Long Term Strategies for Community Placement: Alternatives to Institutions for Mental Disease

Final Report
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Executive Summary

Introduction

This study was designed to analyze and evaluate California's current long-term care system for persons with serious mental illness, specifically the use of IMD and state hospital resources. For the purpose of the Study and unless otherwise noted, the use of the term "IMD" refers to a level of care definition: institutional care for the purpose of mental health treatment and services, and includes state hospitals), Skilled Nursing Facilities (SNFs) which specialize in mental health treatment, and Mental Health Rehabilitation Centers (MHRCs).

Study Methodology

The Study Team conceptualized IMD and state hospital use as a function of complex county systems that are under budgetary and clinical pressure to reduce the use of IMDs and state hospitals

The Study consisted of three phases:

- **Background and Basic Information Gathering.** *The results of this phase were presented in a preliminary report produced in December 2003.*

- **In-depth Information Gathering in Six Counties.** *The counties were selected to reflect the diversity in the state and include both high and low users of IMDs and state hospitals. Four primary sources of information on these counties were analyzed for this report:*

  - **County Site Visits** *to understand county systems*
  - **Tracking Study.** *All clients admitted to IMDs or state hospitals in each county were tracked for approximately one year.*
  - **Long-Stay Clients**. *Four of the five large counties collected information on a selected sample of their clients who had been in an IMD/state hospital for at least 18 months.*
  - **IMD Site Visits**. *Visits to nine IMDs were completed*

- **Analysis and Development of Findings and Recommendations**

Phase I Report

General*:* Most counties place their clients in a number of different IMDs and many use facilities outside of their county. Fiscal pressures provide clear incentives to reduce IMD usage. The IMDs serve two major functions in the counties' adult systems of care – one as a short-term step-down placement from acute care and the other as a long-term placement for selected clients. The placement of the conservatorship function in county government, the nature of the relationship between the Public Guardian and the mental health program staff, and the philosophy of the courts and /or Public Guardian affect IMD utilization. Responses to questions on cultural competence and the recovery philosophy raised doubts about the extent to which these are being implemented in IMDs. Recidivism data is not routinely tracked and varies considerably among counties that had data. State hospitals appear to be a placement of last resort for many counties.

Access and Monitoring**:** Almost all of the counties utilize a centralized process for authorizing admissions to IMDs. Regardless of structure, counties tend to use management or supervisory staff who have clinical experience as gatekeepers. All counties receive periodic updates from IMDs on clients' progress. More active monitoring through on-site visits by county staff occurs at least quarterly. While counties rely on the same types of procedures, the intensity and scope of the monitoring varies across the counties. The conservator also plays a role in the monitoring of IMD residents.

Clients and County Needs: Counties identified clients who exhibit aggressive/explosive behavior and sexual offenders as the most challenging to serve in the community. Expanding community living situations for persons with serious mental illness was consistently identified as critically important to enable people to move out of IMDs. Counties also confirmed the importance of ACT/AB 34 and AB 2034 (programs providing comprehensive services) and intensive case management programs in supporting persons in the community. Most of the counties had at least some of the community services necessary to support clients in the community. Housing-related actions were the most frequently mentioned of the most promising initiatives counties were using to reduce IMD utilization. Some counties reported successful efforts at expanding housing alternatives.

Small counties: Interviews with counties with a population of less than 50,000 people confirmed many of the same issues along with some unique concerns. The smaller resource base of these under 50,000 population counties makes it more difficult to have a full range of appropriate community resources for their clients, and the lack of transportation is a barrier to receiving these services elsewhere.

State activities: Counties' primary need for help from the State is additional funding, especially for housing and board and care facilities. In addition, licensing requirements and monitoring for both IMDs and community care facilities create real or perceived problems in using these facilities appropriately and consistently with the intent of the Olmstead decision; especially for clients who have histories of high risk behaviors such as suicide attempts, aggressive behavior and substance abuse. Counties would like to have licensing standards and their enforcement more consistent with the needs of persons with mental illness. They would also like more collaboration among State agencies; and technical assistance with developing services for clients who have major barriers to living in the community.

Client and family member concerns: An interview with members of the DMH Client and Family Task Force raised concerns about the quality of care in IMDs and the process of transitioning to the community. Specific concerns included the lack of services for persons with co-occurring substance abuse problems; negative staff attitudes toward clients; not enough attention to the tasks of daily living that clients will need in the community; violations of patient rights, particularly for clients placed out of their home county; and the difficulty of the transition from an IMD to a community placement.

Six County Study

Building on the above background, the primary purpose of Phase II of the IMD Study was to understand IMD usage and explore reasons for varying utilization rates among selected counties. Six counties were selected for in-depth study based on IMD utilization rates, demographic characteristics, levels of overall funding, historic IMD use patterns, politics and perceived community tolerance for persons with mental illness and availability of community placements. This part of the Study includes an in-depth analysis of IMD use in the six study counties through tracking individual clients during the IMD Study period, analyzing the needs of a sample of long stay clients and conducting site visits to identify factors that influence decisions about the use of IMDs and state hospitals.

Admissions/Gatekeeping: Indicators of behavior and functioning on Tracking Study clients at admission to an IMD, as well as the site visits confirmed that counties use IMDs for clients who have very serious conditions, and who have often had multiple hospitalizations and unsuccessful community placements. All of the Study counties have a centralized process for authorizing admissions to IMDs, but the results of these processes vary. Two of the Study counties have admission rates that are two to three time higher than the other three. Civil commitment rates are consistent with this pattern. Data from the Tracking Study show not only the interrelationships between IMD admissions and LPS policies and procedures but also the impacts and consequences of these on acute care

lengths of stay. Usage is also affected by the orientation of a county's leadership about the use of IMD and state hospital resources.

Care and Monitoring During Stay in an IMD: While all the counties do some on-site monitoring of clients when placed in an IMD, the intensity and focus varies. In addition to ongoing monitoring, some counties have initiated quality improvement efforts. Concepts of recovery are only in the verbal stage, not yet understood or integrated into the IMD treatment programs. The facilities show a general awareness of cultural issues but little attention to the impact of culture for individual clients. Family involvement was limited in most facilities. The treatment goals recorded for the clients in the Long-Stay Study were largely generic and indicated virtually no client input. Medication practices were highly variable among the facilities, with the biggest deficits in those facilities with the least psychiatric coverage. While inappropriate polypharmacy was not too frequent, appropriate, assertive medication management often was not evident.

Discharge and Transition to Community Placement: About half of the clients in the Tracking Study had a planned discharge to the community during the Study period, with an average length of stay of about 6 months. Ten percent of the clients had an unplanned discharge during the course of the Study. Clients with a planned discharge showed significant gains in functional status since admission. However, about one-third of the clients with a planned discharge were not expected to do well or to do "just OK" in the community. Virtually all of the state hospital discharges are to an IMD or SNF level of care.

In the Tracking Study, seven and one-half percent of the discharged clients were readmitted to an IMD during the remainder of the Study. Clients with very low functional status scores and/or clients that staff are concerned about seem to have a higher likelihood of being readmitted. Clients who are discharged and not readmitted appear to at least maintain their gains while in the community.

Factors influencing Continued Stay in an IMD: The client's functional status is clearly a factor for clients who remain in an IMD or state hospital. Over half of the Long-Stay clients had at least one of four serious conditions (homicidal, suicidal, violence toward self or others). The reasons cited for why clients are still in IMDs or state hospitals are generally similar for both those clients in the Tracking Study and in the Long-Stay Study. There are 20% of the clients in the Long-Stay Study who had none of the three major reasons (dangerousness, safety, or grave disability) for still being in an IMD/state hospital. About one-third of the clients in the Long-Stay Study are expected to remain in the IMD/state hospital for the foreseeable future. When a client has been in an IMD for over five years, staff expectation for a discharge is less than 50%. .

Predictors of Disposition in the Tracking Study: Two factors - age and civil commitment status – show relationships with disposition, but are difficult to interpret. Functional status scores at admission are not predictive except perhaps

for those with high (functioning better) scores. Functional status and current behavioral conditions at three months are predictive of subsequent disposition.

FINDINGS AND RECOMMENDATIONS

The report contains a number of findings. These are followed by recommendations and suggested actions for consideration by counties and the state in the continuing effort to better understand and achieve appropriate utilization of IMDs and State Hospitals.

FINDING 1: INDIVIDUALS WHO ARE PLACED IN IMDS OR STATE HOSPITALS HAVE SIGNIFICANT CURRENT DISABLING ISSUES.

Overall, almost half of the clients in the Tracking Study had at least one of four serious conditions (homicidal, violent toward others, violent towards self, expressed suicidal intent) within thirty days prior to their admission. In addition, 29% were homeless prior to admission, substance abuse was a factor in triggering the episode leading to IMD placement for one-quarter of the individuals, and 23% had moderate or marked health impairment. Fifty-six percent of the clients in the Long-Stay Study had at least one of the four serious conditions and 35% had exhibited at least one of those four within the last three months. It is precisely because these clients are so vulnerable, and their illness is so serious that they deserve the system's best efforts to aid them in their recovery.

FINDING 2: COUNTIES THAT ADOPT COMPREHENSIVE COORDINATED EFFORTS ARE ABLE TO POSITIVELY AFFECT THEIR UTILIZATION OF IMD AND STATE HOSPITAL RESOURCES.

2A: There is no "gold standard" for IMD/STATE HOSPITAL use.

IMDs serve an important role in a county's system of care for clients who are no longer in need of acute care but cannot safely return to a community living situation. This study did not result in a determination of the "correct" level of utilization of IMDs. Many county mental health departments feel pressure to reduce their level of IMD and state hospital use for a variety of financial, regulatory and clinical reasons. Whatever a county decides is the appropriate level of usage for its particular circumstances, there are actions it can take to reach its optimal level. Counties that wish to understand how these resources are being used need to examine their rates of admissions and discharges as well as lengths of stay for IMDs. Comparisons among counties can be helpful in understanding how a county's practices may deviate from effective practices. More accurate and timely statewide data is needed to do this analysis.

***2B*: Initiative and leadership make change in use possible.**

The initiative for change can come from multiple sources and occur for multiple reasons, but for there to be a change there needs to be a "champion" and there needs to be ultimate buy-in by the leadership of the county mental health department. The two counties with the lowest use rates trace system change back to a particular strongly-felt and pursued concern about the way in which the IMD level of care was being used. In two other counties change is also underway. In one the initiation came from concerns about the quality of care in IMDs. In the other, new department leadership undertook change in the long-term care system as a result of major budgetary shortfalls and a chronic service back-up in their Psychiatric Emergency Services Unit. In all of these counties, leaders within the local department of mental health have the issue of long- term care high on their lists of priorities.

***2C*: A clinical/treatment vision that sees IMD placement within a system that is dedicated to client-directed services and recovery facilitates change.**

In the Olmstead decision the Supreme Court held that institutionalization required a burden of proof on the public system to show why community care is not appropriate. While the initial concern about an IMD or state hospital usage may result from a perspective of clients' rights or budget constraints, the existence of a consistent clinical/treatment philosophy which promotes a client-directed and recovery oriented system of care provides an invaluable support to the implementation of change, allowing an IMD or state hospital to become a temporary placement of last resort. While IMD usage can be controlled by strictly administrative means, more effective control is achieved when the treatment philosophy is congruent with both administrative and clinical goals.

2D: Effective supporting structures and processes are necessary to make changes.

While a centralized intake and monitoring structure is important, other factors influence the effectiveness of this structure. These include:

- *Adequate staff to both (a) conduct a timely and thorough evaluation when a referral is made to ensure that there are no other alternatives that could avoid an IMD admission and (b) follow-through with regular and frequent on-site monitoring of clients while they are in IMD or state hospital.*
- *Skilled clinicians who also have knowledge of the resources available in the community that might serve as alternatives and discharge placements.*
- *Budgetary control over the IMD and state hospital resources.*

- *Presence of strong and visible support for the function from the top administrators in the mental health program. The role of gatekeeper and monitor can be difficult without the support and encouragement of supervisors and managers.*

2E: Variations in county implementation of civil commitment procedures can greatly influence IMD and state hospital usage.

Civil commitment policies and practices vary greatly from county to county. The nature of the relationship between the Public Guardian and the mental health program staff, and the philosophy of the courts and /or Public Guardian affect acute hospital lengths of stay, movement into and out of IMDs, and clients' success in the community. Among the more substantial differences we noted in the six counties examined were:

- *Use of the 180-day dangerousness certification*
- *Whether a client can be in an IMD while on a temporary conservatorship*
- *Whether clients discharged from IMDs should remain on conservatorship while in the community*
- *How big a role conservators play in the monitoring of clients' care in IMDs and doing discharge planning.*
- *How much influence public and/or private conservators play in inhibiting discharge because of concerns for clients' safety.*

Developing a consistent vision and supporting policies and procedures for the appropriate use of IMDs and state hospitals cannot be attained in a county without working closely with all of those who implement the county's civil commitment policies and practices.

2F: Co-operation among all stakeholders promotes effective management of IMD and state hospital use.

Other stakeholders are affected in major ways by the availability and usage of IMD/state hospital resources. Among them are clients and client representatives, families, and acute care facilities. Counties who are effective in managing their IMD and state hospital resources have developed procedures for including all relevant interests in the difficult task of developing a common vision of what will be considered the appropriate use of these resources.

RECOMMENDATIONS

2.1. Accurate, timely, and comprehensive statewide data on IMD and state hospital utilization produced by DMH would enable counties to analyze and compare their overall IMD/state hospital use rates with other counties.

2.2 It would be helpful for counties to develop consensus among relevant agencies on an Olmstead-consistent vision of IMD/state hospital usage.

2.3 Applying a client-directed recovery-based orientation to the use of IMDs and state hospital would help in creating a consistent systemwide orientation and approach to the use of institutions as short term interventions to be used as a last resort.

2.4 Centralized gate-keeping and monitoring processes are most effective when they have sufficient financial and management support.

2.5 It is important for county departments of mental health to work closely on an ongoing basis with all the constituencies involved with civil commitment policies and procedures

FINDING 3: QUALITY OF CARE IN IMDs NEEDS IMPROVEMENT

3A: **A recovery vision and an individualized orientation are not infused in IMD services**. *While the facilities visited were found to abide by licensing requirements to develop a client treatment plan and to review it periodically, treatment goals and treatment programs are often generic with little evidence of real client involvement in setting treatment goals, let alone developing a recovery plan. Most IMD programming does not reflect a recovery orientation.*

3B: **Medication practices are less than optimal.** *The major concerns expressed by county staff and reinforced by our findings include the following:*

- **Amount of psychiatrist time.** *There was a large range in medication practices with practices appearing better in IMDs with greater amounts of on-site psychiatrist time.*

- **Monitoring of psychiatrists.** *Medication practices in IMDs appear to be better in counties where there is more active involvement by the county. Two of the Study counties had established medication policies and communicated them effectively to IMDs.*

- **Medication practice for long-stay clients**. *More assertive medication approaches would appear to be warranted with clients who are not making progress on existing regimens in most facilities. Many charts in the Long-Stay Study lacked information about medication history due to periodic "thinning" of charts.*

3C: **Linguistic coverage and some special culturally specific programs are present in IMDs, but there are few signs of comprehensive cultural competence.** *Although some IMDs had specific programs for some cultural groups and most had adequate bilingual staff, it was not apparent that the IMD programming for individual clients made any special reference or took account of the potential impact of culture on individual clients. Also, not all IMDs ensure that their staff have regular training in cultural competence.*

3D: **Staff inertia and pessimism are too predominant regarding many long-stay clients***. About one-third of the clients who had been in an IMD/state hospital for longer than 18 months were not expected to be discharged at any time in the foreseeable future. While this level of care may be necessary for relatively long periods of time for some clients, it appears that facilities and counties have "given up" on some clients. Counties could consider the establishment of special programs, or using established programs that have the best available recovery and rehabilitation programming specifically for some of these very long-stay clients*

3E: **County and IMD quality of care initiatives can make a positive difference***. At least two of the case-study counties employed formal quality improvement initiatives with their IMDs and reported that while it took substantial effort they were pleased with the overall success of the effort.*

RECOMMENDATIONS

3.1. **Counties can undertake quality improvement initiatives with IMDs they use**.

3.2. There are some effective steps that can be taken to encourage better medication practices.

- *Counties can develop reasonable ratios of psychiatric time in the facility to the number of clients in residence.*
- *The structure of the relationship of the psychiatrist to the county could be modified such that counties can monitor and assure appropriate, informed and assertive medication practices.*

3.3 County annual reviews of the status of their long-stay clients to determine what kind of more active treatment is warranted can be critical in assuring appropriate use of institutional resources.

3.4 Pilot programs initiated by the state can be helpful in determining the most effective treatment approaches for clients in IMDs and state hospitals.

3.5 A state-sponsored forum to define and develop more specific psychiatric practice standards for IMDs could improve consistency and quality of care across IMDs.

FINDING 4: IMPROVED COMMUNITY RESOURCES WILL ALLOW FOR MORE APPROPRIATE USE OF IMD/STATE HOSPITALS

***4A*. Lack of adequate housing resources and intensive case management in the community were cited as the major obstacles in transitioning clients out of IMDs back into the community.** *Appropriate housing and sufficient support services can be and are made available in a variety of structures in different counties. Ideally, someone could be able to return to an appropriate* permanent *living situation, where they can remain as long as they choose while supports would be made available 24 hours a day and 7 days a week as necessary.*

***4B.* Counties have reduced IMD usage through the development of specific combinations of housing-support services.** *While temporary programs are not a recommended direction for the system as a whole, step-down programs which combine housing and treatment services may be particularly helpful as options in achieving immediate reductions in IMD utilization while a county is building its more permanent supportive housing. Additionally, intensive case management, ACT teams and integrated service agency programs can provide structure and support services to augment other types of housing such as board and care facilities, apartments, and room and board places.*

***4C.* While more housing and case management resources are needed, coordination and integration of the available and existing resources can improve a county's use of IMDs**. *Responses to the Tracking Study questionnaire made it apparent that the IMD staff/county monitors did not think in terms of community preparation. It is difficult to prepare clients for community living when the staff is not thinking in terms of what it takes to succeed in varying community settings. Similarly, resource shortages limited success of policies requiring community care case managers to follow their clients while they are in an IMD. Teams comprised of IMD staff, county long-term care staff, the Public Guardian and community*

program staff that work with clients on transition out of IMDs as soon as they are placed into the facilities are helpful.

4D. **Board and care facilities are not sufficiently funded and supported by counties and licensing agencies to play the role they are forced to currently play in the system of care**. *While better alternatives could be available in the long run, counties are heavily dependent on board and care facilities as discharge placements from IMDs, yet board and care funding, staffing and licensing standards leave them woefully inadequate to the task.*

4E. **Families are an important resource for many clients**. *Many clients in the study counties were living with their families prior to going into an IMD, and many returned to families upon discharge. Families involved with clients can be important components of clients' social networks and are important to clients' recovery, but families are not fully included in the processes and planning for their loved one.*

RECOMMENDATIONS

4.1. **The development of additional flexible supportive housing resources at both the state and county levels is critical in reducing IMD utilization.**

4.2. **ACT-type teams and integrated service agencies can be used as helpful alternative resources for returning long-stay IMD and state hospital clients to the commun*ity.***

4.3 Intensive case management services help clients be more successful in their transition to the community.

4.4. Counties could consider the development of a range of augmented residential programs.

4.5 Implementing more effective discharge planning processes can reduce lengths of stay and recidivism.

4.6 Counties who must rely significantly on board and care facilities for the near future could enhance quality of life and recovery opportunities for residents in such facilities.

4.6 A collaborative effort initiated by DMH with Community Care Licensing (CCL) would help to promote the appropriate use of community care facilities for clients with serious psychiatric disabilities.

4.7 Counties could consider developing programs to assist families who provide housing and other support to their family member with mental illness, and IMDs could enhance family involvement in their programs.

Long-Term Strategies for Community Placement and Alternatives to Institutions for Mental Diseases

Introduction

This study of Long-Term Strategies for Community Placement and Alternatives to Institutions for Mental Diseases (IMDs) was conducted, under contract, for the California State Department of Mental Health (DMH). The Study Team consisted of Beverly Abbott, J. R. Elpers, Pat Jordan and Joan Meisel. Two consultants worked with the project team, Darlene Prettyman and Alice Washington; they offered additional expertise in family member, consumer and cultural competence issues.

The Study was designed to analyze and evaluate California's current long-term care system for persons with serious mental illness, specifically the use of IMD and SH (SH) resources.

The Study has taken place during a time in which counties have felt significant pressure to reduce the use of IMDs and SHs. Some of these pressures include the following:

- ***Budgetary constraints** have focused attention on these services since they are among the most costly components of a county's system of care.*
- ***The growing emphasis on recovery** by both professionals and consumers has highlighted concerns about the appropriateness of this level of care for assisting the recovery process.*
- ***Implementation of the Olmstead decision** puts the spotlight on this most restrictive of mental health settings.*

Study Methodology

The Study consisted of three phases.

- **Background and Basic Information Gathering.** This phase included interviews with counties and collection and analysis of statewide IMD utilization data. It was designed to create a framework for understanding how IMDs fit into counties' systems of care and for

identifying hypotheses for what accounts for varying use patterns by county. The results of this phase were presented in a preliminary report produced in December 2003. This report highlighted some of the differences in the patterns of usage of IMD/SH resources among counties (Appendix A).

- **In-depth Information Gathering in Six Counties.** This phase of the Study explored in greater depth the factors that influence varying levels of usage of IMD/SHs in six counties. The counties were selected to reflect the diversity in the state and include both high and low users of IMD/SHs. Four primary sources of information on these counties were analyzed for this report:

  - **County Site Visits.** The Study Team conducted a one or two day site visit to each county in the Spring of 2004. Interviews were conducted with county mental health staff representing management, the long-term care unit (the unit responsible for IMD and SH use), the emergency and crisis unit, the acute hospital unit, and the community system. Also interviewed were representatives of private and public acute hospitals, the Public Guardian's Office, the Patient Advocate, families, clients in IMDs, IMD facilities, residential programs, and board and care (B/C) operators. A follow-up call was made to each county in late 2004 or early 2005 to obtain important updates relevant to IMD/SH utilization.

  - **Tracking Study.** Clients admitted to IMDs or SHs in each county were tracked for approximately one year. The sample sizes were 10 in County F, 30 in County A and County D, 60 in County C and County E, and 132 in County B. The total number of clients was 315 and the county Study enrollment period ranged from a low of about three months in County C to over nine months in County A to a full14 months for County F. Information was collected on a three-month basis until the clients were discharged. Follow-up information in the community was collected on as many clients as possible, but obtaining accurate and comprehensive follow-up information was problematic.

  - **Long-Stay Clients.** Four of the five large counties collected information on a selected sample of their clients who had been in an IMD/SH for at least 18 months. The counties reported they had 599 such clients in IMD/SHs in the fall of 2004. Data were gathered on 193 of these clients.

  - **IMD Site Visits.** The psychiatrist member of the Study Team, occasionally accompanied by another Study Team member, visited nine IMDs. The visits consisted of an interview with the facility

administrator and program leaders, a walk-through of the facility, and a review of at least five charts of clients (selected randomly) who had been in residence for at least one year. The chart reviews emphasized the treatment and discharge planning, medication prescription patterns (judged by the general principles embodied in the Cal-MAP and T-MAP protocols), cultural sensitivity and recovery vision.

- **Analysis and Development of Recommendations and Promising Practices**. This phase of the Study, culminating in this report, uses the statewide information from phase one, the empirical information from the client-level data and the qualitative understanding of the unique circumstances in each of the six study counties, to analyze and evaluate California's current long-term care system for persons with serious mental illness, specifically the use of IMD and SH resources. In addition this phase identifies strategies and promising practices and makes recommendations to assist the state and counties in achieving more appropriate usage and lower utilization of IMD/SHs.

Statewide Context

State data[1] suggests a fairly steady number of IMD clients over a five year period but a gradual decrease in the number of IMD days.

The charts below show the trends in the number of IMD clients and the number of IMD days statewide from FY 98-99 to FY 02-03.

[1] The state data was obtained from the DMH and is based on CDS and CSI. For the Phase I Report we compared the information the Study Team obtained from the county interviews with the information in these state data bases and we unable to explain some major discrepancies. We therefore use the state data here only to make general points about trends since the data may not be completely accurate. There is also significant amounts of missing data at the state level; we estimate that at least 18% of the data is missing. We received the final set of date in May 2005.
A number of counties that usually reported IMD data had not yet reported their information for FY 03-04 so we did not use the data for that year. The final year of reported data used in the report is thus FY 02-03.

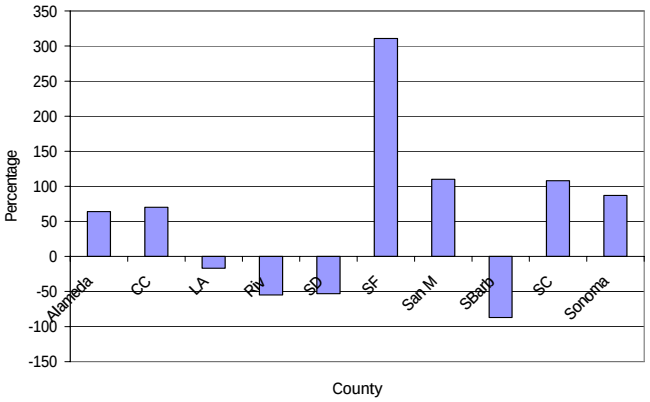
These trends mask wide variations among the counties in their trends over time. Examples of the variations by county can be found in Appendix F.

There are sizable differences among counties in their rates of use of IMD beds.

To get a measure of the relative usage of IMD beds we used the newly created relative ratings of counties used for the Mental Health Services Act (MHSA) distribution of funds for Community Services and Supports Plans. This measure was developed to be a measure of relative need adjusted by available resources[2] We multiplied the percentage weighting of each county according to this formula by the total number of statewide IMD days resulting in an "expected" number of days if each county's use of IMD beds was proportional to its relative need/resources. We compared this "expected" number of days with the "actual" number of days. Those counties who have more actual than expected days are higher relative users of beds while those with fewer actual than expected days are lower relative users. The chart below shows the percentage over or under expected of some counties, selected to show the range of variation.

[2] DMH Letter 05-02, available at www.dmh.ca.gov/MHSA.

5 DIFFERENCE BETWEEN ACTUAL AND EXPECTED FY 02-03



Ideally we would like to identify an optimal level of usage, but we are not yet able to do so.

While there are these clear pressures to reduce usage, neither this study nor any other of which we are familiar is able to provide evidence for the optimal level of usage of non-acute locked 24-hour care. Ideally this evidence will come from the accumulation of decisions made by individual clients in partnership with their treatment staff about what is the most appropriate care for them at various points in their recovery. But such decisions can be meaningful only when there is a full complement of alternative community services to IMDs/SHs.

Since counties do not yet have such full complements of community services, nor do we yet have a fully implemented client-directed recovery-oriented approach to care, the best we can do is to explore how the IMD/SHs are being used within county systems of care and provide information that can be used by counties to review and change their system of care to ensure that IMD and SHs are used only when other community-based alternatives are not available, and then for only so long as necessary.

Six County Study

The Study includes an in-depth analysis of IMD use in the six study counties, and identifies factors that influence decisions about the use of IMDs and SHs.

The Study has examined data and policies regarding admissions, the care that people receive while they are in IMD placements, factors that influence discharge and transitions from IMDs to the community, factors that influence whether people are discharged or remain in locked care and predictors of disposition.

Each of these areas comprises a section of this report. We have included the data for County F in only some of the tables because its small size makes comparisons with the other counties sometimes potentially misleading. For each section we describe the overall factors first and then the differences among the Study counties.

The study of SH usage was more limited than that for IMDs. We explored how counties used the SH as differentiated from IMDs and gathered information about clients admitted to the SH during the Study period and clients who were in the Long-Stay Study. Counties use the SH for clients who have the greatest severity of violent behaviors, who have not done well in other placements including IMDs and/or for individuals who have specialized physical or medical needs that complicate their mental illness.

There is an Appendix for the Phase One Report, and for each of the major sources of data as well one for data from the State DMH Management Information System (MIS).

- Appendix A: Phase One Report, December 2003
- Appendix B: Narrative County Reports. There is a report of information from the site visits for each of six counties.
- Appendix C: Tracking Study
- Appendix D: Long-Stay Client Study
- Appendix E: IMD Site Visits. There is a brief discussion of each facility followed by a summary of overall findings.
- Appendix F: Statewide Data. This data comes from the state Client Data System (CDS) and Client Services Information (CSI) systems and is used mostly to indicate major trends and county variations.

Admissions/Gatekeeping

OVERALL FINDINGS

Indicators of behavior and functioning on Tracking Study clients at admission to an IMD confirm that they have significant current disabling issues.

Counties were asked to indicate for clients entering the Tracking Study as new admits to an IMD whether certain significant behaviors had occurred within the last 30 days. The four most serious were: repeated suicidal ideation with expressed intent, recent homicidal ideation with expressed intent, repeated episodes of violence towards self, and repeated episodes of violence towards others. Overall, 48% of the clients had at least one of these four conditions reported as occurring within the last 30 days. The most frequent condition was violence towards others (31%) followed by suicidal (16%), homicidal (15%), and violence towards self (12%).Clients in the two youngest age categories were

more likely to exhibit one of these serious conditions: 76% for those under 21 and 67% for those between 21 and 30. This could reflect a greater prevalence of these behaviors within this age group or perhaps a greater reluctance to admit younger clients to IMDs unless they had more serious risk conditions.

Counties completed a Multnomah Community Assessment Scale (MCAS) (Appendix G) on each client admitted to an IMD. Norms are available for the MCAS (by age/sex categories) based on a sample of clients in Multnomah, Oregon, described by the scale developers as follows: "clients were enrolled in community support units of Community Mental Health Centers (CMHC). This enrollment implies that they suffer from a major mental illness (i.e. schizophrenia or bipolar disorder), have been hospitalized in the recent past or are at risk of hospitalization, and suffer from social role impairment in several areas." A deficit of this instrument is that norms are not available on ethnically diverse populations. This instrument was selected because a large, diverse Study county was using it.

We would expect that the clients in the Tracking Study would be similar to these clients, but that their scores at the time of intake into an IMD would be lower than the norms of the Multnomah clients because of the more acute nature of their disorder at time of their entry into the IMD. This is in fact the case for most of the population subgroups except for the males aged 35-50 and the females over age 50, which are similar to MCAS norms.

Average MCAS Scores for Tracking Study Clients Compared to Normed Multnomah Clients by Age/Gender

Age/Gender	Tracking Study Clients	MCAS Norms
Males 18-34	49.7 (N=65)	52
Females 18-34	47.4 (N=27)	55
Males 35-50	51.9 (N=77)	52
Females 35-50	47.8 (N=40)	56
Males 51+	47.9 (N=35)	52
Females 51+	52.2 (N=25)	52

Subsets of clients have other issues at intake which require attention either before and/or during episodes in an IMD.

The table below indicates the percentage of clients who at intake to the IMD were rated as being homeless, having a significant substance abuse problem, significant health issues, known history of trauma or abuse, or having a minor child. The mental health systems of most counties are increasing their attention to the issues of homelessness and substance abuse, and we comment below on the perceived attention to medical problems while clients are in residence in IMDs. We suspect that less attention is being paid to the issues of trauma and

abuse during treatment and that attention to the role of clients as parents may also receive less attention than may be warranted.

Conditions/Situations at Admission to IMD

Condition/Situation	%
Last living situation: Homeless/shelter	29%
Substance abuse a factor in triggering this episode	25%
"Moderate" to "marked/extreme" health impairment (on MCAS)[3]	23%
Known history of trauma or abuse	9%
Have a minor child	10%

Additionally, almost two-thirds (62%) of the clients are rated as having a history of medications "non-compliance". The percentage rated with some criminal justice involvement at intake (9%) may be lower than actual, but indicates the importance of relationships with the criminal as well as civil part of the justice system. (See Appendix C for more details.)

About one-quarter of the clients lived with their family of origin prior to the episode leading to the IMD admission.

The percentage of clients who were living with their family of origin was 33% in County A, 30% in County B and 28% in County C. This suggests the opportunity for outreach programs for families which might prevent an acute episode resulting in an IMD admission. Families should be provided with the immediate support they need to avoid an IMD admission and to find less restrictive alternatives to institutionalization when their loved one is experiencing a crisis or relapse.

All of the Study counties had a centralized process for authorizing admissions to IMDs, but the results of these processes vary.

As indicated in our Phase I Report, almost all counties now utilize a centralized process to control access to IMDs – as did all of the case study counties. While the function is common there are major differences in its implementation. This next section presents the differences in admission rates as well as some of the factors which we think help explain these differences.

COUNTY DIFFERENCES

Two of the Study counties have admission rates that are two to three time higher than the other three.

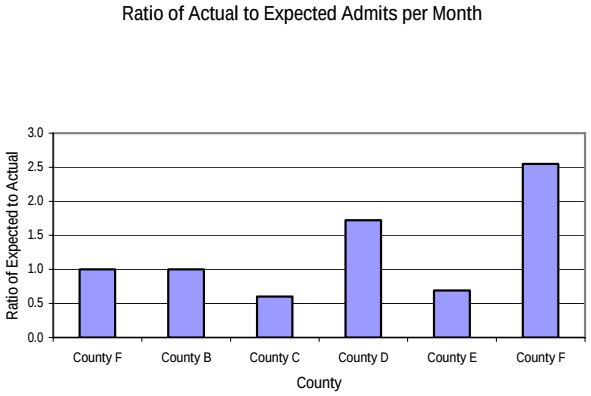
[3] Overall, 37% of the clients had an Axis III condition noted by staff on the Intake form. Two-thirds of these had one medical condition listed, 18.5% had two, 14% had three and 1% had four.

We used a number of ways of assessing admission rates since there is no evidence-based standard for what is optimal. We calculated the number of admissions into the Tracking Study per month for each of the five study counties and divided this by two figures, the total adult population in the county and the total adult population under 200% of poverty. In terms of rates per overall population County C and County E are two to three times the rates of County B and County D; these differences are even greater when compared to population under 200% of poverty.

IMD Admissions to Tracking Study Compared to Population by County

	County F	County A	County B	County C	County D	County E
Tracking Study						
Admits per month/adult pop	6	8	4	11	5	13
Admits per month/adults < 200% poverty	14	20	12	47	16	86

To obtain another measure of "relative need/resources" which might explain some of the differences we utilized the recently developed relative county index which will be used to distribute the Community Services and Supports funding under the MHSA. We used County A as the index county since it was in the middle of the five counties on the two rates using population. We calculated an "expected" number of admissions to IMDs per month (compared to County A) based on the "relative need/resource" index and compared that to the actual admissions per month from the Tracking Study. On this measure (with County A automatically having a value of one with expected equal to actual) County C was over 1 ½ times and County E over 2 ½ times its expected with County B, and County D almost half expected. Again – these figures are used merely to illustrate the differences among the counties without any indication of which may be the most appropriate level.



Civil commitment rates are consistent with the above, with County A and County D having relatively low and OR and SC relatively high rates.

In the Preliminary Report we noted our growing awareness of the critical interplay between IMD/SH utilization and the civil commitment philosophy and process at the county level and indicated that we would pursue this issue in our case studies. The table below shows the number of temporary and permanent conservatorships in relationship to the number of SSI disability clients in the five counties, and shows the same patterns as the IMD/SH admissions.

Rates of Conservatorship Use Per Disability SSI Recipients by County[4]

	County F	County A	County B	County C	County D	County E
Temporary Conservatorships/SSI Recipients	0	0	0.8	2.6	0.3	1.5
Permanent Conservatorships/SSI Recipients	1.3	0.3	2.3	4.8	0.7	4.3

The data about the civil commitment status of clients in the Tracking Study adds other information to the picture. The table below shows the percentage of each county's Tracking Study clients with a particular civil commitment status at entry into the IMD. For example, 41% of County A's 29 clients (12 clients) were on a 180-day dangerousness certification, 55% (16 clients) were on conservatorship, and 3% (one client) was on a temporary conservatorship. The "Total" column is simply the sum of all the clients in the Tracking Study for whom we have this information (305 clients).[5]

Civil Commitment Status at Time of Admit to IMD by County[6]

	County A (N=29)	County B (N=132)	County C (N=59)	County D (N=29)	County E (N=56)	Total (N=305)
180 Day Dangerousness	41%	0	5%	0	0	5%
Conservatorship	55%	80%	17%	55%	70%	61%
T-Con	3%	20%	76%	45%	30%	33%
Voluntary	0	0	2%	0	0	<1%
	100%	100%	100%	100%	100%	100%

[4] Conservatorship figures for FY 99-00 from state DMH, Statistics and Data Analysis Section. Number of SSI Disability Recipients for September 2002 from CDSS, Research and Development Division.
[5] The Total column does not have a precise meaning. It does not reflect any statewide figures. Because the samples for each county were not drawn to be proportionally representative of the total cases from the study counties the figure is not strictly representative of the totals for these counties.
[6] A 30-day extension for Grave Disability was not used by any of the case study counties.

- County A stands out as the only county to use the 180-day certification for dangerousness which is initiated by the acute hospital unit. A psychiatrist in the Department of Mental Health screens clients who then have the right to all LPS procedures and protections, including filing a writ to request a court hearing. A recent (within last week) documented instance of hurting some one or threatening someone is required for the psychiatrist to consider the recommendation of a 180-day dangerousness certification. A separate program has been instituted to serve these clients in the IMD.

- The high percentage of clients on T-cons when admitted to the IMDs in County C results from a current Public Defender policy of aggressively challenging the establishment of permanent conservatorships.[7] As a consequence there is a significant (at least three month) wait for jury trials with a resulting extension of the time during which clients are on T-cons.

- The high percentage of permanent conservatorships in County B results from a policy which essentially requires such a status prior to admittance to an IMD. The courts will not accept the testimony of the IMD physicians in the conservatorship proceedings and so clients must remain in acute units on T-cons until a permanent conservatorship has been established.

Data from the Tracking Study shows not only the interrelationships between IMD admissions and LPS policies and procedures but also the impacts and consequences of these on acute care lengths of stay (LOS).

The table below shows the mean, median and categories of days for the acute care LOS for clients who were admitted to an IMD.

LOS Mean, Median and Percent in LOS Categories in Acute Facilities by County

	County A (N=20/25)	County B (N=53/93)	County C (N=58/58)	County D (N=9/26)	County E (N=47/56)	Total (N=187/259)
Mean (days)	26	80	41	18	16	43
Median (days)	25	72	38	18	11	31
<2 weeks	5%	0	3%	44%	64%	20%
2-4 weeks	65%	11%	22%	44%	28%	26%
4-6 weeks	20%	8%	41%	11%	6%	19%
6-8 weeks	10%	13%	14%	0	0	9%
8-10 weeks	0	13%	10%	0	0	7%
>10 weeks	0	54%	8%	0	2%	19%
	100%	100%	100%	100%	100%	100%

[7] County C Site Visit Report, Appendix B, page 6.

- County B stands out with average acute lengths of stay prior to IMD placement which much longer than the other counties in part because of the lower level of IMD beds available and because of the requirements for the establishment of a permanent conservatorship before entry into an IMD.

- Almost all the admissions to IMDs in County E (86%) came from the county hospital which has increased its efforts to reduce Administrative Days and is thus attempting to move clients through the acute system more quickly.

- In County C, clients back-up in the private acute hospitals, which are the primary referral source for clients into the in-county IMDs which serve as short-term stabilization units for the county.

- County D and County A appear to process their clients through the acute system within 4 to 6 weeks.

Usage is also affected by the orientation of the county's leadership about the use of IMD/SH resources.

As noted in the Introduction, because of constrained resources all counties have been forced to examine the role of IMD/SH care because of its high cost. These budgetary pressures have been the primary influence leading to initiatives to control utilization. The two low usage counties (County A and County D) have also had strong clinical support for the closer scrutiny of IMD/SH usage. This confluence of cost and clinical concerns appears to lead to a more integrated system-wide approach to the question of appropriate usage of IMD/SHs. But it should be noted that obtaining a consensus among all the relevant participants did not come easily in either county; both struggled over time to get everyone on the same page. Two other counties (B and E) appear to control usage through departmental direction and the budgeting of fewer beds.

- County A: The impetus for stricter control of access to IMD beds came from a very active patient right's unit, which, in pursuit of concerns about the quality of care in IMD/SHs, began over a decade ago to question the standards for grave disability for conservatorship determinations. The consequence has been a system-wide restrictive view about conservatorship and IMD/SH placements. While the mental health LTC unit has the final say on IMD admissions, an interdisciplinary team (IDT) (with membership from the acute unit, the appropriate adult SOC rehabilitation team, family members, the conservator's office, and the patient rights advocate) considers clients referred for IMD placement. These IDT meetings have evolved from a contentious bickering to a relatively smooth process in which all parties

are in general agreement about standards for placement in an IMD. The use of standardized forms has helped the process run more smoothly. However concerns have been expressed by some families that conservatorships are too hard to get when families think they are needed.

- County D: The impetus for strict control in County D comes from the adoption of a strong underlying philosophical commitment to place clients in locked facilities only as a last resort; this commitment was made within an overall implementation of a recovery orientation actively pursued by the LTC unit. Admission to an IMD occurs only after a face-to-face interview with a member of the LTC team. They ask clients where they want to go and try to accommodate those requests. They are comfortable with supporting placements in the community even if the placement might "fail".

- County B: The combination of the requirement that clients already be on conservatorship before they enter an IMD and the shortage of available beds results in acute hospital stays in this county which are exceedingly long with a large proportion of administrative days. This leads the hospitals to discharge many clients that might otherwise have entered an IMD. County B maintains tight control over all its IMD/SH resources, tracking census on a daily basis.

- County E: In 2000, when County E began its efforts to reduce its IMD usage it transferred the control over IMD admissions from the county hospital to a centralized unit located within MH which was given strong direction and support from the new department director and the deputy director. Prior to this shift as many as one-quarter of the clients in the acute setting were referred for IMD admission. The morale of the centralized unit is clearly enhanced by having the back-up and first-hand involvement of top DMH management.

- County C: The centralized unit in County C basically processes paperwork. While there is a dedicated staff in this county's centralized unit they do not take an active role in controlling access to IMDs. Most of their IMD admissions come from the private hospitals in the community who make referrals to the unit. After a paper review of the case the unit transfers the paperwork to an IMD to pursue the admission process. Additionally, some clients are admitted directly to the IMD at one of the contract facilities from the acute-level care provided in another part of that facility, with notice being provided to the centralized unit of the admission. There has been no pressure from the top management to alter the level of admissions to IMDs.

MCAS scores differ somewhat by county, although the implications of this are not always clear.

The table below indicates the mean and median MCAS scores on each client at intake to the IMD as well as the percentages in the high, medium, and low categories utilized by the test originators.

MCAS Scores at Intake by County

	County A (N=30)	County B (N=130)	County C (N=57)	County D (N=29)	County E (N=25)	Total (N=271)
Low	43%	26%	68%	72%	16%	41%
Medium	57%	58%	25%	28%	60%	48%
High	0	15%	7%	0	24%	11%
Mean	47	53	45	42	56	50
Median	49	53	43	43	58	50

These scores are generally consistent with what we would predict

- County D, with the tightest standard, has the lowest MCAS scores.
- County E, while trying to reduce its level of IMD usage still has a relatively high proportion of admissions so that higher MCAS scores should not be surprising.
- County B has relatively higher MCAS scores because the MCAS is filled out at the time of admission to the IMD after the client has had a fairly long time period in an acute care setting within which to stabilize and improve.

The relatively lower MCAS scores for County C remain somewhat of a mystery given their generally higher IMD admission rates and moderately long lengths of stay in acute facilities. This might relate to the lack of a county hospital in this county.

Care and Monitoring During Stay in an IMD

Information for this section comes from a variety of sources.

As part of the Study we explored the quality of care in the IMDs, but a formal assessment of the quality of care in IMD/SHs was not a formal part of the Study design. The information provided below was collected to better help us understand the overall picture of IMD care and is not meant to be a definitive quality review.

As noted in the Study methodology, we gathered information about the actual and perceived quality of care in IMDs from the following sources:

- IMD site visits by the psychiatrist member of the Study Team to nine IMDs. These visits and chart reviews provide information about the overall policies of the facilities, including their orientation to recovery principles; medication practices; treatment and discharge planning; and some sense of family involvement and cultural competence.

- A form was completed on clients in the Long-Stay Study which asked about treatment plan goals, medications, reasons for continued stay, and expected disposition.

- Interviews with county staff included questions about the strengths and weaknesses of the various IMDs used by the county and about their monitoring and quality improvement efforts.

OVERALL FINDINGS

Concepts of recovery and rehabilitation are only in the verbal stage – not yet understood or integrated into IMD treatment programs.

In the site visits, the administrator of the IMDs would often articulate recovery principles or even point to recovery principles in policies and procedures, but the tours, discussions with staff and review of charts showed little evidence of implementation of these principles. In some facilities, staff showed no awareness of recovery principles.

In most facilities treatment goals were listed and showed signs of being reviewed on some periodic basis. Even when the goals were concrete and specific they rarely related to discharge issues or capacities for living in the community. There were no instances of goals stated in the client's terms and while a few programs noted staff responsibilities in relationship to the goals, only a few showed corresponding client responsibilities. Here are some comments of the reviewer about different facilities:

- The program as presented was quite comprehensive and excellent. We were assured that recovery principles were in place ….There was no evidence of recovery principles in any chart.

- They do not see themselves discussing recovery principles with clients because they are "too acute."

- Treatment plans were current, specific, and had goals for the clients, but did not address the clients' goals. They were not oriented to community living or barriers to discharge and did not list specific responsibilities.

- The staff of this facility had no idea what recovery principles might be. They were more oriented to nursing home operations than psychiatric care…. Questions on recovery or even cultural competence brought about blank stares.

- Charting in nearly all facilities is more related to licensing requirements than client needs and differences. With the exception of medication prescribed and doctors notes, charts tell little about the care that the client receives.

The treatment goals recorded for the clients in the Long-Stay Study were largely generic and indicated virtually no client input.

The point-in-time assessment of clients in the Long-Stay Study included the listing of the current treatment goals for the clients. We grouped the goals into general categories with behavior management, treatment compliance, and symptom management encompassing the highest percentages.

Goals (N=180)

Category	Examples	Percent
Behavior management	Reduce assaults, reduce verbal abuse, recognize aggressive feelings prior to assault, improve impulse control, communicate needs in a constructive manner without yelling, stop harassing behavior	23%
Compliance with treatment	Attend more groups, improve meds compliance, cooperate with current treatment plan, co-operate with ward routine, attend all assigned groups for 90 days, attend Latino group to increase socialization, attend music group 2X month to decrease agitation, attend anger management group at least 1X month	19%
Symptom management	Reduce hallucinations, reduce paranoia, develop symptom management, decrease nonfactual statements, utilize more effective coping tools to deal with psychotic symptoms, seek out staff 3X week to express paranoid ideas, mood instability, depression	18%
Activities of Daily Livings (ADL)	Improved hygiene, perform ADLs daily, compliance with toileting program, shower once a week, noncompliant with ADLs,	7%
Court issues	Attain trial competence, resolve Murphy conservatorship, verbalize understanding of court process,	7%
Social behavior	Reduce isolation, verbalize in a socially appropriate manner, improve communication, interact with staff and peers without being verbally aggressive, social skills	6%
Mood issues	Mood instability, depression, reduce agitation	6%
Discharge planning	Stabilize and discharge to lower level of care, discharge planning, decrease client's anxiety about discharge, be willing to discuss discharge with staff, place at lower level of care	4%
Health issues	Stable blood pressure, weight gain, nutritional status, reduce visual impairment	3%
Skills or strengths	Low self-esteem, skill management, increase attention span, develop relapse prevention plan for SA	3%
Stability	Be medically and psychiatrically stable, maintain client's current stability,	2%
Judgment and safety	Judgment and safety	1%
		100%

What is most striking about virtually all the goals is that they are generic and flow from a traditional medical model orientation. Only 3% of the goals could be classified (even liberally) as relating to skills or strengths building. And not a single goal appeared to be in the client's wording or reflected anything that was specific to a particular client.

The original intent of the required 27-hours of treatment for Specialized Treatment Program (STP) certification may not be consistent with current treatment approaches.

The state originally instituted the 27-hours of programming requirement for IMDs in order to ensure that clients received active treatment. In reality, the hours requirement is generally filled with very generic group activity, which can be tedious for and irrelevant to many clients. The goal often becomes to get clients to attend the groups rather than having the groups be attractive to the clients and getting the clients to develop and implement an individual recovery plan.

The medication practices were highly variable among the facilities, with the biggest deficits in those facilities without full-time psychiatric coverage.

The Study Team psychiatrist ranked the medication practices of the facilities based on the chart reviews from one to five with one being the best. The table below indicates the rating for each facility along with the number of psychiatrists who are on-site at the facility, a rough approximation of total psychiatric time provided on site and the nature of the relationship among the psychiatrist, the county and the facility. The psychiatrists bill Medi-Cal separately in almost all situations in addition to their other financial arrangements with some counties and/or the facilities.

Facility	# of Beds	Medication Practices Rating*	Number of Psychiatrists	Hours of On-Site Psychiatrist Time per Week	Relationship to County and/or Facility
1	84	3.1	3.5	140	Contract with county
2	65	3.5	2	16	Facility selected, Medi-Cal only
3	46	2	2	80	County Employees
4	170	2.7	2	30	Stipend +Medi-Cal Other employment is with County
5	120	3.9, 3.2**	3	6-9	Stipend from facility& Medi-Cal
6	95	3.6, 3.5**	3	11	Medi-Cal only +$300/Conserv. hearing
7	120	3.4	2	16	Medi-Cal, some counties pay for non Medi-Cal clients
8	74	3.6	3	1-2	Medi-Cal only
9	64	3.9		8	Stipend from facility + Medi-Cal

* Lower ratings indicate better practices

* *Client charts for two different counties were rated within the same facility.

A most striking feature is the wide variation in the number of hours of on-site psychiatrist time. Those with the largest number of hours and the closest relationship to the county have generally higher ratings by the Study Team psychiatrist.

While inappropriate polypharmacy[8] was not too frequent, appropriate assertive medication management was not often evident.

While medication practices were not the most sophisticated, they were better than expected in the majority of the facilities. With some exceptions, and a good deal of variation among psychiatrists, polypharmacy was less than expected. This seems to be the result of assertive efforts on the part of counties, especially County E and County B.

On the other hand, when clients don't improve, doctors are slow to make changes and seek a better drug regimen. This is likely due to the separation of the psychiatrists from the treatment programs and the fact that they carry large numbers of clients, often in multiple facilities. Facilities seemed reluctant to push psychiatrists about their prescribing practices. Those psychiatrists who did respond to counties' prohibition of polypharmacy did not necessarily become better psychopharmacologists. They used less different drugs, but did not practice aggressively, changing medications when needed, pushing doses to maximum effectiveness and justifying the use of multiple drugs when indicated for clients who were not showing signs of improvement. Clozaril[9] was available as an option and prescribed in most of the IMDs.

Many clients' charts in the Long-Stay Study lacked information about the client's medication history.

The survey forms on the long-stay clients asked about medication practices. Roughly one-quarter of the clients were reported to have a medication change over the last year, mostly in the area of neuroleptics.

The survey asked whether the clients had had a trial on Clozaril. Overall, one-quarter had. Of most concern was the fact that in almost half (48%) of the cases the person completing the form (either county or facility staff) did not know. The routine practice of "thinning" charts[10] on clients appears to lead to the loss of information which is vital to the planning of care for these clients.

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[8] The use of multiple drugs of the same type; usually such combinations cause excessive sedation and more side effects with little therapeutic advantage. Such practice can be justified for some individuals who do not respond to standard regimens.

[9] The first and probably the most effective of the new neuroleptics, but a second line drug due to its potentially lethal side effect of agranulocytosis wherein the body stops producing white blood cells. Careful monitoring with frequent blood draws are troublesome for both clients and treating personnel

[10] Facilities periodically remove older sections of the charts and place these in storage in order to keep the size of the charts kept in the facilities more manageable.

The facilities show a general awareness of cultural issues but little attention to the impact of culture for individual clients.

Virtually all the facilities had Spanish-speaking staff on all shifts and many reported either Vietnamese or Filipino staff on at least day and evening shifts. Many celebrated ethnic holidays and had policies about cultural competence.

There was more variation in the use of formal cultural competence trainings with some reporting annual trainings for all staff and some no formal training. About half indicated that at least some of their staff had received formal cultural competence training in the last six months. There was not evidence in the chart reviews, however, of any specific treatment goals or issues relative to a client's culture.

Family involvement was limited in most facilities.

At least two of the facilities hold weekly group meetings for family members. And some indicated that they invited family members to treatment planning and discharge planning meetings if the clients so requested. The facilities noted, however, that most clients had no current involvement with family members.

Some of the facilities described challenges with some family members who were private conservators. They believed that these private conservators were fearful of community placement and were sometimes too protective of their family member in their concerns for their safety and well-being.

Overall, 14% of the clients were transferred at some point during their IMD/SH stay.

Overall, there were 66 transfers for these 45 clients. The highest proportion of the transfers (60.6%) was back to an acute care facility from the IMD. The predominant reasons for the transfers were aggressive/assaultive/threatening behavior or self injury/suicidal ideation. Here are some examples given by staff on the transfer forms.

- Threatening to kill everyone, threw tables at staff, broke nurses' station plexiglass
- Client became aggressive toward peers/staff. Unable to control on unit. Refusing lab work.
- Became severely paranoid, verbally threatening, punching in the air, karate kicks, required seclusion/restraints - too violent for facility
- Swallowed tacks, unstable behavior, needs further stabilization
- Assaultive, unpredictable behavior, refuses meds, delusional, punched wall
- Self-mutilation, swallowed glass

Additionally, 7.6% of the transfers were to a medical hospital. There was one pregnant client who was sent to the hospital to deliver, one with AIDS, and three for diagnostic purposes when the client showed slurred speech, unsteady gait, and confusion.

DIFFERENCES AMONG COUNTIES

While all the counties do some on-site monitoring of clients when placed in an IMD, the intensity and focus varies.

The frequency and intensity of the on-site monitoring varies by county depending on the degree of staffing, the location of the IMDs, and the general philosophy of the counties.

- The case managers in County A with a relatively low caseload of 30 see clients in IMDs at least monthly and hold standard reviews quarterly. The major County A facility indicates that county staff are on site almost daily.
- With similarly sized case loads in County E (down from 80 clients/case manager) there are monthly meetings with the IMDs at which clients' progress is tracked. The unit holds a weekly review of all its IMD cases.
- In County D, a LTC unit staff person sees clients weekly and attends IMD team treatment meetings.
- The situation is mixed in County C depending on the facility. Clients in the in-county facilities are actively monitored. Monitoring of clients in out-of-county IMDs is less frequent with at best weekly phone calls and monthly on-site visits to IMDs in near-by counties.
- The five LTC liaisons in County B work closely with the IMD treatment team. The IMDs complete a Multnomah Community Activity Scale (MCAS) on each client quarterly. The county selects roughly 20% of the clients with the highest MCAS scores (a high score means higher functioning) for quarterly reviews and possible discharge.
- In County F, county staff used to visit clients in the IMDs every three to six months in the past. Now they are unable to visit regularly due to lack of staff. Sometimes case managers visit their clients who are placed in IMDs that are not too far away. Conservators try to see their clients. Telephone communication is more frequent. They try to get quarterly reports from the facilities, but it generally takes a reminder.

In addition to ongoing monitoring, some counties have initiated quality improvement efforts.

County B has established the most extensive formal quality improvement initiative. Several years ago, the county began looking at facilities on an informal basis and noted several areas where they thought quality was deficient, including psychiatric care, incident reporting, nursing care and discharge planning. They instituted quality of care surveys done by nursing staff which review each of these areas. Last year the review process was expanded to include the nurse surveyors sitting in on five groups in each facility. Survey results are reviewed with the facility liaisons and the providers. Training is provided to ameliorate any deficiencies. If quality does not improve, a plan of correction is developed with the provider.

County E is another county that has taken a more aggressive posture recently with its IMDs. Staff felt that two of the three major facilities they use have done very well, in part as a result of an increased county mental health staff presence and clarification of expectations. Prior to the concerted effort to work with IMDs, the MH Department did not have much of a relationship with these facilities. Now they are working together on values clarification and working on medication monitoring guidelines. All of the facilities come to monthly meetings in which they talk about care for clients.

Three of the counties – County F, County C, and County E - had substantially higher rates of client transfers then the others.

The table below shows the number of clients who were transferred by county. In addition, five of County F's 10 clients in the Tracking Study were transferred during the Study.

Number of Transfers	County A (N=30)	County B (N=135)	County C (N=60)	County D (N=29)	County E (N=60)	Total (N=314
1 Transfer	2	4	15	2	7	30
>1 Transfer	1	1	3	1	9	15
Total Number Transferred	3	5	18	3	16	45
Total Percent Transferred	10%	3.7%	30%	10.3%	26.7%	14.3%

The reasons why the three counties have higher than average transfers are in some cases fairly clear while in others less clear.

- **County E:** This county had the most total transfers (30) which represents 47% of all the transfers for the total Study sample. All but one of these were transfers back to an acute psychiatric hospital unit. It is unclear from the data whether this results from differences in the

patient population[11] or IMDs which are simply less able and/or willing to continue to serve clients who exhibit challenging behaviors.

- **County C:** By contrast, County C which had 21 transfers (32% of all the transfers) had a variety of movements among IMDs, reflective of the way in which they have organized their system. Clients go first to the short-term in-county facility and if not discharged from there, usually with a short length of stay[12], will be transferred to other longer-term out-of-county IMDs (4) or to another IMD/MHRC which is considered a lower level-of-care in their system (8). Only five of the transfers were back to acute.
- **County F:** County F county staff noted during the site visit that the IMDs seemed to be requiring readmissions to the county Psychiatric Health Facility (PHF) for conditions which they believed the IMDs should be able to manage. Two clients were transferred twice to the PHF. The length of stay at the PHF before return to an IMD ranged from one client staying just overnight but most staying 2-3 weeks. Most of the returns were to the same IMD, but there was an occasional return to a different IMD. The fact that the IMDs are out-of-county limits the ability of the County F staff to assess the immediate need for a transfer.

Discharge and Transition to Community Placement

OVERALL FINDINGS

About half of the clients in the Tracking Study had a planned discharge to the community during the study period with an average length of stay of about 6 months.

Overall, 54% of the clients had a planned discharge during the course of the Tracking Study. The mean length of stay was 5.8 months and the median 5.3 months. Another 10% of the clients had an unplanned discharge and 36% were still in the IMD/SH at the end of the Study period.[13]

[11] County E had by far the shortest length of stay in acute care (mean of 16 days and 64% discharged within two weeks). It is possible that the greater need for acute care results from clients being less stabilized at the time of admission to the IMD. This interpretation, however, is called into question by the functional status scores of County E clients at admission – which were generally higher than average and the percentage with violence to self or others which were lower than average.

[12] The average length of stay for clients discharged from the short term facility was 3.7months with a median of 2.8 months.

[13] The length of time of the study period varied by county depending on how long it took them to enroll the agreed upon number of clients into the Tracking Study. The following shows the mean and median lengths of time for the clients remaining in the IMD/SH at the end of the Study.

Length of Time (in months) Between Enrollment and Final Status for Clients Still in IMD/SH

	County A *(N=8)*	***County B*** *(N=65)*	***County C*** *(N=15)*	***County D*** *(N=7)*	***County E*** *(N=18)*	**Total** (N=113)
Mean	***10.8***	***10.9***	***13.1***	***12.8***	***13.2***	**11.3**
Median	***10.5***	***11.3***	***12.4***	***13.2***	***13.1***	**11.7**

Clients with a planned discharge showed significant gains in functional status since admission to the IMD/SH.

The table below shows the differences in the MCAS scores of the 126 clients on whom we have an MCAS score at the time of intake and at the time of the planned discharge.

MCAS Scores at Intake and at Time of Planned Discharge (N=126)

	Initial MCAS	MCAS at Discharge
Mean	51	61
Median	50	62
High	14%	48%
Medium	48%	43%
Low	37%	9%
	100%	100%

About one-third of the clients with a planned discharge were not expected to do well or to do “just OK” in the community.

Staff were asked to rate how well they thought the client would do when discharged into the community: 16% said “not very well” and another 20% said “just OK.” The GAF and MCAS scores for those rated as expected to not do very well are significantly lower than for the rest of the discharged clients. (See Table in Appendix C).

For those they rated as doing not very well or just OK, they were asked to indicate what they thought the obstacles were to not doing better. The table below shows those reasons sorted into 9 categories for the 39 clients so rated. Unwillingness to participate with prescribed treatments is the most frequently cited reason followed by the presence of psychotic symptoms or problematic Axis II behaviors. (See Appendix C for some staff comments about these clients.)

Obstacles for Those Expected to Do "Not very well" or "Just OK" (N=39)

Obstacles to Doing Well in the Community	Number	%
Noncompliant with medications/refuses follow-up treatment	17	44%
Presence of psychotic symptoms or Axis II behaviors	14	36%
Substance abuse	7	18%
No or minimal social support	6	15%
Issues with family or private conservator	6	15%
Likely to decompensate without structured environment	3	8%
Behaviors more than board/cares able to cope with	3	8%
No appropriate treatment available	2	5%
Unable to care for self	1	3%

Percentages add to greater than 100% because more than one item was cited for some clients.

Ten percent of the clients had an unplanned discharge during the course of the Study.

The most frequent reason for an unplanned discharge is the client's going Absent Without Leave (AWOL); this represents 32% of the unplanned discharges. The second most frequent reason is the client's leaving the facility after the conservatorship is dropped or as a result of a writ hearing.

Reasons for Unplanned Discharges

Reasons for Unplanned Discharge	Number	%
AWOL	10	32%
Involuntary status (usually conservatorship) removed and client left	9	29%
Taken to jail after assault or discovered that a warrant out	5	16%
Family-related, e.g. parent is conservator and took client out Against Medical Advice (AMA)	3	10%
Transferred to medical or psychiatric acute and whereabouts unknown thereafter	3	10%
Other	1	3%
TOTAL	31	100%

DIFFERENCES BY COUNTY

County B and County F had significantly lower percentages of clients with a planned discharge than the other counties.

While the overall rate of planned discharge during the Study was 48%, this was skewed by County B with planned discharges for only 38% while the other four counties were close to two-thirds. County F discharged only two of the ten clients in the Tracking Study.

Percentage Discharged By County

	County A (N=30)	County B (N=136)	County C (N=60)	County D (N=29)	County E (N=60)	Total (N=315)
Planned Discharge	70%	38%	65%	66%	63%	54%
Unplanned Discharge	3%	14%	10%	10%	7%	10%
Not Discharged	27%	48%	25%	24%	30%	36%

County B was also an outlier in terms of ALOS before planned discharge with an average of 8 months compared to 4-5 months for the other counties.

At least 80% of the clients in County A and County C counties and 71% of the clients in County E were discharged within six months while in County B this figure was only 22%.

Lengths of Stay for Clients With a Planned Discharged (N=169)

	County A (N=21)	County B (N=52)	County C (N=39)	County D (N=19)	County E (N=38)	Total (N=169)
Mean	4.8	8.3	4.2	5.1	4.8	5.8
Median	4.8	8.2	3.0	4.6	4.2	5.3
< 3 months	24%	8%	49%	21%	21%	24%
3-6 months	57%	13.5%	33%	37%	50%	34%
6-9 months	14%	34.5%	13%	26%	24%	24%
>9 months	5%	44%	5%	16%	5	18%
	100%	100%	100%	100%	100%	100%

Functional status scores on the MCAS were roughly comparable at time of planned discharge except for County D which had lower scores.

The lower MCAS scores at discharge in County D reflects their overall orientation to the use of locked care only as a temporary measure with discharge as soon as possible.

MCAS at Time of Planned Discharge by County

	County A (N=18)	County B (N=36)	County C (N=37)	County D (N=17)	County E (N=30)	Total (N=138)
Mean	64.5	64.3	59.0	48.6	62.1	60.7
Median	65	65	60	47	63	62
High	72%	69%	35%	6%	53%	48%
Medium	28%	31%	57%	47%	43%	42%
Low	0	0	8%	47%	3%	10%
	100%	100%	100%	100%	100%	100%

The discharge living situation and the presence of intensive case management reflect the varying strategies of the counties towards "step-down" services.

Interviewees generally expressed the belief that for most clients the move from the highly structured IMD situation to an unstructured community living situation is too great a shift, creating a higher potential for difficulties than is desirable. Counties try to address this discontinuity in the intensity of services by one of two approaches: non-locked residential settings with staffing greater than is present in a regular B/C or Assertive Community Treatment (ACT)-like intensive case management programs with caseloads of less than 15.

There were significant differences among the counties in the living situations to which clients were discharged. Roughly two-thirds of the clients in County B and in County D were discharged to a B/C facility. County E, on the other hand, discharged roughly three-quarters of its clients to a residential program. County A split its discharges between a residential program and B/C facilities. County C stands out with the largest percentage (42%) of its discharges to living arrangements with family members.

Living Situation for Clients with a Planned Discharge by County

	County A (N=20)	County B (N=36)	County C (N=38)	County D (N=19)	County E (N=37)	Total (N=150)
Residential Program[14]	40%	14%	16 %	5%	70%	31%
Board and Care	45%	64%	24%	68%	11%	39%
SRO or Room/Board	0	0	16%	0	0	4%
Family	10%	19%	42%	11%	5%	19%
Independent or Supported Housing	5%	0	3%	16%	3%	4%
SNF or Medical Hospital	0	3%	0	0	11%	4%
	100%	100%	100%	100%	100%	100%

The alternative strategy of using intensive case management programs is most apparent in County D, which instituted an ACT-type program specifically to further reduce its IMD usage. County A and County B also use intensive case management. All County B discharges are now supposed to be placed with an ACT-type program. Neither County C nor County E used intensive case management as a step-down resource for clients discharged from IMDs.

Percentage with Case Managers By County

	County A (N=20)	County B (N=35)	County C (N=39)	County D (N=19)	County E (N=35)	Total (N=148)
Have a case manager	100%	80%	69%	63%	94%	81%
% of discharged with case manager with caseload 15 or less	35%	26%	0	58%	0	18%

[14] Residential facility was defined as a site with licensed staff.

Thus, County D and County B have one approach to step-down which is the use of intensive case management while County E is relying more on residential programs. (See the Case Study of County E in Appendix B for a description of the residential programs they have initiated.) County A appears to rely on both strategies with the use of residential programs and intensive case management. County C appears to not use either, and seems at the same time to have an unusually high percentage (40%) of discharges to the family.

In the Tracking Study, 7½% of the discharged clients were readmitted to an IMD during the remainder of the Study.

There were 15 clients who were re-admitted, 14 once and one twice. This is 7.5% of the 201 discharged clients. The average time to re-admission was 4 months, with a median of 2.8 months, but this data reflects only a partial story because the relatively short time frame for the whole Study limited the number of clients who were in the community for long periods after discharge. The figure below shows the percent of clients who were readmitted in each month using as the denominator the number of clients who had been in the community that number of months post discharge.

Clients with very low functional status scores and/or clients who staff are concerned about seem to have a higher likelihood of being readmitted.

There are no clear predictors of readmissions, but some interesting possibilities. There is some support for the hypothesis that those with lower functional scores at the time of discharge are more likely to be readmitted, but this appears to hold

largely for those with the very lowest scores. The staff's prediction at discharge about how well the client would do did seem to be related to whether or not the client was readmitted, but the relationship was not statistically significant.

A number of other characteristics of clients at discharge were not related to whether or not the clients were readmitted. These included their living situation, their civil commitment status, whether they had a representative payee, whether they had a case manager, or whether the discharge was planned or unplanned.

There are some differences among the counties in the readmission rates, but the small numbers and the lack of a long enough follow-up period makes interpretation of the differences too problematic. It would be useful to be able to continue follow-up on this cohort of clients since it represents a rich data source.

Clients who are discharged and not readmitted appear to at least maintain their status while in the community.

Most counties attempted to complete a community follow-up form on clients approximately 3 months after their discharge and again near the end of the study period. Not all counties were able to do this and not all clients could be located or, if located, not all clients were willing to provide information. For most of the items that follow there were 90 clients at the three-month follow-up and 60 at the final follow-up.

- **Living Situation.** The most common living situations at follow-up are residential programs, B/C, and family of origin. There is a promising trend towards an increase in independent and supported independent living over the intervening time period.

- **Income:** Roughly three-fourths of the clients were reliant on SSI as their primary source of income at both three-months and final follow-up. Significantly, by the final follow-up no clients were noted as having "no income", but only one was listed as having income from employment.

- **Conservatorship.** Somewhat more than half of the clients remain on conservatorship at the three-month and final follow-ups. There is also virtually no change over the intervening time period.

- **Criminal Justice Involvement:** At both the three-month and the final follow-up roughly 10-11% of the clients were reported to have some involvement with the criminal justice system. Of the total clients at follow-up 14.4% had reported involvement with criminal justice at either the three-month and/or the final follow-up.

- **Functional Status:** There was basically no change in GAF scores between discharge and follow-up. The median GAF score was 40 at discharge, three-month follow-up, and final follow-up. The average GAF at discharge for those with any follow-up GAF was 43.6 compared with an average three-month follow-up GAF of 42.4 and an average final follow-up GAF of 41.6.[15]

FACTORS INFLUENCING CONTINUED STAY IN AN IMD/SH

OVERALL FINDINGS

Functional status is clearly a factor for clients who remain in an IMD/SH.

Functional status scores are lower for clients in the Long-Stay Study and for the clients in the Tracking Study still in the IMD/SH at the end of the Study than for those discharged. The scores of the clients still in the IMD/SH are comparable to those for the Tracking Study clients at Intake into the IMD/SH (mean and median of 50).

MCAS Scores at Planned Discharge or Final Status for Tracking Study and for Long-Stay Clients

	Tracking Study: Planned Discharge	Tracking Study: Still in IMD/SH	Long-Stay Study
Number of clients	138	98	192
Mean	60.7	53.4	49.7
Median	62	53	49
High	48%	18%	8%
Medium	42%	49%	46%
Low	10%	33%	45%

[15] MCAS scores were collected on follow-up in selected counties, but we do not include the information since it is not comprehensive and because the knowledge of clients specific functioning was likely not very reliable at follow-up since staff were not in regular face-to-face contact with the clients.

Further, there is a relationship between expected disposition and MCAS scores for clients in the Tracking Study.

Staff were asked to indicate the expected time until discharge for clients still in the IMD/SH at the end of the Tracking Study. Most (71%) of the clients with a high MCAS score were expected to be discharged within the next three months, whereas over half (56%) of those with a low MCAS score were expected to stay at least another 9 months..

Expected Time Until Discharge by MCAS Score Categories

Expected time until discharge	High MCAS	Medium MCAS	Low MCAS
Less than 3 months	71%	24.5%	3%
3-6 months	12%	14.5%	13%
6-9 months	18%	39%	28%
9-12months	0	10%	28%
Over 1 year	0	12%	28%
	100%	100%	100%

Over half the Long-Stay clients had at least one of four serious conditions (homicidal, suicidal, violence toward self or others). The following table indicates the percentage of the long-stay clients who were noted as having each of the four conditions, followed in parentheses by the percentage who had exhibited the behavior within the last three months. Violence towards others was by far the most frequent of these conditions.

Current Condition for Clients in Long-Stay Study

Condition	% (N=193)
Suicidal	12% (4%)
Homicidal	9% (5%)
Violence-Self	14% (8%)
Violence-Others	48% (30%)
Any of four	56% (35%)

The percentage of organically impaired clients is about twice what it was for the Tracking Study clients.

Other Conditions of Clients in Long-Stay Study

Condition	%
Substance abuse (last 3 months)	25% (5%)
AWOL risk (last 3 months)	12% (2%)
Medication noncompliance	52%
Communicable disease and unpredictable behavior	6%
History of fire setting (last two years)	4% (0.5%)
Organically impaired	11%
Known history of abuse or trauma	12%

The reasons cited for why clients are still in the IMD/SH are generally similar for both those clients in the Tracking Study and in the Long-Stay Study.

Staff were asked to describe why the clients were still at this level of care. The answers for the long-stay group of clients were grouped into 17 different categories. The same categories were then used for the clients still in the IMD/SH at the end of the Tracking Study with the addition of four other categories. The top category for both groups was the continuation of psychotic symptoms. The next reasons for both groups were dangerous to others, impaired decision making and symptoms of mood disorders.

Differences between the groups existed with a couple of categories. Discharge issues, sexual issues, and being verbally abusive were more prominent with the long-stay clients while refusing or not participating in treatment and history of prior problems were more common with the Tracking Study group

Reasons Given for Why Clients Remain in IMD/SH for Long-Stay and Tracking Study Clients

Reason	Long-Stay	Tracking Study
Responses to internal stimuli, hallucinations, delusions, bizarre behavior	34%	39%
Dangerous to others, assault, throws things, threatens	29%	23%
Impaired decision making, no insight, poor judgment, safety issues without supervision	22%	26%
Mood disorder: depressed, agitated, labile	21%	24%
Discharge issues: client doesn't want to leave, family/conservator doesn't want discharge, no place will take client, no benefits, client decompensate when DC is planned	21%	5%
Needs assistance with ADLs, needs reminders to shower, poor hygiene,	14%	12%
Refuses treatment, no or spotty attendance at groups, tries to avoid medications	14%	22%
Sexual issues: inappropriate sexual behavior, inappropriate touching	12%	3%
Poor social adjustment: isolated, withdrawn, intrusive	11%	12%
Disorganized, disoriented, confused, need for supervision	10%	8%
Verbally abusive (without danger to others)	8%	0
Dangerous to self, self-injury, suicidal thoughts and expressions	7%	9%
Danger to community if discharged	5%	3%
Major ADL issues: incontinence, smearing feces, total inability to care for self	5%	0
Medical issues: dementia, seizures, end stage of illness, lymphoma, end stage renal failure	4%	2%
Current stealing	2%	1%
Criminal issues still not resolved	2%	0
Benefiting from treatment	0	3%
"Attempts to maintain whatever gains have been made from intensive treatment have limited success"	0	5%
Ready or almost ready for discharge	0	8%
History of assaults, AWOL, substance abuse, meds noncompliance	0	6%

Numbers do not total to 100% because more than one reason was cited for many clients.

Certain characteristics of long-stay clients are related to the reasons why staff say they are still in the IMD/SH.

The reasons for still being in the IMD/SH were further grouped into four major categories, as follows.

- **Dangerousness** which includes dangerous to others, sexual issues, danger to community, and criminal issues still not resolved
- **Safety** which includes dangerous to self, disorganized, impaired decision-making, the serious ADL issues, and current stealing
- **Grave disability** which includes responds to internal stimuli and needs assistance with ADLs
- **None** of the above categories.

Frequencies of these larger categories are as follows, with the percentage in parentheses indicating the percentage of clients for whom it was the only reason cited. The majority of clients had more than one general reason, and 20% had no reason that fit into any of the three major areas.

Major Categories of Reasons for Still in IMD/SH for Long-Stay Clients

Dangerous	45% (20%)
Safety	39% (12%)
Grave Disability	42% (15%)
None	20%

The following are the significant relationships.

- Dangerousness is clearly cited more frequently for males and those in a SH as opposed to an IMD. It is also related to age with its being more frequent with those under thirty and less frequent with those over 50.

- Safety is cited more frequently for females, for those over age 40, and for those in IMDs as opposed to the SH. It is inversely related to total MCAS scores with its being cited more often for those with lower MCAS scores. It is also directly related to the time a person has spent in an IMD/SH with its being cited for 8% of those with a LOS of fewer than 3 years and by 55% for those with a LOS over 8 years.

- Grave disability is cited more frequently for those in a SH vs. an IMD and not surprisingly is inversely related to MCAS scores with those scores over 56 having the lowest likelihood of having a grave disability reason for still being in the IMD/SH.

- Grave disability only (i.e. with no dangerousness or safety issues) is somewhat more frequent with females, and more frequent with older clients, particularly anyone over 65.

- Not having any of the three reasons cited is more frequent for those missing a diagnosis, those with an MCAS score over 56, and for those who have been there for shorter periods of time.

There are 20% of the clients in the Long-Stay Study who had none of the three major reasons for still being in an IMD/SH.

The most frequent reason (11% of total sample) cited for these clients was a discharge-related reason, e.g. client or conservator either refuses discharge or decompensate when discharge is discussed or there is no appropriate placement for the client in the discharge process.

About one-third of the clients in the Long-Stay Study are expected to remain in the IMD/SH for the foreseeable future.

There is a significant relationship between expected length to remain in the IMD/SH and MCAS scores. Seventy percent of those with high MCAS scores have an expected further stay of less than one year with only 14% expected not to be discharged at all. Only 28% of those with the lowest MCAS scores are expected to leave within a year with 45% expected not to be discharged at all.

Expected Length of Time in IMD/SH by MCAS Scores

	Low (N=86)	Medium (N=88)	High (N=14)	Total (N=188)
Less than 6 months	7%	15%	50%	14%
6 months to one year	21%	31%	20%	26%
One to two years	27%	29%	7%	27%
Likely to remain at this level of care forever	45%	25%	14%	33%
	100%	100%	100%	100%

There is also a significant relationship ($p<.001$) between the expected time to discharge with a “safety” reason for still being in the IMD/SH.

“Safety” Reason for Still Being in IMD/SH by Expected Time Until Discharge (N=189)

	Safety Reason	No Safety Reason
Less than 6 months	3%	21%
6 months to one year	21%	29%
One to two years	29%	25%
Likely to remain at this level of care forever	47%	25%
	100%	100%

One might expect that every alternative medication would have been tried with those clients with the worst prognosis- i.e. those not ever expected to be discharged to a lower level of care. In fact, these clients were more likely to have been tried on Clozaril (36%) than those with an expected discharge, but this is still only about one-third of these clients.

When a client has been in an IMD for over five years, staff expectation for a discharge is less than 50%

As shown in the table below, once someone has been in an IMD for more than five years the staff perspective of the chance of being discharged appears to be less than 50-50 (48% for those there from 5-8 years and 35% for those there more than 8 years). This relationship does not hold for clients in a SH, largely because as noted below we have considered a transfer to an IMD as a discharge.

Percent Expected to Be Discharged at Some Time By Length of Stay in IMD or SH

LOS in IMD or SH	IMD (N=114)	SH (N=70)	Total (N=184)
< 3 years	72%	100%	76%
3-5 years	67%	67%	67%
5-8 years	48%	64%	54%
Over 8 years	35%	74%	59%
Total	61.5%	73.6%	65%

Virtually all the SH discharges are to an IMD or Skilled Nursing Facility (SNF) level of care.

Staff were asked what the expected placement would be for those clients who they anticipated might be discharged at some point in the future. Seventy-five percent of the anticipated SH discharges were to an IMD and another 15% to a SNF. We do not know what percentage of these clients might be discharged to the community after the transfer to an IMD. So, if one is talking about a discharge to the community, the one-third figure of clients cited above could be higher.

Anticipated Discharge Placement by IMD/SH

	SH (N=53)	IMD (N=72)	Total (N=125)
IMD/Locked SNF	75%	18%	42%
Residential treatment	2%	18%	11%
Augmented board & care	2%	32%	19%
Regular board & care	0	23.5%	
Regular SNF	15%	5.5%	10%
Other	6%	3%	4%
	100%	100%	100%

For the IMDs, the most frequent anticipated discharge placement is augmented B/C (32%) followed by regular B/C (23.5%), residential treatment (18%), and other IMDs (18%).

DIFFERENCES AMONG COUNTIES

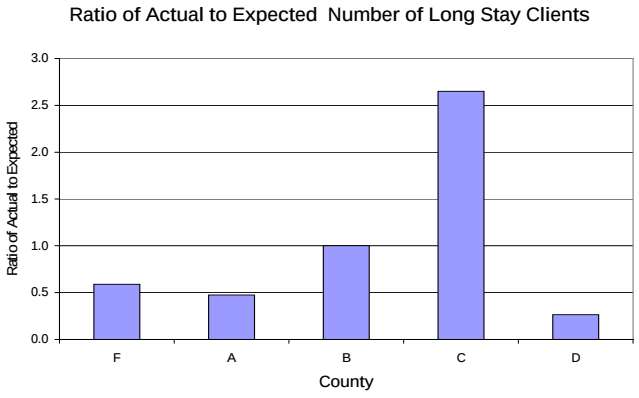
Counties C and E have relatively more clients who have been in IMD/SHs for over 18 months.

The table below shows the number of clients that each county had an IMD or SH with a length of stay over 18 months as of the Fall of 2004 divided by the number of adults in the county and then the number of adults under 200% of poverty. County A and County D had rates of long-stay clients that are at least four times lower.

Rates of Long-Stay Clients by Population and Poverty Population

	County F	County A	County B	County C	COUNTY D	County E
# of clients/adult pop	5.6	2.5	4.6	11.8	1.4	8.4
# of clients/adults < 200% poverty	14.3	6.5	13.1	49.1	4.2	53.3

The figure below shows the number of actual Long-Stay clients compared to an "expected" number based on the same "relative needs/resources" index used in the examination of admits into the Tracking Study. County B is used as the base county, therefore by definition having a ratio of one. Compared to County B, therefore, both County C and County E have over two times their expected number of long-stay clients while County F, County A, and County D have fewer than expected. It needs to be remembered that this does not imply anything about the correct number of long-stay clients – it merely reflects the relative number of long-stay clients in relationship to the county's mental health needs/resources compared to each other.



Over 40% of the long-stay clients in Counties F, C and E are not expected to ever go to a lower level of care.

There are major differences in the expectations about remaining lengths of stay by county. Clearly, County D expects to discharge these clients – about three-quarters within a year. For County C and County E, no discharge is expected for at least 40% of the clients. For County F, five of the seven clients in the Long-Stay Study were expected to remain at this level of care forever. While the numbers are obviously small, this is a considerably dimmer expected disposition than found with any of the other counties.[16]

Long-Stay Study Expectations about LOS

	County B (N=90)	County C (N=45)	County D (N=13)	County E (N=41)	Total (N=189)
Less than 6 months	17%	9%	38.5%	5%	14%
6 months to one year	32%	24.5%	38.5%	19%	26%
One to two years	22%	24.5%	15%	42%	26%
Likely to remain at this level of care forever	29%	42%	8%	44%	34%
	100%	100%	100%	100%	100%

PREDICTORS OF DISPOSITION IN TRACKING STUDY

The issue discussed in this section is whether one can predict the disposition of clients based on their characteristics at intake.

The relationships between client characteristics and disposition (planned discharge vs. continued stay) described above are all based on characteristics at the time of disposition. For example the MCAS scores of the clients when they were discharged were higher than for those clients who were still in the IMD/SH at the end of the Study.

The question here is whether there are any characteristics of the clients at the time of intake that predict whether or not they will be discharged during the course of the Study.

Two factors - age and civil commitment status – show relationships with disposition, but are difficult to interpret.

[16] County F also showed signs of increased expected lengths of stay in the Tracking Study. By the end of the Study 5 of six clients who had been in the IMD for six months already were expected to stay at least one more year.

The older the client is the less likely s/he will be discharged during the Study period. This could be a function directly of age; or of the older clients having a longer history and therefore more issues related to community placement (e.g. being known for destructive behaviors); or a lack of an older adult system of care; or other factors.

Disposition By Age (p<.04)

Age at Intake	N	Planned Discharge	Still in IMD/SH
<21	16	87.5%	12.5%
21-30	18	69%	31%
31-40	65	64.5%	35.5%
41-50	73	59%	41%
51-65	61	49%	51%
65+	6	33%	67%

Another factor which was different was the civil commitment status with those on temporary conservatorships more likely to be discharged. This could again be a function of those with more chronic situations already being on conservatorships or could be influenced by some temporary conservatorships being dropped with clients then leaving the IMD/SH against medical advice (AMA), of which there were some. In other words, it is difficult to know which causes which. This could also be related to the wide variability among counties in the use of temporary and permanent conservatorship.

Disposition by Civil Commitment Status (p<.001)

Civil Commitment Status at Intake	N	Planned Discharge	Still in IMD/SH
180-day	15	80%	20%
Conservatorship	1622	49%	51%
T-Con	90	79%	21%

Functional status scores are not predictive except perhaps for those with high scores.

There were no differences between the GAF score at intake and no more than a tendency with MCAS scores for those with the highest scores to be more likely to be discharged than those with medium and low scores.

Disposition by MCAS Categories (p<.11)

MCAS at Intake	N	Planned Discharge	Still in IMD/SH
High	27	78%	22%
Medium	119	58%	42%
Low	96	55%	45%

Variables that are NOT related to disposition are gender, ethnicity, living situation at time of initial placement, diagnosis, non-compliance with medications, and AWOL risk.

And surprisingly there are a few factors which appear to be predictive in what we might consider an opposite direction. Those with a recent history of being a danger to self or others or at risk of harm are more likely (p<03) to be discharged (66%) than those without such a condition (52%).

Functional status and current behavioral conditions at three months are predictive of subsequent disposition.

The situation changes when one looks at the predictors once clients have been in the IMD for at least 3 months. The tables below are the results of the forms filled out at approximately 3 months after the client entered the IMD/SH. It does not, therefore, include those that have already been discharged in those first three months. At this point functional status and current behavioral conditions are more predictive of whether or not the client will be discharged during the remainder of the Study period.

First are the set of conditions that the staff rated – whether the client had been homicidal, suicidal, a danger to self or others, or done things likely to harm self or others. The following were the relationships which were predictive of disposition.

Disposition by Condition in IMD/SH at Three Months (all p<.001)

Condition at Three Months in IMD/SH	N	Planned Discharge	Still in IMD/SH
Violence to Others			
Yes	32	25%	75%
No	250	64%	36%
Homicidal, suicidal, or violence to self or others			
Yes	45	31%	69%
No	237	65%	35%
Homicidal, suicidal, violence to self or others, or likely to harm self or others			
Yes	66	35%	65%
No	216	68%	32%

The differences between functional status at three months and eventual discharge is also clear and statistically significant.

Disposition by GAF at Three Months (p<.001)

GAF at Three Months	N	Planned Discharge	Still in IMD/SH
<20	16	19%	81%
21-25	35	26%	74%
26-30	57	44%	56%
31-35	42	57%	43%
>35	34	71%	29%

Disposition by MCAS at Three Months (p<.03)

MCAS at Three Months	N	Planned Discharge	Still in IMD/SH
High	19	79%	21%
Medium	74	57%	43%
Low	37	32%	68%
TOTAL	130	53%	47%

These findings imply that by the end of three months it is more predictable who will be able to be discharged by the end of a year's time and who will not.

FINDINGS AND RECOMMENDATIONS

This section of the report contains the major findings of the study. These are followed by recommendations and suggested actions for consideration by counties and the state in the continuing effort to better understand and achieve appropriate utilization of IMDs and State Hospitals.

FINDING 1: INDIVIDUALS WHO ARE PLACED IN IMD/SHS HAVE SIGNIFICANT CURRENT DISABLING ISSUES.

Overall, almost half of the clients in the Tracking Study had at least one of four serious conditions (homicidal, violent toward others, violent towards self, expressed suicidal intent) within thirty days prior to their admission. In addition, 29% were homeless prior to admission, substance abuse was a factor in triggering the episode leading to IMD placement for one-quarter of the individuals, and 23% had moderate or marked health impairment. Fifty-six percent of the clients in the Long-Stay Study had at least one of the four serious conditions and 35% had exhibited at least one of those four within the last three months. The Study confirms that counties use IMD placement for their clients who have the most serious issues and challenges. It is precisely because these clients are so vulnerable, and their illness is so serious that they deserve the system's best efforts to aid them in their recovery.

FINDING 2: COUNTIES THAT ADOPT COMPREHENSIVE COORDINATED EFFORTS ARE ABLE TO POSITIVELY AFFECT THEIR UTILIZATION OF IMD/SH RESOURCES.

Many county mental health departments feel pressure to reduce their level of IMD/SH usage for a variety of financial, regulatory, and clinical reasons. Whatever a county decides is an appropriate level of usage is for its particular circumstances, there are actions it can take to reach this optimal level.

2A: There is no "gold standard" for IMD/SH use.

This study did not result in a determination of the "correct" level of utilization of IMDs. IMDs serve an important role in providing structured placements when clients are no longer in need of hospitalization and are unable to live in the community due to resource issues or due to the clients' functional ability, medical conditions or safety. Some counties use these facilities for both short-term "stabilization" after an acute care stay and for clients whom they feel need a longer-term very structured treatment setting.

IMD/SH utilization rates consist of at least three components: rates of admission to IMD/SH, discharge rates, and lengths of stay. A county that wishes to examine its use rates must consider all three of these elements in order to understand how IMD/SH are being used. Without an appropriate standard of IMD utilization, comparisons among counties can be helpful in analyzing effective practices. Timely and accurate statewide data is necessary to do this. At this time, the statewide data that is available is not adequate.

2B: Initiative and leadership make change in use possible.

The initiative for change can come from multiple sources and occur for multiple reasons, but for there to be a change there needs to be a "champion" and there needs to be either initial or ultimate buy-in by the leadership of the mental health department.

The two counties with the lowest use rates trace system change back to a particular strongly-felt and pursued concern about the way in which the IMD/SH level of care was being used. In both, the impetus was a concern about clients' rights and the inappropriate use of restrictive settings. In one county the initiator was the Patient Rights unit and in the other the Mental Health Department. In both of these counties the concerns have been fully embraced by the leadership of the mental health departments.

In two other counties change is also underway. In one the initiation came from concerns (initially surfaced in newspaper articles) about the quality of care in IMDs. In the other, new department leadership undertook change in the LTC

system as a result of major budgetary shortfalls and a chronic service back-up in their Psychiatric Emergency Services (PES). Again, in both these counties, leaders within the Department of Mental Health have the issue of LTC high on their lists of priorities.

2C: A clinical/treatment vision that sees IMD/SH placement within a system that is dedicated to client-directed services and recovery facilitates change.

While the initial concern about IMD/SH usage may result from a clients' rights or budget constraints perspective, the existence of a consistent clinical/treatment philosophy which promotes a client-directed recovery system of care provides an invaluable support to the implementation of change. Under such an overall philosophy IMD/SHs become a placement of last resort and both community and IMD staff communicate to the client that the placement is temporary. While IMD/SH usage can be controlled by strictly administrative means – e.g. by simply insisting on not exceeding a set number of budgeted bed days –more effective control is achieved when the control is both clinical and administrative. Clinicians become allies when the treatment philosophy is congruent with the administrative goals.

2D: Effective supporting structures and processes are necessary to make changes.

Although all six counties in the Study had centralized[17] intake and monitoring functions, their effectiveness varied greatly. Factors that seem to influence effectiveness of a centralized process include having

- **Adequate staff t**o both (a) conduct a timely and thorough evaluation when a referral is made to ensure that there are no other alternatives that could avoid an IMD admission and (b) follow-through with regular and frequent on-site monitoring of clients while they are in IMD/SHs.
- **Skilled clinicians** who also have knowledge of the resources available in the community that might serve as alternatives and discharge placements.
- **Budgetary control** over the IMD/SH resources.
- **Presence of strong and visible support for the function from the top administrators** in the mental health program. The role of gatekeeper and monitor can be difficult without the support and encouragement of supervisors and managers.

Counties with IMDs located out-of-county have a more challenging job since on-site monitoring of clients becomes a more costly proposition, but in the long run is likely to be cost-effective as well as more effective clinically.

[17] By centralized we do not necessarily mean just one unit for a large county. What is intended is a centralized unit for some geographical area – which could be a region in a large county.

2E: Variations in county implementation of civil commitment procedures can greatly influence IMD/SHs usage.

Conservatorship policies and practices vary greatly from county to county. Where the conservatorship function is placed in county government, the nature of the relationship between the Public Guardian and the mental health program staff, and the philosophy of the courts and /or Public Guardian affect IMD utilization. PG policies and procedures affect acute hospital lengths of stay, movement out of IMDs, and clients' success in the community. Among the more substantial differences we noted in just the six counties we examined were:

- **Use of the 180-day dangerousness certification**
- **Whether a client can be in an IMD while on a temporary conservatorship**
- **Whether clients discharged from IMDs should remain on conservatorship while in the community**
- **How big a role conservators play in the monitoring of client's care in IMDs and doing discharge planning.**
- **How much influence public and/or private conservators exert in inhibiting discharge because of concerns for client's safety.**

Developing a consistent vision and supporting policies and procedures for the appropriate use of IMD/SHs cannot be attained in a county without working closely with all those who implement the county's civil commitment policies and practices.

2F: Co-operation among all stakeholders promotes effective management of usage.

Other stakeholders, besides those directly involved in civil commitment issues discussed above, are affected in major ways by the department of mental health's usage of IMD/SH resources. Among them are clients and client representatives, families, and acute care facilities. For example, families may be concerned that availability of IMD/SH beds is too restricted to adequately meet the needs of their family members. Also, acute care hospitals may apply considerable pressure to increase access to IMD beds so that they can reduce their administrative days.

Counties that are effective in managing their IMD/SH resources have developed procedures for including these relevant interests in the development of a common vision of what will be considered the appropriate use of these resources. Since interests differ and there is no gold standard, the working through of a common vision is not easy. Counties who have successfully accomplished this have struggled through many contentious meetings about both general policies and specific cases. And the process is continuous as new pressures develop on components of the overall system.

Recommendations

2.1 Accurate, timely and comprehensive statewide data on IMD utilization produced by DMH would enable counties to analyze and compare their overall IMD/SH use rates with other counties. In the absence of a clear gold standard, comparisons with other counties can be useful in trying to understand in which areas, if any, a county diverges from common practice. This involves looking at admission rates, lengths of stay, and proportions of long-stay clients. In order to do this, counties need access to timely and accurate data from the State DMH on at least an annual basis. Analysis of this data can provide useful information that will allow counties to focus attention on areas in which they may want to make changes.

2.2 It would be helpful for counties to develop consensus among relevant agencies on an Olmstead-consistent vision of IMD/SH usage. Developing a clear standard with accompanying policies will help to ensure that usage of IMD/SHs meets Olmstead standards. In the Olmstead decision the Supreme Court held that institutionalization required a burden of proof on the public system to show why community care is not appropriate. Thus, IMDs should be used only as long as recovery-oriented treatment professionals do not believe any community-based services would be appropriate and after all other less restrictive alternatives have been considered.

2.3 Applying a client-directed recovery-based orientation to their use of IMD/SHs would help in creating a consistent system wide orientation and approach to the use of institutions as short term interventions to be used as a last resort. A system-wide recovery orientation and integration of IMDs and community programs and services can provide hope and a consistent approach that can be effective in helping people get out of institutions and be successful in the community. The application of this approach to the use of IMD/SHs will promote both client recovery and appropriate use of IMD/SHs. Giving all clients placed in an IMD/SH the message that the placement is temporary and asking clients from the start where they want to live and what they want to do when they leave the IMD/SH promotes hope and a recovery orientation.

2.4 Centralized gate-keeping and monitoring processes are most effective when they have sufficient financial and management support. If the centralized units that counties have developed are to be effective they need to have authority commensurate with their responsibility, have sufficient numbers of well trained clinicians familiar with community resources, and have the ongoing visible support of county DMH leadership. Counties should consider having a quarterly review, with Mental Health Director participation, about issues, policies and resource questions related to IMD utilization, in order to ensure quality improvement of this function consistent with the counties' developed philosophy and policies.

2.5 It is important for county departments of mental health to work closely on an ongoing basis with all the constituencies involved with civil commitment policies and procedures. Because these practices, particularly those related to conservatorship, have so large an impact on IMD/SH usage all parties need to continually ensure that they are consistent with the overall vision of the county with regard to involuntary placements. Clear responsibility needs to be assigned to consistent on-site monitoring of clients while in IMD/SHs and for facilitating discharge planning with the IMDs.

FINDING 3: QUALITY OF CARE IN IMDs NEEDS IMPROVEMENT

While a formal assessment of the quality of care in IMDs was not a specific goal of the Study, information from county site visits, the client data, and the IMD site visits leads us to this overall finding.

3A: A recovery vision and an individualized orientation are not infused in IMD services. While the facilities visited were found to abide by licensing requirements to develop a client treatment plan and to review it periodically, treatment goals and treatment programs are often generic with little evidence of real client involvement in charting a treatment course and setting goals, let alone developing a recovery plan. Most IMD programming does not reflect a recovery orientation.

3B: Medication practices are less than optimal. The major concerns expressed by county staff and reinforced by our findings include the following:

- **Amount of psychiatrist time.** There was a large range in the amount of psychiatrist time on site with practices appearing better in IMDs with greater amounts of on-site psychiatrist time. Counties also varied in their relationship to the treating psychiatrist all the way from employing them, to closely monitoring them according to county established standards of care, to no monitoring at all.

- **Monitoring of psychiatrists**. Medication practices in IMDs appear to be better in counties where there is more active involvement by the county. Examples of this were two of the Study counties, Counties E and B, had established medication policies and communicated them effectively to IMDs.

- **Medication practice for long-stay clients.** More assertive medication approaches would appear to be warranted with clients who are not making progress on existing regimens in most facilities. Many charts in the Long-Stay Study lacked information about medication history due to periodic “thinning” of charts.

3C: Linguistic coverage and some special programs are present in IMDs, but there are few signs of comprehensive cultural competence. It is encouraging that some IMDs have specific programs for cultural groups including Southeast Asian/Pacific Islanders and Vietnamese. Also, it appeared that programs had sufficient bilingual staff to ensure that almost all clients had access at all times to staff who spoke their primary language. It was not apparent, however, that the IMD programming for individual clients made any special reference or took account of the potential impact of culture on individual clients. Also, not all IMDs apparently ensure that their staff have regular training in cultural competence.

3D: Staff inertia and pessimism are too predominant regarding many long-stay clients. About one-third of the clients who had been in an IMD/SH for longer than 18 months were not expected to be discharged at any time in the foreseeable future. While this level of care may be necessary for relatively long periods of time for some clients, it appears that facilities and counties may have "given up" on some clients.

3E: County and IMD quality of care initiatives can make a positive difference. At least two of the case-study counties employed formal quality improvement initiatives with their IMDs and reported that while it took substantial effort they were pleased with the overall success of the effort.

Recommendations

3.1. Counties can undertake quality improvement initiatives with IMDs they use. While there is no evidence for what the optimal investment might be in the quality of care in IMDs, we suggest that counties at least consider some of the following options:

- **Provide higher reimbursement levels for higher quality of staffing**
- **Provide more standards for the care delivered**
- **Provide ongoing staff training for all levels of IMD staff**
- **Engage in quality reviews of the IMDs**
- **Require IMDs to teach recovery concepts and illness management information and skills**
- **Require a minimal level of ongoing cultural competence training**

3.2. There are some effective steps that can be taken to encourage better medications practices. The nature of the IMDs used by each county varies, so it is more appropriate to think in terms of establishing standards rather than insisting on any particular structure.

- **Counties can develop reasonable ratios of psychiatric time** in the facility to the number of clients in residence.

- **The structure of the relationship of the psychiatrist to the county should be such that counties can monitor and assure appropriate, informed and assertive medication practices.** Whether psychiatrists are employed on contract with the county or hired or contracted with directly by the IMD, the ability to require adherence to protocols and/or routine monitoring is important.

3.3 County annual reviews of the status of their long-stay client to determine what kind of more active treatment is warranted can be critical in assuring appropriate use of institutional resources. Reviews of long-stay client's treatment plans could be done periodically to determine what kind of changes are needed in medication regimens and other treatment services. Counties should consider the establishment of special programs, or the augmenting of rates for established programs that have the best available recovery and rehabilitation programming to be used specifically for some of these very long-stay clients. All clients in their long-stay population should be given a chance to succeed in a community placement, even if this means taking some risks.

3.4 Pilot program initiated by the state can be helpful in determining the most effective treatment approaches for clients in IMD/SHs. The State DMH could pilot alternative programming regimens within IMDs that would be more in keeping with the recovery vision. This could also include testing of alternatives that would waive the 27-hour STP standards in favor of more individualized alternative services. An evaluation of the results of such pilots could be useful to the field and could result in a revision of the existing program requirements for STP and MHRC licensing and certification.[18]

3.5 A state sponsored forum to define and develop more specific psychiatric practice standards for IMDs could improve consistency and quality of care across IMDs. The quality of psychiatric practices in IMDs is critical for client success. It would be helpful for State DMH to take the initiative to work with counties in establishing standards for the number of hours of psychiatric coverage required in IMDs and the nature of the monitoring that counties should do to ensure appropriate care.

FINDING 4: IMPROVED COMMUNITY RESOURCES WILL ALLOW FOR MORE APPROPRIATE USE OF IMD/SHS

All interviewed county staff noted that they could reduce the use of IMD/SHs if they had additional community resources.

[18] Attention may also need to be given to altering other STP, SNF, or MHRC regulations because such a recovery orientation may require facilities to take a greater level of risk with clients which they will be reluctant to do if they are too severely penalized by licensing agencies.

4A. Lack of adequate housing resources and intensive case management in the community were cited as the major obstacles in transitioning clients out of IMDs back into the community. The most important ingredients in enabling someone to return to the community from an IMD are appropriate housing and sufficient support services. These can be and are made available in a variety of structures in different counties as we have noted in the report. Ideally, someone should be able to return to an appropriate permanent living situation, where they can remain as long as they choose while supports would be made flexibly available 24/7 to the extent necessary.

4B. Counties have reduced IMD/SH usage through the development of specific combinations of housing-support services. In the absence of a full range of supportive housing options, counties are also using a range of augmented community facilities that provide "step-down" programs, which combine housing and treatment services and which serve as temporary housing. Additionally they use intensive case management, ACT-like and integrated service agency programs to structure support services to augment other types of housing such as B/C, apartments, room and board, etc. Specific targeted strategies by County D to use an ACT program and County E to use step-down residential programs have shown success in reducing IMD usage.

4C. While more housing and case management resources are needed, coordination and integration of the available and existing resources can ensure a county's appropriate use of IMDs. The Tracking Study forms asked every three months whether the client still in the IMD/SH could be placed in the community if an appropriate program or setting were available and if the program or setting, if it already existed, would take the client. It was apparent from the answers that the IMD staff/county monitors did not think in these terms. It is difficult to prepare clients for community living when the staff is not thinking in terms of what it takes to succeed in varying community settings.

Some counties have policies which require or encourage community care case managers to follow their clients while they are in an IMD and/or which assign clients to community case managers prior to their discharge from the IMD. But constrained community resources sometimes results in these policies not being fully implemented.

4D. B/C facilities are not sufficiently funded nor supported (by counties nor licensing agencies) to play the role they are forced to currently play in the system of care. Despite the fact that there may be better alternatives in the long run, counties are heavily dependent on B/C facilities as discharge options from IMDs, yet B/C rates lag behind those for the developmentally disabled, resulting in a decrease in bed availability, and county staff are almost uniformly concerned about the quality of care in B/C homes. Additionally, Community Care Licensing (CCL) faces major challenges in understanding services for clients with

mental illness in the community, and county staff and facilities consistently report frustrations and problems with licensing staff and regulations.

4E. Families are an important resource for many clients. A number of clients in the Study counties were living with their families prior to going into an IMD, and many returned to families upon discharge. While many clients have no family living near and others do not want their families involved, families can be important components of clients' social networks and are important to clients' recovery.

Recommendations

4.1. The development of additional flexible supportive housing resources at both the state and county levels is critical in reducing IMD utilization. Because a supportive housing model is considered a best practice for adults with serious mental illness, this should receive the first priority for funding. State support for the establishment of additional supported housing programs helps counties in expanding their available housing resources.

4.2. ACT-type teams and integrated service agencies can be used as helpful alternative resources for returning long-stay IMD/SH clients to the community. ACT-type teams and integrated service agencies have demonstrated effectiveness in serving as alternatives for clients who are long-term residents of IMD/SHs. Such teams can be funded either with MHSA Full Service Partnership (FSP) dollars or with the savings that result from reduced IMD/SH utilization.

4.3 Intensive case management services help clients to be more successful in their transition to the community. It would be beneficial for intensive service teams and intensive case management programs to maintain contact with any of their clients who are admitted to an IMD to reinforce the temporary nature of the placement and to ensure a more effective transition back to the community. Additionally, assigning all IMD discharges, at least in the short-term, to an intensive service/case management team, if they do not already have such a connection, would help to ensure an effective transition to the community.

4.4. Counties may want to consider the development of a range of augmented residential programs. While not all agree that such temporary programs are a worthwhile direction for the system as a whole, some counties have found such facilities useful as "step-down" programs in reducing lengths of stay in IMDs and diverting some IMD admissions. These facilities may be particularly helpful in achieving immediate reductions in IMD utilization while a county is building its more permanent supportive housing stock.

4.5 Implementing more effective discharge planning processes can reduce lengths of stay and recidivism. The lack of an IMD incentive to discharge

clients and the large caseloads of county and Public Guardian monitors are obstacles to quick and effective discharge planning. Counties may want to consider creating teams comprised of IMD staff, long-term care staff, the Public Guardian and community program staff who will begin to work with clients on transition out of IMDs as soon as they are placed into the facilities. To be effective these teams will need to have thorough and current knowledge of both the clients and the community resources.

4.6 Counties who must rely significantly on B/C facilities for the near future could attempt to enhance quality of life and recovery opportunities for residents in such facilities. Again, while not ideal, many counties may be reliant on B/C facilities for some time in the future. A few of the Study counties struggled with developing an appropriate rate augmentation system for selected facilities and/or clients. Counties may want to collaborate on the development of more effective strategies for enhancing the living environment for clients in such facilities.

4.7 A collaborative effort initiated by DMH with CCL would help to promote the appropriate use of community care facilities for clients with serious psychiatric disabilities. Many facilities in our Study counties expressed concerns about working with clients with serious mental illness because of a fear of licensing problems and sanctions. State DMH and CCL could work together to adopt policies and practices in working with facilities that serve clients with severe mental illness that are more in keeping with what is known about best practices and a recovery oriented approach.

4.8 Counties may want to consider developing support programs to assist families who provide housing and other support to their family member with mental illness. The fact that many clients are living with families at the time of the episode that leads to IMD placement suggests that the provision of special assistance to families prior to and during times of crisis might forestall the path towards acute care followed by an IMD admission. A demonstration project of such an intervention might be worthwhile. Counties could also encourage IMDs to enhance as much as possible appropriate family involvement while their family member is at the IMD. Additionally, as counties continue to reduce the availability of IMD/SH beds they need to be cognizant of family concerns that these resources not become too scarce.

APPENDIX A

IMD PHASE 1 REPORT

DECEMBER 2003

Long Term Strategies for Community Placement: Alternatives to Institutions for Mental Disease

Phase One Report
December 2003

INTRODUCTION

The Department of Mental Health (DMH) is conducting a study of Long-Term Strategies for Community Placement and Alternatives to Institutions for Mental Diseases (IMDs). DMH has contracted with Beverly Abbott, J. R. Elpers, Pat Jordan and Joan Meisel to conduct the study. Two consultants work with the project team, Darlene Prettyman and Alice Washington; they offer additional expertise in family member, consumer and cultural competence issues.

The study has three parts:

Phase I: Background and Basic Information Gathering. *This phase consists of two parts: interviews with counties and collection and analysis of statewide IMD utilization data. It is designed to create a framework for understanding how IMDs fit into counties' systems of care and for identifying hypotheses for what accounts for varying use patterns by county.*

Phase II: In-depth Information Gathering in 6 – 8 Counties. *This phase of the study will explore in greater depth the factors that influence varying levels of usage of IMDs in a variety of selected counties. Participation as a study site for this phase of the study will be voluntary. The contractors will conduct site visits to the participating counties to gain a full understanding of the contextual factors that impact IMD usage and will collect client-level data on individuals entering and leaving IMDs during an approximately one-year period to better understand the process and circumstances surrounding actual use of these facilities.*

Phase III: Analysis and Development of Best Practices and Recommendations *Using the empirical information from the client-level data and the qualitative understanding of the unique circumstances in each county, the contractors will identify strategies and best practices for lowering, as appropriate, the usage of IMDs. A checklist for counties to review and assess how well their system addresses the key factors that impact IMD usage will also be developed.*

This brief report summarizes the Phase I work. It is divided into the following three sections:

- ***Part A: Interview results***
- ***Part B: Statewide data collection***
- ***Part C: Observations and criteria for selection of Phase II counties***

For the purpose of Phase I of the study and unless otherwise noted, the use of the term “IMD” in this report refers to a level of care definition: institutional care for the purpose of mental health treatment and services, and includes state hospitals, Skilled Nursing Facilities (SNFs) which specialize in mental health treatment, and Mental Health Rehabilitation Centers (MHRCs).

The term “IMD” originally came from a federal government definition. Title 42, Code of Federal Regulations, Section 435.1009(b)(2), defines an IMD as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.” IMDs in California generally include facilities in the following licensing categories, if the facility has 17 beds or more: acute psychiatric hospitals, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs) with a certified special treatment program for the mentally disordered (STP), and mental health rehabilitation centers (MHRCs). The definition is important because under Title 42, CFR, Section 435.1008, "FFP is not available in expenditures for services provided to . . . Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under Sec. 440.160 of this subchapter…” Some counties and providers have created parts of a SNF for mental health consumers that occupy less than 50% of the beds. In this situation the SNF is not an IMD under the Federal definition, Such facilities are included in this study, however, as we are primarily interested in a level of institutional care rather than a reimbursement category for Medicaid purpose. For similar reasons, state hospitals are also included in this study.

As described below, county interviews confirmed that mental health programs use all of these facilities either for a relatively short-term step-down placement between acute care and community placement or as a longer-term placement for consumers whom counties have not been able to find appropriate community placements.

PART A: INTERVIEWS

This part of the report summarizes the results from telephone interviews with 35 of the 40 counties in the state with a population greater than 50,000 (see Appendix A for the list of counties). These counties together constitute roughly 90% of the state’s total population. An additional four counties with less than

50,000 population provided written answers to the interview questions. The Mental Health Director of each county was sent a brief description of the study and a copy of the interview protocol and was asked to include in the telephone call whomever s/he felt could provide useful information. The counties' co-operation in the interview process was outstanding.

The interview results are presented in five parts:

- *General information about the counties IMD usage*
- *How counties authorize access to IMDs and monitor consumers in IMDs*
- *Needs of consumers and counties that make community placements challenging*
- *County and state actions that would assist reduction in IMD usage*
- *Under 50,000 population counties and consumer/family perspective*

To as great an extent as possible, this report uses the words counties used in their interview responses. As discussed later in this report, many counties did not use recovery-oriented language. The language used by the persons being interviewed has been reported in order to more accurately reflect current program realities and language.

GENERAL INFORMATION ABOUT COUNTIES' IMD USAGE

Most counties use multiple facilities.

The average number of different facilities that the counties reported using was 6.5 with a median of 6. Interestingly, many of the small counties used as many different facilities as did the larger counties.

Numbers of Facilities Used By Size of County[19]

Population	*50-250,000*	*250-500,000*	*500,000 to 1 M*	*1 – 3 M*	*LA*
Number of counties	*13*	*6*	*6*	*7*	*1*
Average # facilities	*5.4*	*6.5*	*8.5*	*7.1*	*11*
Median # facilities	*5.0*	*5.5*	*7.5*	*7*	*11*
Range of # of facilities	*3-9*	*3-11*	*3-16*	*4-12*	*11*

For some counties the use of many facilities was a conscious strategy that allowed them to meet individual needs of consumers and to move consumers

[19] Two counties (with a total current census of 83) indicated a general contract with Crestwood facilities without specifying which facilities were actually currently being used.

should the treatment in one facility become "stale." For others, the use of multiple facilities was more a matter of necessity because they could not be assured of gaining access to a particular IMD when they needed a bed.

A few counties use facilities within their county almost exclusively, but some counties with facilities within the county also use out-of-county facilities.

Twenty-three of the 35 counties have IMD beds located in their county. The table below breaks the counties into three groups: five counties that use in-county facilities entirely or almost entirely; nine counties that utilize in-county facilities for about half their census (45-65%); and nine counties that send more than 55% of their clients out-of-county.

In-County and Out-of-County Census for Counties with an In-County IMD

	Number (and %) of counties	In-county census	Out-of-county census
Counties with between 75 and 100% of their census in in-county facilities	*5 (22%)*	*1372*	*69*
Counties with between 45 and 65% of their census in in-county facilities	*9 (39%)*	*654*	*639*
Counties with less than 45% of their census in in-county-facilities	*9 (39%)*	*219*	*422*
TOTAL	*23 (100%)*	*2,245 (67%)*	*1,130 (33%)*

Overall, two-thirds of the census (of counties with facilities in-county) is in in-county facilities. This is because four of the five counties that have at least 75% of their residents in in-county facilities are large counties.

Some counties indicated a clear advantage to having clients in-county in terms of allowing for a) better monitoring and b) more opportunities to prepare the consumer for community life (by visiting possible residential sites, by joining a community-based peer group, etc.). This advantage appears to be weighed against the potential for a better match between the client's specific needs and the strengths and capacity of the facility(ies) located within the county. This would be less of a problem in the larger counties since they have more in-county facilities from which to select a placement for any individual consumer.

About half the facilities serve clients primarily from one county, but many have consumers from multiple counties.

The table below is based on the current census information provided by the counties interviewed. Counties indicated using 53 different facilities (excluding state hospitals). Fifty-five percent of the facilities representing about 60% of the total current census served only one or predominately (over 85% of the census) one county. Another 19% of the facilities had residents from two to five counties, with roughly 12% of the total census. The remaining quarter of the facilities (with 29% of the census) had residents from six or more counties.

Number of Counties Using a Particular Facility

Number of Counties *Served by Facility*	Number (and %) *of Facilities*	Number (and %) of Census
Facility has residents from only one county or 85%+ of residents are from one county	*30 (56.5%)*	*2,117 (59%)*
Facility has residents from two to five counties	*10 (19%)*	*444 (12%)*
Facility has residents from six or more counties	*13 (24.5%)*	*1024 (29%)*

The IMDs serve two major functions in the counties' adult system of care – one as a short-term step-down placement from acute care and the other as a long-term placement for selected clients.

Almost all admissions to the IMDs come from acute care facilities. The IMD is used when the county believes the client will NOT be able to be successful in the community if discharged directly from acute care. The function of the IMD is to provide additional time for the client to stabilize, to assist the client to acquire or strengthen community-living skills, and to develop an aftercare plan that will lead to a successful placement in the community. Counties consider these to be short-term placements, but the definition of short-term varied. Some talked about short-term as 30 days while others used the term to refer to stays of from 3 to 12 months.

The second major use of IMDs is for a relatively small subset of clients who are expected to remain in the IMDs for a long period of time, in some cases with no anticipated discharge.

Most counties articulated a difference between MHRCs and IMDs, but a significant minority believe the difference exists only on paper.

One of the study issues is the extent to which the different licensure and reimbursement categories make a difference in the facilities' services and their use by the counties. Some of the interview questions began an ***e***xploration of this by asking what the counties perceived as the differences between IMDs (in this case referring to SNFs either reimbursed by Medi-Cal or not) and MHRCs.

Thirty of the 35 counties used at least some MHRC beds and so should be in a position to articulate differences between the kinds of services rendered and/or the kinds of clients served. The MHRCs were viewed as taking clients with greater rehabilitation potential, focusing more on recovery and developing independence, and having shorter lengths of stay. A few counties said the distinguishing feature was the greater capacity of the IMDs (as SNFs) to take clients with more significant medical complications.

Five counties indicated that while these facilities are supposed to reflect these differences they do not perceive any difference in who the facilities accept or the nature of the treatment.

Most counties indicated using at least some of the IMDs for specific purposes.

The most frequent distinction was between facilities used for the step-down function versus the long-term placements. For example,

- We use different facilities for different roles, e.g. " A" for long-term and "B" and "C" for step-down.
- "A" more long-term and "B" more short-term
- "A" is short-term; others are long-term and special populations
- "A" for very chronic who may be there almost forever
- "A" for first-time IMD clients where they hope to move them back to community quickly.
- Two IMDs are long-term with little chance of discharge.

A few counties made a distinction between a subacute and a regular level of care with the former reserved for clients with greater or more acute needs and receiving higher reimbursement. Some counties talked about particular IMDs having special programs, for Asians, forensic patients, medical problems too severe for other facilities, persons who are deaf, consumers with both mental illness and developmental disabilities, and those with head injuries.

And two counties indicated trying to match all their individual clients with particular IMDs rather than distinguishing just between major categories or very special needs.

- Important to carefully match individual client's needs to capacity of particular IMD.
- The case manager thinks the programs have different areas of expertise and so tries to match the particular needs of the client to the programs strength.

State hospitals appear to play a placement of last resort function for many counties.

A few counties mentioned that the state hospitals are used for their most difficult clients, for example, those who

Are assaultive and unmanageable;
Have greatest severity, e.g. are assaultive and have failed other placements
Have specialized needs e.g. burned out IMDs, aggression, medical needs

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Five counties also indicated that they occasionally used their other IMDs as a transition step between placement in the state hospital and placement in the community.

Conservatorship plays an important role in the use of IMDs.

A number of counties identified issues with conservatorship as contributing to issues with IMD usage. The placement of the conservatorship function in county government, the nature of the relationship between the Public Guardian and the mental health program staff, and the philosophy of the courts and /or Public Guardian affected IMD utilization in a number of counties. The original interview protocol did not include questions about conservatorship but after the issue was raised by some counties, questions were added to the protocol (See Appendix B for a copy of the interview protocol). Ex***amples of issues and differences are:***

- In some counties being on conservatorship always means placement in IMDs, i.e. the conservatorship is terminated when the client is discharged from the IMD
- In one county the respondent complained that the conservator kept consumers on conservatorship in the community and that was not consistent with the recovery model i.e. if they could live in the community they could be off conservatorship.
- Another county responded that the conservator dropped individuals as soon as they were discharged from an IMD, therefore not giving clients a chance to adjust.
- Some counties found the conservators helpful in monitoring clients in IMDs while others felt that they were not helpful.
- One county also mentioned that because of budget cuts conservators have become more conservative and are reluctant to place clients in the community because of difficulty in monitoring them.
- A few counties noted more difficulties with private than public conservators, particularly in regard to an unwillingness to allow discharges from IMDs into the community.

The issue of conservatorship as a whole is beyond the scope of this study. However to the extent possible, its impact on IMD utilization will be explored in the case study counties.

Answers about cultural competence and the recovery philosophy were ambiguous.

The responses to our questions on cultural competence and the recovery philosophy raised questions about the extent to which these are being implemented in IMDs.

- Respondents who were very knowledgeable about cultural competence in two large counties (one in the south and one in the Bay Area) said that cultural competence was very limited in IMDs. Other counties using the same facilities felt differently.
- Counties using the same facilities responded differently on the recovery question as well. In general, we noted that the language of those we interviewed did not always synchronize with recovery vision; words and phrases like “meds compliant”, “following staff direction”, “maintenance” etc. are different words than those used in the recovery vision.

It is difficult to really understand these two issues in a short telephone interview so the above represents our preliminary impressions. Both of these issues will be explored in greater depth in the Phase II case study counties. We will select case study counties to include those with a diverse adult population. We will also in Phase II delve more deeply into how the counties and the IMDs implement the recovery vision with these clients who have serious psychiatric disabilities..

Recidivism data is not routinely tracked and varies considerably among counties that had data.

Only ten of the counties interviewed either had or could fairly easily get information on the percentage of their discharged clients who re-entered an IMD during the year following their discharge. Four of the ten counties reported high recidivism rates (from 32% to 52%) while the other six reported low rates (3% to 13%). We are uncertain at this point whether these reflect real differences or whether counties used different methodologies in calculating recidivism. We will gather this data more precisely from the case study counties and attempt to ascertain whether the recidivism rates vary with use patterns and philosophies.

Similarly, the counties that just guessed at their recidivism rates differed considerable. Four guessed relatively high rates (20% - 50%) while three guessed it was relatively low (10% or under).

ACCESS AND MONITORING

The interview asked a series of questions about the county’s process for admitting a consumer to an IMD and for monitoring the consumer’s progress while in an IMD. The following represents a general picture of these processes. A more in-depth analysis of these processes will be a critical part of the Phase II work in the case study counties.

ACCESS

Almost all of the counties a standard centralized process for authorizing admissions to IMDs.

The concern about the high cost of IMD care has led almost all of the counties to adopt some type of central authorization process. Many counties indicated that these had either been put in place or altered within the last few years, largely in response to fiscal constraints.

There are three counties that appear to not have a centralized process. One allows direct referral from acute care hospitals to IMDs with notification of the county after admission by the IMD. Two others appear to place the decision about placement with the consumer's regional treatment team.

The counties use a variety of centralized authorization processes, in part reflecting differences in the size of the county.

Eighteen counties rely on some type of placement committee to review requests for and make decisions about IMD placement. These 18 include the smallest to the largest counties.

Eight counties – mostly smaller counties but also one of the large counties – have a single person in their departments of mental health who signs off on every IMD admission.

Three counties appear to have placement committees with membership that changes depending on the particular client. Two, for example include the treatment team currently responsible for the consumer's services and treatment.

Regardless of structure, counties tend to use management or supervisory staff who have clinical experience.

Where the county relied on a single staff person to authorize admissions it was almost always a program manager, a supervisor, a clinical director, a medical director, or a director or deputy director.

When a team was involved it invariably included licensed clinical staff (masters-level social workers, psychologists, and/or registered nurses) as well as program managers and supervisors of either case management or treatment teams. There was also often a director of placement or a long-term-care coordinator. Other staff types mentioned were quality assurance/improvement, liaisons with the acute care facilities, and discharge planners from the hospitals. While all

placements have to be approved by the conservator they sometimes functioned as a regular part of a placement team.

Here are a few examples:

- *QI/Managed Care Program Manager in concurrence with Medical Director*
- *Consensus of conservator, inpatient MD, and social worker*
- *Attending psychiatrist, Public Guardian, and program manager who is a licensed psychologist*
- *Master's level clinician and social worker*
- *Clinical Program Manager with sign off by Mental Health Director*
- *Multidisciplinary team, then approved by Adult Program Manager with final review by Medical Director and Adult Administrator*
- *Head of adult system of care, IMD case manager, psychiatrist, conservator, and discharge planner from hospital*

Monitoring

All counties receive periodic updates from IMDs on clients' progress.

Counties generally rely upon IMD forms and procedures for this routine tracking of their consumers while in the IMD. IMDs appear to send reports either monthly or quarterly; some IMDs send minutes of treatment conferences. Some counties require the IMDs to complete a county or STP form for continued authorization.

Most counties also reported that they have periodic telephone contact with the IMDs

More active monitoring through on-site visits by county staff occurs at least quarterly.

All but two counties indicated that county staff visited IMDs to either talk to the treatment team, and/or review resident charts, and/or interview the resident at least quarterly. More frequent monitoring occurred with facilities that were either in the county or in near-by counties and with facilities in which the county had a significant number of their consumers. The frequency of these visits ranges from almost daily to weekly to twice a month to monthly.

Some counties also indicated an increase in frequency of monitoring as a consumer approached the time of discharge.

While counties rely on the same types of procedures, the intensity and scope of the monitoring varies across the counties.

Here are some examples of the ways in which counties mix and match these various monitoring activities.

- One moderately-sized county (250 – 500,000) with no in-county IMDs has one staff person do on-site monitoring of all the IMD clients at least once a month and more often near discharge. She also attends IMD quarterly reviews and receives copies of IMD treatment team minutes.
- One small county (50-250,000) with no in-county IMD receives a monthly status report on its clients from one IMD and quarterly reports from two other IMDs. A case manager who is responsible for discharge planning reviews client progress at least quarterly.
- One larger county (750,000 – 1 M) visits its in-county IMD daily or weekly while two RNs visit the out-of-county IMDs at least monthly. A routine assessment is done on all consumers when they enter the IMD and again when they are ready for discharge. A linkage case manager is brought in when the client is ready to be discharged.
- One larger county (500,000 – 1 M) has case managers who visit all IMDs at least monthly with more frequent visits at facilities (some in and some out-of-county) where they have more clients. They also receive reports (some in writing and some by phone) from some IMDs quarterly and some more frequently.
- One smaller county (50 – 200,000) receives monthly reports from IMDs with a placement team that monitors the progress of all clients in IMDs and that meets three times a week for two hours.
- One large county (2 – 3 M) get a quarterly certification form from the IMDs. A long-term-care unit monitors facilities quarterly during which they see some residents. All residents are seen at least yearly.
- One smaller county (50-200,000) relies on the IMDs charts. A program manager visits an in-county facility weekly and out-of-county facilities monthly. The case manger will have weekly phone contacts with the facilities about their particular clients.
- One moderately sized county (250-500,000) uses STP forms but really relies on site visits for monitoring. Their standard is that the regional team case manager sees their clients every 3 weeks which entails a conversation with the client and the staff and a review of the IMD chart.

The conservator also plays a role in the monitoring of IMD residents.

As noted elsewhere, almost all clients in IMDs are on conservatorship. Many counties noted how their monitoring process related to that of the public conservator. In some instances the Public Guardian has mental health staff assigned to their office who conduct the monitoring. In other instances, the Public Guardian may accompany the county mental health staff during visits to facilities. The frequency of Public Guardian contact varied, with one county including the Public Guardian in the three week standard for face-to-face contact, while most indicated a quarterly vis***it.***

CONSUMER AND COUNTY NEEDS

The interview contained a number of questions about what might cause consumers to be admitted to and/or stay in IMDs longer than necessary from a clinical or programmatic perspective. One approach to this issue is to identify the characteristics of consumers that challenge program's abilities to successfully support them in the community. One can then use this information to explore the kinds of services that might be useful to meet the needs of these consumers in the community thus lessening any inappropriate time in an IMD setting.

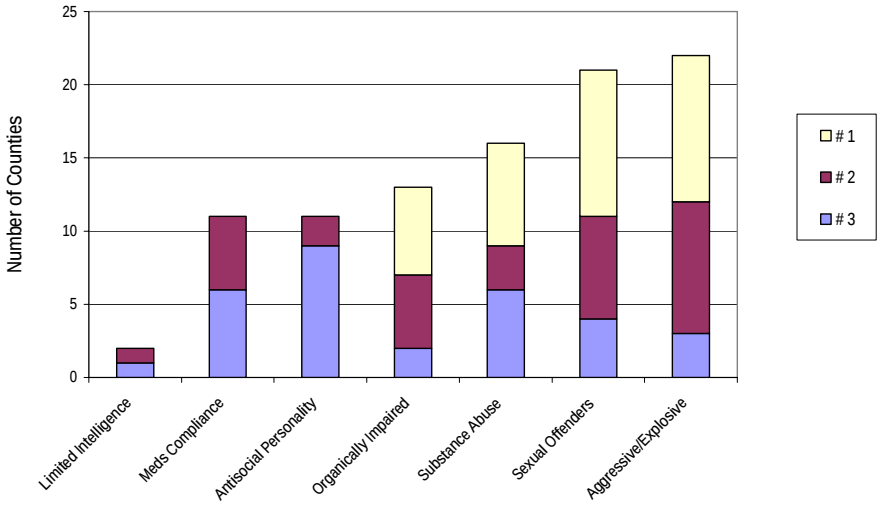
Another approach is to identify gaps or needs from the perspective of the county's System of Care. The interview took two cuts at this. First it asked what community services would allow the county to place their current IMD consumers in the community. The second asked what resources were needed by the county to address general barriers to community placement.

Consumers Who Present Challenges to Successful Community Placement

Counties identified consumers who exhibit aggressive/explosive behavior and sexual offenders as the most challenging to serve in the community.

Counties were asked to rate seven different types of consumer characteristics in terms of most to least difficult to serve in the community. An additional "other" category was also included. Figure 1 shows the number of counties who rated each of the types either as the hardest (#1), the second hardest (#2), or the third hardest (#3).

Figure 1
TYPE OF CLIENT MOST CHALLENGING TO SERVE IN COMMUNITY



Some counties noted that their ranking did not indicate overall county need since some consumers – namely those with a history of sexual offenses – were extremely difficult to place, but also fairly rare in their caseload. By contrast, clients who had substance abuse issues were not as challenging on an individual consumer basis, but the large numbers of consumers who fit this category make it a sizable problem for the county. This confounding of the challenges presented by an individual consumer with the number of consumers with particular kinds of behaviors will be further explored in our case study counties.

County Resource Needs

Housing-related resources were the most frequently mentioned resource that would help the county get their "present IMD residents out in the community."

The counties were asked an open-ended question about what resources were needed to get current IMD residents placed in the community. Fifty-one responses dealt with housing or housing-related resources. (Counties might be counted twice if they mentioned two separate housing-related resources.)

- **Twenty-two responses cited board and care resources. Of these,**

    - 10 indicated regular board and care
    - 11 indicated board and care with programming
    - 1 indicated board and care with a secure perimeter
- Twenty responses cited housing resources. Of these,
    - 12 indicated either housing generally or a range of housing options
    - 4 indicated affordable housing
    - 4 indicated supported housing
- Nine responses cited step-down or residential treatment facilities

The next largest category was a range of intensive case management-type services: 14 counties cited either an Assertive Community Treatment, AB 2034 (integrated services), or intensive case management program.

Eleven counties mentioned a day program. Five of these indicated some type of vocational service; two each cited socialization programs, peer programs, and day treatment.

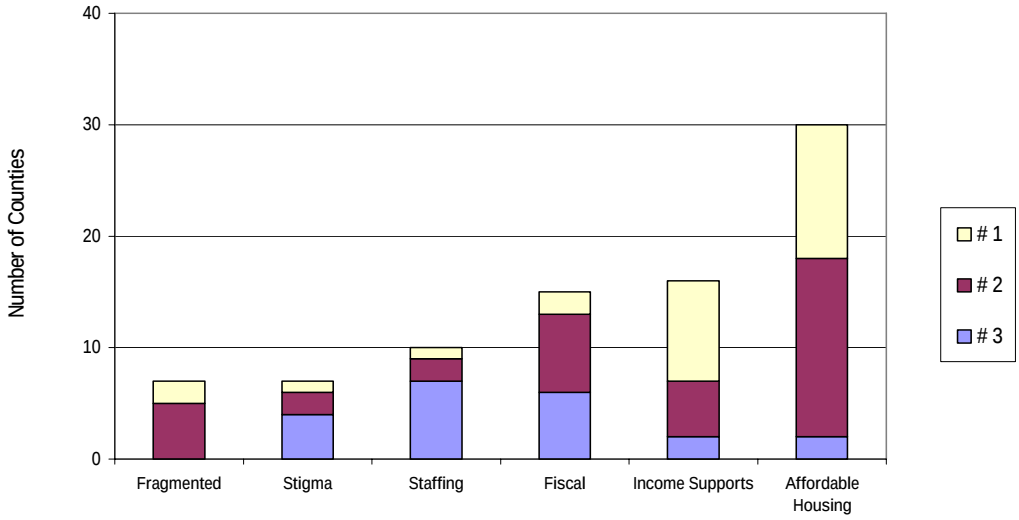
The last category of responses – 7 mentions – was more funding and/or more staff.

The importance of housing was reinforced by county responses to a question about the "most important general barriers to community placement."

A recent SAMSHA report "Overcoming Barriers to Community Integration for People with Mental Illness" identifies eight barriers to the creation and use of services that support persons with mental illness in the community: lack of income support and entitlements; lack of affordable housing; lack of competitive and supported employment; lack of access to culturally appropriate health care; fragmented services; fiscal barriers to individualized flexible services; stigma and discrimination; staffing shortages. We added to these three others: lack of access to culturally appropriate specific mental health services; undocumented immigration status; and legal and conservatorship barriers. The counties were asked to rank the three most important of these eleven general barriers to community placement.

Figure 2 shows the barriers most frequently rated within the top three. Affordable housing was rated in the top three by 30 of the counties, with 28 rating it as most or second most important. The second most frequently ranked barrier was the lack of income supports and entitlements, followed by fiscal barriers to individualized, flexible services. Staffing shortages were next followed by stigma, usually within the context of neighborhood difficulty in the citing of residential services. The last of the top six was fragmented services.

Figure 2
MOST IMPORTANT BARRIERS TO COMMUNITY PLACEMENT



Most of the counties had at least some of the community services necessary to support consumers in the community.

In these relatively short interviews we were not able to obtain definitive information about each county's full adult system of care, but we did inquire about the availability (and number of slots) for some of the major types of service. We will explore the role of the relative amounts of these services in greater depth in our Phase II case studies. Here, we simply summarize the extent to which the counties reported that they had at least some of these services.

Number of Counties Reporting Having Community-Based Supportive Services

Kind of Service	Number of Counties	Percent of Counties
Intensive Outpatient	*31*	*89%*
Residential	*24*	*69%*
B/C with either supplemental rates or county patches	*28*	*80%*

All but four of the over 50,000 population counties had some intensive outpatient services (AB 34, ACT, ICM, MIOCR).[20] Almost 70% reported some type of residential program.

Most counties had specific information about the number of regular board and care beds available in their counties, but not all did. Eighty percent did report the number of board and care beds that received either a supplemental rate or a special county patch. A few counties noted that they "patched" (provided additional funding for) all the board and care beds they used, but the vast majority had far more regular board and care beds than those that received some type of supplemental funding.

COUNTY AND STATE ACTIONS

County Initiatives to Overcome Barriers

Counties were asked what actions they are taking to overcome the barriers to community placement that they identified. They were also asked which of these appear to be the most promising.

Housing-related actions were the most mentioned of the most promising initiatives.

Not surprisingly, some housing-related action was cited by 27 of the counties. Nineteen of these included their housing-related initiatives as among their most promising. These initiatives can be divided into two general categories: a) work with housing authorities and community collaborations around longer-term strategies for increasing affordable housing or residential treatment programs, or b) short-term work on increasing the immediate supply of placements. Examples of long-term initiatives included:

- A housing coordinator working with Housing and Community Development to develop a housing plan for people with disabilities.
- Working with a multi-agency housing workgroup that includes the Housing Authority, the Homeless Program, Social Services, Law Enforcement, Aging, and Adult Services to expand housing opportunities at all levels.
- Working with major players in housing including the Housing Authority and local realtors
- Grant writer for housing grants
- Created an IMD workgroup that has now expanded to be an adult SOC Advisory Committee that is taking a broad look at all housing options.

[20] The four that did not were among the smaller counties: one has a population in the 50-100,000 range; two in the 100-200,000 range; and one in the 200-250,000 range.

- Housing coordinator working with multiple housing forums and advocating with seven different housing entities including developing housing stock.

Examples of short-term efforts to increase housing availability include the following:

- Paying patches to board and care to keep housing in the community; working with board and care around a single supplemental rate
- Collaborating more with board and care operators to maximize housing options
- Contracting with board and care beds out of county
- Use a lot of interim placement money while improving communication with board and care operators
- Work more closely with Community Care Licensing to support residential care operators
- Better supportive programming has been developed in community apartments
- Begun meeting with residential providers to clarify expectations under their contracts
- Supporting clients in getting housing certificates
- Creating a centralized housing resource data base
- Plan to cut four IMD beds in next six months and create nine supported housing beds

Some counties reported successful efforts at expanding housing alternatives.

Examples of county efforts that have resulted in enhanced placement alternatives include the following:

- Non-profits developed independent living programs that have Medi-Cal reimbursable services available on-site
- Opened a 16-unit apartment complex with Shelter-Plus Care funds
- Opened 10 houses (50 beds) which are assisted independent living. Consumers rent apartments from NAMI which purchased the houses.
- Opened a 10-bed supported housing facility
- Developed 12-bed social model transitional residential program with 24-hour staffing and a follow-up supported housing component including Section 8. About half the clients come from IMDs.
- Developed a contract with a housing development corporation for set-asides for affordable housing units. This is combined with supportive services through a contract with a local non-profit.

The second most promising activity was the use of intensive outpatient services.

Eight counties noted an expansion of their ACT/AB 2034/Intensive Case Management programs as most promising for clients in either preventing IMD placements or reducing recidivism. Some of the counties noted the use of these intensive services for a short-term, for example after a consumer is discharged from an IMD. Examples of county comments follow:

- ACT – very helpful in reducing recidivism
- Intensive treatment team which selects consumers ready to come off conservatorship or at risk of going on conservatorship and works intensively with them over a two-month period
- Using a combination of harm reduction and strength-based approach in AB 2034 programs
- Short-term wrap-around focused teams that follow IMD clients up to 59 days following discharge.
- Targeted case management focusing on clients at-risk of long-term placement. Rather than waiting until hospitalized assess what they need to stay in the community and deliver it.

A few counties are engaged in reviewing and changing parts of their system of care to better address barriers to community care.

Five counties cited these system changes as the most promising of their activities. Examples of activities mentioned (whether or not counties cited them as their most promising activity) include the following:

- Reorganized some outpatient services in order to enhance the flexibility and responsiveness of the service system.
- Continue strategy to shift fiscal resources from IMD to fund augmented Board and Care and staff support
- Try to limit conservatorship referrals
- Trying to centralize placements
- Revamp day rehabilitation program to focus on ex-IMD clients who need support to maintain in the community
- High priority for outpatient clinics to see IMD clients immediately after discharge
- Re-looking at whole adult SOC structure

A question about unique or special programs highlighted other system and programmatic ideas.

We asked counties if they had any unique or special programs that might be relevant to the study. These could be either long-standing practices, policies, or programs or ones that had been newly devised. While some mentioned the kinds of housing alternatives and intensive outpatient ***services already mentioned***

above there were also some other interesting practices that will warrant attention in Phase II of the study.

In addition to the programs cited above, there were a few others that counties felt were very successful. Most of these have been created and are viewed as fitting into specific parts of the system of care in a way that addresses problems that lead to IMD placement and difficulty being discharged from an IMD.

- An AB 1425 program that will allow the county to provide recovery model services to clients in independent living. Clients to be seen daily.
- A SHIA (supported housing) program that allowed the county to move some clients out of residential facilities thus freeing up slots for IMD clients.
- Transitional youth program that focuses on getting clients housing. Many of these clients moved from Level 14 group homes straight into IMDs.
- Older adult program staff by nurses who work with SNFs to keep clients in regular SNFs who would otherwise have to be in IMDs.
- Providing short-term (up to 59 days) of intensive wrap-around services to consumers discharged from IMDs.

Some counties cited system actions, including the following:

- Using only in-county IMDs that served only (or predominantly) the county's consumers. This allowed a greater congruence between the goals of the county and the IMDs.
- Tracking each client on the Multnomah Community Ability Scale starting at entry and then quarterly thereafter.
- Conducting routine quality of care surveys of contracted IMDs.
- Conducting medications training for staff of IMDs.
- "Mobilizing the whole system" to reduce usage, a multi-pronged effort including changes in gatekeeping, closer contacts with IMDs, and creating more step-down options.

State Activities

The counties were asked what were the two most important things that the state could do to reduce or eliminate their use of IMDs. Not surprisingly, all but two counties included more funding of some sort as one of their suggested actions.

Fourteen counties suggested some variation of additional funding for board and care homes.

These suggestions generally took two separate tacks. The more frequent was to increase the rates for general board and care for mental health clients (a) to

overcome the lower rates paid for board and care beds by mental health compared to developmental disabilities and the elderly and b) to overcome inadequate SSI/SSP payments. Both of these problems were cited by the California Mental Health Planning Council's Housing for California's Mental Health Clients: Bridging the Gap as reasons for the shortage of Board and Care beds.[21]

A second general thrust was to increase payments to board and care operators for supplemental services. For example:

- Higher funding for structured board and care programming
- Offer grants for enhanced board and care services
- Incentivize specialized "patches"

Twelve counties suggested additional funding for housing.

While some of the counties mentioned more money for housing alternatives generally, some indicated more specific ideas for funding, including the following:

- More housing grants like Shelter Plus
- Funding to provide subsidies and support to landlords
- Assist with low cost loans to purchase property
- More funding for different kinds of supported housing

Additional money for specific services was mentioned 16 times, while more money or more staff generally was mentioned nine times.

The most frequent specific service mentioned (nine times) was some type of very intensive outpatient program such as ACT/AB 2034/intensive case management. Other specific programs that counties wished could receive more funding included the following: short-term regional alternative to IMDs with aggressive and intensive programs to move clients into the community; flexible outpatient services; forensics team; vocational programs; SNFs with STP.

Some counties felt that up-front seed funds would be very useful.

Some counties directly reduce their IMD capacity through reducing the IMD budget and use the funds that are saved to create community alternatives, most of which are Medi-Cal reimbursable. Some counties find this strategy impossible because of the high demand for the IMD level of care. From this latter group came the suggestion that the state might provide start-up funds for community

[21] One of the reasons for lack of Board and Care beds for MH clients "Other disability groups, such as those serving the developmentally disabled and older adults, are able to pay facility operators a higher rate to house their clients." Another reason sited is "The inadequate reimbursement rate under SSI/SSP makes the expense to run such a facility difficult."

programs which could then be maintained with county funding through savings in IMD usage.

Work on licensing standards and enforcement was the most frequently mentioned legal and regulatory activity that the state could pursue.

Seven counties mentioned licensing issues, most having to do with the Department of Social Services Community Care Licensing of board and care facilities. County mental health efforts to entice board and cares to take clients with more severe problems are blocked by the operator's reluctance to get in trouble with licensing regulations.

- Work with Community Care Licensing to develop standards for board and care operators accepting placements of adults with serious mental illness
- Some help with licensing issues which residential providers cite as reason for not taking some clients

Other regulatory issues mentioned were enhanced civil commitment procedures (four mentions) and allowing greater resource flexibility (two mentions).

Two others suggested actions were the DMH taking a technical assistance role and working more collaboratively with other state agencies.

There were six suggestions related to the state's playing a stronger role in program development, training, and sharing information about good programs, for example,

- Look at what other states are doing to implement Olmstead
- Develop concrete plans about what to do with really tough clients, e.g. wanderers, confused, medical
- Find ways to help counties get more effective services under Medicaid
- Technical support and exposure to other mental health programs that have been successful in keeping IMD usage down

Stronger collaboration with other state agencies was suggested by four counties. Two related to enhanced cooperation with the Department of Alcohol and Drug Program "to reduce administrative hassles around different funding, regulations, approaches, etc." and "to allow more flexible use of funds for dual diagnosis." Two others related to working with the Department of Health Services to "deal with organic brain syndrome issues, namely the placement of these people who are not mentally ill being given mental health diagnoses and being placed in mental health facilities" and "encourage flexible blended funding with Department of Health Services for those with brain injuries and medical problems."

Under 50,000 Population Counties and Consumer/Family Perspective

Interviews with counties with less than 50,000 population confirmed many of the same issues along with some unique concerns.

One of the study contractors discussed this study with attendees of the County Mental Health Directors (CMHDA) Small County Committee. That committee consists of 33 self-identified small counties, the largest of which are around 200,000 in population. Counties were invited to participate in interviews if they desired. The interviews with 11 of these counties with population over 50,000 are included in the data analysis in the main part of the report.

Interviews with four counties with population under 50,000 are not included above. The combined IMD current census for these four counties was nine consumers. The smaller resource base of these under 50,000 population counties makes it more difficult to have a full range of appropriate community resources for their consumers, and the lack of transportation is a barrier to receiving these services elsewhere. One of these counties noted that "rural communities lack the infrastructure for all types of services." Two of the four counties indicated they were just trying to maintain their current services, as one said, "we are trying to keep our heads above water." The smaller budgetary base places these counties at high financial risk since the presence of just a few clients needing IMD services can create a huge strain on their budget.[22]

The small county state hospital bed pool will be phased out in FY 03-04

Since Realignment there has been a shared bed pool for state hospital use which was managed by CMHDA. Access to these beds was controlled through a committee comprised of rotating membership from all the counties. The fiscal incentives actually encouraged greater use of state hospitals since the counties had to make a contribution to the pool whether or not they used the beds and only received back a portion of those funds if they did not use their bed allotment. The utilization management was also a significant burden on the counties. So, beginning in FY 03-04, the small counties will be billed only for the actual state hospital days that they use.

An interview with members of the DMH Client and Family Task Force raised concerns about the quality of care in IMDs and the process of transitioning to the community.

Specific concerns about the care in IMDs included the lack of services for persons with co-occurring substance abuse problems, negative staff attitudes

[22] One small, but a bit larger county (50,000-100,000), had an incident in which a mental health client committed murder resulting in community reaction which pressured the mental health system to institutionalize a larger number of clients.

toward consumers, not enough attention to the tasks of daily living that clients will need in the community, and violations of patient rights particularly for clients placed out of their home county.

A number of participants stressed the difficulty of the transition from an IMD to a community placement. One said, “It’s a four foot drop,” and “we need to build a ramp, rather than a step-down.” One person suggested allowing residents to visit clubhouses while they are still in the IMDs to ease the transition.

PART B: STATEWIDE DATA COLLECTION

Interviews with counties resulted in discrepancies between the statewide data collected by DMH and information from individual counties. We are working with DMH to insure the reliability of the statewide data and will review and analyze this data when this task is accomplished.

PART C: OBSERVATIONS AND CRITERIA FOR SELECTION OF PART II CASE STUDY COUNTIES

Observations

Expanding community living situations for persons with serious mental illness is critically important.

The county interviews were striking in their highlighting of the need for additional housing resources. As noted above, the Mental Health Planning Council has generated a careful analysis of some of the critical issues related to housing and has made a series of recommendations.

The Technical Assistance Collaborative and the Consortium for Citizens with Disabilities Housing Task Force note that while housing resources are essential to implementing solutions to Olmstead, “‘housing’ does not appear in the decision. Instead, the Supreme Court uses terms such as ‘community placements’ and ‘less restrictive settings.’”[23] At the time of the publication of this issue of Opening Doors (December 2000) “none of the committees formed, Executive Orders issued, or legislation enacted by states in response to Olmstead mentions housing or includes housing officials or experts.” And none of the 22 Olmstead-related state plans sent to HHS for review mentioned housing.

[23] *Opening Doors: The Olmstead Decision and Housing: Opportunity Knocks.* Technical Assistance Collaborative and the Consortium for Citizens with Disabilities. Issue 12 of *Opening Doors*, December, 2000.

Fortunately, California's Long Term Care Council does include the Director of the Housing and Community Development (HCD) and its Olmstead Plan acknowledges the importance of housing. The Plan contains information about housing resources available in the state including the Supportive Housing Initiative Act (SHIA) which is a collaboration among the state's Department of Mental Health, HCD, and the Supportive Housing Council. The program has dispensed $48 million for supportive services and rental subsidies to 46 projects, 45 of which have a primary focus on persons who have serious mentally illness. One of the housing recommendations in the plan is "to expand DMH's Supportive Housing program," but the recommendation has the proviso of "subject to additional funds."

The counties confirmed the importance of ACT/AB 34/intensive case management programs in supporting persons in the community.

As expected, counties repeatedly noted the value of intensive outpatient services in sustaining clients in the community. Those that had ACT or AB 34 programs said they had made a difference, and most felt they could use additional slots. And those without such programs had them on their wish list.

In Phase II of the study we hope to examine IMD utilization among clients in such programs to identify policies or practices which may contribute to lower utilization.

Counties differ in their monitoring practices and procedures, and in the proximity of the IMDs utilized to the county. It will be important to assess the impact of these factors on IMD utilization.

Counties varied in the frequency with which they monitored clients in IMDs. Frequency of visits to the facilities where clients were placed ranged from almost daily to quarterly. Generally, counties visited facilities that were located close-by more frequently than those that were further away, and visited facilities in which they had a number of clients more often than facilities where they had only placed one or two clients. Clients with active discharge plans in the near future were often visited more frequently. In Phase II of the study we will examine the impact that the geographic location of the facility and different monitoring practices have on IMD utilization and factors such as length of stay.

In some cases there is a difference between the language of the recovery vision and the realities of IMD use.

The language of those who are managing and working with clients in IMDs does not always synchronize with the recovery vision. As noted above, interviewees frequently used concepts in describing IMDs and their clients that are not consistent with the importance of client driven service plans and activities. While we recognize that some of the more ill clients in IMDs may not be able to

participate fully in recovery-oriented programs, it is important to ascertain whether medication and behavioral therapies are being continually tried and evaluated in an effort to ready clients for other recovery-oriented services. Opinions differed on whether MHRCs were more consistent in their recovery orientation than SNF-based IMDs.

Consumers and county systems of care would clearly benefit from a consistency of the recovery perspective throughout the service system. While an assessment of the functioning of IMDs is beyond the scope of this study, we will attempt to highlight ways in which the IMDs used by our study counties appear to follow or conflict with recovery concepts.

Fiscal pressures provide clear incentives for actions to reduce IMD usage.

Counties were asked what changes, if any, there had been in their level of IMD usage over the last few years. Eight counties indicated significant decreases in overall usage the last two years, reportedly ranging up to 45-50%. In each of these cases, fiscal constraints were cited as the, or one of the reason(s), motivating the change. We plan to include some of these counties in the Phase II part of the study to explore the factors leading to these decisions.

Unfortunately, the same fiscal constraints were cited by a number of counties for the situation either worsening or staying the same because it tightened the availability of alternative community resources.

Understanding the needs of long-stay patients in IMDs is critical to the state's ability to implement Olmstead.

As noted above, there is a subset of consumers whose prospects for discharge appear dim because the counties believe there are no feasible untried community placements. Examining the circumstances of this subset of consumers will be particularly critical in relationship to the dictates of the Olmstead decision. We will explore in Phase II of the study how frequently these consumers receive a full re-assessment that aims to determine whether or not there is a less restrictive placement for them.

Licensing of IMDs and community care facilities create real or perceived problems in using these facilities appropriately and consistently with Olmstead.

The mission of facility licensure is the protection of resident. The Department of Health Services licensing of SNFs and the Department of Social Services licensing of community residential facilities try to ensure that there are no deaths, suicides, substance abuse or other negative occurrences and to give sanctions to and restrictions on facilities where any of these or other dangerous incidents occur. County mental health is responsible for treating individuals who are at greater risk for all of these negative consequences.

Implementing Olmstead and the recovery vision requires that facilities and the community take a reasonable level of risk. Counties identified the need for licensing entities to have a better understanding of mental illness and service programs. The tradeoffs are not easy or always clear-cut, but a more sophisticated dialogue is needed about how to both protect consumers and the community while giving every consumer the best chance for leading a meaningful and productive life.

The role of conservators can influence IMD utilization both to increase it and decrease it not always in relation to the needs of the clients as determined by any objective criteria.

Counties described different attitudes and actions by conservators, which appear to be influenced by factors other than clients' needs. For example, after a major community incident in one county IMD utilization increased substantially. Counties also described conservators willing to continue conservatorship in the community to help clients adjust verses those who dropped the conservatorship as soon as a client was discharged. This problem is not unique to conservatorship but is consistent with issues raised by clients and families about the different implementation of the Lanterman Petris Short Act (LPS) among counties.

Selection of Case Study Counties

The primary purpose of Phase II of the study is to explore reasons for varying rates of IMD usage.

We have identified two major hypotheses regarding (and collected some information about) what accounts for the varying county rates of IMD usage: gate keeping and monitoring procedures and the availability of community placements. There are additional factors that are likely to have an impact:

- Demographic characteristics including size and cultural diversity
- Levels of overall funding
- Historical usage patterns
- Politics and community tolerance
- Conservatorship issues

The strategy used to select case study counties was as follows:

1. Usage rates. *The top 10 and the lowest 10 counties were identified*

2. Explanatory factors. *These 20 counties were weighed on how they stood on the range of explanatory factors cited above, i.e. gate-keeping/monitoring processes; availability of community placements; demographic factors; level of overall funding; historical usage patterns; politics and community tolerance and conservatorship. The purpose is to obtain as much variety on these factors as possible.*

3. Data systems and willingness to participate. *Added weight was given to including counties with good data systems and with high willingness to participate in the study.*

Appendix A
Counties Interviewed

Alameda
Butte
Contra Costa
El Dorado
Fresno
Humboldt
Kern
Los Angeles
Marin
Mendocino
Merced
Monterey
Napa
Nevada
Orange
Placer
Riverside
Sacramento
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Solano
Sonoma
Stanislaus
Sutter/Yuba
Tuolumne
Ventura
Yolo

Four Counties Under 50,000 in Population
Glenn
Mariposa
Siskiyou
Trinity

Appendix B
County Interview Protocol

County: **Date:** **Persons Interviewed:**

PART I: GENERAL INFORMATION:

We are interested in the numbers and types of IMD/state hospital/MHRC beds your county uses.

1) *Which IMDs do you utilize (Note whether state hospitals, MHRCs, SNF, or IMDs)?*
_____ *(_____)_ # of beds*
_____ _____*(_____)_ # of beds* _____ _____*(_____)_ # of beds* _____
_____*(_____)_ # of beds*
_____ _____*(_____)_ # of beds* _____

2) *Are there any differences between the IMDs and the MHRCs? If so, what are the differences*

3) *How many clients did you send to IMDs in FY 0l/02?* _____
FY 02/03? _____

4) *What is your current census at each IMD you use?*

Facility: _____ *Census* _____
Facility: _____ *Census* _____
Facility: _____ *Census* _____
Facility: _____ *Census* _____
Facility: _____ *Census* _____

5) *Have your IMD usage patterns changed in the last three years?*
Yes _____ *If "yes", please describe how they have changed.*
No _____

6) *If yes, what caused the changes?*

7) *Do you know what your recidivism rate is for persons discharged from IMDs in their first year in the community? If so, what is it?*

8) *How do IMDs fit into your system of care? Are they short term, step down from more acute facilities, long term, for special populations? Please explain how they vary from each other.*

PART II – ACCESS AND MONITORING

We are interested in the process by which clients are admitted to your IMDs and the process by which they are monitored while they are there.

9) *What kinds of situations/placements do the clients that get placed in IMDs come from?*

10) *IMD referrals are screened/approved by persons in what role?*

11) *What documents are used in the process?*

12) *Do you have a standard form that you use at time of admission? If "yes", please email or fax a copy to us.*

13) *Do the IMDs you use have treatment plans in place that helps individuals work toward recovery and treatment in the community?*

14) *Do the IMDs you use have programs which deal with the cultural issues and diversity of their clients?*

15) *Are standard forms or progress reports from the IMDs used to document progress while County clients are in the IMDs ? _____ Frequency of submission _____*
Please email or fax copies of any forms to us.

16) *How does the County monitor the progress of clients in IMDs?*
By whom?
How often?

PART III - CLIENT NEEDS:

We are interested in the characteristics of clients that are most difficult to place or maintain in the community. We would also like to know about what makes community placement of difficult clients hard in general, i.e. what community factors in general are barriers to placement for all your clients. And we would like to know what might make a difference for you in addressing these client needs and community barriers.

17) *What type clients with mental illnesses are most difficult to serve in the community? Please rank these–with # 1 being the most difficult.*

Substance abusers _____
Limited intelligence (Incl. But not limited to DD) _____
Organically impaired _____
Aggressive or Explosive Personalities _____
People who do not take medications _____
Antisocial Personalities _____
Sexual Offenders _____
Others _____

18) *What resources do you need to get many of your present IMD residents out in the community?*

19) *What are the three most important general barriers to community placement in your county?*

Lack of income support and entitlements _____
Lack of affordable housing _____
Lack of competitive and supported employment _____
Lack of access to culturally appropriate health care _____
Fragmented services _____
Lack of access to culturally appropriate/specific mental health services

services _____
Fiscal barriers to individualized, flexible services _____
Stigma and discrimination _____
Undocumented Immigration Status _____
Legal and/or Conservatorship barriers _____
Staffing shortages _____
Categories? _____
Others _____

20) What are you doing to overcome these barriers?

21) Which of these activities are most promising?

22) Which of these services do you currently have in your county?

Intensive Case Management/Comprehensive Service Programs (like AB2034, ACT, etc)? _____
 # slots _____

Residential beds with some programming? _____
 # slots _____

*Self Help Programs*_____
*# slots or capacity*_____

Board and Care Beds (no programming) _____
 # slots _____

*Board and Care Beds with Supplemental Services (old SB155 model*_____
*# slots*_____

*Board and Care Beds with county treatment patch*_____
 # slots _____

Programs for Co-Occurring Disorders? _____
 # slots _____

Please describe the kinds of Crisis Services that you have.

23) What additional intensive services would be desirable in your county?

24) What do you think the two most important things the State could do to reduce/eliminate your counties use of IMDs?

25) Does your county have unique or special programs that we might want to review in detail in the course of our study? If so, please describe.

26) Would your county be willing to participate in a more detailed study that will closely monitor all persons admitted to IMDs over a 12 to 15 month period?

Questions Added on Conservatorship

27. Who does conservatorship investigation in your county and who is responsible for ongoing conservatorships?
28. Are most of the clients in IMDs on conservatorship?
29. Do the conservators participate in the monitoring process?
30. What is the relationship between the mental health department and the public guardian or conservator?

Appendix B:

Six County Case Studies

County A

"The easier the path to commitment the more likely there will be a mistake."
"The role of the IMD is to serve those clients who cannot be safely *served in special intensive residential programs."*

Summary: County A has the lowest rate of IMD usage of the case study counties. Low usage is reached through a consensus on philosophy of the mental health leadership, the Public Guardian, and the strong patient rights organization. The groups have worked closely on the development of both clear standards for the use of the IMD level of care and the processes through which access to IMD services is gained and ongoing stays monitored. The hospital acute unit, in recognition of this general philosophy, will hold some clients until they can be placed safely in the community rather than making an IMD referral. The County uses primarily one IMD facility – located in the county – which facilitates the process of controlling IMD usage and the ensuring of active focused treatment while in the IMD. The County has some step-down capacity provided through enhanced board and care (B/C) facilities. The County has an adequate number of regular B/C placements with some supplements for extra individualized services, but has a very limited supply of supportive housing. Adult system of care (SOC) services are provided through regional outpatient teams. The county has a high rate of Misdemeanor-Incompetent to Stand Trial (MIST) penal code commitment clients, but a low rate of conservatorship.

Part 1: County Demographics

The table below details the demographic features of all six study counties and the entire State, with the county in this report highlighted. Data is taken from the U.S. Census Bureau, Census 2000 Quick Facts

Demographic Features of Case Study Counties

	County F	County A	County B	County C	County D	County E	State
Population (2004)							
Total Population 2004 (000s)	*213*	*735*	*9,519*	*2,988*	*1,921*	*1,685*	*35,894*
Pop growth rate 2000-2004	*4.8%*	*11.1%*	*4.4%*	*5.0%*	*12.4%*	*0.2%*	*6.0%*
Pop aged 18-64 2004 (000s)	*128*	*434*	*5,931*	*1,885*	*1,135*	*1,109*	*22,290*
Race/Ethnicity (2000)							
White	*84.5%*	*61.6%*	*48.7%*	*64.8%*	*58.9%*	*53.8%*	*59.5%*
African American	*1.4%*	*6.0%*	*9.8%*	*1.7%*	*9.1%*	*2.8%*	*6.7%*
Native American	*1.9%*	*1.5%*	*0.8%*	*0.7%*	*1.2%*	*0.7%*	*1.0%*
Asian/P.I.	*3.4%*	*3.5%*	*12.2%*	*13.9%*	*5.0%*	*25.9%*	*11.2%*
Other race	*4.8%*	*23.2%*	*23.5%*	*14.8%*	*20.8%*	*12.1%*	*16.8%*
Two or more races	*3.9%*	*4.1%*	*4.9%*	*4.1%*	*5.0%*	*4.7%*	*4.7%*
TOTAL	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*
Hispanic/Latino Origin	*10.5%*	*38.6%*	*44.6%*	*30.8%*	*39.2%*	*24.0%*	*32.4%*
Other characteristics (2000)							
Language other than English Spoken at Home (% aged 5+)	*12.5%*	*33.4%*	*54.1%*	*41.4%*	*34.0%*	*45.4%*	*39.5%*
High School Graduation (% aged 25+)	*76.8%*	*68.5%*	*69.9%*	*79.5%*	*74.2%*	*83.4%*	*76.8%*
Home Ownership	*60.7%*	*62.1%*	*47.9%*	*61.4%*	*64.5%*	*59.8%*	*56.9%*
Median Family Income (1999)	*$31,924*	*$35,446*	*$42,189*	*$58,820*	*$42,066*	*$74,335*	*$47,493*
% Under Poverty (1999)	*19.8%*	*20.8%*	*17.9%*	*10.3%*	*15.8%*	*7.5%*	*14.2%*

Part 2: Crisis and Acute Components of the Adult SOC

The County uses its 23-hour crisis stabilization to avoid hospitalizations.

County A's emergency services unit is located in the County's Medical Center Emergency Room. The unit evaluates roughly 300 clients a month. About 75-80 clients are admitted each month to the acute unit. The 6-bed Crisis Stabilization Unit is usually full every night; about one-third are walk-ins to the Emergency Department with the rest brought by the police.

A Crisis Case Management Outreach Team responds largely to calls from other hospitals in the county. They call the police if they think necessary; otherwise they go alone to do the assessment.

County mental health also has a Mobile Emergency Team (MET) which is available from 8AM to midnight Monday through Friday to join the police on instances where a mental health problem is expected. The unit is also available to do 5150s for other hospitals.

The County utilizes aggressive treatment planning in their major acute units.

The County Medical Center's 25-bed locked unit is the only locked unit in the county. Their payer mix is correspondingly mixed: approximately 30% Medi-Cal, 25% Medicare, 11% indigent, and 34% private insurance. Their Average Length of Stay (ALOS) is 7-8 days. A treatment plan is developed within 3 days which includes preliminary discharge plans. The unit meets with an adult SOC rehabilitation team at 3 days and weekly thereafter. A decision is generally made within the first few days on whether to start the T-conservatorship process; decisions about a 180-day dangerousness commitment are usually made within one week.

The manager of the acute unit knows well the stringent standards required in the county to obtain a conservatorship and also the standards used by the long-term care unit for IMD placement. Thus some clients whom she knows will not qualify for conservatorship and IMD placement remain on the unit for additional time until an appropriate community placement can be arranged. The availability of housing options – including B/Cs and room and boards – is sufficient to allow the unit manager to usually arrange such placements in a timely fashion so that the unit's administrative days are quite low, e.g. they had 4 administrative days out of 680 days in April, 2004.

Part 3: Structure of IMD Administrative Control

The County has used a central Long Term Care (LTC) unit since 1995.

The County's service system is divided into four levels of service with Level 4 encompassing the IMDs, SHs, and enhanced B/C facilities. The LTC unit has control of the budget for all Level 4 services.

The County has handled access to the IMD level of care through a centralized unit for roughly ten years. The unit has an annual budget for IMD usage which is translated into a contract with the one in-county IMD and the one out-of-county IMD added in FY 04-05. The LTC unit checks the census on a weekly basis. The unit usually is able to maintain a census within the allocated budget, but a few years ago required a mid-year augmentation to its budget. The number of contracted beds in the in-county IMD was reduced from 26 to 22 within the last few years. The new contract for the out-of-county IMD is for 6 beds.

Part 4: Type, Location and Quality of IMD Level of Care Facilities

TYPE AND LOCATION

The County works almost exclusively with one in-county Mental Health Rehabilitation Center (MHRC) supplemented by an out-of- county Special Treatment Program (STP) Skilled Nursing Facility (SNF).

The one in-county IMD facility was converted within the last few years from an STP SNF to an MHRC license. Interviewees think the conversion brought an increased focus on active treatment and a recovery focus which has been positive. But one of the downsides has been the facility's increased reluctance under its new licensing to accept clients with more serious medical problems. As a consequence the LTC unit has initiated a contract with an out-of-county STP SNF facility which has the capacity to serve clients with these medical complications.

The County's use of state hospital (SH) beds has increased in the last few years.

The County uses the SH for three populations: persons on LPS conservatorships for whom community placement is or has been insufficient; persons who have been found Incompetent to Stand Trial of Misdemeanor charges (CA Penal Code section 1370.01); and persons who have been certified as being dangerous to others (CA W&I Code 5300). Generally, these populations are served in the SH due to one or more of three reasons: fragile health condition that prevents placement at a lower level of care; risk of danger (assaults) to other residents at a lower level of care; persons over the age of 59 for whom no lower level of care can be found.

The County has a total of ten clients at two SHs. The County attributes the increase in the last few years to greater use of the 180-day dangerousness certification. The County will use the SH for clients who are too assaultive to be handled in the local MHRC. A number of the SH clients have been at that level of care for a number of years. There are long waits for IMD admissions. Clients often have to stay longer at the SH due to a lack of IMD beds.

The County has transitioned some clients to regular SNFs.

A handful of clients who have medical problems have been transferred to regular SNFs. This occurs when the client's behavioral health issues are not so serious that they can't be handled in a regular SNF. These clients are followed by the LTC unit until the placement has been successfully completed, and the patient rights' unit continues to follow many of these on a quarterly basis after the transfer is made. Most of these clients are on LPS conservatorship and so are followed as well by the Conservator's Office.

QUALITY OF CARE

The quality of care at the one in-county MHRC is perceived as good.

Interviewees felt generally positively towards the care provided at the in-county MHRC. The communication between the behavioral health department and the facility is excellent. The active involvement of the LTC unit case manager, the patient rights advocate, and the conservator's office in the Interdisciplinary Team (IDT) meetings and the quarterly update meetings on the client's progress also facilitate positive interactions.

The county has done some training in Cal-Map and is hopeful that it will influence medication practices in the MHRC.

Part 5: Access to and Monitoring of an IMD Stay

INTAKE

The County utilizes a team approach to IMD intake.

While the ultimate decision on IMD placement rests with the LTC team, decisions are generally made through the consensus of an interdisciplinary team (IDT) meeting. The team consists of representatives from the acute unit, the psychiatrist from the acute unit, representatives from the appropriate adult SOC rehabilitation team, family members, a representative of the conservator's office, and the patient rights advocate. These IDT meetings have evolved from a contentious bickering to a relatively smooth process in which all parties are in general agreement about standards for placement in an IMD. The use of standardized forms has helped the process run more smoothly.

MONITORING

Low caseloads allow for aggressive on-site monitoring of the clients' stays in IMDs.

When clients are expected to return to the facility in six months or less, responsibility for case management remains with their community team. Care coordinators bring important information to the facility about their client's functioning in the community. Case management is transferred to the LTC unit for longer term residents. The case managers in the LTC unit have caseloads of 30 clients. They see each client at least monthly and often more frequently. The IDT meets at least quarterly to review the client's progress with a focus on the obstacles that prevent the client from being discharged to a lower level of care. When a client is stabilizing and approaching discharge, the IDT meets monthly.

DISCHARGE PLANNING

For longer term residents, the LTC case manager remains the main contact for a client in an IMD and through transition to the community until the client is ready for a regular B/C (i.e. one that is not augmented).

The LTC case manager retains contact if the client is discharged to an enhanced B/C. Responsibility for case management is transferred to the rehabilitation team whenever the client is ready for a regular B/C which can be directly from the IMD or from the enhanced B/C.

Part 6: LPS Criteria and Public Guardian Processes

County A is among the counties with the lowest conservatorship rates in the state.[24]

The County's rate of permanent conservatorship per SSI recipient is 0.3%; the range across counties in the state is 0.3% to 5.3%. The rate of temporary conservatees is below 0.1%; the state range is from <0.1% to 3.1%. In FY'02 the county had only 25 new temporary conservatorships and in FY '03 only 28. The rates of conversion to permanent conservatorship were 52% in FY '02, 46% in FY '03 and 38% to date in FY '04. Temporary conservatorships will occasionally be extended in order to prevent a client's placement on a permanent conservatorship. But, based on the experience of other counties the low permanent conservatorship rates are more a reflection of tighter access to temporary conservatorship than the conversion rate to permanent conservatorship.

Rates Per 10,000 by Category of Involuntary Status (FY 02-03)[25]

	County F	County A	County B	County C	County D	County E	State
72-hour Evaluation & Treatment	59.5	13.7	73.2	45.5	59.6	28.7	54.4
14-day Intensive Treatment	3.8	3.5	30.0	9.9	6.6	9.0	16.9
30-day Intensive Treatment	0	0	5.1	0	0	0	1.6
180-day Post Certification	0	0.11	0.01	0	0.01	0	0
Temporary Conservatorships Established	1.9	0.4	1.4	1.9	1.3	2.1	1.8
Permanent Conservatorships Established	5.0	0.6	5.1	5.8	2.2	5.4	4.1

CONSERVATORSHIP STANDARDS

[24] Data is from state DMH Statistics and Data Analysis for FY 99-00.
[25] California Department of Mental Health, Statistics and Data Analysis, March 2005

A strict and narrow definition of grave disability evolved from the initiative of the patient rights' unit.

About ten years ago the Patient Rights unit began an aggressive effort to require the mental health treatment system to document the measurable behaviors, by which a client is determined to be gravely disabled along with ensuring that any such client then receive aggressive treatment to change those behaviors. The impetus for the initiative was concern about the quality of care that clients on conservatorship were receiving at the IMD-level of care – namely that they lacked active treatment plans which were required by the law for any client on conservatorship. Their position was supported by the county counsel who wanted to ensure that the county was following the letter of the law.

The Patient Rights unit took the position that they would fight the assignment of a conservator if that was the desire of the client. They felt that a strict interpretation of the statute stipulates that any client who was voluntarily accepting help was not gravely disabled. Additionally, grave disability as a secondary condition is not sufficient. An example was presented of a client who refused to eat and whose weight had dropped to a life threatening level. The advocate took the position that the client was a danger to herself and therefore not gravely disabled or eligible for conservatorship.

The tight path to conservatorship and IMD placement are reinforced through the IDT process.

At the insistence of the Patient Rights unit the county developed a set of forms which are reviewed at the IDT meetings. The forms require the explicit noting of the behaviors which qualify the person for grave disability and placement at an IMD-level of care. The corresponding treatment plan must also include what will be done to ameliorate the behaviors which are preventing the client's movement to a lower level of care. These forms evolved through the early meetings of the IDT group amid considerable initial disagreement about what should be the appropriate standards. Early meetings sometimes took four hours with various constituencies "posturing" thinking that they had the right answer. One participant said that it took lots of time and training for the participants to learn how to interact with each other. Over time the group developed a consensus which allows the IDT meetings and recommendations about conservatorship to generally occur without much dissension.

The IDT reviews clients quarterly after placement in the IMD, and the forms are reviewed and revised as necessary.

OTHER LPS PROCEDURES

The County uses extensively the 180-day post certification for dangerousness.

The 180-day certification for dangerousness is initiated by the acute hospital unit. A psychiatrist in the Judicial Services unit of the Department of Mental Health is responsible for the 180-day post certification program and screens clients who then have the right to the LPS procedures and protections including filing a writ to request a court hearing. These clients also go through the IDT process.

A recent (within last week) documented instance of hurting some one or threatening someone is required for the psychiatrist to consider the recommendation of a 180-day dangerousness certification. The county counsel routinely accepts the recommendation of the psychiatrist.

The County has established a separate treatment program for the clients who are under a 180-day dangerousness certification.

The County has found that the 180-day certified clients differ from those on conservatorship. The former are more mobile, more likely to be involved with criminal justice, more anti-social, often more manipulative, and more functional than the conservatorship clients who have more negative symptoms and have more "chronic" disabilities. They find that the 180-day clients are often more difficult to engage in services.

In order to ensure that the 180-day clients are not just isolated and ignored the county has developed an aggressive treatment program at the in-county IMD focused on helping the clients change the behaviors that are getting them into trouble. The treatment groups stress reality testing and anger management.

An effort is made to have the clients discharged from the IMD prior to the termination of the 180-day certification period so that they can monitor the client's adjustment in the community. Theoretically the county psychiatrist could have the police detain a client and remand him to the hospital, but this has not happened thus far.

CRIMINAL JUSTICE

The County also has an unusually high number of MIST clients in its IMDs.

About 30% of the clients placed in IMDs are MIST (PC 1370.1) clients. Up until about 10 years ago any mentally ill persons who was sent to the state hospital under criminal statues was paid for by the state. This was changed so that while felons remained the financial responsibility of the state, misdemeanants were paid for by the counties. The County decided that they could provide appropriate and less expensive mental health care in the county and so contracted with the in-county IMD to provide a program for these clients. According to county staff, most other counties either have the courts drop any misdemeanor charges and

try to get the clients on conservatorship or have the charges considered to be a felony so that the state will pay for state hospital care.

One county forensic psychologist is in charge of the MIST clients and program. County mental health operates a mental health unit at the jail from where most of the MIST clients are referred for IMD placement. The psychologist makes recommendations on placement, but the final gate keeping for the IMDs for MIST clients remains with the LTC unit. The IMD runs a special tract for these clients.

There is some concern within the County that the standards for conservatorship and IMD placement and 180-day certification might be alternatively too tight and too loose.

A number of interviewees expressed some concern that the standards for placement in IMDs may have become too tight within the last few years. The concern is greatest for those with serious medical and/or psychiatric problems who are placed in the community without sufficient supports. One person also noted that conservatorships are sometimes removed earlier than might be in the best interests of the client once the client is doing well in the community. The County is revisiting these issues as part of a broader strategic planning process that is exploring the needs of clients with high treatment costs.

There was an alternative view expressed by some that the 180-day dangerousness process may have become too accessible. The numbers apparently increased while there was a temporary hiatus in the activity of the Patient Rights unit. Because there are less procedural safeguards against the use of the 180-day certification there is some fear that it may be being overused.

Part 7: LPS Structure

The LPS unit was moved out of mental health and rejoined the Probate unit in a new department.

The County consolidated its probate and LPS units into a new department – Aging and Adult Services along with the Office on Aging, the older adult mental health outreach unit, IHSS, and Adult Protective Services. Some state advocates were at that time urging counties to consolidate all their services for the elderly into a single department.

A consequence is that there are some services for dependent adults (e.g. LPS and some IHSS services) which are included along with the services for the elderly. The Public Guardian considers the move a positive. It allows cross training of his staff on both LPS and Probate. There was no change in the leadership, the staffing, or the philosophy of the LPS unit as a consequence of the move.

The leadership of the unit has been unchanged since 1997. The unit head came from mental health, and his two deputies have mental health backgrounds. The unit head was actively involved in the evolution of the IDT process. The conservator's office was a willing participant in the changes as it was going through a crisis caused by an instance of child molestation by a conservatee who it turned out was not mentally ill.

Part 8: Step-Down Resources

The demand for the County's augmented B/C beds exceeds the supply.

The County relies heavily on "Augmented B/C" homes. They contract with several B/C providers in a fee for service arrangement so that the B/C home staff can provide several recovery activities to the residents each week. There is a menu of services that are approved. The provider, client and mental health service coordinator agree on a plan of activities as well as the frequency of service. This service is also considered transitional in nature. It is funded by a combination of Realignment funds and a SAMHSA grant.

The supply of augmented B/C beds is controlled by the budget with the gate keeping responsibility lying with the LTC Unit on the recommendations of the IDT. These facilities receive a supplemental rate for all the clients in the facility. These facilities function primarily as a step-down for the IMDs. The following describes the basic programs that fit into this step-down level of care.

- Five beds at a 15-bed unit operated by an IMD provider located next to the IMD. This provides some continuity with the same psychiatrist at the B/C as at the IMD. This is a semi-structured open setting with the emphasis on skills building and learning to navigate in the community.

- Nineteen beds in three 6-8 bed facilities run by one operator. The focus of these programs is to help clients better understand their mental impairment and learn how to manage it. They try to create a home-like environment and have young staff. They emphasize individualized programming with both daily living skills and social skills. The facilities are used as a long-term placement for a few clients, but the beds are used mostly for clients as a transition from an IMD to a regular B/C.

- Seven beds at a ranch-like setting in another county.

Some clients are reluctant to move out of the augmented B/Cs either because of fear or knowing they have "a good deal." The County has more leverage in moving clients through this intermediate step when the client has a conservator.

The County tries to not utilize these beds when intensive outpatient care would be sufficient support for a client who could be placed in a regular board and care.

The augmented board and care facilities noted an insurance problem with older adult clients.

The county contract with the augmented B/C facilities requires the facility to indemnify county harmless for any suits against the facility. At least one facility noted that its insurance carrier would not allow it to accept any clients older than 60 because of this provision in the contract. It is unclear whether the insurance companies' reluctance is based on actuarial concerns or because of something in the licensing of the facilities.

Many clients attend day treatment services during the transition from the IMD.

The county contracts for a day-treatment center located in their largest city. Many of the clients in the enhanced B/C facilities attend the day treatment program as well as almost all of the clients in regular B/Cs who are still being monitored by the case manager of the LTC unit. The day treatment program is oriented to the needs of individual clients with clients attending variable numbers of days according to their needs.

The County has sufficient B/C beds and supplements facilities to provide enhanced services.

Interviewees agreed that there is not a shortage of B/C beds in the community, but there is an ongoing concern about the quality of care provided in some of them. The County has a program for enhancing B/C facilities for the addition of specific services for specific clients. (This is different from the augmented B/C facilities cited in the prior section, which receive a supplemental daily rate for all their clients.) "Enhanced B/C" is accomplished through a contract for daily services by a B/C staff (usually as a transition from a higher level of care). For this, they pay a daily rate or "patch" for services above and beyond those provided at the customary ***B/C rate. These services are funded by*** realignment funds. The County has defined 12 different service categories for which B/C facilities can be reimbursed if they hire additional staff to perform these services for a specific client pursuant to a client's treatment plan. The County will pay $15 per service per client for up to 12 services per month.

The County would like to have more supported housing programs.

County mental health is part of a multi-agency housing workgroup trying to expand housing opportunities at all levels. The County is developing an AB 1425

program (a type of supported housing) that will have the capacity for 24 clients. They will take the first clients from the augmented B/C level.

The Patient Right's advocate expressed concern about the use of unlicensed room and board facilities for some clients. They would like experienced providers to be able to provide supportive services to those clients at this level who need such services.

Part 9: Adult SOC and Community Resources

SERVICES

The County's adult SOC is organized into six regional rehabilitation teams.

Most services are provided through the teams. Each client has a coordinator who handles any direct provision of services and makes referrals to other services available through the team. Care coordinator caseloads are between 40 and 50 clients. They are required to see their clients at least monthly, but the frequency of contact among clients varies tremendously based on the clients' needs at any point in time. The teams organize themselves differently to handle meds and therapy services, with some having meds only clinics.

Most of the Community Service Teams have trained substance abuse staff. For those teams who do not have a Substance Abuse Specialist, they arrange for such staff from other teams to provide services at the team site. The services reflect the state's goal of "One team with one plan for one person" i.e. having mental health and substance abuse treatment fully integrated.

Some services are available on a countywide rather than regional basis. The County has a large Dialectical Behavioral Therapy (DBT) service with 13 staff that have had formal training in this method. This unit has 40 clients each of whom makes a one-year commitment to attend two sessions a week. Other central services include vocational services and educational support in conjunction with the Junior College.

The County has not made use of Assertive Community Treatment-type (ACT) programs for the population likely to use the IMD level of care.

While the County operates an AB 2034 program with 175 clients the resource is not generally available as an alternative or as a step-down to IMD usage. Interviewees noted that the county has not generally seen the benefit of ACT teams for the LTC population, but the county is currently piloting a very small program.

CULTURAL COMPETENCE

The County SOC has a strong focus on cultural competence.

The County has done a lot of work on cultural competence for their system as a whole. The in-county IMD is not only compliant with their standards but also is embracing cultural competence and learning. The parent corporation for this IMD actively shares program ideas between their facilities.

RECOVERY

The County SOC articulates a focus on recovery.

Conversion of the in-county IMD to an MHRC helped with the recovery focus for services. The role of the case manager is also important in bringing this focus to client service plans. The County does not see the SH as having this focus

Part 10: Lessons

A consistent philosophy across agencies and from the leadership of the mental health department can promote a low, but targeted usage of the IMD level of care.

The role and function of the IMD level of care in County A is clear:

- ***Role: It is for clients who can not be <u>safely</u> served in the community.***
- ***Function: The services are to be focused on the measurable behaviors that prevent the client from being served at a lower level of care.***

This philosophy is held by all the crucial parts of the system – including the conservatorship office and the patient right's unit. The shared philosophy creates a strong culture which then extends to all parts of the mental health system service system.

Building an effective structure to support the philosophy is also critical.

The philosophy is implemented through an effective process of IDT meetings. The IDT paperwork focuses everyone on the measurable behaviors that necessitate the IMD level of care and make the amelioration of these conditions the goal of treatment. While the overall control of access to the IMD level of care is held by the LTC unit within Behavioral Health, the IDT meeting structure has evolved to the point where its decisions usually form the basis for the decisions by the LTC unit.

A periodic review of the philosophy and its implementation ensures an appropriate balance.

The usage of the IMD level of care and the use of permanent conservatorships is as low in this county as any where in the state. The leadership of the Behavioral Health Department is attentive to the danger that that usage rate could get too low and jeopardize the safety and quality of care provided to clients. The annual budget is reviewed with these cautions in mind, and the strategic planning process of the Department looks periodically for any indications that the balance may have tipped too far towards low utilization.

There are alternatives to the LPS conservatorship track that appear to have value.

The County's concern about the deleterious impacts of conservatorship and the subsequent stringent standards for grave disability have led the county to use alternative LPS procedures – namely the 180-day post certification for dangerousness to others. The County has found this a useful category since it seems to define a set of clients with different characteristics and treatment needs than most of the clients on conservatorship. This has allowed the County and the IMD to devise a special treatment tract which may be more appropriate for these clients.

An active, persistent and politically astute advocate, knowledgeable about the LPS law can have a significant impact on the LTC system in a county.

The staffing of the patient right's unit within this county has been consistent over the last twenty years. The ongoing involvement of this unit in the interpretation of LPS law and in the monitoring of service needs of the LTC clients has been a critical impetus for change. The concern of the patient right's unit has always been on the quality of care being received by the clients, particularly the concern that clients on conservatorship have ***a***ggressive treatment plans and not be left "to languish." This concern for clients' treatment and the building of community resources has allowed the unit to be an effective and respected part of the system over the years.

Being a relatively small county that can utilize an in-county IMD facilitates good working relationships between the county and the IMD.

The County has been able to develop very good relationships with the IMD operator who is able to accommodate most of the County's clients at this level of care. This has allowed the County to monitor the care provided to its clients to ensure that active focused treatment is provided. It also allows for a level of client monitoring that ensures appropriate timing of discharges.

Relatively low caseloads for the LTC case managers who do the monitoring also help.

The case manager for the LTC unit has about 30 cases. This allows her to not only do active monitoring while the clients are in the IMD, but also to follow clients while they are in step-down augmented B/C facilities and then for a short while into the community to ensure that connections are made to the outpatient rehabilitation teams.

The presence of a step-down level of care seems to facilitate earlier and more effective discharges from the IMD level-of-care.

The County has a number of augmented B/C facilities that provide active support and skills building for clients who are transitioning from the IMD and are deemed to need more services than they would receive in a regular B/C. Many of these clients also attend an individualized day treatment program. The County has some difficulty in using this as a transitional level of care as some clients do well and there is reluctance to move them to a regular B/C.

Update – March 2005

Since the site visit, the County has expanded some of its services.

It expanded its MET (this team responds to calls from law enforcement agencies in the community); increased expenditures on psychiatric staff (including psychiatric residents) to strengthen inpatient and crisis services and address shortages in outpatient settings (especially in Children's services); and, converted its MIOCR team (formerly funded by the Mentally Ill Offender Crime Reduction Grant) into a Mental Health Court Team. This team works to divert mentally ill persons who have committed felony offenses into community mental health services to provide necessary ***s***upport to prevent re-offense and promote recovery. The County has placed a greater emphasis on evidence-based programs in adult and children's programs; for this study, the most relevant of which is DBT.

Overall, IMD and state hospital use has increased slightly.

The Department believes that this change is a result of improved crisis services (e.g. MET, Crisis Services Unit, Emergency Room, and Designated Inpatient Unit). As these services have been strengthened and overall capacity increased, they are identifying more persons who require IMD services.

The County has experienced some increase in the use of SHs as a result of unpredictable circumstances mostly in the criminal justice system (MIST) along with special clinical circumstances for which there are not adequate community

resources (e.g. aging adults and/or persons with significant medical conditions). This resulted in an increase from 3 to 6 beds. They also contracted with a new facility to care for a portion of clients who would otherwise need the SH. This contract resulted in a 6-bed increase in IMD use. Additionally they increased the rate paid to IMDs by 7%.

They are using the same process for referring and authorizing admissions to IMDs. The contract monitoring process has been enhanced in the last year and the two IMD contractors are included in the new process. The size of the LTC team is unchanged (2 FTE).

The County is attempting to promote greater independence for clients living in the community.

The major change in the outpatient services was a decision to dedicate a portion of one of the outpatient service contracts to providing intensive support services to allow five individuals to move toward independence in the community. The contractor has successfully transitioned these five individuals from their B/C to independent residences in the community. Four others have moved from the B/C setting to more independent room and board homes (group living setting) with additional supports from the contractor to do so. The contractor is planning to transition these four individuals to independent community residences.

There are no specific plans for the use of Mental Health Services Act (MHSA) funding at the present.

They are engaging in a robust stakeholder planning process to identify county priorities. One of the many ideas discussed has been the need do develop services that address the needs of mentally ill persons whom have been difficult to engage. Previous needs assessments/gap analyses have pointed to adult wraparound and/or intensive case management teams as possible improvements to serving this population.

Appendix C:

TRACKING STUDY

The following analysis is on the 314 clients from the five large counties in the Tracking Study (County A=30; County B=135; County C=60; County D=29; County E=60). There are different Ns in each table because of missing data. The percentages that are shown are of the clients on whom we have data for that item, i.e. excluding those with missing data. We have included a "Total" *column in each table that is the sum of all the clients in the samples from all five counties. It does not have any precise meaning since it does NOT reflect any statewide figures NOR does it even reflect the estimated actual totals of the five counties since we sampled a different percentage of clients in each county.*

There are five sections in this Appendix.

- *At Entry Into IMD*
- *Disposition*
- *Predictors of Disposition*
- *Transfers*
- *Community Follow-Up*

PART 1: AT ENTRY INTO IMD

ETHNICITY

Percent Ethnicity By County

	County A ***(N=30)***	*County B* ***(N=135)***	*County C* ***(N=60)***	*County D* ***(N=27)***	*County E* ***(N=57)***	Total **(N=309)**
African American	***13%***	***31%***	***3%***	***22%***	***5%***	**18%**
Asian/Asian American	***7%***	***7%***	***7%***	***3%***	***16%***	**8%**
Caucasian	***50%***	***41%***	***68%***	***52%***	***60%***	**52%**
Hispanic	***30%***	***18%***	***18%***	***22%***	***18%***	**19%**
Other	***0***	***2%***	***3%***	***0***	***2%***	**2%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

EDUCATION

Overall, 50% do not have a high school degree or GED. County E seems to have the least educated group.

Percent Education By County

	County A (N=28)	County B (N=120)	County C (N=53)	County D (N=25)	County E (N=56)	Total (N=282)
No High School	***4%***	***12%***	***4%***	***12%***	***5%***	**9%**
Some High School	***32%***	***40%***	***42%***	***26%***	***62%***	**42%**
High School or GED	***32%***	***19%***	***32%***	***36%***	***23%***	**25%**
Some College	***21%***	***25%***	***11%***	***28%***	***4%***	**18%**
Some Degree	***11%***	***3%***	***11%***	***4%***	***5%***	**6%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

GENDER

There are interesting differences here between County D, County E and the rest of the counties. The former have closer to a 50/50 split in males and females while the latter all have one-third or less females.

Percent Gender By County

	County A (N=30)	County B (N=135)	County C (N=60)	County D (N=29)	County E (N=60)	Total (N=314)
Female	***33%***	***32%***	***28%***	***45%***	***48%***	**36%**
Male	***67%***	***68%***	***72%***	***55%***	***52%***	**64%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

AGE

Overall, nearly half of the clients (47%) are over 40 years old. Seven percent are under 21.

Mean and Median and Percent Age Categories By County

	County A (N=24)	County B (N=133)	County C (N=59)	County D (N=26)	County E (N=58)	Total (N=300)
Mean	***38***	***41***	***38***	***37***	***40***	**39**
Median	***34***	***41***	***37***	***38***	***39***	**39**
<21	***12%***	***5%***	***7%***	***15%***	***7%***	**7%**
21-30	***25%***	***14%***	***22%***	***19%***	***22%***	**18%**
30-40	***21%***	***27%***	***31%***	***23%***	***21%***	**26%**
40-50	***8%***	***31%***	***29%***	***27%***	***17%***	**26%**
50-65	***29%***	***21%***	***14%***	***15%***	***29%***	**21%**
>65	***4%***	***3%***	***0***	***0***	***3%***	**2%**

AGE BY GENDER

The younger clients are predominately male. There is a switch to about half and half in the 50-65 age range and then mostly female among the few >65. But there is substantial variation among the counties with the trend most pronounced in County E with 81% females in 50-65 age category.

Percent Gender By Age Category

	N=300	Female	Male
<21	**20**	**35%**	**65%**
21-30	**55**	**27%**	**73%**
30-40	**77**	**33%**	**67%**
40-50	**77**	**35%**	**65%**
50-65	**64**	**45%**	**55%**
>65	**7**	**71%**	**29%**

REFERRAL SOURCE

Percent Referral Source By County

	County A (N=30)	County B (N=133)	County C (N=60)	County D (N=27)	County E (N=60)	Total (N=310)
Acute	**3%**	**16%**		**4%**	**3%**	**8%**
County Acute	**80%**	**21%**	**0**	**33%**	**87%**	**37%**
Private Acute	**0**	**31%**	**97%**	**52%**	**3%**	**37%**
State Hospital	**10%**	**17%**	**0**	**7%**	**5%**	**10%**
Other IMD	**3%**	**11%**	**0**	**0**	**0**	**5%**
Jail	**0**	**3%**	**2%**	**4%**	**0**	**2%**
Other	**3%**	**1%**	**2%**	**0**	**1%**	**1%**
	100%	**100%**	**100%**	**100%**	**100%**	**100%**

There are three “acute” categories – county and private and the third “acute” category if they didn’t indicate whether it was county or private. So the total of all the acute referrals is the “acute” plus “county acute” plus “private acute” – or a total of 82% for the total sample. The split between county and private is what we would expect based on the interviews. The use of the IMDs as a step-down from the state hospitals is particularly noteworthy in County B.

LENGTH OF STAY IN ACUTE FACILITIES

There were 259 clients who came from an acute setting. We have LOS information on 187 of these. The numbers of acute admits are indicated as the denominator in the “N=” ratio in the table.

LOS Mean, Median and Percent in LOS Categories in Acute Facilities by County

	County A (N=20/25)	County B (N=53/93)	County C (N=58/58)	County D (N=9/26)	County E (N=47/56)	Total (N=187/259)
Mean (days)	26	80	41	18	16	43
Median (days)	25	72	38	18	11	31
<2 weeks	5%	0	3%	44%	64%	20%
2-4 weeks	65%	11%	22%	44%	28%	26%
4-6 weeks	20%	8%	41%	11%	6%	19%
6-8 weeks	10%	13%	14%	0	0	9%
8-10 weeks	0	13%	10%	0	0	7%
10-12 weeks	0	24%	3%	0	0	8%
>12 weeks	0	30%	5%	0	2%	11%
	100%	100%	100%	100%	100%	100%

These patterns are pretty clear and consistent with information from the interviews and site visits.

CIVIL COMMITMENT

Civil Commitments by County

	County A (N=29)	County B (N=129)	County C (N=59)	County D (N=27)	County E (N=56)	Total (N=300)
180 Day Dangerousness	41%	0	5%	0	0	5%
Conservatorship	55%	81%	17%	56%	70%	61%
T-Con	3%	19%	76%	44%	30%	33%
Voluntary	0	0	2%	0	0	<1%
	100%	100%	100%	100%	100%	100%

Of those who are on conservatorship 26% are private and 73% are Public Guardian with 1 (0.5%) Murphy Conservatorships. Counties B and C have more private conservators. Percent Public Guardian: County A=100%; County B=61%; County C=67%; County D=88%; County E=95%.

LIVING SITUATION

This item refers to the client's most recent community living situation. The only exception is a SNF which we thought should also be included. There are more missing data here since we eliminated the answers that referred to an institutional setting, i.e. state hospital or IMD or jail.

There were quite high percentages in Counties B, C and D of clients who had been homeless or in shelters prior to the episode that led to their being in the IMD. Another interesting result is

the relatively high percentage of clients who were living with their family of origin in Counties A, B, and C.

Living Situation by County

	County A (N=27)	County B (N=107)	County C (N=60)	County D (N=22)	County E (N=48)	Total (N=264)
Homeless/Shelter	**11%**	**32%**	**40%**	**45%**	**8%**	**28%**
SNF	**7%**	**0**	**2%**	**5%**	**6%**	**3%**
Residential Program or Sober Living	**11%**	**2%**	**2%**	**9%**	**46%**	**11%**
Board & Care	**18%**	**28%**	**15%**	**23%**	**12%**	**21%**
SRO/ Room & Board	**7%**	**2%**	**10%**	**4.5%**	**4%**	**5%**
With Family of Origin	**33%**	**31%**	**28%**	**4.5%**	**19%**	**26%**
Supported Independent Living	**7%**	**1%**	**0**	**4.5%**	**2%**	**2%**
Independent Living	**4%**	**5%**	**3%**	**4.5%**	**2%**	**4%**
	100%	**100%**	**100%**	**100%**	**100%**	**100%**

INCOME

About one-fifth of the clients in County A, B, and C have no benefits at the time they are admitted to the IMD.

Income Sources By County

	County A (N=30)	County B (N=1247)	County C (N=55)	County D (N=26)	County E (N=59)	Total (N=294)
*SSI Only**	**53%**	**66%**	**62%**	**69%**	**83%**	**68%**
SSDI Only	**10%**	**1%**	**7%**	**8%**	**2%**	**4%**
SSI & SSDI	**10%**	**2%**	**2%**	**15%**	**0**	**4%**
Family	**0**	**2%**	**2%**	**0**	**0**	**1%**
GA	**3%**	**1%**	**0**	**0**	**0**	**1%**
SSI Suspended or Pending	**7%**	**6%**	**0**	**0**	**5%**	**4%**
Work or Pension or SSA	**0**	**2%**	**6%**	**0**	**2%**	**2%**
None	**17%**	**19%**	**22%**	**8%**	**8%**	**16%**
	100%	**100%**	**100%**	**100%**	**100%**	**100%**

Two of the SSI only also had family support and two of the SSI also had VA funds.

There is reason to suspect that there is an under-reporting of SSDI. There are more people (60) reported as on Medicare (either alone or with Medi-Cal) than are on SSDI (22) (either alone or with SSI).

INSURANCE

County B appears to have the highest problem of clients with no insurance.

Insurance Status by County

	County A ***(N=30)***	*County B* ***(N=128)***	*County C* ***(N=60)***	*County D* ***(N=27)***	*County E* ***(N=59)***	Total **(N=304)**
Medi-Cal Only	***53%***	***50%***	***58%***	***67%***	***71%***	**58%**
Medi-Cal Pending	***23%***	***5%***	***0***	***0***	***7%***	**6%**
Medicare Only	***7%***	***4%***	***3%***	***11%***	***2%***	**4%**
Medi-Cal & Medicare	***13%***	***18%***	***25%***	***11%***	***8%***	**16%**
VA	***0***	***1%***	***0***	***0***	***0***	**1%**
Family	***0***	***1%***	***0***	***4%***	***0***	**1%**
None	***3%***	***21%***	***13%***	***7%***	***10%***	**15%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

CRIMINAL JUSTICE STATUS

Most forms had nothing entered on this item – this could be either because there was none or because it was unknown. While there was an "Unknown" option we are not sure it was checked all the time. This means that the counts below are a minimum number in each county. In any case, the numbers are quite small.

Numbers of Clients With Current Criminal Justice Involvement

	County A ***(N=30)***	*County B* ***(N=135)***	*County C* ***(N=60)***	*County D* ***(N=29)***	*County E* ***(N=60)***	Total **(N=314)**
Probation or Parole	***1***	***5***	***4***	***1***	***0***	**11**
Under Supervision of Court	***0***	***1***	***0***	***1***	***0***	**2**
Criminal charges Pending	***3***	***2***	***3***	***0***	***0***	**8**
MDO	***1***	***4***	***0***	***0***	***0***	**5**
Sexual Offender	***1***	***0***	***0***	***0***	***1***	**2**
Total	***6***	***12***	***7***	***2***	***1***	**28**

Because of the reporting problems it is not clear whether the higher percent in County A (6/30 or 20%) is real (i.e. more of their clients really do have criminal justice involvement), or just better knowledge of the clients, or greater contact with the courts because of their 180-day dangerousness. The same problem exists with the very low county, County E (1/60). The overall for the total sample (28/318) is 9%.

CHILDREN

Number of Minor Children (and Living Situation) by County

	County A (N=30)	County B (N=121)	County C (N=59)	County D (N=30)	County E (N=58)	Total (N=298)
% Who Have Minor Children	13%	8%	10%	27%	5%	10%
Number Who Have Minor Children	4	10	6	8	3	31
# Living with Relatives or Friend	3	6	2	7	2	20
# In Out-of-Home Placement	1		2	1		4
# Status Unknown		4	2		1	7

There is a small percent with minor children and in no cases was the client listed as the primary caretaker. Twenty-one of the 31 are females.

GAF

The overall average GAF in the total sample is 27.2 and the median is 26. The minimum is 19 and the maximum is 50. There is virtually no difference among the counties in the means and medians. Averages range from 26.7 to 28.3; the medians from 25 to 30.

There do seem to be some differences among the counties when you break the GAF scores into categories, e.g. County D has 3% over 30 and County A has 15% over 30 compared to 31% for County B, 28% for County C, and 32% for County E.

GAF Mean and Median and Ranges by County

	County A (N=26)	County B (N=129)	County C (N=60)	County D (N=28)	County E (N=60)	Total (N=303)
Mean	27	27	28	27	28	27
Median	25	25	30	25	30	26
Range	15-40	10-47	10-50	20-40	15-50	10-50
<=15	4%	9%	10%	0	5%	7%
16-20	15%	29%	13%	7%	27%	22%
21-25	38%	15%	17%	54%	12%	20%
26-30	27%	16%	32%	36%	25%	23%
31-35	8%	21%	22%	0	22%	18%
>35	8%	11%	7%	3%	10%	9%

DIAGNOSES

Axis I Diagnoses By County

	County A (N=26)	*County B (N=135)*	*County C (N=59)*	*County D (N=28)*	*County E (N=58)*	Total (N=306)
Schizophrenia – Schizoaffective	***38%***	***30%***	***44%***	***50%***	***34%***	**36%**
Schizophrenia – Paranoid	***42%***	***27%***	***29%***	***32%***	***22%***	**28%**
Schizophrenia – Undifferentiated, not specified, other	***8%***	***26%***	***15%***	***11%***	***21%***	**20%**
Major Depression or Bipolar	***4%***	***13%***	***10%***	***4%***	***16%***	**12%**
Other	***8%***	***4%***	***2%***	***4%***	***7%***	**5%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

Overall, only 6.3% of the clients had an Axis II diagnosis indicated. There were 3% antisocial, 1% borderline, 1% schizoid, and 1% either NOS or mixed. The two counties that accounted for most of the diagnoses were County B which had Axis II diagnoses for 9% of the clients and County C with 10%.

Overall, 37% of the clients had some Axis III condition indicated. Two-thirds of these had one medical condition listed, 18.5% had two, 14% had 3 and 1% had four.

CURRENT CLINICAL AND BEHAVIORAL CONDITIONS

Most Serious

The first four categories are the most serious – recent suicidal ideation with expressed intent; recent homicidal ideation with expressed intent, repeated episodes of violence toward self, and repeated episodes of violence towards others.

Percent of Clients with Most Serious Conditions By County

	County A (N=30)	*County B (N=135)*	*County C (N=60)*	*County D (N=29)*	*County E (N=60)*	Total (N=314)
Suicidal	***7%***	***22%***	***10%***	***24%***	***10%***	**16%**
Homicidal	***30%***	***19%***	***10%***	***21%***	***2%***	**15%**
Violence-Self	***3%***	***18%***	***3%***	***13%***	***10%***	**12%**
Violence-Others	***40%***	***35%***	***13%***	***45%***	***30%***	**31%**
Any of four	***53%***	***52%***	***32%***	***62%***	***48%***	**48%**

Overall, about half of the clients had at least one of these conditions. The “violence against others” was the most frequent at 31% of all the clients. The suicidal and homicidal are also quite frequent accounting for 16% and 15% of the clients respectively.

The breakdown by counties is what we might expect with lower percentages in County C and the highest in County D.

Clients under 30 were more likely than older clients to have one of the four conditions, but there were no differences by gender or by ethnicity.

Percent of Clients with Most Serious Conditions By Age

	N=317	*Any of Four Conditions*
<21	***21***	***75%***
21-30	***55***	***67%***
30-40	***79***	***45.5%***
40-50	***77***	***39%***
50-65	***66***	***44%***
>65	***7***	***43%***

The overlap between violence directed towards self and others is shown below.

Overlap Between Violence Towards Self or Others

Suicidal and/or Homicidal		Violence Towards Self and/or Other	
Suicidal Only	***10%***	***Violence Self Only***	***6%***
Homicidal Only	***9%***	***Violence Other Only***	***25%***
Both	***6%***	***Both***	***6%***
ANY	***25%***	***ANY***	***37%***

Harm

This was listed on the form as “Repeated other behaviors likely to harm self or others.” We calculated the percentage for this and then repeated taking out those where the client had already been listed as having actual episodes of violence towards self or others. So the second row below includes only those where there were no actual episodes of violence but presumed only likely harm.

Percentage of Clients With Harm to Self or Others by County

	County A ***(N=26)***	*County B* ***(N=135)***	*County C* ***(N=60)***	*County D* ***(N=29)***	*County E* ***(N=60)***	Total **(N=314)**
Harm to self or others	***40%***	***36%***	***28%***	***50%***	***27%***	**34%**
Harm to self or others only if no episodes of violence to self or others	***23%***	***14%***	***22%***	***33%***	***25%***	**19%**

Substance Abuse

The form asked whether the client had a history of substance abuse. If the answer was yes then they were to indicate if substance abuse was a significant factor in triggering this episode of care.

Percent of Clients with Substance Abuse Conditions by County

	County A ***(N=26)***	*County B* ***(N=138)***	*County C* ***(N=59)***	*County D* ***(N=30)***	*County E* ***(N=58)***	Total **(N=311)**
History of substance abuse	***63%***	***59%***	***47%***	***60%***	***20%***	**50%**
Substance abuse a factor in triggering this episode	***10%***	***30%***	***30%***	***30%***	***12%***	**25%**
% of those with history for whom it was a factor in this episode	***16%***	***52%***	***64%***	***50%***	***58%***	**50%**

Overall, almost two-thirds of the clients were said to have a history of substance abuse. The only outlier here is County E which most likely either did not have a sufficient history of the clients or just did poor reporting in citing so low a percentage (20%) with a history of substance abuse. The percent in which substance abuse was a significant factor in this episode is 25% with County E again below the rest of the counties (at 12%) but this time in line with County A (10%). County A stands out in the last row with only 16% of the clients with a history of substance abuse having it play a factor in this episode.[26]

History of Medications Non-compliance and AWOL Risk

These were two very frequently cited conditions.

	County A ***(N=26)***	*County B* ***(N=138)***	*County C* ***(N=59)***	*County D* ***(N=30)***	*County E* ***(N=58)***	Total **(N=311)**
History of Medications Non-compliance	***73%***	***66%***	***72%***	***69%***	***28%***	**62%**
AWOL Risk	***53%***	***51%***	***12%***	***38%***	***18%***	**36%**

Other Conditions

Some of the other conditions occurred with far lower percentages so that comparisons among the counties cannot be done reliably

Percent of Clients with Other Conditions in Total Sample

Condition	***%***

[26] One possibility is that County A has the best information about the actual circumstances of the client's current situation (thus this is low at 10%) combined with the most thorough history (thus this is high at 63%).

Communicable disease and unpredictable behavior	***3.2%***
History of fire setting	***1.9%***
Organically impaired	***4.1%***
Known history of abuse or trauma	***9.2%***

MULTNOMAH AT INTAKE

Overall Scores Compared with Multnomah County Norms

There were 228 MCAS at intake which had every item marked. Imputed scores were used for missing values for subscale items as suggested in the MCAS manual so long as only one item was missing for that scale. Doing this increased the number of usable MCAS's to 269.

The MCAS manual has norms for a population they describe as follows: "clients were enrolled in community support units of CMHCs. This enrollment implies that they suffer from a major mental illness (i.e. schizophrenia or bipolar disorder), have been hospitalized in the recent past or are at risk of hospitalization, and suffer from social role impairment in several areas." The table below shows the mean scores for the Tracking Study sample by age and gender in relationship to the normed sample.

Comparison of Our Total Sample with MCAS Sample by Age/Gender

Age/Gender	*Our Total Sample*	*MCAS Norms*
Males 18-34	***49.7 (N=66)***	***52***
Females 18-34	***47.4 (N=27)***	***55***
Males 35-50	***51.9 (N=77)***	***52***
Females 35-50	***48.1 (N=39)***	***56***
Males 51+	***47.9 (N=35)***	***52***
Females 51+	***52.2 (N=25)***	***52***

In every case except for the oldest female category the means from our sample are lower than from the MCAS norms which makes sense since their population while potentially of the same type of clients are outpatients at the time of testing as opposed to the Study population being at IMD intake. The difference is most pronounced with the females aged 18-34 and females aged 35-50.

MCAS Total Scores by County

They divide their population into three categories: High (little disability) with scores of 63-85; Medium with scores of 48-62; and Low (severe disability) with scores of 17-47. Below are the Study counties using this categorization.

MCAS Scores at Intake By County

	County A (N=30)	County B (N=130)	County C (N=57)	County D (N=27)	County E (N=25)	Total (N=269)
Low	**43%**	**26%**	**68%**	**70%**	**16%**	**41%**
Medium	**57%**	**58%**	**25%**	**30%**	**60%**	**48%**
High	**0**	**15%**	**7%**	**0**	**24%**	**11%**
Mean	**47**	**53**	**45**	**42**	**56**	**50**
Median	**49**	**53**	**43**	**44**	**58**	**50**

On the overall scores, County D and County C appear to have the highest percentage in the Low category and have the two lowest mean scores. Counties A and D have no clients in the "high" category. Counties B and E have the highest scores as well as the highest percentages in the "high" category of scores.

In an attempt to further differentiate the counties we made four instead of three categories – using arbitrary categories that would yield about one-quarter of the clients in each.

MCAS Scores at Intake by County

	County A (N=30)	County B (N=130)	County C (N=57)	County D (N=27)	County E (N=25)	Total (N=269)
<43	**27%**	**10%**	**49%**	**44%**	**8%**	**23.5%**
43-49	**30%**	**26%**	**25%**	**41%**	**8%**	**23%**
50-55	**33%**	**30%**	**7%**	**15%**	**24%**	**23.5%**
56+	**10%**	**34%**	**19%**	**0**	**60%**	**27%**

This categorization makes just as clear that Counties B and E are different from the other counties in having a higher percentage of clients with higher MCAS scores while Counties D and C have clients who score lower.

The MCAS in County B is done by the IMD facility after the client is admitted not at the time that the client is assessed for placement on the IMD waiting list. As noted earlier, the ALOS in County B for clients entering IMDs is quite long. It is certainly possible that the clients are functioning better by the time they are assessed on the MCAS by the facility merely because of the passage of time. If this is true, County B might consider reassessing clients before taking them off the waiting list and sending them to the IMD.

MCAS Scores Vs Conditions, GAF, Diagnosis

There are no clear relationships between the MCAS scores and the conditions, the GAF scores, or diagnoses.

Subscales

The MCAS has four subscales: interference with functioning; adjustment to living; social competence; and behavioral problems. The table below shows the differences among the counties in the subscale scores. The number of clients for each subscale is noted in parentheses. low scores indicate greater impairment.

Mean MCAS Subscale Scores By County

Subscale	*County A*	*County B*	*County C*	*County D*	*County E*	*Total*
Functioning	***15.1 (30***	***16.6 (130)***	***16.9 (59)***	***14.5 (29)***	***17.8 (54)***	***16.5 (302)***
Adjustment	***6.4 (30)***	***7.8 (131)***	***6.1 (58)***	***5.4 (29)***	***8.9 (39)***	***7.2 (287)***
Social	***12.9 (29)***	***13 (131)***	***11.1 (59)***	***11.3 (29)***	***15.8 (46)***	***12.8 (321)***
Behavior	***12.7 (30)***	***15.7 (131)***	***10.7 (58)***	***10.4 (29)***	***12.9 (41)***	***13.5 (289)***

The two higher scoring counties – B and E – have a different pattern. The County E scores are generally higher in functioning, adjustment, and social behavior but not in behavioral problems, i.e. their clients have the same magnitude of behavioral problems than the other counties, but are doing better in the other three areas. The opposite appears to be the case with County B with their scores being considerably higher in behavioral problems (fewer problems) but not so much in the other three categories.

Individual MCAS Items

A couple of findings from the individual items are noteworthy.

- *Less than half the population (47%) was judged to have "no health impairment: 30% had a slight health impairment, 14% a moderate health impairment, and 9% a marked or extreme health impairment.*

- *Thirty percent were scored as having lower than normal intellectual functioning. Sixteen percent had slightly low intellectual function with another 9% judged as low, and 4.6% as moderately or extremely low intellectual functioning.*

- *Slightly less than half (47%) were scored as having an extremely or markedly abnormal mood.*

- *The extent of social networks was generally rated lower than social acceptability, social interest, or social effectiveness. Less than one-third (31%) were rated as having at least a moderately extensive network with 48% rated as having a limited network and 22% as having a very limited network.*

MCAS scores by individual items are available for anyone who wants to use the data for comparison purposes.

PART TWO: DISPOSITION

PERCENTAGE OF CLIENTS DISCHARGED

The table below indicated the percentage of the clients in the Tracking Study in each county who had a planned discharge to the community, an unplanned discharge, or who were still in an IMD/SH at the end of the Study period. While slightly over half (54%) of the clients in the whole sample had a planned discharge these numbers are skewed by the numbers for County B. Clearly County B differs from the other counties having the lowest percentage (38%) of its clients discharged compared to roughly two-thirds for the other counties.

Percentage Discharged By County

	County A (N=30)	*County B (N=135)*	*County C (N=60)*	*County D (N=29)*	*County E (N=60)*	Total (N=314)
Planned Discharge	***70%***	***38%***	***65%***	***66%***	***63%***	**53.5%**
Unplanned Discharge	***3%***	***14%***	***10%***	***10%***	***7%***	**10.5%**
Not Discharged	***27%***	***48%***	***25%***	***24%***	***30%***	**36%**

Average Length Of Stay (ALOS)

The ALOS for those clients who had a planned discharge was roughly 6 months. Again there were differences by county with County B again being the outlier with longer lengths of stay for those clients who had a planned discharge. Overall about one-quarter (26%) were discharged within three months with County C discharging about half (49%) of its clients this time frame. At least 80% of the clients in County A and County C counties and 71% of the clients in County E were discharged within six months while in County B this figure was only 22%.

Lengths of Stay for Clients With a Planned Discharged (N=168)

	County A (N=21)	*County B (N=51)*	*County C (N=39)*	*County D (N=19)*	*County E (N=38)*	Total (N=168)
Mean	***4.8***	***8.4***	***4.2***	***5.1***	***4.8***	**5.8**
Median	***4.8***	***8.3***	***3.0***	***4.6***	***4.2***	**5.4**
< 3 months	***24%***	***8%***	***49%***	***21%***	***21%***	**24%**
3-6 months	***57%***	***12%***	***33%***	***37%***	***50%***	**34%**
6-9 months	***14%***	***35%***	***13%***	***26%***	***24%***	**24%**
>9 months	***5%***	***45%***	***5%***	***16%***	***5***	**18%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

LIVING SITUATION

There were significant differences among the counties in the living situations to which clients were discharged. Roughly two-thirds of the clients in County B and in County D were

discharged to a board and care (B/C) facility. County E, on the other hand, discharged roughly three-quarters of its clients to a residential program. County A split its discharges between residential programs and B/C facilities. County C stands out with the largest percentage (42%) of its discharges to setting with family members.

Living Situation for Clients with a Planned Discharge by County

	County A ***(N=20)***	*County B* ***(N=36)***	*County C* ***(N=38)***	*County D* ***(N=19)***	*County E* ***(N=37)***	Total **(N=151)**
Residential Program[27]	***38%***	***14%***	***16%***	***5%***	***70%***	**30%**
Board and Care	***43%***	***61%***	***24%***	***68%***	***11%***	**38%**
SRO or Room/Board	***0***	***0***	***16%***	***0***	***0***	**4%**
Family	***10%***	***22%***	***42%***	***11%***	***5%***	**20%**
Independent or Supported Housing	***5%***	***0***	***3%***	***16%***	***3%***	**4%**
SNF or Medical Hospital	***5***	***3%***	***0***	***0***	***11%***	**4%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

INCOME

Most clients (79%) were reported to have SSI or SSI Pending at the time of discharge with another 11.5% having SSDI or Social Security Income. Five percent were reported to be on "Interim Funding" at the time of discharge with 3% having no reported income and 1.5% supported by family.

CIVIL COMMITMENT STATUS

In keeping with their general orientations to the use of conservatorship (see County Site Visit Reports) the counties differed in their planned reliance on conservatorship after the planned discharge from the IMD/SH. Over 90% of the clients discharged in Counties B and E were on a conservatorship when they left the IMD/SH with no plans to terminate it. County A also had about 90% of its clients on a civil commitment status when they left the IMD/SH, but theirs were split between conservatorship and the 180-day certification for dangerousness. At the other end was County D which had two-thirds of its discharged clients either already off conservatorship or with plans to have the conservatorship removed.

Civil Commitment Status at Discharge by County

	County A ***(N=19)***	*County B* ***(N=36)***	*County C* ***(N=38)***	*County D* ***(N=18)***	*County E* ***(N=35)***	Total **(N=146)**
Remain on conservatorship	***42%***	***92%***	***53%***	***33%***	***91%***	**68%**
Plans to terminate conservatorship	***5%***	***3%***	***3%***	***28%***	***9%***	**8%**
Off conservatorship	***5%***	***6%***	***45%***	***39%***	***0***	**18%**
180-day certification	***47%***	***0***	***0***	***0***	***0***	**6%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

[27] Residential facility was defined as a site with licensed staff.

Three-quarters of the clients with a planned discharge had a representative payee arranged at discharge while there were plans for a payee for another seven percent of the clients. Over 90% of the clients in Counties A, B, and E either already had a representative payee or there were plans for one compared to roughly two-thirds of the clients in Counties C and D.

Percentage of Clients at Planned Discharge with Representative Payee by County

	County A ***(N=19)***	*County B* ***(N=36)***	*County C* ***(N=38)***	*County D* ***(N=18)***	*County E* ***(N=35)***	Total **(N=146)**
Have a rep payee	***79%***	***88.5%***	***57%***	***50%***	***88.5%***	**75%**
Plans for a rep payee	***21%***	***3%***	***5%***	***12.5%***	***3%***	**7%**
No plans for a re[payee	***0***	***8.5%***	***38%***	***37.5%***	***8.5%***	**18%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

CASE MANAGEMENT

Overall, 81% of the clients had a case manager when they were discharged. The counties ranged from a low of 63% in County D to a high of 100% in County A. But the picture looks quite different in terms of the percentage of clients who had a case manager with a caseload of 15 or less. Neither County C nor County E had any clients with case managers with these low caseloads, whereas over 90% of County D's clients who had a case manager had one with a low caseload. Presumably these County D clients were being discharged to the new ACT team. In County B and in County A about one-third of the clients with a case manager had one with a low caseload. This number should rise over time in County B with its new policy that every IMD/SH discharge go to an ACT-type program.

Percentage with Case Managers By County

	County A ***(N=20)***	*County B* ***(N=34)***	*County C* ***(N=39)***	*County D* ***(N=19)***	*County E* ***(N=35)***	Total **(N=148)**
Have a case manager	***100%***	***79%***	***69%***	***63%***	***94%***	**81%**
% with case manager with caseload 15 or less	***35%***	***41%***	***0***	***92%***	***0***	**24%**
% of discharged with case manager with caseload 15 or less	***35%***	***32%***	***0***	***58%***	***0***	**19%**

GAF AND MCAS AT DISCHARGE

There are fairly striking differences among the counties in the level of functional status as measured by the GAF and the MCAS at the time of a planned discharge. One clear pattern is the lower scores on both the GAF and the MCAS for the discharged clients in County D. County C is an anomaly with higher than average functional scores on the GAF, but scores comparable to the other counties on the MCAS.

GAF at Time of Planned Discharge by County

	County A (N=20)	County B (N=11)	County C (N=25)	County D (N=19)	County E (N=35)	Total (N=110)
Mean	36.3	41.6	55.2	35.3	43.2	43.1
Median	36	40	55	34	40	40
21-25	0	0	0	10%	0	2%
26-30	25%	0	0	31.5%	9%	13%
31-35	25%	27%	0	31.5%	14%	17%
>35	50%	73%	100%	26%	77%	68%
	100%	100%	100%	100%	100%	100%

Note: **County B did not have very many discharge GAF scores (N=11).**

MCAS at Time of Planned Discharge by County

	County A (N=18)	County B (N=43)	County C (N=37)	County D (N=18)	County E (N=31)	Total (N=147)
Mean	64.5	64.3	59.0	48.6	62.1	60.6
Median	65	65	60	47	63	62
High	72%	63%	35%	6%	52%	48%
Medium	28%	33%	57%	44%	45%	42%
Low	0	5%	8%	50%	3%	10%
	100%	100%	100%	100%	100%	100%

ANTICIPATION OF HOW WELL CLIENTS WILL DO

Staff were asked to indicate how well they anticipated that the clients would do in the community after discharge. About one-third of the clients were expected to not do better than "OK". The highest percentage of clients expected to do not very well is in County D, reflecting their greater willingness to discharge clients and give them a try in the community.

How Well Clients Will Do by County

	County A (N=20)	County B (N=22)	County C (N=35)	County D (N=18)	County E (N=35)	Total (N=130)
Not very well	20%	5%	6%	39%	20%	16%
Just OK	15%	36%	20%	0	23%	20%
Moderately well	50%	45%	57%	33%	34%	45%
Very or extremely well	15%	14%	17%	28%	23%	19%
	100%	100%	100%	100%	100%	100%

One would expect that there would be some relationship between how well clients are expected to and their discharge level of functioning. There is some relationship, particularly with those not expected to do very well who have lower GAF and MCAS scores.

How Well Clients Will Do By Functional Status at Discharge

How well will client do?	GAF			MCAS		
	N	***Mean***	***Median***	***N***	***Mean***	***Median***
Not very well	***20***	***36.6***	***37.5***	***18***	***50.6***	***51.5***
Just OK	***22***	***42.8***	***40***	***25***	***61.6***	***62***
Moderately well	***44***	***45.7***	***41***	***52***	***61.2***	***63***
Very or extremely well	***19***	***43.5***	***40***	***23***	***64.6***	***67***
Total	***105***			***118***		

Staff were asked to indicate what "obstacles to doing well in the community" those faced whom they rated as likely to do either "not very well" or "just OK." The following shows the reasons which were classified into nine different categories for the 39 clients with such ratings. (The total number of reasons is greater than 39 because some clients had more than one reason cited.) Unwillingness to participate with prescribed treatment is the most frequently cited reason followed by the presence of psychotic symptoms or problematic Axis II behaviors.

Obstacles for Those Expected to Do "Not very well" or "Just OK"

Obstacles to Doing Well in the Community	*Number*	%
Noncompliant with medications/refuses follow-up treatment	***17***	**44%**
Presence of psychotic symptoms or Axis II behaviors	***14***	**36%**
Substance abuse	***7***	**18%**
No or minimal social support	***6***	**15%**
Issues with family or private conservator	***6***	**15%**
Likely to decompensate without structured environment	***3***	**8%**
Behaviors more than board/cares able to cope with	***3***	**8%**
No appropriate treatment available	***2***	**5%**
Unable to care for self	***1***	**3%**

Here are some examples of comments made about clients not expected to do very well or just OK.

She has a lengthy history of failed placements due to increase paranoia, drug alcohol abuse and AWOL behavior.
Client will want to go AWOL to his mother's house. He will probably substance abuse to self medicate.
Client refuses to interact with others and has no support.
Client has history of decompensating in an unstructured setting (less than IMD).
Likely SA. Likely refusal of meds. No insight.
Monolingual Spanish speaker which limits community options. He is dependent on family. and they are inconsistent in addressing Tx for him
High risk of alcohol abuse. Antisocial traits
No income yet. Risk of relapse given substantial hx of SA
Meds noncompliant, drug hx, guarded and irritable, delusional, poor participation in activities, poor insight
Hx of multiple hospitalizations. Has difficulty living in B/Cs. Client has poor insight and has minimal support system. Fair motivation. Mother interferes with Tx.
Chronic ETOH abuse, denial of illness, no support system, refusal of follow-up services
Communication impairment, disorganized, confused.
Indigent status. Lack of CM to follow client in the community

UNPLANNED DISCHARGES

There were 33 clients who had unplanned discharges. This represented 10% of the clients in the Tracking Study. The following list the reasons for the unplanned discharges classified into six differ categories. The most frequent reason is the client's going AWOL; this is most frequently while out c the facility (e.g. on an outing or a visit to parents or while being transferred to EPS) rather than dire from the locked facility. The next most frequent is the client's leaving the facility after the conservatorship is dropped or as a result of a writ hearing.

Reasons for Unplanned Discharges

Reasons for Unplanned Discharge	*Number*	%
AWOL	***10***	**32%**
Involuntary status (usually conservatorship) removed and client left	***9***	**29%**
Taken to jail after assault or discovered that a warrant out	***5***	**16%**
Family-related, e.g. parent is conservator and took client out AMA	***3***	**10%**
Transferred to medical or psychiatric acute and whereabouts unknown thereafter	***3***	**10%**
Other	***1***	**3%**
TOTAL	***31***	**100%**

As would be expected, clients who have unplanned discharges leave the facility in a shorter period time than those with planned discharges; the average length of stay for the former is 4.1 months compared to 5.8 months for the former.

STILL IN IMD/SH AT END OF STUDY

As noted above County B had the highest percentage of its clients in the Tracking Study still in the IMD/SH at the end of the Study. While there were some differences in the length of time that clients were in the Study since the pace of enrollment differed, these differences were not large and do not explain the differences in client disposition between the counties. Below are the mean and median times from the time of enrollment until the time when there is a final status on each client.

Length of Time (in months) Between Enrollment and Final Status for Clients Still in IMD/SH

	County A (N=8)	*County B (N=65)*	*County C (N=15)*	*County D (N=7)*	*County E (N=18)*	Total (N=113)
Mean	***10.8***	***10.9***	***13.1***	***12.8***	***13.2***	**11.3**
Median	***10.5***	***11.3***	***12.4***	***13.2***	***13.1***	**11.7**

As would be expected the functional status scores for the clients still in the IMD/SH are lower than those who had a planned discharge. The overall median GAF was 30 and was 30 for every county except County D for which it was 29. There are differences among the counties in the MCAS score Those who remain in an IMD/SH in County D have lower MCAS scores, and those in County C hav higher MCAS scores than in the other three counties. The numbers of clients is relatively small, bu are probably reliable given that they mirror what we would expect from what we know about the counties.

MCAS Scores of Clients Remaining in IMD/SH at End of Study Period

	County A (N=6)	*County B (N=55)*	*County C (N=15)*	*County D (N=6)*	*County E (N=16)*	Total (N=98)
Mean	***53.8***	***53.5***	***58.7***	***43.2***	***51.4***	**53.4**
Median	***53.5***	***54***	***58***	***46.5***	***48***	**53**
High	***17%***	***15%***	***47%***	***0***	***12.5%***	**18%**
Medium	***67%***	***58%***	***27%***	***33%***	***37.5%***	**49%**
Low	***17%***	***27%***	***27%***	***67%***	***50%***	**33%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

Overall, 16% of the clients are expected to remain in the IMD/SH for at least another year, and 7% for at least two years. The latter are the clients who have the potential to become long-stay clients.

The differences among the counties are interesting, but we should be careful in interpreting results for Counties A and D since the numbers are so small. It does appear, however, that County A has discharged in a timely manner everyone who they could, leaving only those who they believe need longer period of time in the IMD/SH and who could potentially become long-stay clients. County D, the other hand, does not expect to have anyone staying longer than one year thus not anticipating any of these clients becoming long-stay. County B reflects its pattern of longer lengths of stay with sizable percentage expected to be discharged within another 9 months and only 6% expected to st longer than one more year. Except for County A, County C has the highest percentage in the over two year category – 8% - perhaps reflecting their greater acceptance of long-stay clients in this leve of care.

Expected Time Until Discharge for Clients Still in IMD/SH at End of Study

Expected time until discharge	*County A* ***(N=4)***	*County B* ***(N=53)***	*County C* ***(N=13)***	*County D* ***(N=4)***	*County E* ***(N=17)***	Total **(N=91)**
Less than 3 months	***0***	***30%***	***38%***	***25%***	***6%***	**25%**
3-6 months	***0***	***13%***	***15%***	***0***	***23.5%***	**14%**
6-9 months	***0***	***41.5%***	***15%***	***25%***	***17.5%***	**31%**
9-12months	***0***	***9.5%***	***15%***	***50%***	***23.5%***	**14%**
1 – 2 year	***25%***	***2%***	***8%***	***0***	***29.5%***	**9%**
Over 2 years	***75%***	***4%***	***8%***	***0***	***0***	**7%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

There was a clear relationship between the MCAS score and the anticipated length of time until discharge.

Expected Time Until Discharge by MCAS Score Categories

Expected time until discharge	*High MCAS*	*Medium MCAS*	*Low MCAS*
Less than 3 months	***71%***	***24.5%***	***3%***
3-6 months	***12%***	***14.5%***	***13%***
6-9 months	***18%***	***39%***	***28%***
9-12months	***0***	***10%***	***28%***
Over 1 year	***0***	***12%***	***28%***
	100%	***100%***	***100%***

Staff were asked to "briefly explain the reason for the continued stay at the IMD/SH." The same categories were used as for the long-stay clients with the addition of four which are noted in italics the bottom which did not appear for the long-stay clients. The results were quite similar to those for long-stay clients with the exception of a few items. Most of the differences were in the direction of

lower rates for these clients than the long-stay clients, namely dangerous to others (23% Vs 29%), discharge-related issues (5% Vs 21%), and sexual issues (3% Vs 12%). The one item that was hig was the refusing treatment (22% Vs 14%).

Reasons Why Clients Remain in IMD/SH at End of Study Period (N=101)

Reason	Percent
Responses to internal stimuli, hallucinations, delusions, bizarre behavior	***39%***
Dangerous to others, assaultive, throws things, threatens	***23%***
Impaired decision making, no insight, poor judgment, safety issues without supervision	***26%***
Mood disorder: depressed, agitated, labile	***24%***
Discharge issues: client doesn't want to leave, family/conservator doesn't want discharge, no place will take client, no benefits, client decompensates when DC is planned	***5%***
Needs assistance with ADLs, needs reminders to shower, poor hygiene,	***12%***
Refuses treatment, no or spotty attendance at groups, tries to avoid medications	***22%***
Sexual issues: inappropriate sexual behavior, inappropriate touching	***3%***
Poor social adjustment: isolated, withdrawn, intrusive	***12%***
Disorganized, disoriented, confused, need for supervision	***8%***
Verbally abusive (without danger to others)	***0***
Dangerous to self, self-injury, suicidal thoughts and expressions	***9%***
Danger to community if discharged	***3%***
Major ADL issues: incontinence, smearing feces, total inability to care for self	***0***
Medical issues: dementia, seizures, end stage of illness, lymphoma, end stage renal failure	***2%***
Current stealing	***1%***
Criminal issues still not resolved	***0***
Benefiting from treatment	***3%***
"Attempts to maintain whatever gains have been made from intensive treatment have limited success"	***5%***
Ready or almost ready for discharge	***8%***
History of assaults, AWOL, substance abuse, meds noncompliance	***6%***

SUMMARY OF DIFFERENCES AMONG COUNTIES

The differences among the counties in orientation to the use of IMDs, the use of conservatorship, and the availability of community resources reveals itself in this set of data. Two counties clearly stand out in terms of the data – County D and County B - and in each case the findings are consistent with what was learned from the county site visits.

- County D's reluctance to use IMDs shows itself in the shorter LOS, the lower functional status at discharge, the lower levels of conservatorship on discharged clients, and the greater number of clients not expected to do well in the community. They do not have an intermediate augmented B/C and/or residential treatment system and so most clients are discharged to regular board and care facilities. While their case management system is more limited they do provide the higher level ACT team services to some of their discharges.

- County B discharges the lowest percentage of clients because they keep clients longer before they are discharged. The functional status of their clients at discharge is comparable to the average as is their expectation of how well clients will do. They do not have much of an intermediate level so most clients are discharged to regular B/Cs with almost all still on conservatorship. While the expectation is that everyone will get an ACT team referral, so far this is not happening.

The other counties have more complicated stories.

- County A discharges everyone within 9 months and splits most of the discharges between its step-down facility and regular B/Cs. Its use of the 180-day certification is clear from the data which is its most unique feature compared to the other counties. The functional status data is mixed with their planned discharges having lower GAFs but this difference is not reflected on the MCAS. So overall, unlike County D, they seem to achieve a lower IMD usage not by discharging early but perhaps by doing a better job with treatment or monitoring treatment.

- County C discharges many clients very quickly – about half within three months. This reflects the short stay philosophy of the facility to which most clients go from the acute setting. They discharge a far higher percentage to family (40%) than any of the other counties, and they are also the only ones who appear to use unlicensed single room occupancy settings or room and board facilities for their discharges. They also have a higher percentage of clients who are off conservatorship when they leave the IMD. They have the highest GAF scores at discharge, but this is not reflected in the MCAS scores where they are comparable to the other counties. They also have no intensive case management for their discharges.

- County E is notable largely in its reliance on its step-down facilities; 70% of the discharged clients went to a residential program. They discharged half their clients. Their ALOS and the functional status of *t*heir clients are right in the middle of the Study counties. They have 90% on conservatorship and also high representative

payee. While they have most on case management it is not with low caseloads. They seem to be keeping control of IMD usage through the use of the step-down facilities. The question becomes whether they can continue to move people out of those facilities so that they have room for new IMD discharges.

PART THREE: PREDICTORS OF DISPOSITION

The question to be asked here is whether there are any differences in the initial characteristics of the Tracking Study clients and their disposition, i.e. whether they were discharged (planned discharge) or were still in the IMD/SH at the end of the Study period. There are a few clear predictors, with some possible predictors and many not.

Age seems to be one of the best differentiators of who will be discharged and who will still be in an IMD/SH. The older the client is the less likely s/he will be discharged during the Study period. This could be a function directly of age or of the older clients having a longer history and therefore more issues related to community placement, e.g. being known for difficult to manage behavior.

Disposition By Age (p<.04)

Age	*N*	*Planned Discharge*	*Still in IMD/SH*
<21	***16***	***87.5%***	***12.5%***
21-30	***18***	***69%***	***31%***
31-40	***65***	***64.5%***	***35.4%***
41-50	***73***	***59%***	***41%***
51-65	***61***	***49%***	***51%***
65+	***6***	***33%***	***67%***

Another factor which was different was the civil commitment status with those on temporary conservatorships more likely to be discharged. This could again be a function of those with more chronic situations already being on conservatorships or could be influenced by some temporary conservatorships being dropped with clients then leaving the IMD/SH AMA, of which there were some. In other words, it is difficult to know which causes which.

Disposition by Civil Commitment Status (p<.001)

Civil Commitment Status	*N*	*Planned Discharge*	*Still in IMD/SH*
180-day	***15***	***80%***	***20%***
Conservatorship	***162***	***49%***	***51%***
T-Con	***90***	***79%***	***21%***

Another factor is functional status. While there are significant or nearly significant differences in MCAS scores there are not on GAF scores, and the amount of difference is not sufficient to probably be too useful except for the very low and the very high scores. Shown below are the two ways of categorizing that have been used throughout the analysis.

Disposition by MCAS Categories (p<.11)

MCAS	*N*	*Planned Discharge*	*Still in IMD/SH*
High	***27***	***78%***	***22%***
Medium	***119***	***58%***	***42%***
Low	***96***	***55%***	***45%***

Disposition by MCAS Category (p<.04)

MCAS	*N*	*Planned Discharge*	*Still in IMD/SH*
56+	***66***	***73%***	***27%***
50-55	***57***	***53%***	***47%***
43-49	***64***	***59%***	***41%***
23-41	***55***	***49%***	***51%***

Variables that are NOT related to disposition are gender, ethnicity, living situation at time of initial placement, diagnosis, non-compliance with medications, and AWOL risk.

And surprisingly there are a few factors that appear to be predictive in what might be considered an opposite direction. Those with a recent history of being recently a danger to self or others or at risk of harm are more likely (p,>03) to be discharged (66%) than those without such a condition (52%).

The situation changes quite dramatically when one looks at the predictors once clients have been in the IMD for at least 3 months. The tables below are the results of the forms filled out at approximately 3 months after the client entered the IMD/SH. It does not, therefore, include those that have already been discharged in those first three months. At this point functional status and current behavioral conditions are more predictive of whether or not the client will be discharged during the remainder of the Study period.

First are the set of conditions that the staff rated – whether the client had been homicidal, suicidal, a danger to self or others, or done things likely to harm self or others.

The following were the relationships which were predictive of disposition.

Disposition by Condition in ID/SH at Three Months (all p<.001)

Condition at Three Months in IMD/SH	*N*	*Planned Discharge*	*Still in IMD/SH*
Violence to Others			
Yes	***32***	***25%***	***75%***
No	***250***	***64%***	***36%***
Homicidal, suicidal, or violence to self or others			
Yes	***45***	***31%***	***69%***
No	***237***	***65%***	***35%***
Homicidal, suicidal, violence to self or others, or likely to harm self or others			
Yes	***66***	***35%***	***65%***
No	***216***	***68%***	***32%***

The differences between functional status at three months and eventual discharge are also clear and statistically significant.

Disposition by GAF at Three Months (p<.001)

GAF	*N*	*Planned Discharge*	*Still in IMD/SH*
<20	***16***	***19%***	***81%***
21-25	***35***	***26%***	***74%***
26-30	***57***	***44%***	***56%***
31-35	***42***	***57%***	***43%***
>35	***34***	***71%***	***29%***

Disposition by MCAS at Three Months (p<.01)

MCAS	*N*	*Planned Discharge*	*Still in IMD/SH*
23-42	***20***	***20%***	***80%***
43-49	***29***	***45%***	***55%***
50-55	***26***	***58%***	***42%***
56+	***55***	***67%***	***33%***
TOTAL	***130***	***53%***	***47%***

The improvement in average MCAS scores from the initial rating to the three-month re-assessment is greater for the group of clients who are eventually discharged (+6.6 points) than for those who will still be in the IMD/SH at the end of the Study (+3.0 points).

What happens in that first three months in the IMD seems to make a difference. It is possible that the GAFs and MCAS and ratings of behaviors are more accurate at three months than at intake because the facility (or county case manager) knows the clients better and so are predictive as one might expect them to be. Or it is possible that the client's behavior actually

changes over the first three months because of something the facility does (some get better and some don't) or the facility may develop a mind-set about the client that covers both their perception of the client's behavior and of potential for discharge.

PART 4: TRANSFERS

County staff were instructed to complete a form every time a client was transferred from one long-term care setting to another. The table below shows the number and percentage of clients in each county who were transferred during the course of the Study. A transfer to an acute setting and then back again was counted as one transfer while a transfer from an IMD to a SH to another IMD was treated as two transfers. Overall, 14.3% of the clients in the Tracking Study were transferred at least once. There were sizable differences among the counties with the highest percentages in County C (30%) and County E(27%),

Number of Transfers	*County A (N=30)*	*County B (N=135)*	*County C (N=60)*	*County D (N=29)*	*County E (N=60)*	*Total (N=314*
1 Transfer	***2***	***4***	***15***	***2***	***7***	***30***
>1 Transfer	***1***	***1***	***3***	***1***	***9***	***15***
Total Number Transferred	***3***	***5***	***18***	***3***	***16***	***45***
Total Percent Transferred	***10%***	***3.7%***	***30%***	***10.3%***	***26.7%***	***14.3%***

Overall, there were 66 transfers for these 45 clients. The highest proportion of the transfers (60.6%) was back to an acute care facility from the IMD. The predominant reasons for the transfers were aggressive/assaultive/threatening behavior or self injury/suicidal ideation. Here are some examples given by staff on the transfer forms.

- *Threatening to kill everyone, threw tables at staff, broke nurses station plexiglass*
- *Client became aggressive toward peers/staff. Unable to control on unit. Refusing lab work.*
- *Became severely paranoid, verbally threatening, punching in the air, karate kicks, required seclusion/restraints - too violent for facility*
- *Swallowed tacks, unstable behavior, needs further stabilization*
- *Assaultive, unpredictable behavior, refuses meds, delusional, punched wall*
- *Self-mutilation, swallowed glass*

Additionally, 7.6% of the transfers were to a medical hospital. There was one pregnant client who was sent to the hospital to deliver, one with AIDS, 3 for diagnostic purposes when the client showed slurred speech, unsteady gait, confusion.

There were differences between the two counties with large numbers of transferred clients, both of which might *be explained by their overall system of care.*

- County E: County E had the most total transfers (30), which represents 47% of all the transfers for the total Study sample. All but one of these were transfers back to an acute psychiatric hospital unit. County E had by far the shortest length of stay in

acute care (mean of 16 days and 64% discharged within two weeks). It is possible that the greater need for acute care results from clients being less stabilized at the time of admission to the IMD. This interpretation, however, is called into question by the functional status scores of clients at admission – which were generally higher than average and the percentage with violence to self or others which were lower than average. So it is possible that the IMDs in this county are simply less able and/or willing to continue to serve clients who exhibit challenging behaviors.

- County C: By contrast, County C which had 21 transfers (32% of all the transfers) had a variety of movements among IMDs, reflective of the way in which they have organized their system. Clients go first to the shorter term facility and if not discharged from there will be transferred to other longer-term out-of-county IMDs (4) or to another IMD/MHRC which is considered a lower level-of-care in their system (8). Five of the transfers were back to acute care.

PART FIVE: COMMUNITY FOLLOW-UP

There were a total of 201 clients in the Tracking Study with a planned or an unplanned discharge. The nature and quality of follow-up information varies by county. All counties provided information on clients if they re-entered the IMD system[28]. Most counties also attempted a community follow-up with the clients approximately 3 months after their discharge and again near the end of the Study period. Not all counties were able to do this and not all clients could be located or if located were willing to provide information. Therefore, for each analysis that follows the denominator may be different.

READMISSION RATES

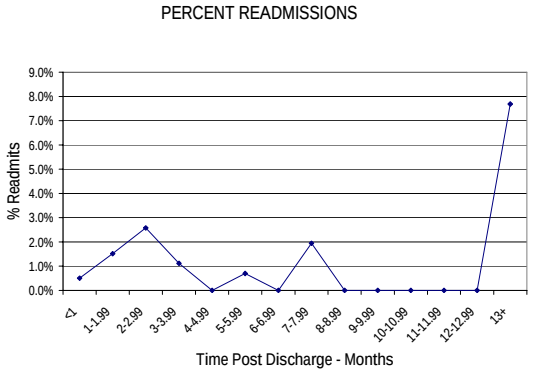
The issue of greatest concern is the number of readmissions to an IMD/SH level of care after discharge during the duration of the Tracking Study. There were 15 clients who were re-admitted, 14 once and one twice. This is 7.5% of the 201 discharged clients. The average time to re-admission was 4 months with a median of 2.8 months.

Time to Readmission

Time	Number
< 1 month	***1***
2-3 months	***8***
3-6 months	***3***
6-12 months	***2***
>12 months	***1***

[28] Some counties made an extra effort to check all clients who had been discharged against their roster of current clients in IMDs at the end of the Study to ensure that no clients in the Tracking Study had inadvertently been re-admitted without our being notified. This was particularly important in those counties which had trouble completing a follow-up with the discharged clients. Thus while we cannot be sure that we have all the readmissions, we are fairly confident that we do.

The length of time during which the clients could be re-admitted (i.e. the time between when they were discharged and when the county ended the Study) varied by client. We used as an "end of study" date either the date of the last Community Follow-up Form or, if there was no such form, the last date on which we got updated information on clients, for most counties the middle of July. Using the number of clients who had been discharged for a particular length of time as the denominator we are able to determine the percentage of readmissions of those who had been discharged for each particular length of time. The chart below shows that about ½ of one percent of the clients were readmitted during the first month post-discharge, going up to about 2 ½ % in the second month post-discharge. There is another peak in month seven and then no readmits until month 14 when one client was readmitted. Because the number of readmissions is so small it is unwise to make too much of this except that there are no really clear patterns.



Using this measurement, Counties C, D, and E had the longest time periods during which a client might have been readmitted, an average of roughly 8 months for County D and 9 months for Counties and E and E. Counties A and B had shorter periods, an average of roughly 5 months for County A and 5 ½ for County B. Thus we would expect a greater percentage of readmissions in Counties C, D, and E based on just the greater length of time in which to be readmitted.

These figures need to be used very cautiously. There is, as noted above, some uncertainty about the comprehensiveness of the data reporting. And as also noted, there are varying periods of time during which a client might have been readmitted. And finally, the numbers are really too small to have great certainty about the figures. It would be extremely interesting to track these same clients through the next year or so using the counties' information systems to determine their subsequent use of inpatient and IMD resources.

Readmissions By County

Readmissions	County A	County B	County C	County D	County E	Total
Number of discharges	***27***	***70***	***45***	***22***	***42***	***201***
Number of readmissions	***2***	***1***	***3***	***3***	***6***	***15***
Readmission rate	***9.1%***	***1.4%***	***6.7%***	***13.6%***	***14.3%***	***7.5%***
Average time from DC to End of Study (months)	***5.9***	***6.3***	***8.8***	***7.9***	***9.3***	***7.6***

There is some support for the hypothesis that those with lower functional scores at the time of discharge are more likely to be re-admitted, but this appears to hold largely for those with the very lowest scores. (Note: The total per cent readmitted is different in both tables because different sets of clients had MCAS and GAF scores reported at discharge.)

A number of other characteristics of clients at discharge were not related to whether or not the clients were readmitted. These included their living situation, their civil commitment status, whether they had a representative payee, whether they had a case manager, or whether the discharge was planned or unplanned.

The staff's prediction at discharge about how well the client would do did seem to be related to whether or not the client was readmitted, but the relationship was not statistically significant.

How Well Will Client Do	N	% Readmitted
Very well	***25***	***4.0%***
Moderately well	***58***	***6.9%***
Just OK	***26***	***11.5%***
Not very well	***21***	***19%***

Thus it appears that the clients who are most at risk of readmission are those with very low functional status scores and/or those who staff are particularly worried about. It would seem appropriate to be sure to identify these clients at discharge and make sure they are provided with appropriate services and supports at discharge.

LIVING SITUATION AT FOLLOW-UP

The table below shows the percentage living in various settings for those clients on whom such information was available at the three-month follow-up and at the final follow-up. The most common living situations are residential programs, B/C, and family of origin. There is a

promising trend towards an increase in independent and supported independent living over the intervening time period.[29]

Living Situation at Three Months and Final Follow-up

Living Situation	3-Month Follow-Up (N=90)	Final Follow-Up (N=60)
Homeless/shelter	***3%***	***2%***
Residential program	***19%***	***25%***
SRO/Room & Board	***2%***	***0***
Board & care	***38%***	***28%***
Family of origin	***29%***	***25%***
Independent or supported housing	***4%***	***15%***
Acute, hospital, SNF	***2%***	***5%***
Other	***2%***	***0***

INCOME SUPPORTS

Roughly three-quarters of the clients were reliant on SSI as their primary source of income at both 3-months and final follow-up. Significantly, by the final follow-up no clients were noted as having no income and one was listed as having income from employment.

Sources of income at Three month and Final Follow-Up

Sources of Income	3-Month Follow-Up (N=89)	Final Follow-Up (N=59)
SSI	***77.5%***	***78%***
SSDI/Social Security	***10%***	***15%***
Interim Funding	***4.5%***	***0***
Family	***3%***	***0***
Employment	***0***	***2%***
GA	***0***	***2%***
None	***4.5%***	***0***
Unknown	***2%***	***4%***

CIVIL COMMITMENT STATUS

Somewhat more than half of the clients remain on conservatorship at the three-month and final follow-ups. There is also virtually no change over the intervening time period.[30]

[29] If one considers only those clients on whom we have both a 3-month and a final follow-up living situation information the same trend holds with an increase from 3% to 11%.

[30] The same holds true for those who have both a three-month and a final follow-up; they go from 54% on conservatorship at three months to 57% at the final follow-up.

Civil Commitment Status at Three Month and Final Follow-Up

Civil Commitment Status	3-Month Follow-Up (N=90)	Final Follow-Up (N=60)
On conservatorship	***59%***	***60%***
Not on conservatorship	***41%***	***40%***

The rates of clients with a representative payee are higher with 77% at the Three Month Follow-up and 80% at the Final Follow-up. There was some change over this time period with 21% of those on conservatorship at 3-months no longer on conservatorship at the Final Follow-up. Conversely, 24% of those not on conservatorship at 3-months were at Final Follow-up.[31]

CRIMINAL JUSTICE INVOLVEMENT

At both the Three-Month and the Final Follow-up roughly 10-11% of the clients were reported to have some involvement with the criminal justice system. Of the total clients at follow-up 14.4% had reported involvement with criminal justice at either the Three-Month and/or the Final Follow-up.

GAF

There was basically no change in GAF scores between discharge and follow-up. The median GAF score was 40 at discharge, 3-month follow-up, and final follow-up. The average GAF at discharge for those with any follow-up GAF was 43.6 compared with an average Three Month follow-up GAF of 42.4 and an average Final Follow-up GAF of 41.6.

MCAS scores were collected on follow-up in selected counties, but we do not include the information since it is not comprehensive and because the knowledge of clients specific functioning was likely not very reliable at follow-up since staff that completed the information were not in regular face- to-face contact with the clients.

[31] These differences could also reflect errors in reporting so should be interpreted very cautiously.

Appendix D:

LONG-STAY CLIENTS

SAMPLE

Four counties collected information in early 2005 on 193 clients who were in IMD/SHs for more than 18 months. The counties reported that they had 564 clients in IMD/SHs in the fall of 2004. No effort was made to get a representative sample from these 564; rather the counties were told to sample a certain number from each of the facilities that had at least five long-term clients. The total number of clients and the resulting number in the sample are as follows.

Long-Stay Clients in Sample and Counties

	County B			County C			County D			County E		
	IMD	***SH***	***T***	***IMD***	***SH***	***T***	***IMD***	***SH***	***T***	***IMD***	***SH***	***T***
Total Number (Fall 2004)	***144***	***136***	***280***	***196***	***13***	***209***	***5***	***9***	***14***	***62***	***34***	***96***
Sample	***47***	***45***	***92***	***37***	***9***	***46***	***8***	***5***	***13***	***27***	***15***	***42***

The results should thus be interpreted as just a sample of clients that have been in IMD/SHs for over 18 months in these four counties and not as representative of all their long-stay clients or all the long-stay clients in the state. The information is useful for providing insights into the kinds ***of issues facing these client and efforts to discharge them into the community.***

ETHNICITY

The ethnic breakdown of long-stay clients appears similar to that for the Tracking Study sample.

Ethnicity by County

	County B ***(N=***	*County C* ***(N=***	*County D* ***(N=)***	*County E* ***(N=)***	Total **(N=192)**
African American	***30%***	***4%***	***31%***	***0***	**18%**
Asian/Asian American	***7%***	***16%***	***0***	***12%***	**9%**
Caucasian	***33%***	***69%***	***61%***	***57%***	**48%**
Hispanic	***30%***	***11%***	***8%***	***29%***	**24%**
Other	***0***	***0***	***0***	***2%***	**1%**
	100%	***100%***	***100%***	***100%***	**100%**

EDUCATION

The educational level of the long-stay clients is lower than for the clients in the Tracking Study. For example, 22% of the Long-Stay clients had no high school compared to 8% of the Tracking Study clients. As with the Tracking Study clients, County E clients appear to have a lower level of education.

Percent Education by County

	County B ***(N=)***	*County C* ***(N=)***	*County D* ***(N=)***	*County E* ***(N=)***	Total **(N=180)**
No High School	***28%***	***13%***	***15%***	***20%***	**22%**
Some High School	***31%***	***36%***	***46%***	***60%***	**39%**
High School or GED	***25%***	***38%***	***15%***	***7.5%***	**23%**
Some College	***9%***	***13%***	***23%***	***10%***	**11%**
Some Degree	***10%***	***0***	***0***	***2.5%***	**4%**
	100%	**100%**	**100%**	**100%**	**100%**

GENDER

As with the Tracking Study the split between females and males is about 1/3 and 2/3. An interesting difference occurs with County D and County E which had more of a 50/50 split with clients in the Tracking Study.

Percent Gender by County

	County B ***(N=92)***	*County C* ***(N=46)***	*County D* ***(N=13)***	*County E* ***(N=42)***	Total **(N=192)**
Female	***33%***	***30%***	***15%***	***38%***	**32%**
Male	***67%***	***70%***	***85%***	***62%***	**68%**
	100%	***100%***	***100%***	***100%***	**100%**

AGE

The clients in the Long-Stay sample are older than those in the Tracking Study, an overall difference in mean age of 47 versus 40. In the Tracking Study, 24% of the clients are under 30 compared to only 6% of the Long-Stay clients; and, 44% are between 40 and 60 compared to 73% of the Long-Stay clients. County E is most notable with 61% of their long-stay clients over age 50. As with the Tracking

Study clients there is a higher percentage of females in the 50-65 age range than in the other ages – 43% of this age range are female.

Mean and Median and Percent Age Categories by County

	County B ***(N=91)***	*County C* ***(N=45)***	*County D* ***(N=13)***	*County E* ***(N=39)***	Total **(N=188)**
Mean	***46***	***46.5***	***46.5***	***50***	**47**
Median	***46.5***	***47***	***45***	***53***	**48**
<21	***2%***	***2%***	***0***	***0***	**1%**
21-30	***4%***	***4%***	***0***	***10%***	**5%**
30-40	***18%***	***24%***	***39%***	***5%***	**18%**
40-50	***36%***	***36%***	***23%***	***23%***	**32%**
50-65	***36%***	***33%***	***38%***	***62%***	**41%**
>65	***3%***	***2%***	***0***	***0***	**2%**

CRIMINAL COMMITMENTS

Overall, 17% of the clients were admitted to the IMD/SH on a criminal offense. This ranged from a high of 30% in County B and in County D to 2% each in County C and County E. Only 6% of the clients in the IMD had begun with a criminal offense compared to 35% of those in a SH. Overall, 10% of the females in the sample and 21% of the males had been admitted on a criminal charge. Those admitted on a criminal charge were more frequent among those with a LOS of between 5 and 8 years.

LENGTHS OF STAY (LOS)

The average LOS for the sample was 6.3 years. The fact that the medians were lower than the means indicates that the averages are influenced by some very long LOS in each county. Those in SHs had an average LOS of 8.2 years (median of 6.1 years) compared to an average LOS for clients in IMDs of 5.1 years (median of 5.7 years).

There are differences among the counties in LOS – with County D standing out the most with a lower mean and particularly a lower median. Two-thirds of the County D clients had been in the IMD/SH for less than three years.

Lengths of Stay by County

	County B ***(N=89)***	*County C* ***(N=44)***	*County D* ***(N=13)***	*County E* ***(N=42)***	Total **(N=188)**
Mean	***5.7***	***6.8***	***4.8***	***7.3***	**6.3**
Median	***4.3***	***4.4***	***2.0***	***6.3***	**4.7**
< 3 years	***28%***	***32%***	***61%***	***21%***	**30%**

3-5 years	***36%***	***20 %***	***0***	***21%***	**27%**
5-8 years	***19%***	***21%***	***15%***	***21%***	**20%**
> 8 years	***17%***	***27%***	***23%***	***36%***	**24%**
	100%	***100%***	***100%***	***100%***	**100%**

DIAGNOSES

It appears that the diagnostic picture becomes murkier over time rather than clearer. A striking 8% of the clients have no Axis I diagnosis in the chart (or available to the county staff monitoring the case) and roughly one-third (35%) have an un-differentiated or non-specified schizophrenia diagnosis (compared to 20% at intake on the Tracking Study clients).

Axis I Diagnoses By County

	County A ***(N=)***	*County B* ***(N=92)***	*County C* ***(N=46)***	*County D* ***(N=13)***	*County E* ***(N=42)***	Total **(N=193)**
Schizophrenia – Schizoaffective		***28%***	***26%***	***8%***	***41%***	**29%**
Schizophrenia – Paranoid		***23%***	***24%***	***25%***	***14%***	**21%**
Schizophrenia – Undifferentiated, not specified, other		***32%***	***46%***	***23%***	***33%***	**35%**
Major Depression or Bipolar		***10%***	***0***	***8%***	***0***	**5%**
Other		***2%***	***0***	***8%***	***2%***	**2%**
Missing		***5%***	***4%***	***38%***	***10%***	**8%**
	100%	***100%***	***100%***	***100%***	***100%***	**100%**

The tendency for the diagnosis to be undifferentiated schizophrenia increases with the length of time someone has been in the IMD/SH, going from 27% of those who have LOS of less than 3 years to 32% for those with LOS between 3 and 8 years and up to 49% for those with LOS over 8 years. Diagnosis is more often missing for those in state hospitals (18%) than in IMDs (2.5%) as is the percentage of undifferentiated schizophrenia (42% Vs 30%).

CURRENT CONDITIONS

The following table indicates the percentage of Long-Stay Clients who were noted as having each of the four conditions, followed in parentheses by the percentage who had exhibited the behavior within the last three months. The final row shows the same percentages for any *of the four situations. Over half of the Long-Stay sample had one of the four situations and over one-third (35%) had exhibited the behavior in the last three months. By far the most common was violence towards others.*

Current Condition by County

	County B **(N=92)**	*County C* **(N=46)**	*County D* **(N=13)**	*County E* **(N=42)**	Total **(N=193)**
Suicidal	***8% (5%)***	***17% (2%)***	***15% (8%)***	***17% (2%)***	**12% (4%)**
Homicidal	***9% (5%***	***4% (2%)***	***8% (8%)***	***17% (7%)***	**9% (5%)**
Violence-Self	***11% (10%)***	***13% (4%)***	***0***	***21% (12%)***	**14% (8%)**
Violence-Others	***42% (28%)***	***54% (24%)***	***38% (23%)***	***52% (40%)***	**48% (30%)**
Any of four	***50% (34%)***	***61% (28%)***	***46% (31%)***	***67% (45%)***	**56% (35%)**

The percentage of organically impaired clients is about twice what it was for the Tracking Study clients.

Percent of Clients with Other Conditions in Total Sample

Condition	*%*
Substance abuse (last 3 months)	***25% (5%)***
AWOL risk (last 3 months)	***11.9% (2.1%***
Medication noncompliance	***52.3%***
Communicable disease and unpredictable behavior	***5.7%***
History of fire setting (last two years)	***4.2% (0.5%)***
Organically impaired	***10.9%%***
Known history of abuse or trauma	***12.4%***

GAF

The average GAF score at intake for the Tracking Study sample was 27 and had gone up to 31 for those clients still in an IMD/SH after 3 months – the same average score as for the Long-Stay clients.

While the GAF scores may not be very reliable, there are noticeable differences among the counties which make sense in terms of what we know about usage, i.e. County B and County C have higher mean scores and a higher percentage of clients with GAF scores over 30 (53% for County B and 66% for County C) compared to County D (30%) and County E (27%). No such differences were noted in the scores at intake with the Tracking Study sample.

GAF by County

	County B ***(N=88)***	*County C* ***(N=35)***	*County D* ***(N=13)***	*County E* ***(N=40)***	Total **(N=176)**
Mean	***33***	***32***	***29***	***27***	**31**
Median	***35***	***35***	***27***	***25***	**30**
<=15	***2%***	***3%***	***0***	***10%***	**4%**
16-20	***7%***	***9%***	***15%***	***18%***	**10%**
21-25	***13%***	***3%***	***31%***	***25%***	**15%**
26-30	***25%***	***20%***	***23%***	***20%***	**23%**
31-35	***20%***	***43%***	***15%***	***20%***	**24%**
>35	***33%***	***23%***	***15%***	***7%***	**24%**
	100%	***100%***	***100%***	***100%***	**100%**

MCAS

*The same pattern among the counties is demonstrated with the MCAS scores with those for County B and County C being higher than those for County D and County E. This was not the pattern at intake with the Tracking Study sample where County B and County E had MCAS scores that were higher than th**e other counties.***

MCAS by County

	County B (N=92)	*County C (N=45)*	*County D (N=13)*	*County E (N=42)*	*Total (N=192)*
Mean	***52***	***51***	***45.5***	***45***	***50***
Median	***52***	***52***	***45***	***44***	***49***
<43	***16%***	***13%***	***23%***	***43%***	***22%***
43-49	***28%***	***31%***	***62%***	***29%***	***31%***
50-55	***23%***	***24%***	***15%***	***19%***	***22%***
56+	***33%***	***31%***	***0***	***9%***	***25%***

The average MCAS scores do not differ significantly between those in state hospitals (49.5) and those in IMDs (49.8) or among those with differing lengths of stay (e.g. 50.6 for those with a LOS of less than 3 years and 48.1 for those with LOS over 8 years).

REASON FOR STILL BEING IN IMD/SH

One item on the form for each client asked "Briefly describe why the client remains in the IMD or state hospital." The narrative responses were coded into the following items with the following overall frequencies. The total is greater then 100% since staff cited more than one reason for most clients.

Reason	Percent
Responses to internal stimuli, hallucinations, delusions, bizarre behavior	***34%***
Dangerous to others, assaultive, throws things, threatens	***29%***
Impaired decision making, no insight, poor judgment, safety issues without supervision	***22%***
Mood disorder: depressed, agitated, labile	***21%***
Discharge issues: client doesn't want to leave, family/conservator doesn't want discharge, no place will take client, no benefits, client decompensates when DC is planned	***21%***
Needs assistance with Activities of Daily Living (ADL), needs reminders to shower, poor hygiene,	***14%***
Refuses treatment, no or spotty attendance at groups, tries to avoid medications	***14%***
Sexual issues: inappropriate sexual behavior, inappropriate touching	***12%***
Poor social adjustment: isolated, withdrawn, intrusive	***11%***
Disorganized, disoriented, confused, need for supervision	***10%***
Verbally abusive (without danger to others)	***8%***
Dangerous to self, self-injury, suicidal thoughts and expressions	***7%***
Danger to community if discharged	***5%***
Major ADL issues: incontinence, smearing feces, total inability to care for self	***5%***
Medical issues: dementia, seizures, end stage of illness, lymphoma, end stage renal failure	***4%***
Current stealing	***2%***
Criminal issues still not resolved	***2%***

We combined these into broader categories as follows

- ***Dangerousness*** *which includes dangerous to others, sexual issues, danger to community, and criminal issues still not resolved*
- ***Safety*** *which includes dangerous to self, disorganized, impaired decision-making, the serious ADL issues, and current stealing*
- ***Grave disability*** *(GD) which includes responds to internal stimuli and needs assistance with ADLs*

Frequencies of these larger categories are as follows

Dangerous	***45%***
Safety	***39%***
Dangerous and Safety	***20%***
Dangerous only	***25%***
Safety only	***12%***
Neither Dangerous or Safety	***36%***

Grave Disability	***42%***
Grave Disability but no Dangerous or Safety	***15%***

There are a number of significant variations in these categories depending on age, gender, MCAS scores, IMD vs. SH and LOS. These are shown in the table below with the "prob values" in parentheses.

Reason for Being in IMD/SH by Gender

Gender	Dangerous (p<.001)	Safety (p<.13)	GD	GD Only (p<.12)	None
Male	***55%***	***35%***		***12%***	
Female	***23%***	***47%***		***21%***	

Reason for Being in IMD/SH by Age

Age	Dangerous (p<.01)	Safety (p<.03)	GD	GD Only (p<.01)	None
<30	***67%***	***17%***		***0***	
30-40	***53%***	***24%***		***12%***	
40-50	***54%***	***46%***		***10%***	
50-65	***30%***	***46%***		***21%***	
>65	***0***	***0***		***75%***	

Reason for Being in IMD/SH by Education

Education	Dangerous (p<.02)	Safety	GD	GD Only (<.02)	None
No high school	***30%***			***28%***	
Some high school	***59%***			***6%***	
High school graduate or GED	***40%***			***21%***	
More than high school	***38%***			***12%***	

Reason for Being in IMD/SH by Axis I Diagnosis

Axis I Diagnosis	Dangerous	Safety	GD (p<.07)	GD Only	None (p<.01)
Depression/bipolar			***30%***		***20%***
Schizoaffective			***48%***		***23%***
Schizophrenia: Non-differentiated			***46%***		***12%***
Schizophrenia: Paranoid			***45%***		***20%***
Missing			***6%***		***56%***
Other			***50%***		***25%***

Reason for Being in IMD/SH by MCAS

MCAS	Dangerous	Safety (p<.02)	GD <.06	GD Only	None (p<.02)
23-42		***57%***	***40%***		***14%***
43-49		***40%***	***47%***		***18%***
50-55		***38%***	***55%***		***14%***
56+		***23%***	***27%***		***38%***

Reason for Being in IMD/SH by IMD vs. SH

IMD/SH	Dangerous (p<.02)	Safety (p<.08)	GD (p<.03)	GD Only	None
IMD	***38%***	***44%***	***49%***		
SH	***55%***	***31%***	***32%***		

Reason for Being in IMD/SH by Length of Stay

Length of Stay	Dangerous	Safety (p<.001)	GD	GD Only	None (p<.001)
< 3 years		***8%***			***46%***
3-5 years		***29%***			***29%***
5-8 years		***44%***			***12%***
>8 years		***55%***			***13%***

Not all of the relationships in the above tables tell a straightforward story. Here is what we would take from them in the way of a summary.

- *Dangerousness is clearly cited more frequently for males and those in a SH as opposed to an IMD. It is also related to age with its being more frequent with those under thirty and less frequent with those over 50.*

- *Safety is cited more frequently for females, for those over age 40, and for those in IMDs as opposed to the SH. It is inversely related to total MCAS scores with its being cited more often for those with lower MCAS scores. It is also directly related to the time a person has spent in an IMD/SH with its being cited for 8% of those with a LOS of less than 3 years and by 55% for those with a LOS over 8 years.*

- *Grave disability is cited more frequently for those in a SH vs. an IMD and not surprisingly is inversely related to MCAS scores with those scores over 56 having the lowest likelihood of having a GD reason for still being in the IMD/SH.*

- *Grave disability only (i.e. with no dangerousness or safety issues) is somewhat more frequent with females, and more frequent with older clients, particularly anyone over 65.*

- *Not having any of the three reasons cited is more frequent for those missing a diagnosis, those with an MCAS score over 56, and for those who have been there for shorter periods of time.*

There are 20% of the clients who had none of the above three categories listed as a reason for still being in an IMD/SH. Here are the reasons listed for why they were still in the IMD/SH.

Other Reasons for Why Still in IMD/SH (N=39)

Reason (in the absence of dangerousness, safety, or GD reason)	Percentage
Discharge-related ***Client, parent, or conservator refuses or clients decompensates or becomes overly anxious about DC plans (6%)*** ***No appropriate placement, no benefits (1.6%)*** ***In discharge process (3.6%)***	***11%***
Wild or violent mood swings	***2%***
Medical issues	***2%***
Other	***3.6%***
Missing	***1.6%***
TOTAL	***20%***

TREATMENT: GOALS AND TREATMENT PLANS

The survey asked what the goals were in the treatment plan. The goals were grouped into one of 12 categories (data is from the first goal stated but is reflective of all the goals listed). The most frequently cited goals relate to controlling behavior, most often assaultive behaviors. The next most frequent type of goal relates to the client's increased compliance with the treatment plan including more attendance at groups and more compliance with medications. The third most frequent relates to the control of symptoms characteristic of the thought disorder.

Goals (N=180)

Category	Examples	Percent
Behavior management	***Reduce assaults, reduce verbal abuse, recognize aggressive feelings prior to assault, improve impulse control, communicate needs in a constructive manner without yelling, stop harassing behavior***	***23%***
Compliance with treatment	***Attend more groups, improve meds compliance, cooperate with current treatment plan, co-operate with ward routine, attend all assigned groups for 90 days, attend Latino group to increase socialization, attend music group 2X month to decrease agitation, attend anger management group at least 1X month***	***19%***
Symptom management	***Reduce hallucinations, reduce paranoia, develop symptom management, decrease nonfactual statements, utilize more effective coping tools to deal with psychotic symptoms, seek out staff 3X week to express paranoid ideas, mood instability, depression***	***18%***

ADLs	***Improved hygiene, perform ADLs daily, compliance with toileting program, shower once a week, noncompliant with ADLs,***	***7%***
Court issues	***Attain trial competence, resolve Murphy conservatorship, verbalize understanding of court process,***	***7%***
Social behavior	***Reduce isolation, verbalize in a socially appropriate manner, improve communication, interact with staff and peers without being verbally aggressive, social skills***	***6%***
Mood issues	***Mood instability, depression, reduce agitation***	***6%***
Discharge planning	***Stabilize and discharge to lower level of care, discharge planning, decrease client's anxiety about discharge, be willing to discuss discharge with staff, place at lower level of care***	***4%***
Health issues	***Stable blood pressure, weight gain, nutritional status, reduce visual impairment***	***3%***
Skills or strengths	***Low self-esteem, skill management, increase attention span, develop relapse prevention plan for SA***	***3%***
Stability	***Be medically and psychiatrically stable, maintain client's current stability,***	***2%***
Judgment and safety	***Judgment and safety***	***1%***
		100%

What is most striking about virtually all the goals is their traditional treatment model orientation. Only 3% of the goals could be classified (even liberally) as relating to skills or strengths building. And not a single goal appeared to be in the client's wording or reflected anything that was specific to a particular client.

There were 4% of the goals that reflected a discharge planning issue but they were all either very general "discharge planning" or related to the client's general anxiety about discharge planning.

The survey asked whether the client's treatment goals had been updated or changed within the last six months. Ninety percent indicated that it had been updated, but given the generality of the goals it is not clear that this would have been a particularly constructive activity.

TREATMENT: MEDICATIONS

The survey asked whether there had been a major change in the client's medications in the last year, and if so in what kind of medications. Roughly one-quarter of the clients had such a change, largely in a neuroleptic medication. There was no significant difference among the counties in these answers.

Major Changes in Medications Over Last Year By County

	County B (N=91)	*County C (N=44)*	*County D (N=13)*	*County E (N=42)*	*Total (N=190)*
Yes	***30%***	***25%***	***23%***	***24%***	***27%***

No	***51%***	***70%***	***77%***	***74%***	***62%***
Don't know	***20%***	***5%***	***0***	***2%***	***11%***
Neuroleptic	***17%***	***20%***	***23%***	***19%***	***18%***
Anti-Depressant	***3%***	***0***	***0***	***2%***	***2%***
Both	***2%***	***0***	***0***	***2%***	***2%***
Unspecified	***8%***	***5%***	***0***	***0***	***5%***

The survey also asked whether the client had ever been tried on Clozaril. Overall, at least one-quarter of the clients were reported to have had such a trial. There were differences between counties with a lower percentage in County D (8%) and a higher percentage in County E (38%). Most striking is the lack of information in all the counties about this question. Because most of the facilities do not have records that reflect earlier experiences with the client this information does not appear to be routinely available to the current treatment staff or setting.

Percentage of Clients Who Have Had a Trial on Clozaril By County

	County B (N=92)	*County C (N=45)*	*County D (N=13)*	*County E (N=42)*	*Total (N=191)*
Yes	***23%***	***22%***	***8%***	***38%***	***25%***
No	***29%***	***13%***	***8%***	***31%***	***24%***
Not appropriate	***3%***	***2%***	***0***	***5%***	***3%***
Don't know	***45%***	***62%***	***85%***	***26%***	***48%***

The percentage with a reported trial of Clozaril were more likely to have had a major medication change in the last year. Of those with such a change in medications, 45% were reported to have had such a trial compared to only 20% of those with no reported change.

There was a greater chance that a client would have received a try on Clozaril the longer they were in an IMD/SH. About 18% of those in residence less than 5 years were reported to have had such a trial compared to 32% of those there 5-8 years and 38% for those with a LOS over 8 years.

The survey asked whether there had been any discharge planning in the last six months. According to the surveys one-third of the clients had some discharge planning within the last six months. There was variation among the counties with the highest figures in County C and County D and the lowest in County E. The survey question may have been too vague about what constituted discharge planning so we am not sure how much weight to put in this table.

Discharge Planning Within the Last 6 Months by County

	County B (N=91)	*County C (N=44)*	*County D (N=13)*	*County E (N=42)*	*Total (N=190)*
Yes	***33%***	***55%***	***46%***	***7%***	***33%***

Some of the relationships suggest that the variable might be meaningful, i.e. there is a relationship with reason for discharge. Those with a dangerousness or a safety reason for still being in the IMD/SH were significantly less likely to have had discharge planning in the last six months than those without those: for dangerousness 26% vs. 39% (p<.06) and for safety 18% vs. 49% (p<.001). There was also a significant relationship (p<.001) between discharge planning in the last 6 months and MCAS scores.

MCAS By Percent With Recent Discharge Planning

MCAS	Percent with Discharge Planning in Last Six Months
23-42	***14%***
43-49	***26%***
50-55	***24%***
56+	***64%***

EXPECTED DISPOSITION

The survey asked how long the client was expected to remain in the IMD/SH. Overall about 30% are expected to stay less than a year and about one-third to remain at that level of care forever. There are major differences in these expectations by county. Clearly, County D expects to discharge these clients – about three-quarters within a year. For County C and County E, no discharge is expected for at least 40% of the clients.

Expected Time to Discharge By County

	County B (N=90)	*County C (N=45)*	*County D (N=13)*	*County E (N=41)*	*Total (N=189)*
Less than 6 months	***17%***	***9%***	***38.5%***	***5%***	***14%***
6 months to one year	***32%***	***24.5%***	***38.5%***	***19%***	***26%***
One to two years	***22%***	***24.5%***	***15%***	***42%***	***26%***
Likely to remain at this level of care forever	***29%***	***42%***	***8%***	***44%***	***34%***
	100%	***100%***	***100%***	***100%***	***100%***

There is a significant relationship between expected length to remain in the IMD/SH and MCAS scores, particularly with those having the lowest and highest scores. Over 60% of those with MCAS scores over 56 have an expected further stay of less than one year with only 17% expected not to be discharged at all. Only one-quarter of those with the lowest MCAS scores (under 42) are expected to leave within a year with almost 60% expected not to be discharged at all.

Expected Length of Time in IMD/SH by MCAS Scores

	23-42	*43-49*	*50-55*	*56+*
Less than 6 months	***7%***	***8%***	***10%***	***30%***
6 months to one year	***19.5%***	***27%***	***24%***	***33%***
One to two years	***15%***	***37%***	***32%***	***20%***
Likely to remain at this level of care forever	***58.5%***	***28%***	***34%***	***17%***
	100%	***100%***	***100%***	***100%***

There is also a significant relationship (p<.001) between the expected time to discharge with a "safety" reason for still being in the IMD/SH. One might expect that every alternative medication would have been tried with those clients with the worst prognosis- i.e. those not ever expected to be discharge to a lower level of care. In fact, these clients were more likely to have been tried on Clozaril (36%) than those with an expected discharge, but this is still only about one-third of these clients.

"Safety" Reason for Still Being in IMD/SH by Expected Time Until Discharge (N=189)

	Safety Reason	*No Safety Reason*
Less than 6 months	***3%***	***21%***
6 months to one year	***21%***	***29%***
One to two years	***29%***	***25%***
Likely to remain at this level of care forever	***47%***	***25%***
	100%	***100%***

The survey also asked what was the anticipated discharge placement for the client. The question could be confusing since it was possible to answer the question even if the prior answer indicated that the client was not expected to ever be discharged. So we have excluded the latter from the anticipated discharge placement, leaving an N of 125.

Overall, the most frequent discharge placement (see "Total" column in table below) was an IMD/locked SNF with 42%. This was followed by augmented board and care facilities with 19%. But with this variable it is important to distinguish between anticipated placements for clients in SH from those for clients in an IMD. There should be few IMD anticipated placements for those clients already in IMDs. There are a few exceptions to this, e.g. one facility in County B which is a specialized sub-acute facility that could discharge clients to

another IMD/locked SNF and a few cases in County E and County C where there might be an anticipated discharge to another IMD which would be more appropriate.

Seventy-five percent of the anticipated placements from SHs are to IMDs with another 15% to regular SNFs. For the IMDs, the most frequent anticipated discharge placement is augmented board and care facilities (32%) followed by regular board and care facilities (23.5%), residential treatment (18%) and other IMDs (18%).

Anticipated Discharge Placement by IMD/SH

	SH Number	*SH %*	*IMD Number*	*IMD %*	*Total Number*	*Total %*
IMD/Locked SNF	***40***	***75%***	***13***	***18%***	***53***	***42%***
Residential treatment	***1***	***2%***	***13***	***18%***	***14***	***11%***
Augmented board & care	***1***	***2%***	***23***	***32%***	***24***	***19%***
Regular board & care	***0***	***0***	***17***	***23.5%***	***17***	
Regular SNF	***8***	***15%***	***4***	***5.5%***	***12***	***10%***
Other	***3***	***6%***	***2***	***3%***	***5***	***4%***
	53	***100%***	***72***	***100%***	***125***	***100%***

The table below shows the differences among the counties in the anticipated placements first for clients in SHs and then for clients in IMDs. The entries in the tables are numbers of clients, not percentages because the numbers are relatively small when looked at by county. County D stands out from the others in anticipating regular SNF placements for its SH clients as opposed to IMDs/locked SNFs for the other counties.

Anticipated Placement by County for Clients in SH (Ns, not %s)

	County B (N=31	*County C (N=5)*	*County D (N=4)*	*County E (N=13)*	*Total (N=53)*
IMD/Locked SNF	***24***	***4***	***0***	***12***	***40***
Residential treatment	***1***	***0***	***0***	***0***	***1***
Augmented board & care	***1***	***0***	***0***	***0***	***1***
Regular board & care	***0***	***0***	***0***	***0***	***0***
Regular SNF	***3***	***1***	***4***	***0***	***8***
Other	***2***	***0***	***0***	***1***	***3***

County D again differs from the other counties in anticipating that its IMD clients will be placed in regular board and care facilities as opposed to County B which

anticipates using augmented board and care facilities, and County C and County E that cite residential treatment as their most likely discharge placement.

Anticipated Placement by County for Clients in IMDs (Ns, not %s)

	County A (N=)	*County B (N=33)*	*County C (N=21)*	*County D (N=8)*	*County E (N=10)*	*Total (N=72)*
IMD/Locked SNF		***8***	***3***	***0***	***2***	***13***
Residential treatment		***1***	***8***	***0***	***4***	***13***
Augmented board & care		***15***	***4***	***2***	***2***	***23***
Regular board & care		***5***	***6***	***6***	***0***	***17***
Regular SNF		***2***	***0***	***0***	***2***	***4***
Other		***2***	***0***	***0***	***0***	***2***

DIFFERENCES BY GENDER AND ETHNICITY

Gender

The following differences by gender were noted in the above analyses.

- *A higher proportion of females were in the older (50-65) year age range.*
- *Males were more likely to have been admitted on a criminal offense.*
- *Males were more likely to have a "dangerousness" reason for still being in the IMD/SH while the females were more likely to have a "safety" reason for still being there.*

Additional differences are as follows.

- *Females are significantly more likely (p<.01) to be in IMDs (76%) than in state hospital (24%) compared to males (55% in IMDs and 45% in state hospitals).*
- *Females (21%) were more likely to have been suicidal than males (12%) and more likely to have been suicidal within the last three months (8% vs. 2%); and more likely to have been violent towards themselves (23% vs. 8%; within last three months 18% Vs 4%).*
- *Males (12%) were more likely to have been homicidal than females (3%) and more likely to have been such within the last three months (7% vs. 2%).*
- *While there was no difference in the percentage of females or males who were reported to have been homicidal, suicidal, or violent to self or others, females (43.5%) were more likely than males (30.5%) to have had one of these within the last three months.*
- *Males (31%) are significantly more likely (p<.02) to have had a trial on Clozaril than are females (13%). While the percentage reportedly*

having a major change in medications within the last six months is about the same there is a higher percentage of females (21%) than males (6%) in which the information is not known.

- *Females are more likely (p<.06) to be expected to remain at the IMD/SH level of care forever (43%) than are males (30%).*

There were no significant differences in gender for Axis I diagnoses, MCAS scores, or LOS.

Ethnicity

There are differences by ethnicity in age and education. Caucasians are older with the highest average age (49.0) and over half aged 50 or older while Asian/Asian Americans and Hispanics are somewhat younger with an average age of 44.6 and 43.8 respectively.

Ethnicity by Age (p<.02)

Age	African American	Asian/Asian American	Caucasian	Hispanic
Mean	***47.2***	***43.8***	***49.0***	***44.6***
Median	***46.9***	***46.3***	***51.0***	***44.7***
<30	***3%***	***6%***	***3%***	***13%***
30-40	***15%***	***31%***	***18%***	***18%***
40-50	***47%***	***38%***	***28%***	***31%***
50-65	***35%***	***25%***	***47%***	***38%***
>65	***0***	***0***	***4%***	***0***
TOTAL	***100%***	***100%***	***100%***	***100%***

The Asian/Asian Americans and Hispanics have lower overall education levels than the others with a third or more having no high school education.

Ethnicity by Education (p<.03)

Education	African American	Asian/Asian American	Caucasian	Hispanic
No high school	***9%***	***33%***	***14%***	***39%***
Some high school	***47%***	***28%***	***34%***	***37%***
High school graduate or GED	***23%***	***17%***	***26%***	***15%***
More than high school	***21%***	***22%***	***26%***	***9%***
TOTAL	***100%***	***100%***	***100%***	***100%***

There were differences by ethnicity in terms of current conditions. Having any of the four current conditions was more likely for Asian/Asian Americans and less likely for African Americans (p<.10) with the difference even more striking for any of the conditions within the last three months ((p<.03), for example 56% of the

Asian/Asian Americans having one of the four conditions within the last three months compared to only 15% for the African Americans).

Current Conditions by Ethnicity (within last 3 months)

Current Condition	African American	Asian/Asian American	Caucasian	Hispanic
Suicidal	***3% (0)***	***11% (0)***	***15% (5%)***	***13% (6.5%)***
Homicidal	***12% (3%)***	***6% (6%)***	***10% (4%)***	***9% (9%)***
Violent to self	***3% (0)***	***11% (11%)***	***16% (9%)***	***15% (13%)***
Violent to others	***38% (12%)***	***61% (44%)***	***46% (29%)***	***50% (39%)***
Any of four	***41% (15%)***	***78% (56%)***	***56% (34%)***	***59% (43%)***

African Americans (53%) were significantly more likely (p<.001) to have been committed under a criminal charge than were Asian/Asian Americans (17%), Caucasians (6.5%), or Hispanics (13%). Caucasians and Hispanics are more likely to be in an IMD while African Americans are more likely to be in a state hospital with Asian/Asian Americans split 50/50.

IMD or SH by Ethnicity

IMD or SH	African American	Asian/Asian American	Caucasian	Hispanic
IMD	***44%***	***50%***	***70%***	***63%***
SH	***56%***	***50%***	***30%***	***37%***
TOTAL	***100%***	***100%***	***100%***	***100%***

African Americans (9%) were less likely (p<.06) to have had a trial on Clozaril than were Asian/Asian Americans (39%), Caucasians (23%), or Hispanics (37%).

There were no differences by ethnicity in length of stay, MCAS scores, Axis I diagnostic categories, or expected length before discharge.

SUMMARY OF FINDINGS

Roughly two-thirds of the long-stay clients are males. *For County B and County C this is similar to the Tracking Study, but in County D and County E the split for the Tracking Study was more 50/50.*

The long-stay clients are older – with a mean age of 47 compared to 40 for the Tracking Study clients. The females are older than the males.

Overall, 17% of the long-stay clients were initially committed under a criminal charge. *This varied substantially by county with 30% for County B and County D. These clients were more prevalent in the SH part of the sample (35%) than the IMD part (7%).*

Average lengths of stay for the long-stay clients in the sample was 6.3 years. Lengths of stay were longer for clients in SHs than for IMDs. County D stood out from the other counties with considerably more clients with short LOS.

Over 40% of the clients have no Axis I diagnosis in the charts (8%) or a diagnosis of schizophrenia-undifferentiated or non-specified (35%). *These are more frequent the longer one has been in an IMD/SH and more frequent in the SHs than in IMDs.*

While more than half (56%) of the clients had been homicidal, suicidal, violent towards others or themselves, only 35% had such an incident within the last three months. *Violence towards others was by far the most frequent of these four conditions. About half (52%) were recorded as being noncompliant with medications. Eleven percent were described as being organically impaired.*

Average MCAS scores for the total sample of long-stay clients is the same as for the Tracking Study sample at intake – 50, but there are different patterns among the counties. *MCAS scores are higher for County B (52) and County C (51) than for County D (45.5) and County E (45). MCAS scores did not differ between those in SH or IMDs or between those with differing LOS.*

Some element of dangerousness to others was cited as a reason why 45% of the clients were still in the IMD/SH; some element of client safety was cited for 39% of the clients; and some element of a grave disability for 42% of the clients. *About two-thirds (64%) had either a dangerousness and/or a safety issue cited as a reason why the person was still there with another 15% with a grave disability reason (without dangerousness or safety).*

- *Dangerousness is clearly cited more frequently for males, for those in a SH, and for those under 30.*

- *Safety is cited more frequently for females, for those over age 40, for those in IMDs, for those with lower MCAS scores, and for those with very long LOS.*

- *Grave disability is cited more frequently for those in a SH and least likely for those with high MCAS scores.*

Treatment goals were very generic and not really client-specific. There was no indication of a recovery or client-directed orientation in the treatment plan. *Behavior management goals were most frequent (23%), followed by treatment compliance goals (19%) and symptom management goals (18%). Only 4% were at all related to discharge and only 3% to any kind of strength or skill development. While the plans were reportedly updated within the last 6 months for 90% of the clients, it is unclear that they would have been significantly changed.*

Roughly one-quarter of the clients had had a major change in medications during the last year. *These changes were related largely to neuroleptics.*

Roughly one-quarter of the clients were reported to have had a trial at some point on Clozaril, *but information on this was lacking for almost one half (48%) of the clients.*

Some discharge planning activity was reported within the last six months for one-third of the clients, with large differences between counties. *Such activity was more likely for those without a dangerousness or safety reason for still being in the IMD/SH and for those with the highest MCAS scores.*

Overall, about 40% of the clients are expected to be discharged within a year with about one-third expected to remain at an IMD/SH level of care forever. *There are significant differences between the counties with County D expecting clients to be discharged more quickly and over 40% of those in County C and County E not expecting to ever be discharged to a lower level of care. Expected length of time until discharge is related to MCAS scores with 60% of those with the lowest scores not expected to be discharged.*

The anticipated placement at discharge for clients in state hospitals is an IMD or locked SNF (75%) *with another 15% for a regular SNF.*

Anticipated discharge placements for clients in IMDs include augmented board and care facilities (32%), regular board and care facilities (23.5%), residential treatment (18%), and regular board and care facilities (18%).

Appendix E:

REPORT ON SITE VISITS TO IMDS UTILIZED BY STUDY COUNTIES

Summary: All of the facilities visited appeared to want to do the right thing. However, there are many issues with the care. Nearly all of the IMD personnel were very protective of their clients, feeling that they could be harmed or get lost on the outside. They frequently stated that locked board and care (B/C) facilities are needed for clients' protection if they are to be released. Most thought that a significant portion of their clients – 33% to 75% -- could be released to the community if they were enrolled in intensive treatment programs, but with 24-hour staffing necessary. Some knew about the concept of recovery, but did not really understand it. The charts reflected no evidence of recovery-oriented programming. Cultural competence was not a topic anyone charted on. Similarly, the various counties' involvement in discharge planning was generally not something that was documented in charts.

The MHRCs saw themselves as step-down from IMDs and while they talked a lot about rehabilitation and their programming was a bit more active, it did not really prepare people for community living. Activities were primarily in the facilities and only those who earned higher privilege levels were allowed out. The outings tended to be local shopping and other activities. The MHRCs did not accept responsibility to see that clients get whatever they need to recover; instead they attributed "failures" to the clients themselves and sent them to more restrictive settings, usually IMDs.

Medication practices varied with the amount of psychiatric time available. With some exceptions and a good deal of variation among psychiatrists, polypharmacy was less than expected. This seems to be the result of aggressive efforts on the part of counties, especially Counties B and E to improve medication practices. Two of the MHRCs had some of the worst medication practices (judged by the general principles embodied in the Cal-MAP and T-MAP protocols) observed in any of the facilities visited.

Methodology

This section of the report encompasses a series of visits to many of the IMDs utilized by Study counties. Consistent with the general approach for the Study, the visits were not meant to be an evaluation of the individual IMDs but to provide another source of information in addition to county site visits, client-tracking data and data on long stay clients. Each facility is discussed individually, identifying its unique characteristics, stated philosophies and treatment modalities and the findings from the chart reviews. After the individual facility discussions there is a

summary of the overall impression of the IMDs and the conclusions that might be extracted from this phase of the Study.

Because the design of the overall study follows new clients sent to IMDs by counties and tracks their progression through the IMDs and, in most cases, back to the community, the Study Team felt that during the visits to the IMDs charts of long stay clients should be examined. In all cases except for one facility in County C, this meant that the charts selected for review were a random sample of clients in the IMD for greater than one year. The sample from that one facility was drawn from clients in residence greater than 5 months because there were few residents there greater than one year. For this reason, the chart reviews emphasized the treatment and discharge planning, medication prescription patterns (judged by the general principles embodied in the Cal-MAP and T-MAP protocols) cultural sensitivity and recovery vision. A major problem in this review was that charts had often been "thinned" and, due to time and logistics, only the past three months of the charts were complete. A particular emaphasis of the review was to look for the coordination between the IMDs and the referring counties regarding the determination of readiness for discharge and discharge planning.

The Facilities:

Facility One

The first facility visited is perhaps the most difficult to categorize. This facility consists of three different wards of a much larger skilled nursing facility. Its psychiatric clientele is less than half of its residence so it does receive MediCal. On the same grounds, but separately administered is the County Emergency Treatment Service which is the primary mental health emergency receiving facility for the entire county. One unit has a 7 to 9 day length of stay and functions for the county much as a psychiatric hospital unit. (County C has no county general hospital or county psychiatric hospital.) There are two additional longer stay units (units 2 and 3) that do fulfill many of the roles of an IMD and are subjects of this report. All of the units have a healthy "treatment patch" supplied by the county which provides for additional clinical staff. The clinicians are either county employees or, in the case of the physicians, on contract to the county.

A tour of the facility showed the units to be, while not particularly attractive, clean and well kept. There was a sense of both staff and clients being busy – not many persons wandering the halls or lying around in bed or in lounges. There were groups and activities in process. Activity rooms were well utilized.

In the past, units 2 and 3 were differentiated, unit 2 being utilized for clients thought to need a shorter stay and unit 3 for longer stays, with clients frequently transferred from unit 2 to unit 3. However, at the time of the site visit, the units are both utilized in a similar manner with few inter-unit transfers. Unit 2 has 48

beds and unit three 36, both are at full capacity all of the time. In addition to the basic SNF nursing care, each unit has one RN and other support staff on each shift. For both units, there are a total of 3.5 psychiatrists, 5 BA level social workers, 4 Adjunctive Therapists, one substance abuse counselor and one Ph.D. psychologist. Currently, Unit 2 has an average Length of Stay (LOS) of 75 days and unit 3 of 112 days.

In the area of social work, the staff is very stable, but in nursing the turnover is rather high – 20% in 6 months with the LVNs being most difficult to retain. The facility does have extensive written policies regarding assessment, treatment and discharge planning but does not purport to have a recovery approach. However they say clients are fully involved in the treatment and discharge planning. There are weekly family meetings and, if available, families are involved in discharge planning. The substance abuse program consists of a dual diagnosis group, one Alcoholics Anonymous (AA) group and one Narcotics Anonymous (NA) group on each unit each week, plus 6 to 10 individual sessions per week.

The facility management believes that cultural competence is evident throughout the program. They say they have cultural awareness groups for both clients and staff and there are Spanish-speaking staff on all shifts and Vietnamese-speaking staff on two-thirds of the shifts. In addition, they have contract interpreters and cultural advisors and they believe that most direct care staff have had cultural training in the previous 6 months.

Coordination of treatment and discharge planning is problematic. They would like much more contact with the Public Guardian (PG) staff and the care coordinators from that office. County outpatient staff are on site at least monthly and there are weekly phone calls. Roughly 40% of their clients go home, 10 % to B/C, 5 % to residential treatment (MHRC), 15% to IMDs, 4% to more acute facilities, 2% to shelters, 3 % to drug rehabilitation and 1% to an AB 2034 program. They had little knowledge of what we were discussing in regard to intensive community treatment programs, but thought that perhaps half of their clients could be discharged in 30 days should such programs exist in the county.

The facility chart reviews showed that referral information was quite complete, treatment plans were current, reviewed monthly and specific to clients; however they were not oriented to clients own goals or barriers to successful community living. Five of the six charts reviewed showed the clients making moderate progress; one was making no progress. Four of the six had appropriate treatment plan adjustments. Medication management was not stellar – there was considerable polypharmacy, some medications were inappropriately used, adjustments of medications were often not timely and poorly justified. On a medication management rating (see discussion below) of one to five, with the best being one, this program rated a 3.1.

For five of the six clients, discharge planning was evident at admission or within 30 days of admission. One had no discharge plan. Readiness for discharge was reviewed by the facility monthly. Four of the clients were minimally involved in their discharge planning; two were not involved at all. One family was involved but that was to block placement. Three clients had no local family.

There was minimal evidence in the charts of local mental health staff from outside the facility being involved in discharge planning. Those involved were usually from the PG's office. Linkages to mental health services in discharge plans were sparse. Of the six clients, one was to go to a B/C only, and two were to go to IMDs.

No chart had any references to cultural competence or recovery principles. Of the six clients, four were still there due to placement issues, one client's illness still required the level of care and one private conservator was resisting placement.

Facility Two

This facility is on contract with County C and is an MHRC. The physical plant is good, once having been a private psychiatric hospital. It had very nice grounds and recreational space and a garden that clients could work in. A county mental health clinic shares the facility, utilizing the adjacent office building. However, the staff of the MHRC report minimal interaction with the county clinic staff.

This facility is licensed as a MHRC and sees its mission to be a rehabilitation facility receiving its clients from other long-term care facilities used by the County C. This facility has 65 beds and runs at 90% occupancy; they had 60 referrals on the waiting list and the occupancy on the day of the visit was 60. Its programs are divided into levels and clients progress from one to another. The program levels seem to be staffed by different persons and located on different floors. While staff could not discuss recovery principles in detail, they stated that they were the most progressive program in the County. The average length of stay is nine months and staff turnover is said to be 10-15% annually.

This facility has an organized substance abuse program and they include a smoking cessation component. They have both AA and NA meetings twice a week. They state that discharge planning begins within 30 days of admission and is reviewed monthly. Barriers to discharge are identified at 90 days and usually involve lack of placement beds and the lack of Section 8 housing. They said clients are involved in their discharge planning; however, on further discussion that seems limited to stating their preference as to what part of the county they wish to return to. The program staff and the PG determine the level of care and the case managers "match" the clients to the available facilities. Families are said to be fully involved in discharge planning, but this is because this facility has a high number of private conservators; the staff see the private

conservators as often delaying discharge. The facility has written, but pretty generic cultural competence policies and staff feel that cultural competence is evident throughout the program. Most of the staff have attended cultural competence training, but not in the last six months. There are Vietnamese-speaking staff on two-thirds of the shifts, and Spanish-speaking staff on all shifts.

Of the 40 clients discharged in the previous quarter, 55% went to B/C, 15% went to longer stay IMDs, 10 % went to home or family, 13% went to acute hospitals, 5% went to residential treatment facilities, and 3% went to a Psychiatric Health Facility (PHF). The staff estimated that if intensive community treatment programs were in place, 60% of their population could be discharged within 30 days.

The chart reviews at this facility were of eight people, all of whom had been in the facility over one year, averaging 14 months. Two had very complete referral information and the other six had acceptable information. All had specific and updated treatment plans, and seven had specific goals for the client. Reviews were monthly, but the clients own goals were never discussed. Five of the eight were seen as making slight to moderate progress, three were making no progress. Adjustments to the treatment plans had been made for only four. There was a great deal of polypharmacy, most of which was unjustified in the chart. The overall rating of the psychopharmacology practiced in this facility was 3.5.

In the area of discharge planning, five charts had evidence of discharge planning within 30 days of admission, the rest within 90 day of anticipated discharge. Discharge plans were reviewed by the facility staff monthly, using a standard MHRC form. One client seemed to be strongly involved in planning his/her discharge, the other seven only minimally. The clients' wishes seemed to be followed in one case, the others weakly or not at all. Only one family was involved – the mother is the conservator – and four had no local families. In only one case was the local mental health program staff involved and that was to look for a board and care. None of the discharge plans addressed needs other than placement level. According to the charts, six of the clients needed to stay because of their illnesses; the other two had placement problems – one had been referred for placement 8 months ago. None of the charts had any references to cultural competence or recovery principles.

Facility Three

This is another county model SNF – a program in a larger nursing home so less than half of the clientele have mental illnesses. There are 46 beds in the mental health unit and 19 county staff – the director, two psychiatrists, 12 Mental Health Specialists, 2 social workers and support staff – supplement the regular SNF nursing staff. The facility always runs at full capacity and gets its clients

predominantly from acute hospitals, Facility One, or the SH. The average length of stay is between 180 and 200 days. Staff turnover is said to be very low.

The facility is pleasant, well maintained and has a sense of intimacy. A building adjacent to the unit is used for conference and activity space. Clients seemed engaged and busy and one got the impression of a well-managed program. There are written policies regarding admission, treatment and discharge, but they are minimal. The facility staff were not familiar with recovery principles. Discharge planning is to begin within 30 days of admission and is reviewed every 30 days. At three months there is a case conference at which it is decided whether the client stays or is to be sent elsewhere. The staff take clients to visit placement facilities. They state that clients are fully involved in their discharge plans as are families, although there are not written policies about either client or family involvement.

There is said to be annual trainings on cultural competence; some staff have attended in the last six months and it has been longer for others. County outpatient staff visit at least monthly and there are phone conversations weekly. These communications seem to often involve the PG staff and the mental health staff in that office. There are staff fluent in both Spanish and Vietnamese on all shifts. This facility has a special program for Vietnamese clients.

On discharge, they estimate that about 25% go home, 50% to B/C (regular or augmented), 3 or 4% go to IMDs, 3 or 4% go to acute hospitals and 3 or 4% go to Facility One. They believe that should there be intensive community treatment programs in the community, 75% of their clients could be discharged within 30 days.

Five long-stay charts were reviewed at this facility, all had been there over one year, and one individual had been there for four years because he has a history of many years in the hospital and has been abused in other facilities and is kept here for “humanitarian reasons.” The average length of stay of the five is 1.5 years and ages ranged from 38 to 49 years.

Referral information was very complete on all charts and treatment plans were current. All identified specific goals for the client, but only one involved goals related to successful community living. Team member and client responsibilities were identified and all showed some progress. Medication management was said to follow county prescribing rules and was rather good, with a rating of 2.0.

Discharge planning was noted on the charts within three months of anticipated discharge in three cases; the others had no discharge planning on the chart. Readiness for discharge was reviewed monthly in all cases but no formal instruments were used. In one case the client was fully involved; two clients were minimally involved in their planning. Two families were fully involved and one minimally. In only one case was there mental health staff involved from

outside the facility. There was evidence of a linkage in only one case and that was for referral to a board and care. There were no assessments of other needs. There were no mentions of cultural competence issues, but none of these clients were Vietnamese or Hispanic. Three of the clients reviewed were considered by staff as too ill to go elsewhere and two had placement issues. In one of those cases the family was resisting any change.

Facility Four

This visit consisted of a 3 ½ hour visit by two members of the Study Team with the administrators, a tour of the facility, and the review of eight randomly selected charts of persons who had been in the facility for greater that one year out of 50 such clients from County E in the facility. It is noteworthy that many of these long stay clients had been there much longer than one year and represented 29% of the census. The facility is licensed as a MHRC by the State Department of Mental Health (DMH).

The program as presented was quite comprehensive and excellent. We were assured that recovery principles were in place and staff trainings regularly addressed cultural competence. The population has changed drastically in recent years, becoming more severely ill but lengths of stay have shortened from an average of seven months to six months. They need to keep their census around 170 (of 173 beds) to meet their budget. Their cost/person/day is $162.06. Most of their clients come from County E (150 of 173). Annual staff turnover was said to be 17%.

The facility admits 320 to 250 clients per year, 95% from acute hospitals and they have occasional returns from board and cares, occasional transfers from other IMDs and 1 or 2 clients per month from the jail mental health unit. Treatment plans are reviewed monthly and discharge planning begins within 30 days of admission and is reviewed monthly using functional skills assessment. Discharge planning is said to occur with the County and clients are taken to visit potential living sites. Families are also said to be fully involved in discharge planning. The County has staff at most treatment reviews and they are on site daily. Less than 5% of their discharges go home and these are mostly to the ethnic communities. About 15% go to B/C and 80% go to residential treatment facilities. Very few go to acute hospitals or other IMDs. The administrators estimated that 1/4 to 1/3 of the clients could be discharged within 30 days if more intensive community treatment programs were available.

They have a dual recovery program with a full time recovery specialist, a recovering person who works Thursdays, Fridays and weekends. They have full-time Hispanic and Vietnamese cultural specialists. There is a Vietnamese psychiatrist there approximately 10 hours per week. Vietnamese-speaking staff are available one shift per day, five days a week and Spanish-speaking staff are

available 24/7. Most direct care staff have attended cultural training in the past six months.

In addition to the Vietnamese psychiatrist, they have a half time Caucasian psychiatrist. Both psychiatrists work the rest of their time for County E. The facility pays them a stipend and in addition they bill Medi-Cal for their services. The facility uses the County's medication policies for all patients.

At the time of our tour, the facility was clean and well maintained. Many clients were standing or pacing in the halls; there seemed to be few places for them to sit. There are several activity areas, but most were locked and not being used. Three activities were observed – one was an aid giving haircuts; another was an art class where a few clients were making pictures using watercolors, crayons and stencils. The third activity was a class on travel and art. Smoking was not allowed in the facility, but outdoor smoke breaks were scheduled every hour and a full hour every afternoon. The daily schedules were posted, but on closer examination, groups and therapeutic activities did not occupy the expected amount of time. The facility seemed to have the rooms and equipment, but not the staff to implement a full day of appropriate activities.

All charts were very well organized and the documentation excellent. It seemed clear that reviewing eight of fifty clients' charts was more than adequate to get a clear picture of the care of long stay clients in the facility. It should be noted that only the chart of the last approximately one year was available since old chart materials were in long-term storage. However, it was possible to obtain an adequate picture of the clients and the program. There was no question that all were quite ill and had not responded to medications. Two of the individuals reviewed were on Clozaril at the time of the review, and we were assured that in all likelihood all had been tried since Clozaril is used frequently in the facility. 21% of the clients in the facility were on Clozaril at the time of our visit. The medication management seemed fairly good, but not as highly assertive as one might wish in a population that has not responded to standard medication regimens. The reason for this may well be the facility's policy of following County E's guidelines. A review of those guidelines shows that they have fairly strict maximum dose limits and discourage experimentation. The protocols are essentially those of the American Psychiatric Association done for/with the National Institute of Mental Health. They are quite appropriate for an outpatient population. Very good clinical and laboratory monitoring was in place for all persons on medications. The overall medication rating score was 2.7.

The charts of all of the clients reviewed strongly suggested that not much, if any, improvement was expected of these persons. There were generally no discharge plans even discussed, thus no discussions of barriers. County review notes for each client are not included in the chart but are kept in a separate location and said to be done monthly. The facility reviews discharge readiness quarterly Barriers to discharge were alluded to in that one client was noted to be

a sex offender and another a brittle diabetic and that these issues are barriers to placement. One woman had a problem with incontinence and appeared to be very preoccupied with internal stimuli; however, it was not clear whether she had an organic brain disorder or the incontinence was related to her psychotic condition. There was no evidence of recovery principles in any chart nor was there any references to cultural issues. We reviewed two charts of Vietnamese clients and while the Vietnamese cultural specialist acted as interpreter, there was no discussion of cultural issues. For example one client complained that he missed Asian food and that there was no fish in the diet but no response to or discussion of this complaint was charted.

This facility has its own rating scale – the Functional Skills Assessment, which is completed for every client quarterly. However, it is more attuned to functioning in the institution than in the community. Goals were defined, but goals of staff seemed to take precedence over those of the clients, which were often dismissed as unrealistic. In most charts, it was noted that the client refused to sign the goals sheet and it was doubtful that they had participated much in the discussion of their own goals. For example, in one chart it was noted that the client surrounded himself with newspapers which he read and at one point had expressed a desire for a "fair trade" of information with staff, yet in spite of one excellent note by a mental health worker about this clients interest in news, there was no attempt to work with this client around his interest in current events as a first step in engagement for a more meaningful service plan. This client was very impaired but his interest in the news and learning was a possible connection for future work.

Facility Five

This facility has 150 beds, of which 120 are STP beds for persons with mental illnesses; 30 are for persons with developmental disabilities. All funds for clients with mental illness come from the host county or other referring counties or sources. The facility runs at 98% capacity and has a waiting list. Roughly 90% of their clients come from County B and 10% from County C. For persons discharged in 2003, the average length of stay was 14 months. Annual staff turnover rate is 40 % and the cost per day is $145, but this is skewed upward by the Developmental Disability rates. In 2003, 80% of referrals came from more acute facilities and 20% were lateral transfers due to one county's discontinuing use of other facilities. There is no mechanism to readmit people from B/C facilities but they think there should be. The staff are quite dedicated, but protective of their clients. They have several examples of persons who have left who suffered bad outcomes including one individual whom a county took out and was subsequently killed by a violent gang.

Initial assessments are completed in 14 days and reviewed quarterly thereafter. The facility does not claim to utilize recovery principles; the only choice a client has is which of the board and care facilities the client might wish to live in on discharge.

County B sets medical policy for its clients through quarterly pharmacy committee meetings. The County and the treating physicians set policies regarding medications. There are 3 psychiatrists who come in 2 to 3 hours twice a week. They bill Medi-Cal plus they are paid stipends by the facility. There is a strong well-described substance abuse program, with about 30 persons on a dual diagnosis track.

They say that discharge planning starts with admission and plans are reviewed quarterly. When clients are designated as ready for discharge they join a weekly group that meets with the county liaison. Plans seem to be made for the clients rather than by them although they do have policies saying that clients should be involved as well as families. They have monthly Saturday meetings for families; about 8 families attend. Staff report that families often resist discharge; in the last 2 years they discharged several clients who had been in residence over 10 years at the families' insistence.

They believe that they are culturally competent although they have limited formal training. One quarter of their staff are Latino and they have an Asian-Pacific group attended by 25 to 30 clients and run by county staff from an Asian-Pacific ACT Team. They do celebrate the holidays of all of their ethnic groups. They have personnel who speak all of the Asian-Pacific languages (but might have dialect problems) on days and weekends, but not on the night shifts. A difficult experience with a Hungarian client makes them hesitant to accept a client in the future if they do not have someone who can communicate with that person.

The facility was clean and well maintained. The group rooms were in use, the activities were tightly scheduled, the clients seemed engaged; there was little aimless wandering in the halls. Bedrooms were open, but clients were not in bed. Their recently established dual diagnosis program is staffed full time with several groups every day. They say they get no extra money for having this program. The program director took the courses at the community college to be a certified counselor, and then set up the program.
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Their 2003 discharges were 47% to B/C facilities, 7% to home, 2% to independent living, 9% AMA/AWOL, 20% were lateral transfers, 7% to medical facilities and 7% to a more acute level of care (all men with violence problems). County B has staff at most treatment reviews and staff on site 4 days per week. County C communicates by phone weekly and reviews charts twice a month. The impetus is on the facility to alert County C when someone is ready for discharge. Facility Five staff believe that integrated service programs might allow

25 to 40% of their clients to be released to the community, but they say that the existing ACT programs are highly variable. They are very concerned about the vulnerability of their clients.

A large number, perhaps 80%, of their County B clients have private conservators who sometimes want to dictate the medications their family members get and also some resist discharge. However, they much prefer them to the PG. They believe that the latter is understaffed, there is high staff turnover, they have little knowledge of clients or their responsibilities, they don't return phone calls and they don't get clients their personal and incidental monies. Getting consents for treatment can be very difficult. They report that County C's PG is much better; they are better staffed, stable, and they answer their phones!

Of the five charts reviewed of County B clients, their length of stay varied from 17 years to 16 months, with an average of 5.5 years. The referral information was acceptable on five clients and minimal on one client. Treatment plans were current, specific and identified treatment goals for clients, but did not address the clients' goals or goals related to successful community living or barriers to community living. Staff, but not client, responsibilities were addressed for five people; no responsibilities were addressed for the client who had been there 17 years. Treatment plans were reviewed quarterly, but none showed any progress and program adjustments were made in only one instance. There was only moderate polypharmacy noted, but medication adjustments were not aggressively pursued and adjustments were not timely. Staff expressed some concerns about clients no longer being heavily medicated due to fear of increased violence. The overall medication rating was 3.2.

There was no evidence of discharge planning on any of the charts, but readiness for discharge was reviewed quarterly using the MCAS, which staff considered not that relevant to their population. Clients were not involved in any discharge considerations. Cultural issues were noted on one chart, an Asian-Pacific ACT team was seeing that client. Four of the clients were considered too ill (wandering, violence, shoplifting) for discharge; the other had a private conservator who did not want the client released.

Charts for two County C clients were reviewed and showed an average length of stay of 2 years. Referral information was acceptable and the treatment plans were current and specific. They identified treatment goals and responsibilities of staff, but not the clients. They were reviewed quarterly, showed moderate to slight progress and were never modified. Medication management was not good – one chart showed lots of polypharmacy and the doctor's note suggested that he did not even know that the client was on Haldol. The medication management rating was 3.9. There was no evidence of discharge planning on either chart. While readiness for discharge was reviewed quarterly, no standardized instrument was used. Neither chart addressed cultural competence

or recovery principles. Both clients were considered too ill for discharge and were on public conservatorship.

Facility Six

This IMD has 95 beds and runs at 99% occupancy; all beds were filled at the time of the visit. Approximately half of their clients come from County B, 25% from County C and the rest from another county and private sources. The length of stay generally is about 9 months, but in the past year it was skewed upward to 18 months because County C discharged some very long stay clients. The daily rate is $112.92, which includes $5.72 STP augmentation. Nearly all of the clients come from acute and sub acute facilities, with an occasional private client coming from an emergency room. It is rare for clients to come from other IMDs. Client assessments are completed in 7 to 14 days and treatment plans are reviewed quarterly. They see their purpose as stabilizing the clients on medications and returning them to the community. They do not see themselves discussing recovery principles with clients because the clients are "too acute." However they want them to understand their medications and there is an adult education program on the premises which provides 70 or more teaching hours per week.

Psychiatrists and the referring counties set medication policies.
Psychiatrists do not get a stipend from the facility; they bill Medi-Cal and are paid $300 per conservatorship hearing. There are three psychiatrists who visit the facility, averaging 16 hours on site per month. The facility staff believe that private conservators often interfere with the medication prescribing. There is no formal substance abuse program, but there are AA and NA meetings twice a week and their staff conduct one-hour substance abuse meetings three times a week. About 20 to 25 persons attend all of these meetings. Counselors have 12 clients each and these clients are in all groups with them each day. They also use a token economy. They talked a lot about how they would like to do more and the limitation of being an IMD. They would like to have the options of the MHRCs, but have been afraid to give up the SNF license because of the rate guarantee.

They say that discharge planning begins at admission and is reviewed every 90 days, using the MCAS (inappropriate in their opinion) for County B clients. They say that counties call the shots regarding discharge. County B's ACT programs take clients to potential living sites; County C does not and doesn't even tell the clients that they are to be discharged. Clients are minimally involved in discharge planning and there are no policies on the matter. Families are involved when they are the conservators, but here that is only 10%. Most County B and all County C clients are on PG conservatorships. They were far more appreciative of the PGs than the private family conservators. They believe that many of the families resist discharge and interfere with medication regimens. They have an assigned County B PG who handles all of their clients and they have a good relationship with that person.

They did not seem concerned with cultural competence issues, having no policies on the subject. However, they have lots of bilingual Hispanic and Asian-Pacific staff and feel all languages are covered 24/7. No direct care staff have attended cultural competence training in the last six months.

County B has staff at most treatment reviews and they visit twice a week. County C staff visit monthly, communicate by phone weekly and attend some treatment reviews. 90% of discharges go to a B/C facility. In the last four months all County B discharges have gone to an ACT program and are placed without regard to where in the County they came from. Some County C clients go to in-county MHRCs or IMDs. It is rare for a client to go to another IMD and, in the last year, two went to an acute hospital. They believe that half of their clients could be discharged in 30 days if there were more intensive community programs available.

The facility is old, looks rundown, but is reasonably clean. On tour, it had more of a "back ward" feel. Rooms were open; there were usually three-bed rooms, with some two and some four-bed rooms. While clients had a narrow locked hanging locker and a drawer which they could lock and keep the key, there was no other furniture except the beds. There was a large central patio that was used primarily for smoking. While the schedules showed many groups and some were in session, there were still a lot of clients wandering the halls and making requests of the program director and administrator who were conducting the tour. They did have a computer lab with all 6 computers being used for playing games while clients waited for a group session to begin. The nursing stations here were fully enclosed with glass, isolating the nursing staff from the clients. There were no comfortable chairs in the open areas for clients and the lounge and TV areas were locked, open only in the evenings.

Chart reviews included 4 from County B and two from County C. The County B charts were for people 26 to 55 with an average length of stay of 25 months. One had acceptable referral information; three had minimal information. Treatment plans were current, specific, and had goals for the clients, but not the clients' goals. They were not oriented to community living or barriers to discharge and did not list specific responsibilities. Three had quarterly reviews, one only an annual review. None were making progress and there were no adjustments in treatment plans. Medication management varied among the psychiatrists, but the rating for the facility was 3.5.

There was no evidence in the charts of discharge planning but readiness was done quarterly using the MCAS. There was no client or family involvement in discharge planning except one private family conservator who did not want the client discharged. No references were found to either cultural competence or recovery principles.

The two County C charts were for clients ages 39 and 42 who had been there 3.5 years and 2.5 years, respectively. One chart had minimal referral information, the other none. Treatment plans were current and specific, but had no references to client goals or discharge barriers. Treatment plans are reviewed quarterly but no progress was noted nor were changes made to the plans. Medication management was consistently poor, with a rating of 3.6. There was no evidence of discharge planning in the charts, but readiness was reviewed quarterly without any standardized instrument. Neither clients nor families were consulted and both clients were considered too ill to be discharged, but the reviewer found no documentation to verify that assessment.

Facility Seven

Facility Seven has 120 beds, occupancy is 99% and 70% of their clients come from County C, 23% from two other counties and 7% from the VA. They are proud of the fact that they have full CARF certification. This facility is a SNF with a STP. They have an average length of stay of 7 to 8 months. Their staff turnover rate is 22% annually and the cost per day is $125.32 including the STP augmentation.

Referral sources for this facility are more diverse than most. They get admissions from one county's Emergency Treatment Service, acute hospitals, sometimes from sub acute facilities, and B/C facilities. They did not have specific breakouts of the percentages. Referrals from other IMDs were not common. They state that treatment plans are reviewed monthly as needed and all clients are reviewed quarterly. This facility has its own mental health rehabilitation program but feels that it is underused because when clients are ready for their program they are usually transferred to County C's MHRC. They feel that they are strong on recovery principles and they do have written policies regarding rehabilitation and community preparation; however, these are limited and traditional. The administrator and program leaders all plead for better continuity of care with community programs. The administrator stated: "we never want to deprive any of our residents of hope." They seem to have less written policies than other IMDs, but seem to have more "action" than seen elsewhere.

Psychiatrists are selected by the facility and only get paid from their Medi-Cal billings for County B clients; the other counties and the VA pay the physicians. There are two of them who collectively spend 16 hours on the premises weekly. The facility and the doctors set medication policy.

They do not have a formal, accredited substance abuse program, but they do put their dual diagnosis clients in a special track and have eight groups a week attended by an average of 25 clients. They make liberal use of AA and NA groups and attempt to link clients with them on discharge.

This facility says that discharge planning begins "when they walk in the door" and is reviewed at weekly team meetings as well as quarterly. County C is good

about participating in discharge planning; the other counties are invited but usually do not show up. They say that the County C people are great to work with. There are no written policies on client involvement, but say they have an ongoing involvement process. Families are only minimally involved and they say that they have major problems with family conservators – they are controlling, over involved with medication issues and often fail to get money to the clients. All families are notified of treatment and discharge planning conferences and those who are not conservators may attend if clients consent.

In the area of cultural competence this facility has monthly cultural exchange days, but little formal cultural competence training. They say that they have annual trainings, but the administrator was not aware of any training in the last six months. They have a diverse staff, with bilingual Spanish-speaking staff 24/7, Vietnamese-speaking staff on most shifts, and they have people who speak Tagalog. They will not take a client if they do not have someone who can communicate with that person.

Communication with counties varies. County C has staff at some treatment reviews and are on site at least monthly. The other counties do less. They like County C because they leave clients there until all agree that they are ready to go. They feel the other counties move their clients around too much.

On discharge, their clients usually go to B/C homes, but they also go to an MHRC. Two or three a month go to a hospital on a 5150 hold. They are afraid to try and keep clients with difficult behaviors due to licensing sanctions. They felt that 60% of their clients could be discharged if there were intensive community treatment programs.

The facility is the nicest SNF/STP seen. Rooms are two and three beds, with a couple of singles for special circumstances. There is little furniture in the rooms, but there are nice, readily available lounge areas. Nursing stations are currently open, but they are going to close them off because of HIPPA/licensing concerns. They are terrified of incidences of violence, even minor brush-ups because of all of the paper work and fear of sanctions. The administrator would like to license the facility as an MHRC, but corporate headquarters resists this change. (This is a large corporation's only mental health facility.) Maintenance and décor was excellent. They were planning to remodel areas that were currently much nicer than most other IMDs.

This facility, like others, has very little to offer clients as incentives to return to the community. They are some distance from the communities of their clients and the clients' families.

The review of charts of six County C long stay clients included persons 36 to 61 years old with an average length of stay of 2 ¾ years. Referral information was minimal for all charts. Treatment plans were current and had specific goals for the clients, but not the client's goals. Three charts had goals related to

successful community living and three identified barriers and their mitigation. All plans identified team members and clients' responsibilities. Treatment plans were reviewed monthly and quarterly and 5 clients were making moderate or slight progress; for one it was impossible to tell if there was progress. Treatment plans were adjusted in 4 charts. Medication management was not impressive; there was lots of polypharmacy and inappropriate use of some medications. The overall medication rating was 3.4.

Only one client had any evidence of discharge planning and that was within 3 months of anticipated discharge. Readiness for discharge was reviewed monthly and quarterly by the facility, but without any formal instruments. One client was fully involved in his discharge plans, one had made his wishes known, and in both cases there was a weak attempt to address their wishes. Two families were involved and they were both blocking discharge. These families held private conservatorships and did not want the clients released. In one case, the local mental health program was involved in the discharge planning but there was no clear linkage to local services or other needs. Cultural competence was not mentioned in any chart and one had some discussion of recovery principles. Three of the clients were assessed to need continued stays due to their illness. As previously mentioned their conservators held two. The last client was noted to have poor hygiene as a reason for his continuing stay.

Facility Eight

This 74-bed program is a SNF/STP that is part of a large geriatric SNF. It is unlocked although the residents had limited options as to when they went out and where they might go. Because the psychiatric wing manager (who had said he would be there) had gone on vacation, information came from the social worker and charge nurse who did not have answers to many of our questions. Their data collection/record keeping is strictly limited to that required of SNF/IMDs and the minimal documentation required for STP funding, i.e., a rehabilitation specialist who made quarterly notes.

The facility runs at 95% occupancy and their current census was 72. They state that 90% of their clients come from County C, the rest from County B and elsewhere. At the time of the visit, they had 56 County C clients, 42 of whom were on the list of clients there over one year. Ten of these had been there over six years. Yet they said they planned on people staying 3 to 6 months with a 6-month average length of stay. They said staff turnover was low and costs varied by room. They did not have statistics on where their clients came from, but sources included acute hospitals, board and care facilities, residential treatment facilities (MHRCs) and other IMDs.

The staff of this facility had no idea what recovery principles might be. They were more oriented to nursing home operations than psychiatric care. Staff seemed to have little psychiatric training or experience. Staff could not address

questions on recovery or even cultural competence. They were pleased to say that those who could not speak the staff's languages – English, Spanish or Tagalog – could make their needs known adequately through a few words or other patients (their word) could translate for them. They run classes that seemed primarily oriented to busy work with some attention to activities of daily living that might help clients be more pleasant to be around in the facility. They state that the classes are available and running 27 hours a week. Direct care staff have little involvement in treatment planning and they have never attended cultural competence training as part of their jobs.

Medication policy is strictly up to the treating psychiatrists. The three doctors bill Medi-Cal and come in once a month for a few hours each month. They are available for phone orders. Some visits were covered by a nurse practitioner working for one of the physicians. They do not have a substance abuse program, but have "classes" twice a week, attended by 2 to 10 clients.

They really do not do any discharge planning. Instead staff from County C come out once a month to see their clients and they decide if anyone should be discharged. Should someone be discharged, it is the county staff that take him or her to visit B/C facilities. They have no policies on discharge planning and say clients are minimally involved. Families are involved only if they are the conservators. County C staff determine where the client might go – 80% or more probably go to B/C. Occasionally they might go an IMD or acute hospital. They stated that none of their clients could be released earlier if intensive community treatment resources were available, but they had no idea what such resources might be. While County C has a "contract" with the facility, it is not evident that they pay any of their own funds for the care. Thus there is little interest in getting these clients out.

Chart reviews were conducted for seven clients, ranging from 37 to 71 years old with an average length of stay of 2 years, 7 months. One chart had minimal referral information, the rest none at all. Treatment plans were technically up to date, but were perfunctory. Five charts had specific goals as required; two were strictly generic. Client goals, goals oriented to successful community living or the elimination of barriers to community living were never addressed nor were any individual responsibilities. Perfunctory quarterly treatment plan reviews were written by the social worker. One client showed slight progress, five none, and one chart did not contain enough information to tell. Treatment plans were never amended.

Pharmacological management was poor, not so much due to polypharmacy but due to the infrequent visits by doctors and a disconnect with any treatment planning. Medications were simply oriented to maintaining the status quo. The overall rating of the pharmacology was 3.6.

In no case was there any evidence of discharge planning in the charts, except in one case when it was discussed at admission. There were no chart notes from County C staff, no mentions of cultural competence or recovery principles. Perhaps most importantly, there was no documentation as to why these clients needed to remain in the facility. The cases reviewed did not seem to have a high acuity and it appeared that most had rehabilitation potential. This program is an excellent example of why there need to be incentives to get clients out of institutions.

Facility Nine

This facility was added to the list of facilities to be visited because it was said to be an excellent facility that had a close working relationship with County A. The visit occurred in May, sometime later than the other IMD visits. Discussions about the program were held primarily with the Program Director, and Head Nurse because the Director was on vacation.

This facility is licensed as a MHRC and has 64 beds. There is also a separate program that has 15 beds and is an open transitional program that operates out of the same building. This program is not an IMD by the Study definition, being an open facility where the clients maintain the facility, do the laundry and have considerable community access. Clients from the locked MHRC frequently go to this program prior to their return to the community.

The facility serves predominantly County A (30%), two other counties also at 30% each, and some clients from several other counties. At the time of the visit, the occupancy rate was 85%, much lower than the usual 95%. The average length of stay was 112 days in 2003 and 150 days in 2004. They attribute the increased length of stay to the increase in severity of clients referred with the drop in numbers of referrals. Staff turnover was said to be 8% per month, which would be 96% per year; however they say the turnover is primarily among new hires and that they have many long time employees. The cost per client per day is $170.

Most referrals come from acute or sub acute facilities, but they also get significant referrals from County A's jail via the Misdemeanor Incompetent to Stand Trial (MIST) program. Referrals from other sources are very infrequent. The facility likes the way County A uses the 180-day holds and works closely with the facility in regard to these clients.

This facility is the only one visited that has an outside organization doing outcome measures. A number of instruments are used including one called CQI plus as well as versions of the BPRS and Basis 32. The case managers at admission, quarterly, and at discharge complete most documents. The contractor does a 6-month follow-up of the clients in the community. Managers interviewed did not seem to have a high level of confidence in the outcome

studies and did not make results available to us. They did not feel that the instruments had any value in assessing readiness for discharge.

Treatment plans are reviewed quarterly and as needed. They state that recovery principles are heavily invoked – "every client has the full potential for recovery". They try to decrease self-stigmatization and they only recruit staff that really believe in recovery.

Medication policies are set only by the psychiatrist who spends approximately one day per week in the facility and is available by phone the rest of the time. The psychiatrist is paid a stipend of $3500 per month and bills Medi-Cal and Medicare for clients except she does not bill Medi-Cal for County A clients. The psychiatrist does see all new admissions within 72 hours. The psychiatrist is selected by the facility and has no relationship to the counties served.

There is a substance abuse program, one of four treatment "tracks" to which clients are assigned. The others are MIST, Community Integration Education and Routine Psychiatric Care. Each track has its own staff and schedule. However the schedules appear to be very similar on the "therapeutic program schedule." They state that discharge planning starts at admission and is formally reviewed quarterly by the case manager and nursing and the "discharge team may include the conservator, family, patient's rights advocate, and client as appropriate. Discharge planning is done jointly with the counties; county conservators or case managers take clients to prospective living sites. Every County A client is assigned to a rehabilitation team on discharge. Managers feel that some conservators keep clients in too long and some counties take clients out too soon. They clearly felt that County A was the best to work with, having staff on sight nearly every day.

They state that clients and families are both involved in treatment and discharge planning and they have written policies to that effect. They assert that they are highly sensitive to cultural competence; a Cinco de Mayo celebration was being held on the site visit day. Spanish-speaking staff are available at all times and Philippine staff are available on days and evening shifts. It is rare for them to get clients from other ethnic groups. All staff have had cultural competence training in the last year.

In their data collection system they categorize discharges as going to higher, equal or lower levels of care. In 2003, there were 41, 3, and 153 respectively and in 2004 there were 23, 4, and 105. They estimated that with intensive, assertive community programs, 75% of their clients could be discharged in 30 days.

For the chart review, County A staff identified only 6 long-term clients. Five charts were reviewed, 4 men, 1 woman; ages 27 to 45; lengths of stay from 9 months to 2 years; and all had diagnoses of schizophrenia. One chart had

acceptable referral information, 4 minimal. All had current, specific treatment plans that identified specific treatment goals, but they were not the clients' goals nor did they relate to community living. None identified barriers to discharge, but all identified team and client responsibilities and were updated quarterly. Three showed moderate to slight progress, one chart showed no progress and from one chart progress could not be determined. Only one chart showed clear evidence of a treatment plan adjustment.

Psychopharmacology was judged to be poor in this facility with lots of polypharmacy for the clients reviewed, entries in charts were only monthly and appropriateness of medications was often not clear. Medication adjustments were not timely, justifications inadequate and doses often seemed excessive. The rating scale for medication management in this facility was 3.9.

Discharge planning was evident on admission in two cases only and was found elsewhere in none of the cases. Here, as in all IMDs visited, the counties' discharge reviews are not noted in the chart and thus cannot be evaluated from chart reviews. As noted previously, they do formal outcome evaluations, but not discharge readiness.

Cultural competence issues were not discussed in charts except that one client was noted to be a devout Muslim who prayed often. One chart evidenced recovery principles and all clients were in the facility because their illness required their continued stay.

Discussion of Medication Practices:

While medication practices were not the most sophisticated, they were better than expected in some of the facilities. With some exceptions and a good deal of variation among psychiatrists, polypharmacy was less than expected. This seems to be the result of aggressive efforts on the part of counties, especially Counties E and B. Some facilities seemed concerned about the trend away from polypharmacy because they thought that fewer drugs might lead to more violent behavior. On the other hand, when clients don't improve, doctors in some facilities are slow to make changes and seek a better drug regimen. This is likely due to the separation of the psychiatrists from the treatment programs and the fact that they carry large numbers of clients, often in multiple facilities. Facilities seemed reluctant to push psychiatrists about their prescribing practices. Those psychiatrists who did respond to counties' prohibition of polypharmacy did not necessarily become better psychopharmacologists. They used less different drugs, but did not practice assertively, changing medications when needed, pushing doses to maximum effectiveness and justifying the use of multiple drugs when indicated in clients that were not responding. Clozaril was available as an option and prescribed in most of the IMDs. Two of the MHRCs had some of the worst medication practices observed in any of the facilities visited.

Using a simple overall rating of medical management (below) on a scale of 1 to 5 considering frequency of visits, quality of notes, presence of polypharmacy timeliness of changes, and appropriateness of dosage an interesting picture was created. In this review of IMD charts, the two facilities that appear to have the best medication practices – Facilities Three and Four – are those where county psychiatrists are taking care of the clients and on premises regularly. The ones that appear to have the worst are those facilities with the least county contact with the psychiatrists. In between are situations where counties have tried to influence the medication practices and/or are around more in general.

There were extreme variations in the amount of psychiatric time per client. The range was from one psychiatrist full time equivalent (FTE) to 24 clients in residence to one FTE to 740 clients. One FTE per 250 to 300 clients seemed to be typical and the limited amount of psychiatric time on site was also reflected in the medication ratings.

Discussion of Programming in the Facilities

Even the better run IMDs that were visited seemed to function much like state hospitals functioned in the early late 1960's and early 1970's. Concepts of recovery and rehabilitation are only in the verbal phase, not yet understood or integrated into the treatment program. Our impression was that the clients whose charts we reviewed deserved a chance at a really good treatment in an integrated service program with intense skilled staffing. While not all would succeed, in most cases that cannot be determined without a trial. Some appeared to have sufficient cognitive impairment to make success doubtful, but even in those cases the risk is well worth taking considering the difference in potential for clients and the cost of such programs. Finally, if clients cannot succeed in these programs due to organic impairment, following a model such as that used by County A and placing clients in SNFs for physical care and stimulation may be more appropriate.

Finally, the "no cost" SNF/STP may be a good deal for counties, but it may represent a poor deal for clients. The attitude in one such facility was similar to what one observes in a geriatric nursing home. They took care of their clients, but placed no expectations on them to improve or leave.

Appendix F:

STATE DATA

The information in this appendix was provided by the State Department of Mental Health. It was compiled from CDS, CSI, ADT, and Cost Report sources. The data is not complete and there are some questions about its accuracy. We have only included specific county data in order to illustrate a point. We have not used the data for the six case study counties because two of the counties provided no information on IMD usage to the State and because it was impossible (without additional work which could not be completed within the scope of this contract) to reconcile the figures we received from the counties at the beginning of the Study and those reported by the State.

For the Phase I Report we used three different denominators for calculating rates of usage – one was total adult population, one was adult population under 200% of poverty, and one was the number of adult SSI recipients. That gave us a days per population use rate, which is a standard way of talking about usage.

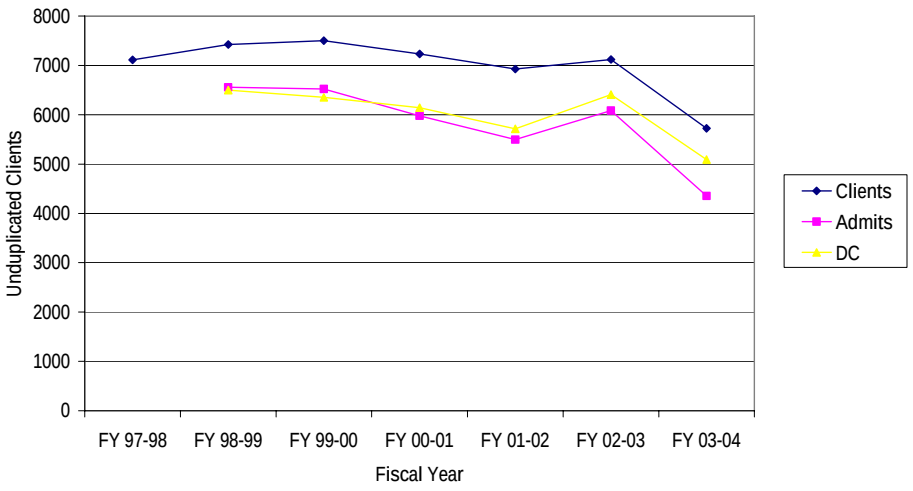
For this report we added another kind of denominator – a proxy for need/resource availability. For this we used the weighting formula that has been proposed by the state as the formula to be used for distribution of the MHSA funds. That formula is population, percent under 200% poverty, estimated prevalence percentages, relative costs by region, and dollars spent historically.

TRENDS IN USAGE

The IMD category used by the State for our data request included IMDs, MHRCs, and SNFs with STPs; however this information only includes what the counties entered into CDS and then CSI.

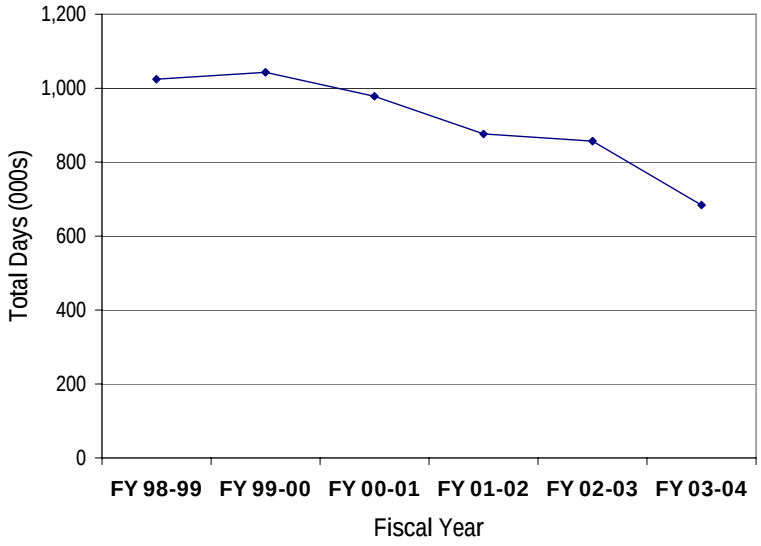
The first graph below is total unduplicated clients served per year. These figures include Fiscal Year (FY) 03-04, but this last year will not be used in the summary report because the numbers are understated as some counties who usually report data had not reported by the time we got the data (May, 2005). The trends were down from FY99-00 to FY00-01 and again from FY01-02 but then went up again in FY02-03, essentially back to the earlier figures. There were no dramatic differences in terms of numbers of clients, admission and discharges.

UNDUPLICATED CLIENTS IN IMD BY FY



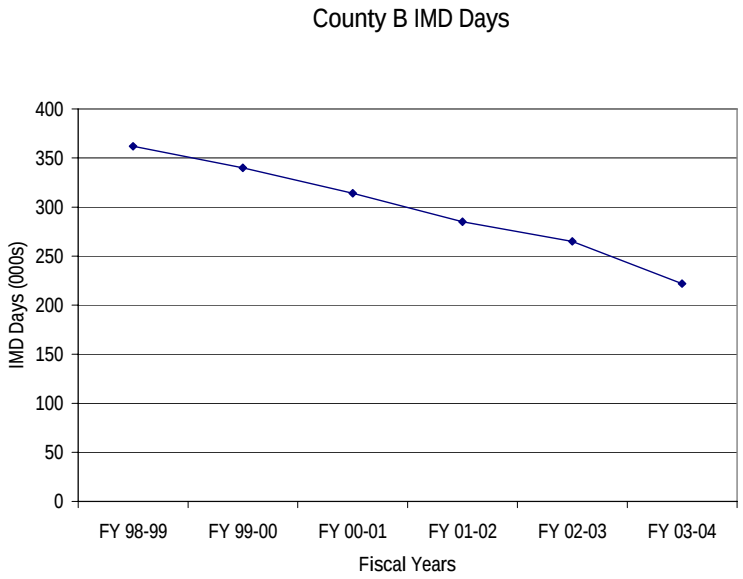
The story is the same but a bit more pronounced when you look at total days. The same two-year downward trend is noted followed by a rise in FY02-03, but in this case the days just level off rather than rising,

TOTAL IMD DAYS



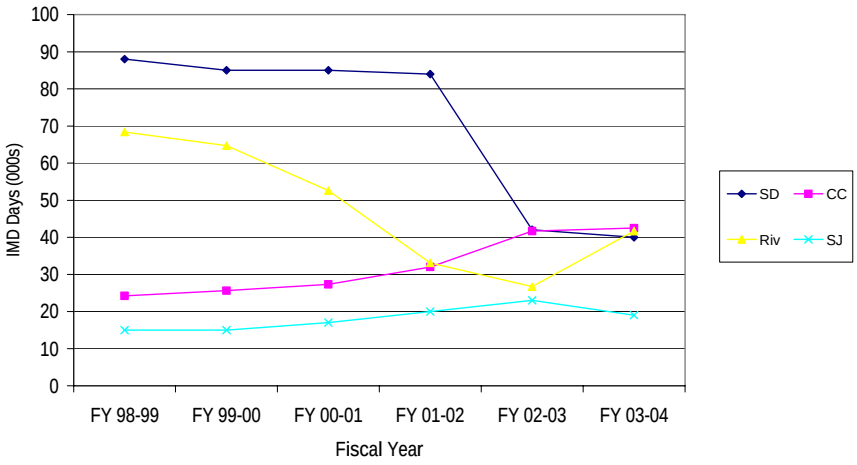
The total number of clients and days is understated because numerous counties – including some of those in our case studies – do not report. The relative percentages (of the total 100% pie based on the state's MHSA formula) is 18% (not including the counties who would be estimated to have less than 3 people in an IMD. So the actual FY02-03 total bed days should be inflated by 18%, yielding 1,045, 400 days or an ADC of 2,864.

Here are a few typical county patterns. County B is the only one of the study counties for which we suspect the state data is accurate. They show a steady decrease in IMD days just as they reported in the site visit.



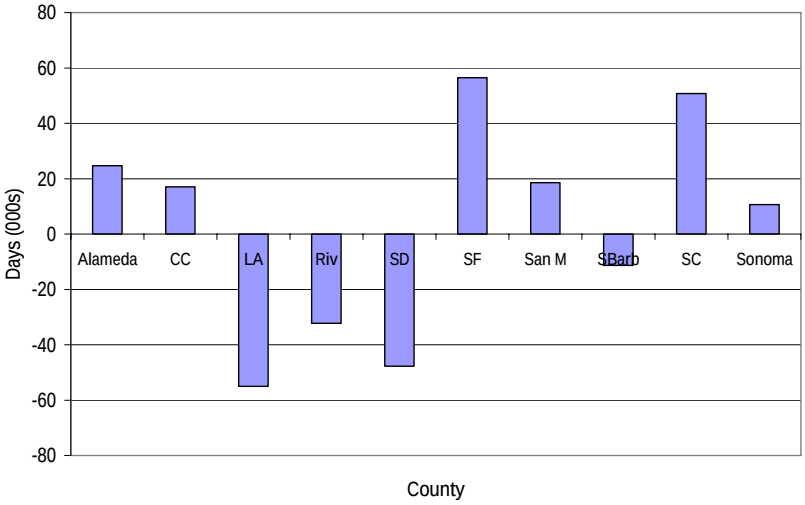
Here are a few other counties. San Diego may have done a major closing or some other significant change since they have a major drop in FY 02-03. Riverside shows a steady decrease down to less than half their days followed by an increase in FY03-04. Two counties show a steady increase. Contra Costa almost doubles its number of days while San Joaquin turns back down in FY03-04. The finding to take away from this data is that the patterns are different for each county. What appears to make a difference is what a county actually does in terms of its policies not an overall change in the nature of the clients. While the overall pattern is down for the state this is made up of lots of different county patterns.

IMD TRENDS BY COUNTY



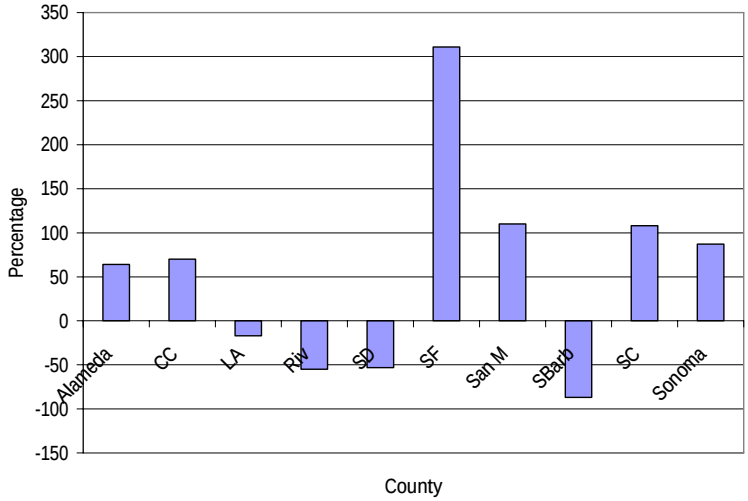
We compared for each county their actual IMD days in FY 02-03 with what would be an expected number of days if days were distributed according to the MHSA formula. Some counties (above the baseline in the graph below) used more days than would be expected while some (below the baseline) used fewer days. (We eliminated the counties who either did not report or whose data looked odd for that year – 21% of the expected total.) The counties included are the ones with the most actual days over and under that which would be expected.

ACTUAL VS EXPECTED BY COUNTY, FY 02-03



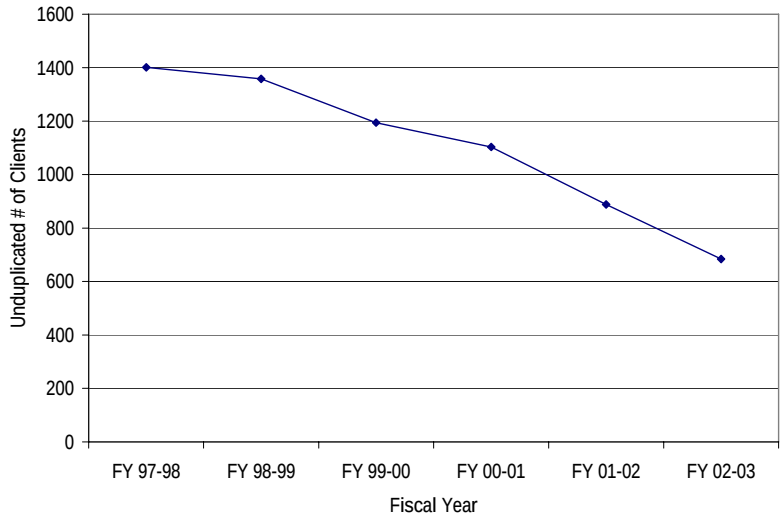
Another way to look at this is by the percentage that each county is over or under their expected days. Looked at this way, LA is not so far below what would be expected while counties like San Mateo and Sonoma are more relatively over than expected.

5 DIFFERENCE BETWEEN ACTUAL AND EXPECTED FY 02-03



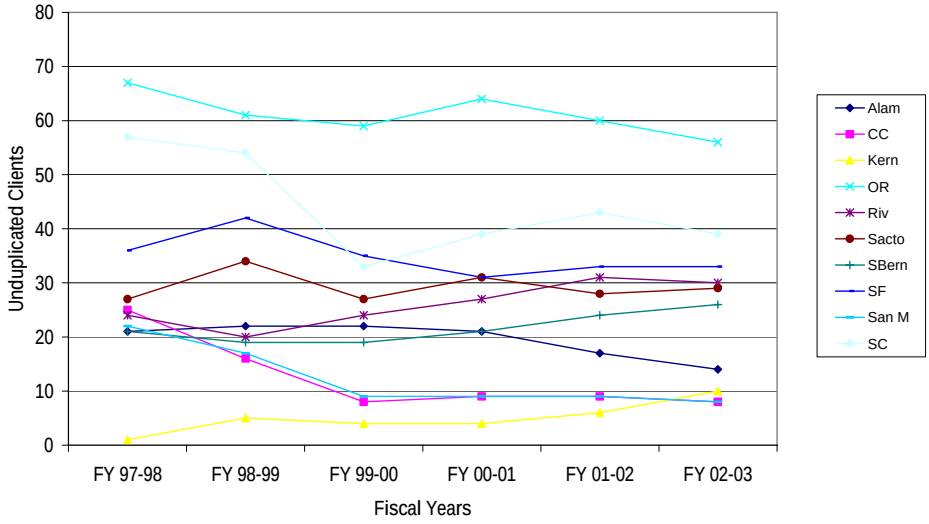
Total state hospital unduplicated LPS clients have clearly gone down. These are unduplicated clients per fiscal year.

STATE HOSPITAL CLIENTS



There is again substantial variation among the counties in the patterns of change over time. Some – like Contra Costa and San Mateo – reduced the number of clients in FY99-00 and FY00-01 and then leveled off. Some – like Kern – have gradually increased usage while others – like Riverside – increased just in the last few years. Others – like SF – have stayed basically the same.

STATE HOSPIAL PATIENTS BY COUNTY



DEMOGRAPHIC CHARACTERISTICS

The tables below compare demographic characteristics of the total population of users of MH services with those who used an acute service, an IMD service, or a state hospital (SH) service. The data is from 02-03.

The percentage of females to males is roughly 50/50 for all mental health services and for acute services. But the percentage of males increases substantially for those in IMDs and even more for those in SHs.

Gender by Type of Service (FY02-03)

	N	% Female	% Male
All services	***449,595***	***52.3%***	***47.7%***
Acute/PHF	***44,687***	***47.6%***	***52.4%***
IMD/SNF/MHRC	***7,120***	***40.2%***	***59.8%***
State Hospital	***684***	***25.1%***	***74.9%***

There do not appear to be any significant differences in ethnicity according to the type of service, except perhaps for the slightly higher percentages of African-Americans in all three of the 24-hour services compared to their percentages for all services.

Ethnicity by Type of Service

	N	Caucasian	African-American	Hispanic	Asian	Other	Total
All services	***424,198***	***50.1%***	***18.1%***	***21.0%***	***7.5%***	***2.7%***	***100 %***
Acute/PHF	***42,230***	***53.8%***	***19.1%***	***17.1%***	***7.8%***	***2.1%***	***100 %***
IMD/SNF/MHRC	***6,916***	***51.6%***	***19.5%***	***17.4%***	***9.3%***	***2.2%***	***100 %***
State Hospital	***684***	***50.6%***	***21.9%***	***18.4%***	***6.6%***	***2.5%***	***100 %***

The age of the clients receiving acute services appears to be somewhat younger with the highest percentage of 18-21 year olds and the lowest percentage of 51-64 year olds. The clients in the IMDs are slightly older than those receiving any service and those in state hospitals older still.

Age by Type of Service (FY02-03)

	N	18-21	22-35	36-50	51-64	Total
All services	***449,595***	***8.9%***	***30.9%***	***41.7%***	***18.5%***	***100%***
Acute/PHF	***44,687***	***10.5%***	***34.6%***	***40.3%***	***14.7%***	***100%***
IMD/SNF/MHRC	***7,120***	***5.7%***	***30.9%***	***43.3%***	***20.2%***	***100%***
State Hospital	***684***	***5.8%***	***23.5%***	***46.7%***	***24.0%***	***100%***

CLINICAL STATUS

GAF scores are not readily available on most clients in outpatient services; thus 51% of the clients in the "all services" category lack a GAF score. Even in the IMDs, 42 % do not have a recorded GAF score.

The pattern of GAF scores is as expected with the percentage of lower scores increasing with the level of service.

GAF Scores by Type of Service

	N	<20	21-30	31-40	41-50	51-60	60+	Total
All services	***227,396***	***3.5%***	***7.2%***	***20.6%***	***33.5%***	***23.8%***	***11.4%***	***100%***
Acute/PHF	***15,556***	***9.8%***	***13.3%***	***23.5%***	***32.3%***	***16.9%***	***4.2%***	***100%***
IMD/SNF/MHRC	***4,157***	***10.9%***	***29.8%***	***33.6%***	***17.2%***	***6.4%***	***2.0%***	***100%***
State Hospital	***684***	***16.8%***	***31.4%***	***35.7%***	***11.7%***	***3.8%***	***1.0%***	***100%***

Diagnostic categories show increasing levels of schizophrenia from all clients, to acute to IMD/state hospitals. The higher percentage of "other" in the state hospitals is largely due to "cognitive disorders" at 6.6%.

	All Clients (N=449,507)	Acute (N=44,571)	IMD (N=7,119)	State Hospital (N=684)
Schizophrenia	***20%***	***41%***	***76.5%***	***73%***
Other psychosis	***9%***	***19%***	***11.5%***	***2.5%***
Bipolar	***15%***	***15%***	***7%***	***8%***
Depressive Disorder	***30%***	***20.5%***	***3.5%***	***4%***
Other	***20%***	***4.5%***	***1%***	***12.5%***
None/deferred	***6%***		***0.5%***	
	100%	***100%***	***100%***	***100%***

LENGTHS OF STAY AND TURN-OVER IN IMDs

Unfortunately we were not able to get data on the total lengths of stay for clients discharged in a particular year going back across fiscal years. The data below is thus only for a single year so the longest length of stay is 365 days for a client there on 7/1/02 and still there on 6/30/03 of the following year.

The major point we conclude from the data is that the bulk of the resource is used by clients who stay at least six months, but there is significant turnover of clients during the fiscal year. The reasoning behind that finding follows; it is complicated because of the limitations of the data.

In FY 02-03 there were 7120 unduplicated clients in IMDs and 7,653 different episodes of care in an IMD. The average number of days for all 7,120 clients was 120 days. The table below indicates that

- Nearly three-quarters (74%) of the clients in an IMD during the FY were discharged during the year.
- Of those discharged, at least 20% were readmitted and discharged again during the FY. The actual percentage of readmissions would be higher since some of those readmitted might be in the group still in residence on 6/30/03.

Clients and Episodes of Care in IMDs during FY 02-03
For Clients Discharged and For Clients Still in Residence
On 6/30/03

	Discharged in FY 02-03	Still in IMD on 6/30/03
Clients	***5689***	***1964***
Episodes	***6757***	***1964***
DC	***6757***	***0***
Days/Episode	***77***	***173***
Days/Client	***91***	***173***
Episodes/Client	***1.2***	***1***
Total Days	***517,613***	***339,591***

Another way to look at this information is by categories of lengths of stay. While nearly half (48%) of the clients who were discharged had lengths of stay of less than one month (remember that this is only for the FY in question and their actual *length of stay could be longer if it crossed the FY) they accounted for just a small percentage (7%) of the days. The figures are, of course, the opposite for those with LOS over 6 months. They account for a lower percentage of the episodes (15% for those discharged and 41% of those still in residence), but a higher percentage of the total days (50% for those discharged and 78% for those still in residence). Overall, those clients with LOS over 6 months (whether discharged or not) accounted for 61% of the total IMD days.*

Episode IMD ALOS for Clients Discharged in 02-03 and Those Still in Residence on 6/30/03

	Discharged in FY 02-03		**Still in IMD on 6/30/03**	
ALOS	***Episodes N=6,757***	***Days N=517,613***	***Episodes N=1,964***	***Days N=339,591***
1-14	***32%***	***3%***	***10.5%***	***0.5%***
15-30	***16%***	***4%***	***11%***	***1.5%***
31-90	***21%***	***16%***	***20%***	***7%***
91-180	***16%***	***27%***	***17.5%***	***13%***
181-365	***15%***	***50%***	***41%***	***78%***
	!00%	***100%***	***100%***	***100%***