature that demonstrate that social supports – often informal supports – help individuals integrate into the community. She cites a study by Brier and Strauss¹³ which revealed that individuals with mental illness reported ways in which social relationships were beneficial. They included ventilation (conversing with others), reality testing (assistance to maintain clear distinctions between reality and psychotic distortions; material support; help with financial, housing, and transportation problems), social approval and integration (receiving assurance when people accept them and provide a sense of belonging), constancy (associating with people they know before hospitalization, connecting current identity with pre-hospital identity and giving roots to existence), motivation (receiving encouragement to achieve higher levels of occupational and social functioning), modeling (observing the behavior of others and incorporating it into their own behavior), symptom monitoring (having others alert them to manifestation of symptoms), problem solving (discussing problems and getting concrete feedback), empathic understanding (being understood by people important to them), reciprocal relating (becoming an equal partner, able to share and be of assistance to others), and insight (acquiring more complete and accurate understanding of themselves).

Build on What is Available

Diagnostic and Assessment Services

Diagnostic and assessment services are important to determining the services an individual needs. Individuals presenting at a comprehensive community mental health center may have many needs. Establishing a diagnosis and undertaking a comprehensive assessment may involve obtaining a social history, psychological testing, examination by a psychiatrist and referral to a primary health care provider.

Assessment services are required to obtain reimbursement for services that are later delivered.

The emphasis and requirements for diagnostic and assessment services should include a focus on the strengths and goals of individuals requesting services. While may be necessary to identify a diagnosis and functional limitation, this is not sufficient.

For example, Medicaid, Medicare, and insurance companies require establishing a diagnosis and documentation to support that diagnosis. Grant agreements with comprehensive community mental health centers, through which the Bureau for Behavioral Health and Health Facilities purchases services, includes definitions prioritizing individuals to be served.

Assessment is also necessary to identify the needs of an individual who is seeking service and to initiate treatment planning. In addition to delineating needs to validate services, the process includes identifying the goals an individual wishes to pursue. Stuart Forman, M.D. of the Capitol Region Mental Health Center in Hartford, Connecticut, has initiated a process employed by many comprehensive community mental health centers: blending the

¹² See Ralph, Ruth O. "Review of Recovery Literature 2000." National Technical Assistance Center for State Mental Health Planning; National Association for State Mental Health Program Directors. 2000.

¹³ Breier, A., & Strauss, J. S. (1984). The role of social relationships in the recovery from psychotic disorders. *American Journal of Psychiatry*, 141(8), 949-955.



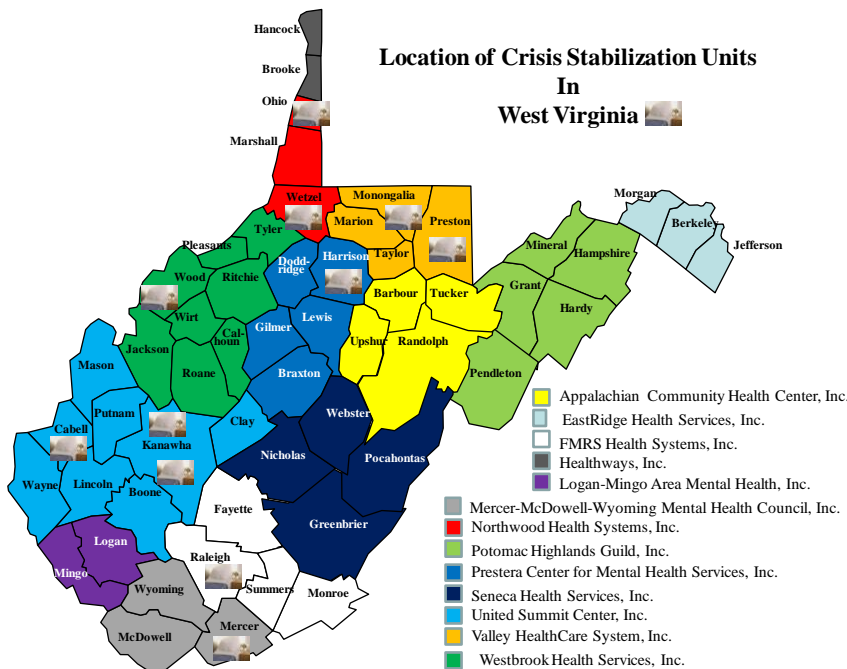
technical justification for treatment and the human context for treatment. Dr. Forman recommends creating a treatment plan which meets the requirements of funding sources while including recovery goals and principles.¹⁴ The use of Motivational Interviewing, “a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence,”¹⁵ is also being adopted by trained practitioners in comprehensive community mental health centers.

Other assessment services may be utilized when a consumer of mental health services creates a Wellness Recovery Action Plan (WRAP) or an Advance Psychiatric Directive. These self-assessment processes may be incorporated into an overall treatment plan.

Comprehensive community mental health centers serve as gatekeepers for publicly-funded mental health services. Some assessments are undertaken when an individual has been referred to commitment to involuntary treatment. Center staff must be involved in these assessments and must be enabled to link the individual to the appropriate service to meet his or her needs. Services may include inpatient treatment at a local hospital or other community-based services, such as Crisis Stabilization or a combination of services.

Crisis Services

It is essential that community-based crisis services exist throughout the State. Access to crisis services can prevent suicides, ameliorate crises, decrease or prevent recidivism, and decrease dependency on involuntary inpatient care.



Access is the most important element. Each comprehensive community mental health center has telephone and walk-in access for persons in crisis. There are State-wide crisis lines for suicide prevention, individuals who are problem gamblers,

¹⁴ Forman, Stuart. “A New Context for the Treatment of Schizophrenia”. Mental Health News. Vol. 7. No. 4. Fall 2005)

¹⁵ See <http://www.motivationalinterview.org/clinical/whatismi.html> for more information on motivational interviewing.



and persons who are addicted to drugs.

Eleven (11) crisis stabilization units are operated by eight (8) comprehensive community mental health centers. The map at the left identifies the centers and location of crisis stabilization units. The purpose of these units is to provide a place to serve an individual who is in crisis but does not require inpatient care. Crisis stabilization units may serve individuals who have been involuntarily committed. The units may also serve individuals who have been hospitalized but no longer need the care provided in an inpatient setting. Sufficient resources to enable utilization of charity care funds should be available to enable serving individuals who have no source of payment for service.

The recent Agreed Order in *Hartley* specifies areas or cities in which additional crisis stabilization units should be created. The goal should be to have available Crisis Stabilization Units within 45 to 60 minutes of any West Virginian. A system to identify availability of crisis stabilization beds in real time should be developed in collaboration between comprehensive community mental health centers and the Bureau for Behavioral Health and Health Facilities. This will enable locating a community-based service when State-operated hospitals are at capacity. Crisis Stabilization Units should be able to serve individuals who have been committed for involuntary treatment, if the comprehensive community mental health center has the capacity to do so. The two State-operated psychiatric hospitals should refer individuals to Crisis Stabilization Units when appropriate, instead of to private hospitals.

Crisis Stabilization Units should also be utilized for “step down” for individuals who have been committed to a State-operated psychiatric hospital and no longer need that level of care. This will require the development of contracts between the Bureau for Behavioral Health and Health Facilities and specific comprehensive community mental health centers and referrals from the two State-operated psychiatric hospitals.

Another crisis service element identified as helpful is mobile crisis services. That is, to provide crisis intervention “where the person is.” Williams¹⁶ described mobile crisis services at one comprehensive community mental health center: The service is available 24 hours a day, seven days a week. Staff “go to homes with police. They go to hospital emergency rooms, police stations, bars, grocery stores, schools, or to any location within the service area that the psychiatric emergency demands. Frequently, the Mobile Crisis response is in tandem with State or local police. Mobile Crisis Services begin the Mental Hygiene process when necessary and collaborate with the Emergency Services clinician and the licensed psychologist to coordinate information about the pending evaluation.” Staff are “able to make quick decisions on

Each of the 13 comprehensive community mental health centers should have available a continuum of crisis services. This continuum would include access to 24 hour, seven-day immediate crisis intervention, coordination with hospital emergency rooms, mobile crisis teams teamed with Crisis Intervention Teams, linkages with mental hygiene commissioners and the judicial system, crisis stabilization units, and seamless admission to essential community-based treatment services.

¹⁶ Williams, Robert D.



patient disposition and get great cooperation in implementing those decisions regardless of the time of day.” Referrals may be to an inpatient program, a crisis stabilization unit, an intensive outpatient addiction program or any other outpatient service. Emergency psychiatric appointments may be immediately made.¹⁷

The key is for each of the 13 comprehensive community mental health centers to develop a continuum of crisis services in each respective service area – access to 24 hour, seven-day immediate crisis intervention, coordination with hospital emergency rooms, mobile crisis teams teamed with Crisis Intervention Teams, linkages with mental hygiene commissioners and the judicial system, crisis stabilization / residential units, and seamless referral / admission to essential community-based treatment services.

This continuum of crisis services can best be developed by each comprehensive community mental health center if new Charity Care funds are provided to reimburse centers for Charity Care and Community Mental Health Center consumers. Redirecting existing funds is not effective and will not enable development of a continuum of crisis services. APS Healthcare guidelines will be utilized for all individuals admitted to Crisis Stabilization Units, regardless of payment source.

Careful evaluation of the Highlands Center model should be conducted by the Bureau for Behavioral Health and Health Facilities. If this service is effective, similar programs may be established. This service may be more effective if the Bureau for Behavioral Health and Health Facilities requires private hospitals to cease admitting only patients who have been committed.

Another element in crisis intervention and stabilization services may be so-called “warm lines,” typically operated by organizations of consumers / survivors / ex-patients. Warm lines offer an opportunity for persons in crisis to contact a peer to discuss issues and obtain support during times of crisis. An informal warm line process is operated by the West Virginia Mental Health Consumers Association and is typically utilized by individuals served by the organization’s transitional living services or wellness and recovery centers.

Linkages with Inpatient and Residential Treatment Facilities

A system of care for adults with a mental illness or a co-occurring mental illness with abuse of or dependence on alcohol or other drugs requires linkages with inpatient and / or residential treatment facilities. The absence of such linkages creates an impression that the individual has moved to a new “community” when he or she enters inpatient or residential care, reinforcing isolation and the “inside / inside” stage described by Deegan.

¹⁷ Another approach to crisis services can be found in the practice of Crisis Intervention Teams. Crisis Intervention Teams are partnerships between providers, mental health consumers and family members to establish standards with respect to treatment of individuals with mental illness. Law enforcement officers are trained to be a part of a specialized team which can respond to a crisis at any time and resolve each situation in a manner that shows concern for the citizen’s well being. (See <http://www.memphispolice.org/Crisis%20Intervention.htm> for more information.)



Gatekeeping

Treatment Planning /
Medication Coordination

Discharge Planning /
Implementation

Linking community-based mental health services and inpatient care is continuous. It includes gatekeeping and a continuum of crisis services to divert to less restrictive settings, coordinating treatment, including medication, and planning and implementing discharge.

Linkages may range from assisting in the development of an inpatient treatment plan, to arranging for follow-up care following hospitalization, to providing some services to an individual while the individual is hospitalized.¹⁸ Linkages between psychiatrists serving an individual in the community and psychiatrists serving the individual in the inpatient setting are important. Some linkage services may be provided through the Grant Agreement between a comprehensive community mental center and the Bureau for Behavioral Health and Health Facilities or in coordination with consumer-operated organizations (creating WRAP plans).

An electronic tracking system to identify and track individuals who have been committed to involuntary treatment would facilitate the role of comprehensive community mental health centers in serving as gatekeepers.

Comprehensive community mental health centers must be considered the gatekeepers for publicly-funded mental health services. Center staff must be involved in assessments which may lead to a commitment to involuntary treatment. Center staff must be enabled to link with any service to which an individual is committed to involuntary treatment in order to effectuate a discharge plan and community-based treatment plan.

A Web-based tracking system may be utilized to:

- Notify comprehensive community mental health centers of impending discharges;
- Serve as a management tool for treatment teams in hospitals or residential treatment facilities;
- Serve as a monitoring tool for staff of the Bureau for Behavioral Health and Health Facilities.¹⁹

¹⁸ Note: an official from the Center for Medicaid and Medicare Services of the U.S. Department of Health and Human Services reported at a national Olmstead Conference September 22, 2009 that Medicaid could reimburse from administrative funds for case management services provided to an individual in an Institute for Mental Disease 180 days prior to discharge. Even these limitations (time or funding source) do not exist when an individual is an inpatient in a psychiatric unit of a larger hospital.

¹⁹ An example of a Web-based discharge management system may be found in Utah. The REDI (Readiness Evaluation and Discharge Implementation) Program notifies mental health center staff that an individual in the hospital is ready for discharge and enables monitoring of discharge plans. In the aggregate, the process identifies needs or service system gaps in regions of the State.



The tracking system should enable linking comprehensive community mental health centers with private hospitals. All individuals committed to involuntary treatment who remain hospitalized more than 10 days should be reviewed with a goal of discharge into appropriate community-based services. Private hospitals accepting individuals who are committed should be required to refer individuals to community-based services when clinically appropriate.

Comprehensive community mental health centers should be empowered to provide these linkages with any inpatient psychiatric setting or residential treatment setting for individuals who have been involuntarily committed to treatment.

Treatment Services

Individuals with a mental illness or a co-occurring mental illness with abuse of or dependence on alcohol or other drugs need a range of services. Services should be available based on an individual's needs and desires.

Self-directed care is an extension of the concepts suggested by Dr. Forman. Five states have implemented self-directed care programs for adults with serious mental illness. These are services that include person-centered planning, individual budgeting and access to support services. Self-direction has been shown to improve consumer satisfaction with services compared to traditional community mental health services. "According to interviews with consumers, this is in large part due to the focus on recovery rather than symptoms; the flexibility of the approach in meeting individual needs; and the support provided by counselors and peers in articulating goals and developing spending plans."²⁰

The treatment of mental illness can include the use of medication (such as antidepressants, anxiety medications, mood stabilizers and antipsychotics), psychotherapy, support and self-help or other methods / interventions.

Necessary in the array of treatment services will be medication, psychiatric services, and counseling. Some training in basic living skills may be necessary, particularly for individuals who have been hospitalized for a long period. There should be opportunity for intensive outpatient therapy, using a partial hospitalization model or frequently occurring outpatient therapy. A menu of services from which a consumer can choose, ranging from periodic medication clinics through Assertive Community Treatment should be available regardless of payment source. Treatment services should offer physical health care. Individuals diagnosed with mental illness die 25 years earlier than the general population.²¹ In addition to providing primary care services, individuals with mental illness should have access to information on healthy lifestyle choices.

²⁰ See <http://aspe.hhs.gov/daltcp/reports/2007/MHslfdir.htm#execsum> for more information. Also see: http://www.thenationalcouncil.org/cs/policy_resources/overview/contribution_of_selfdirection_to_improving_the_quality_of_mental_health_services_summary and <http://mentalhealth.samhsa.gov/publications/allpubs/NMH05-0194/default.asp>.

²¹ See <http://www.nri-inc.org/conferences/Presentations/2009/27Rogers.pdf> for a summary of studies.



A time-limited workgroup should be established to develop specific plans and approaches to serving individuals with co-occurring mental illness and substance abuse issues. In the interim, to better serve this population, it is recommended that the Bureau for Medical Services lift the moratorium on intensive outpatient services, since Federal restrictions on clinic and rehabilitation services have been lifted. Intensive Outpatient Programs should be available by January 2010.

Assertive Community Treatment (ACT) is an Evidence-Based Practice for individuals who have multiple needs for treatment and support services. It may not be possible for every comprehensive community mental health center to implement ACT as an Evidence-Based Practice due to numbers of persons eligible for this service or due to workforce issues. Alternatives to serve individuals with multiple needs for treatment and supports should be supported.²² There are many options which may be supported by Medicaid reimbursement or State general revenue funds.

Assertive Community Treatment (ACT) is an Evidence-Based Practice serving individuals with multiple treatment and support needs. Alternative, but intensive, services should also be supported for such individuals where workforce issues or numbers of eligible consumers prevent implementation of ACT.

Additional day treatment services are necessary, as demonstrated in the *Hartley* Agreed Order. Sufficient numbers of day treatment services should be available so that anyone qualifying for this service has access to it. State general revenue funds should be provided to supplement day treatment programs to enable expanding services and supports provided by these programs. Day treatment programs should be designed to support recovery goals.

The Day Treatment definition should be considered broadly. Day Treatment should include elements of day programming, day supports, and consumer-operated Wellness and Recovery Centers.

The seven Day Treatment centers to be developed in the next three years envisioned by the *Hartley* Agreed Order may be a minimum. A quick county-by-county assessment of the availability of Day Treatment should be made and State support should be provided for starting new programs in areas where there are none. State support should also be provided to enable Day Treatment programs to expand the support and services they offer beyond the present limitations of Medicaid-defined Community Focused Treatment and Day Treatment.

²² The State of New York utilizes a “Blended Case Management” service, which “tailors ... services to the needs of individual recipients, rather than imposing a single model of service intensity on all recipients. The result is that case managers have the flexibility to change the intensity of case management consistent with immediate individual needs as determined by the recipient and the team. Under the blended model, the program caseload is a combination of persons needing both an intensive level of case management and a supportive level. As individuals served in this program require more or less intensity of services, these changes can be made within the program... This allows the case management team (ICM and SCM case managers) to focus their energy and time on meeting client goals and objectives.” For more, see http://www.omh.state.ny.us/omhweb/policy_and_regulations/part506pa.htm.



A workgroup of providers and representatives of the Mental Health Consumers Association should further develop concepts of Day Treatment.

Services provided by consumer / survivor / ex-patient support organizations may be included among treatment services. These services may include opportunities for day activities (Wellness and Recovery Centers).

Support Services

Half of all lifetime cases of mental illness begin by age 14; 75% by age 24 according to researchers at the National Institute of Mental Health. Decades may elapse between the first onset of symptoms and when people seek and receive treatment. Young people experience a disability when they are in the prime of life, when they would normally be the most productive.²³

Adults with a mental illness or a co-occurring mental illness with abuse of or dependence on alcohol or other drugs who enter the publicly funded mental health system have frequently delayed completion of the education they desire, have been unable to sustain employment, do not have a permanent place to live, and lack social connectedness. While treatment (medication, counseling, therapy) may be necessary, it is not sufficient without adequate supports. Long ago, Maslow posited that physiological needs, safety needs, belongingness, and self-esteem must be realized before an individual could work on what he termed “growth needs.”²⁴

A range of housing, with appropriate supports, should be available in each of the regions of the 13 comprehensive community mental health centers.

Supports should be designed to assist an individual in his or her recovery. Chief among supports needed is safe and affordable housing. Additional supports include opportunities for meaningful work and social connectedness. Self-direction in identifying supports needed is essential.

Housing envisioned by the recent agreed order in the *Hartley* case includes group homes and “slots” for supportive living. Group homes, typically operated by a comprehensive community mental health center, should not typically be the “last” residence for an individual. Appropriate, recovery-oriented day treatment services coupled with group homes (but not mandatory) will enable utilizing group homes for transitional living. The supportive living slots required by the agreed order and development of additional safe and affordable housing will further enable using group homes for transitional living.

Group homes should be developed by soliciting proposals from comprehensive community mental health centers in regions where the need has been identified through discharge planning at the two State-operated psychiatric hospitals. Proposals should include allowing renovation costs to upgrade residences and / or apartments suggested by the comprehensive community mental health center. Referral to group homes should be a product of discharge planning.

²³ See <http://www.nih.gov/news/pr/jun2005/nimh-06.htm> for more information.

²⁴ See <http://chiron.valdosta.edu/whuitt/col/regsys/maslow.html> for an explanation of Maslow’s Hierarchy of Needs.



Operationalizing residential slots might include two program concepts. An hourly support service for up to 90 hours a month could be provided for long-term support if an individual has a history of needing what are termed Level III services. Residential supports, using a per diem rate, could be provided for individuals with extensive service needs who have a history of frequent hospitalizations. The services can be developed in homes (3 beds or less) or in apartment settings. The per diem rate should be sufficient to provide support for a ratio of one staff to three consumers. Admission criteria and reimbursement rates would need to be developed for either concept.

Group homes, hourly support services and per diem services should form a range of housing in each region of the State. Housing should be developed first in regions with the highest commitment rates, but each region should have all components within three years.

Another important support service is Care Coordination. The *Hartley* Agreed Order envisions increasing the number of Care Coordinators to serve the dual roles of assisting in discharge planning and diverting individuals from involuntary inpatient treatment. These roles are the responsibility of comprehensive community mental health centers as gatekeepers in the publicly-funded mental health system. If the Bureau for Behavioral Health and Health Facilities funds agencies other than comprehensive community mental health centers to provide Care Coordination, collaboration with a regional center must be required.

A portion of the funds for Care Coordination should be allocated to the West Virginia Mental Health Consumers Association for Peer Support for consumers who have been frequently hospitalized.

Comprehensive community mental health centers support that the funding system for this proposal continue to be a “fee for service” system reflecting reasonable rates that are annually and jointly reviewed and agreed to by providers, the Bureau for Medical Services, and the Court Monitor for reasonableness. Comprehensive community mental health centers believe that the solution to the behavioral health crisis is the provision of appropriate and timely psychiatric community crisis services that are adequately reimbursed when provided. Further, we recommend again, as we have in the past, that Uncompensated Care Funds only be distributed on a similar “fee for service” basis encouraging and rewarding timely psychiatric service provision as well as other types of community services.



Summary

Community-based services for adults with mental illness and adults with co-occurring mental illness and substance abuse issues are, by West Virginia statute, the responsibility of the 13 comprehensive community mental health centers. Each center should have a continuum of services including diagnostic / assessment services → crisis intervention / stabilization services → linkages to psychiatric inpatient / residential treatment services → treatment services → support services. Services should be linked in collaboration with mental hygiene commissioners, hospital emergency rooms, consumer-operated services and supports, and the judicial system.

Recent events provide an opportunity to better fund a comprehensive system of care for adults with mental illness and adults with co-occurring mental illness and substance abuse issues. Supporting the statutory comprehensive community mental health centers to design and implement a comprehensive system of care as defined in this document will have benefits:

- A life in the community for adults with mental illness and adults with co-occurring mental illness and substance abuse issues;
- Reduced reliance on the involuntary commitment process; and
- Decreased utilization of inpatient care and the costs associated with diverting individuals from over-crowded State-operated psychiatric hospitals to other hospital psychiatric inpatient care.

The mechanism for assuring appropriate decision-making and the specific components of a community-focused system of care are as follows:

- 1) **Gate keeping** – The comprehensive community mental health centers would be the gatekeepers for publicly-funded mental health / addiction services. Mental health center staff would be responsible for assessing individuals at risk of losing or being removed from their community placement. The staff would determine the most appropriate level of treatment for the individual that required the least penetration into the system. The comprehensive community mental health center would be responsible for monitoring the individual's treatment progress and initiate movement into the least restrictive setting that can provide the appropriate level of treatment and support. For those individuals that require commitment for involuntary treatment, the comprehensive community mental health center would recommend and coordinate the appropriate placement. This may be an inpatient unit at a local hospital, a Crisis Stabilization Unit or a combination of services. With the comprehensive community mental health centers performing these gate-keeping responsibilities, the private hospitals currently contracting for diversion beds will become a part of the continuum of care and there will not be the need to develop a separate bureaucracy to provide oversight of this increasingly expensive by-product of the over-bedding problem. For adults with mental illness or co-occurring mental illness and substance abuse issues, the following continuum consists of critical components of a successful and humane community-focused alternative to hospital / institutional care.



- 2) **Continuum of Services**--WV Code 27-2A-1 states that “No person who can be treated as an outpatient at a community mental health center shall be admitted involuntarily into a state hospital.” The continuum of services would include:
- a) Emergency services, including “walk-in”, 24/7 on-call, and mobile crisis services;
 - b) Outpatient treatment provided by medical and clinical staff;
 - c) Community support services, including Care Coordination. A key component of the community support system is the inclusion of the West Virginia Consumers Association in providing aftercare and peer support activities for these consumers;
 - d) Intensive outpatient mental health, co-occurring, and addiction programs;
 - e) Day treatment programs that provide a range of services / supports that include training, family / provider respite, and community integration. The intensity, type and location of these activities would be based on the individual’s needs to remain in the community;
 - f) Assertive Community Treatment (ACT) services that have the flexibility to be effectively operational throughout the State. The varied availability of professional resources, population density and regional geography would not be barriers to the development and sustainability of ACT. Utilization of current videoconferencing and other technology would be an example of expanded flexibility as would approving different compositions and staffing requirements of the ACT team;
 - g) Residential programs that provide a range of support / training / treatment services that are based upon the individual’s needs, strengths and level of functioning. Examples of the range of services are:
 - i) periodic monitoring of current status in non-staffed living environments;
 - ii) daily scheduled training and support activities during non-sleeping time in varied living arrangements;
 - iii) short-term housing available to individuals primarily needing assistance with securing necessary / available entitlements and locating / securing permanent housing; and
 - iv) traditional 24/7 staffed group homes;
 - h) Crisis Stabilization services that includes a residential component. In addition to providing services to consumers that meet current APS admission criteria, the Crisis Stabilization programs will be utilized for consumers who are involuntarily committed and can be managed in a staff-secure facility. Those committed individuals that require a locked facility would be placed at Bateman or Sharpe hospital. The private community hospitals currently serving as diverted hospitals would provide services to those committed individuals that have medical conditions requiring specialty medical care beyond psychiatry and any committed individual requiring a locked facility. In addition:



- i) Crisis Stabilization units must be within 45 minutes to one hour distance for every resident of West Virginia. The Bureau for Behavioral Health and Health Facilities must work collaboratively with the comprehensive community mental health centers to determine where the number of beds needs to be expanded or new Units be developed;
- ii) The Bureau for Behavioral Health and Health Facilities will work with the comprehensive community mental health centers to quickly develop the bed capacity to serve those committed individuals who could appropriately be served in a Crisis Stabilization program. They currently have no alternative other than the State hospitals or private community hospitals that accept diversions with limited monitoring or oversight; and
- iii) The Bureau for Behavioral Health and Health Facilities will evaluate the Highlands Center model and utilize that information to further develop and enhance the continuum.

