COMMUNITY TRANSITION PROGRAM AT THE HEATHER

4th Compilation
January 2013

Psychiatric Rehabilitation in the Community: A Program Evaluation

Collaboratively Provided By:
Community Mental Health Center of Lancaster County
University of Nebraska – Lincoln
O.U.R. Homes

COMMUNITY MENTAL health HEALTH CENTER
of Lancaster County

Community Transition Program at the Heather

A PROGRAM EVALUATION

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INTRODUCTION

The Community Mental Health Center of Lancaster County (CMHC) initiated program evaluation of the Community Transition Program at the Heather (CTP-H) for the purpose of continuing quality improvement and program development. The results of the evaluation will demonstrate the effectiveness of the program and highlight changes in the program since its opening in 1998. Results will also highlight how the CTP-H fits within the agency's larger continuum of mental health care.

Description of Program Mission and Philosophy

The CTP-H is a 15-bed intensive rehabilitation program designed to assist participants with severe and persistent mental illness to achieve their recovery goals. For administrative purposes (e.g. Medicaid reimbursement) it is classified as a *psychiatric residential rehabilitation* program. Services at CTP-H are collaboratively provided by CMHC, the University of Nebraska – Lincoln, and O.U.R. Homes. CMHC provides fiscal and administrative services and technician staff; UNL provides program leadership and clinical staff; and O.U.R. Homes provides the physical facility and associated management duties.

Designed as the smallest incremental step down from the state hospital system, the CTP-H is an integrated and interactive training and skill-building program. It was developed as a community-based alternative to inpatient care for participants with especially severe and persistent psychiatric disabilities who have failed to respond to standard community-based and short-term inpatient services. The primary mission of CTP-H is to help participants achieve a level of functioning sufficient for success in a less supervised setting, requiring less intensive services. In addition, CTP-H aims to help participants overcome common and debilitating barriers to recovery. Barriers include lost or undeveloped living, social, and occupational skills; social stigma of mental illness; insufficient skills for maintaining wellness (e.g., stress and symptom management); persistent positive and/or negative symptoms; persistent vulnerability to relapse; family conflicts and related problems; vulnerability to social isolation; and depression, demoralization, and hopelessness. These problems often cause treatment failure, high treatment costs, high rates of hospital use, and unacceptable levels of quality of life among participants with the most severe and persistent conditions. Unless these problems are effectively addressed in rehabilitation, the result will be continued high rates of hospital use, functional deterioration, increased need for intensive services and poor quality of life. Psychiatric residential rehabilitation as offered by CTP-H is specially designed to address these problems. In addition, particular problems such as impulsiveness and poor social judgment, poor or complicated medication response, persistent socially unacceptable behaviors, history of aggression that is not attributable to acute psychosis, general uncooperativeness with services, "revolving door" syndrome, and numerous "burned bridges" within the community service system pose additional barriers to returning to the community. These particular problems require that treatment and rehabilitation be provided with the structure, security, and intensity that psychiatric residential rehabilitation provides. Specifically, these are some the problems that make services in less secure settings too risky and too costly.

The philosophy of the program is based on the principle that participants receiving mental health services are capable of functional, psychological, and psychiatric recovery, and are entitled to opportunities for such recovery. Some participants with severe and persistent mental illness need substantial support, structure, and on-site training to make the transition from the state hospital system to productive community living and ongoing recovery. With adequate support, skill training, and practice within a supervised, highly structured, community-based residence, these participants can achieve a greater degree of independence and a less restrictive level of care.

The program goals and objectives include:

- To provide a transitional residential treatment setting in which a person may transition from an inpatient psychiatric program to the community while developing independent living skills and moving toward a less restrictive environment.
- Assist participants in making the transition from inpatient hospitalization to community living using the basic tenets of recovery. [1]
- Using the strengths identified in the assessments, provide education and skill training in areas of deficits as defined through assessment and rehabilitation planning process.
- Assist participants in the transition from psychiatric residential rehabilitation to less intensive levels of care.

CTP-Heather Referral Process

CTP-H accepts referrals from mental health agencies and professionals who serve participants with the most severe and disabling psychiatric conditions. Referrals can be initiated by contacting Jay White, RN, at (402) 441-9105. When a referral is accepted, the person referred will be added to a waiting list to await the next available room. Participants are generally admitted from the waiting list on a first-come-first-served basis, although factors such as gender, acuity of illness, and legal status may override the order. Highest priority is given to individuals who are completing a course of inpatient psychiatric rehabilitation at the time of referral.

Referrals are evaluated according to the following criteria:

- The person's condition meets criteria for "severe and persistent mental illness" as defined by state policy and regulations.
- The psychiatric condition is stabilized sufficiently that inpatient treatment is not required.
- The person is unable to function safely in a less restrictive environment than CTP-H, due to instability of psychiatric condition, inability to perform necessary activities of daily living without assistance, need for continuous supervision (e.g., under court orders), or risk of not adhering to treatment and rehabilitation.
- There is a reasonable expectation that the person can achieve a level of functioning sufficient for more independent living within 1-2 years of psychiatric rehabilitation.
- The person is eligible for funding/reimbursement resources accessible by the CTP-H (primarily the Medicaid Rehabilitation Option).

[1] According to Davidson and colleagues (2005), the concept of recovery includes the following aspects: hope for a better life & renewed sense of purpose, a sense of self beyond the role of "mental patient", accepting limitations of illness & finding strength in weakness, involvement in meaningful activities, overcoming stigma, assuming control and responsibility for one's own recovery, managing symptoms, and participating in community life.

The Transitional Process after Referral

CTP-Heather Rehabilitation and Discharge Planning Process

The process of rehabilitation and discharge planning begins immediately upon the participant's arrival at CTP-H. Within 10 days, a Master Treatment and Rehabilitation Plan (MTRP) is constructed by the participant's treatment team, which consists of the participant, the treatment coordinator, the participant's assigned psychiatric technician, substitute decision makers where applicable (e.g., guardian), the psychology extern, and the supervising practitioner. The MTRP follows a standard problem-oriented format, supplemented by an inventory of the participant's goals, desires and preferences. The overall goals of the MTRP are:

- The participant will achieve a level of personal and social functioning sufficient to live in a less restrictive setting within the shortest possible time period, and
- The participant's choices regarding place of abode, occupational and vocational activities, continuing mental health services and other desires will be pursued as much as possible.

Specific components of the participant's discharge plan are identified and included in the plan as soon as possible. These generally include the living situation or residential destination, continuing mental health services, and occupational and vocational activities. As these components are identified, the MTRP is fine-tuned to ensure its goals and objectives are relevant to the discharge plan. Progress toward implementation of the discharge plan is assessed as part of the regular Treatment Plan Review process. When the participant has met the goals and objectives necessary for safe and stable functioning in the post-discharge environment, the discharge is implemented and CTP-H services are discontinued.

Services Provided By CTP-H to Individuals Who Are Not Program Participants

Medication Monitoring. In addition to serving program participants at CTP-H, staff at CTP-H provides medication management services to an average of 6 and up to 10 individuals with mental illness living in the Independent Heather at any given time. Staff members monitor and help manage psychiatric medications for individuals at least twice per day (morning and evening) with additional times as needed.

Transitional Visits. CTP-H also hosts visitors from the Lincoln Regional Center (LRC) an average of twice per week for three hours at a time. Visitors are participants who are receiving inpatient psychiatric treatment at LRC and are advanced within their rehabilitation program to start actively working on their discharge plan, which includes living at CTP-H. Visitors learn about the CTP-H program by participating for a few hours in the program (including community meetings and community outings).

Description of Program Evaluation Procedures

This program evaluation addressed the following questions:

- Who are the participants being served by CTP-H?
- What is the impact of the program on participants' functioning during CTP-H rehabilitation?
- What kind of living arrangements do participants enter following discharge from CTP-H?
- What changes has the program experienced since its opening in 1998?

Information was gathered for participants served by CTP-H from records at CMHC and the CTP-H clinical database.

From its inception in 1998 to December 2012 a total of 140 participants have been served by CTP-H. Of these 140 participants, 29 participants were served by CTP-H between January 2011 and December 2012 and were thus included in this compilation program evaluation. Of these 29 participants, 16 were current participants at CTP-H. The remaining 13 participants graduated from the program and are included in the current analyses of program outcomes. For certain analyses, less data was available and is so noted. Description of participants being served includes demographics (e.g., race, age, etc.) and clinical characteristics (e.g., diagnosis, legal status, etc.). Description of participants' functioning during CTP-H rehabilitation includes participation in program-based skills training and functional community activity (e.g., work, day rehabilitation program, etc.). Discharge locations are described.

PART 1: DESCRIPTION OF PARTICIPANTS SERVED BY CTP-H

Summary of Description of Participants Served

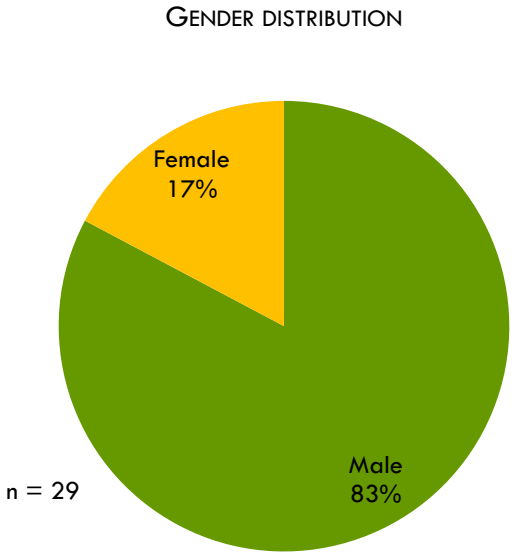
CTP-H serves participants with particularly severe and persistent psychiatric disorders. This severity is expressed as:

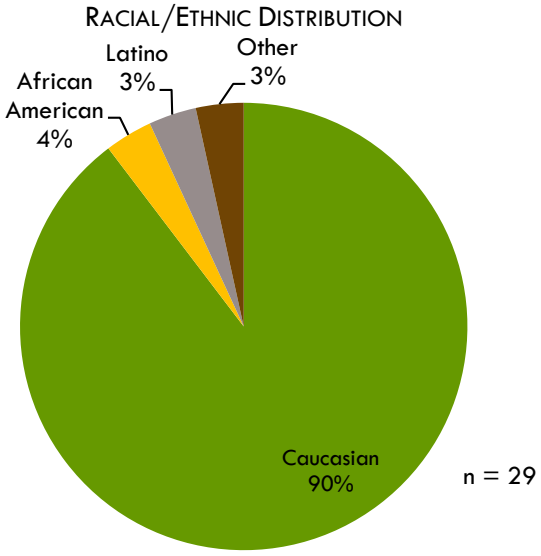
- Severity of symptoms associated with Axis I disorders
- High comorbidity of Axis II disorders
- Degree of medication resistant psychiatric symptoms
- Degree of legal involvement
- Major functional impairment in skills associated with successful independent community living

Demographics

With regard to the 29 participants served by CTP-H between January 2011 and December 2012:

- 24 (82.8%) were men and 5 (17.2%) women
- At admission, they were on average 38.0 years old (range = 19 to 58)
- 26 (89.7%) were Caucasian, 1 (3.4%) was African American, 1 (3.4%) was Latino, and 1 (3.4%) was of another race





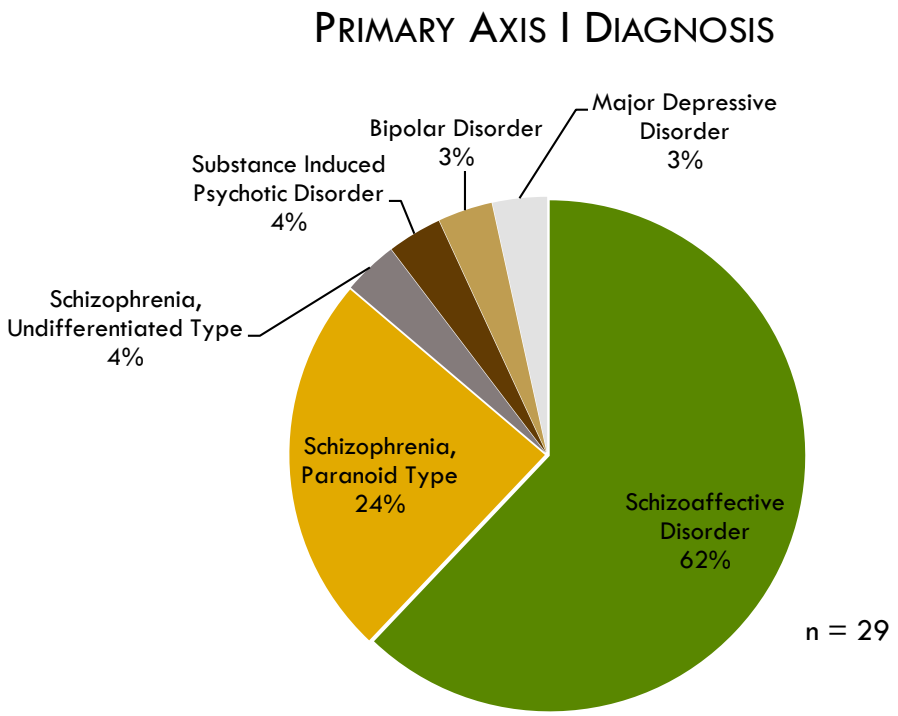
Clinical Characteristics of Participants Served

Participants admitted to CTP-H have histories of especially severe and persistent psychiatric disorders, protracted institutionalization, and/or failure to respond to community-based and short-term inpatient services. These participants are usually hospitalized because they present severe deficits in ordinary living skills and/or their behavior is dangerous to themselves or others.

With regard to the participants served by CTP-H between January 2011 and December 2012, sample size varies per analysis as indicated due to missing data.

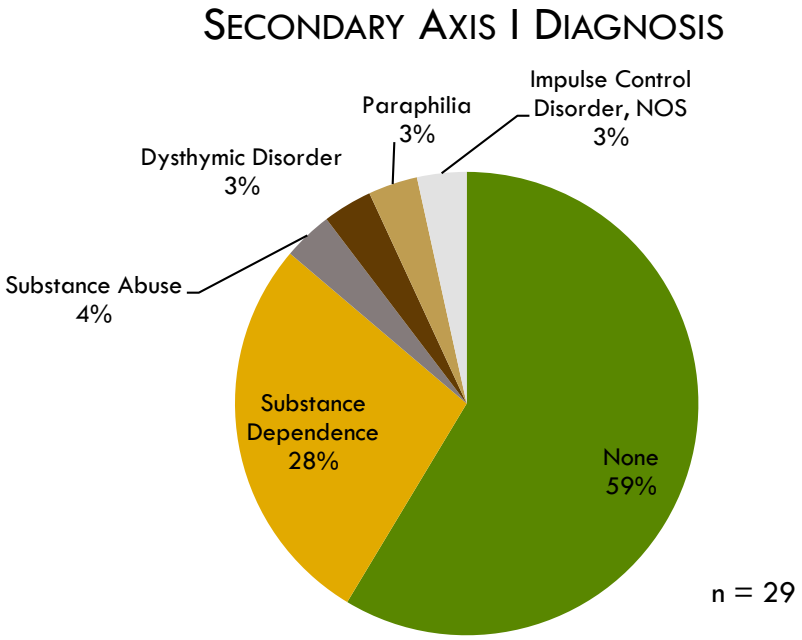
Psychiatric Diagnoses

As seen in the chart below (Figure 3), the majority of participants served (89.6%) have a diagnosis of either schizophrenia or schizoaffective disorder as their primary Axis I disorder, thus representing an especially severe portion of the SMI population.

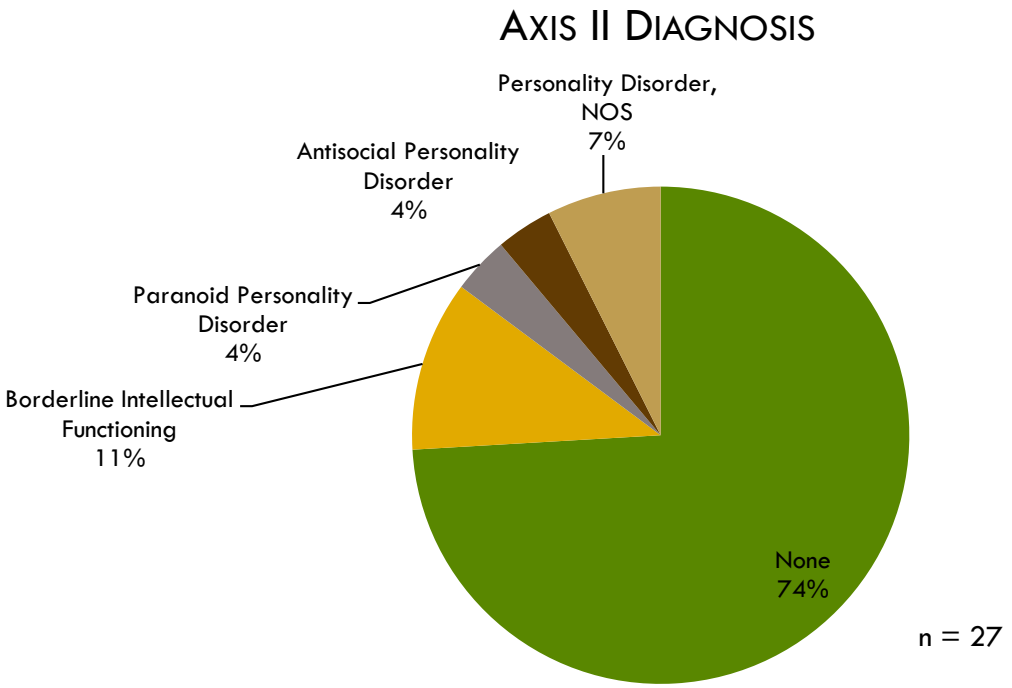


Comorbid Psychiatric Conditions

Some participants served (37.9%) also had a secondary Axis I diagnosis, and one participant had a third Axis I diagnosis. These secondary and tertiary diagnoses included substance dependence (66.7%), substance abuse (8.3%), dysthymic disorder (8.3%), a paraphilia (8.3%), or Impulse Control Disorder, NOS (8.3%).



A minority of participants (25.9%) also had an Axis II diagnosis. These diagnoses included Borderline Intellectual Functioning (11.1%), Paranoid Personality Disorder (3.7%), Antisocial Personality Disorder (3.4%), and Personality Disorder, NOS (7.4%). Information was not available for 2 participants.



Psychiatric Symptomatology

Starting in 2006, the Brief Psychiatric Rating Scale (BPRS) was routinely administered to CTP-H participants, including at the time of admission. The current analysis includes the 19 participants (65.5%) served between January 2011 and December 2012 who were administered the BPRS at admission.

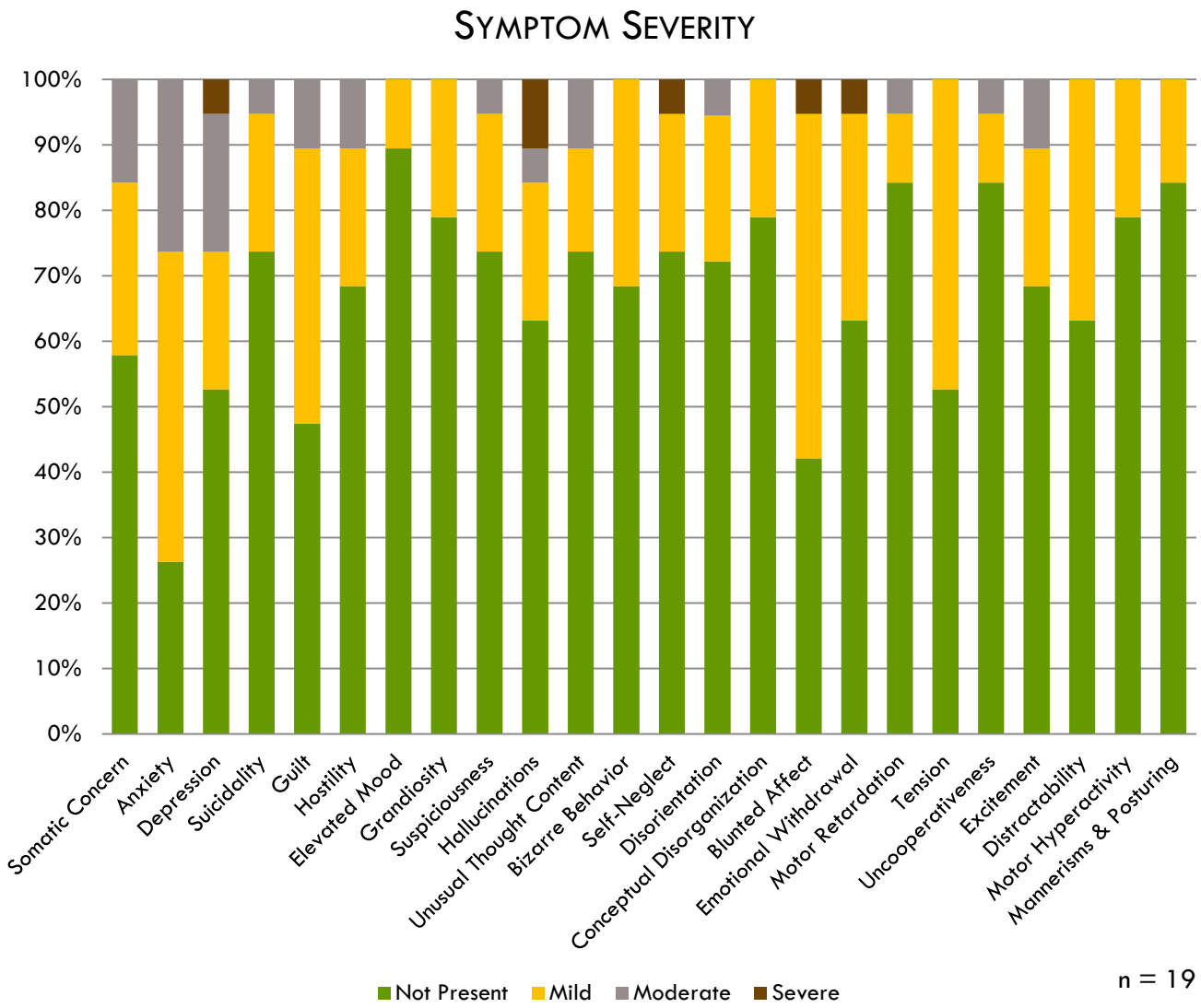
47.4% of participants scored in the *not present* to *mild* range on all 24 symptoms assessed.

15.8% of participants had at least 1 symptom in the *severe* or *extremely severe* range.

26.3% of participants had just one or two symptoms in the *moderately severe, severe,* or *extremely severe* range.

26.3% of participants had three or more symptoms in the *moderately severe, severe,* or *extremely severe* range.

This symptomatology level is consistent with participants stabilized on medications and compares to the overall level of symptomatology observed for CTP-H participants since its opening.



Community Ability

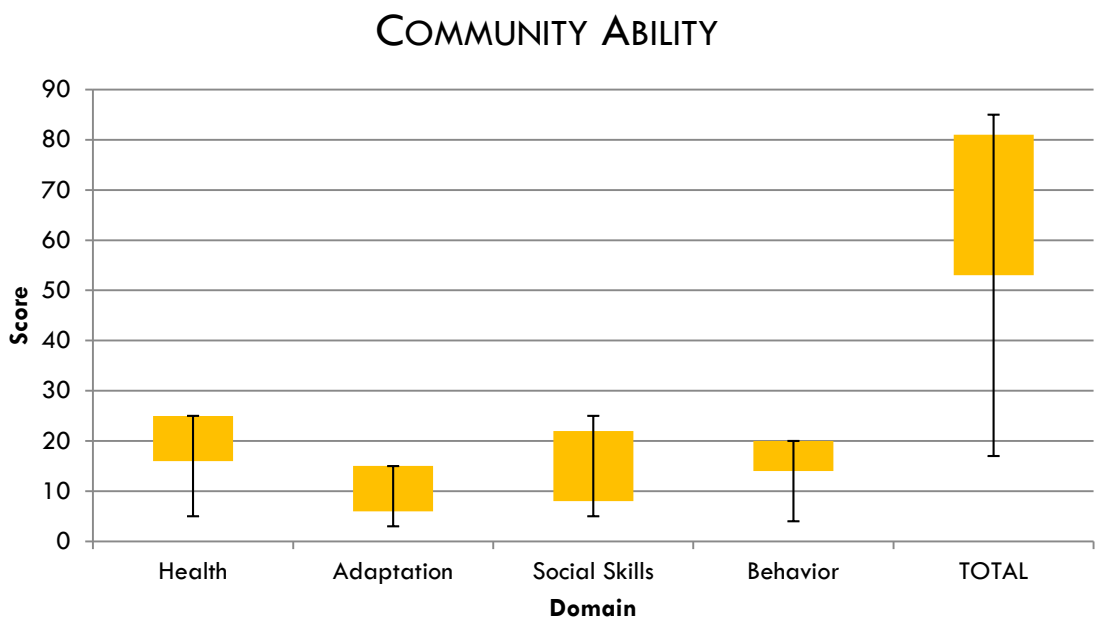
The Multnomah Community Ability Scale (MCAS) is routinely administered to participants during their rehabilitation at CTP-H. The following analysis includes the 18 individuals whose community ability was assessed within 6 months of their admission to CTP-H (average delay between admission and assessment was 70 days, ranging from 1 day to 146 days).

The MCAS assesses community ability in four domains:

- Health: Ability to manage physical, mental, and emotional symptoms that could interfere with overall health and functioning (e.g., ability to manage physical health problems; cognitive functioning; thought processes; mood disturbance; stress management)
- Adaptation: Ability to function in daily life and adapt to living with mental illness (e.g., ability to manage money; independence in daily living; acceptance of psychiatric disability)
- Social Skills: Ability to engage in interpersonal relationships and meaningful activity
- Behavior: Ability to perform behaviors that are identified with successful community integration and with positive treatment outcomes (e.g., medication adherence; engagement with treatment; substance abuse; impulse control)

Overall MCAS scores range from 17 to 85, with higher scores reflecting greater ability to function successfully in the community. At admission, participants' average score was 66.7 (range 53 to 81), representing substantial impairment in the above abilities. More specifically, overall scores in the Health domain range from 5 to 25. Participants' average score was 21.3 (range 16 to 25). Overall scores in the Adaptation domain range from 3 to 15. Participants' average score was 11.2 (range 6 to 15). Overall scores in the Social Skills domain range from 5 to 25. Participants' average score was 16.9 (range 8 to 22). Overall scores in the Behavior domain range from 4 to 20. Participants' average score was 18.2 (range 14 to 20).

The figure below represents the range of scores obtained by CTP-H participants, relative to the possible scores in each domain. The shading represents the obtained scores for each domain, and the bars represent the range of possible scores for each domain.



See table below for more specific information about performance in each domain.

Domain	Possible Scores	Participants' Range of Scores	Average Score
Health	5 to 25	16 to 25	21.3
Adaptation	3 to 15	6 to 15	11.2
Social Skills	5 to 25	8 to 22	16.9
Behavior	4 to 20	14 to 20	18.2
TOTAL	**17 to 85**	**53 to 81**	**66.7**

All participants had at least two items rated as "no impairment" (average = 7 items, range 2 to 15). Six participants (33.3%) had at least one item rated as "extremely impaired." Nearly all participants (94.4%) had at least one item rated in the clinically significant range (moderately, markedly, or extremely impaired), with the average person having 5 items rated in this range (range 0 to 11 items).

These results indicate the population served by CTP-H has significant impairments in the abilities identified with successful community living. These participants would likely fail to succeed in alternative community placements without the intensive rehabilitation provided by CTP-H.

Independent Living Skills

The Independent Living Skills Inventory (ILSI) is routinely administered to participants during their rehabilitation at CTP-H. The following analysis includes the 20 individuals whose independent living skills were assessed within 6 months of their admission to CTP-H (average delay between admission and assessment was 58 days, ranging from 0 to 167 days).

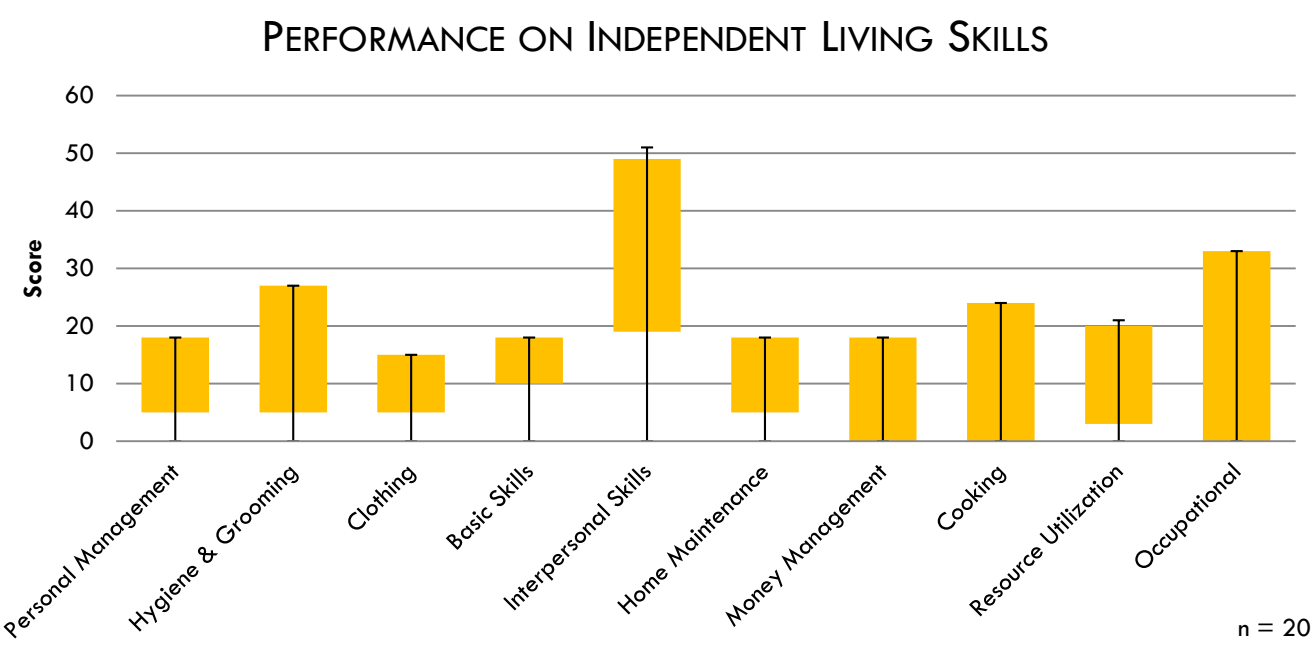
The ILSI assesses independent living skills in 10 domains:

- Personal Management: Skills in maintaining and managing a daily schedule and solving general problems
- Hygiene and Grooming: Personal and health care skills
- Clothing: Skills in maintaining an appropriate wardrobe and appearance
- Basic Skills: Skills in reading, writing, telling time, using postal service and telephone, avoiding legal problems, etc.
- Interpersonal Skills: Skills in social behavior, from basic skills (e.g., responding to others) to more sophisticated social skills (e.g., solving interpersonal conflicts)
- Home Maintenance: Skills in caring for living quarters and dealing with breakdowns and emergencies
- Money Management: Skills in handling money
- Cooking: Skills in cooking, shopping, and kitchen use
- Resource Utilization: Skills in use of community resources, including public transportation, locating stores and offices, etc.
- General Occupational Skills: Work skills and motivation

Overall ILSI scores range from 0 to 243, with higher scores reflecting greater independence in performing the particular skill. At admission, participants' average score was 169.4 (range 75 to 239), indicating that participants enter the program with basic skills but cannot perform the skills adequately without guidance or supervision. CTP-H provides such guidance and supervision to help participants perform those skills independently.

The domain with the greatest competence among participants on average was the Basic Skills domain, and the domain with the least competence among participants on average was the Money Management domain.

The figure below represents the range of scores obtained by CTP-H participants, relative to the possible scores in each domain. The shading represents the obtained scores for each domain, and the bars represent the range of possible scores for each domain.



See table below for more specific information about performance in each domain.

Domain	Possible Scores	Participants' Range of Scores	Average Score
Personal Management	0 to 18	5 to 18	11.7
Hygiene & Grooming	0 to 27	5 to 27	21.9
Clothing	0 to 15	5 to 15	11.9
Basic Skills	0 to 18	10 to 18	16.2
Interpersonal Skills	0 to 51	19 to 49	36.6
Home Maintenance	0 to 18	5 to 18	14.3
Money Management	0 to 18	0 to 18	9.2
Cooking	0 to 24	0 to 24	17.3
Resource Utilization	0 to 21	3 to 20	12.2
Occupational	0 to 33	0 to 33	18.5
TOTAL	**0 to 243**	**75 to 239**	**169.4**

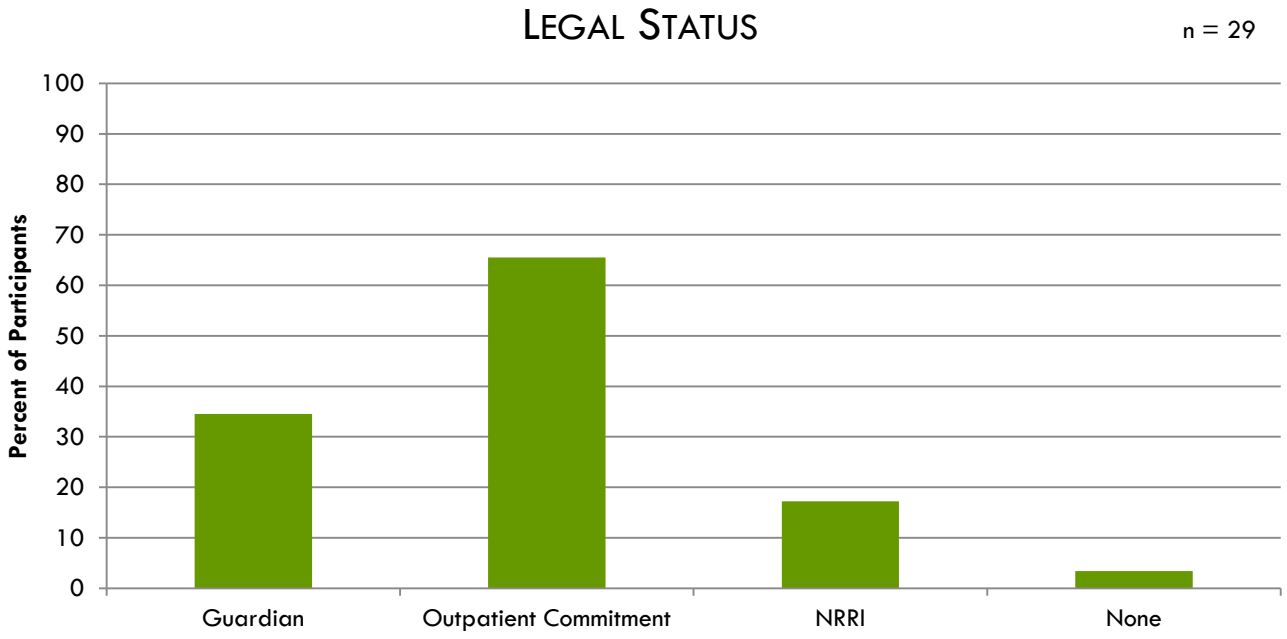
All participants had at least six items rated as "independent competence" (average = 38.5 items, range 6 to 77, out of 81 total items), indicating that all participants possessed a set of skills they were capable of performing within the range of normal functioning independent of supervision. The skills participants were most adept at performing independently were wearing shoes and clothes that fit, telling time, reading at survival level, writing at survival level, and using the telephone. However, most participants (75.0%) also had at least one item rated as "non-competence" (average = 6.35 items, range 0 to 34, out of 81 total items), indicating

that there were skills for which participants had no competence at all. The skills participants had the most difficulty performing independently at admission were using public transportation, using a checking account correctly and appropriately, maintaining a close circle of trusted friends, maintaining a reasonable intimate personal relationship, and making repairs in minor damages to clothing..

These results indicate the population served by CTP-H has significant impairments in basic independent living skills. These participants would likely fail to succeed in alternative community placements without the intensive rehabilitation provided by CTP-H.

Legal Status

Nearly all CTP-H participants (96.6%) required one or more forms of legal interventions in order to assist them in managing their disorder, treatment decisions, and aspects of daily living. It should be noted that all participants receive therapeutic personal financial management counseling as part of their rehabilitation program at CTP-H; hence, payee services are not included in this analysis. As seen in the chart below, 10 (34.5%) have a guardian, 19 (65.5%) have an outpatient commitment, and 5 (17.2%) have NRRI court mandated treatment. This data is a further index of the severity of the population served.



PART 2: PARTICIPANTS' FUNCTIONING DURING CTP-H REHABILITATION

Summary of Participants' Functioning During Their CTP-H Stay

CTP-H provides a residential rehabilitation setting in which participants can transition from an inpatient psychiatric setting to the community while developing independent living skills and moving toward a less restrictive environment.

The data suggest the program is successful as evidenced by:

- The very high level of TAC (Therapy/Activity/Class) activities per week.
- The very high progress rating on TAC activities indicating independent performance of activities of daily living.
- The relative high level of functional community activities participants engage in: 41.4% of participants at CTP-H hold either competitive employment, supported employment, or a volunteer job.

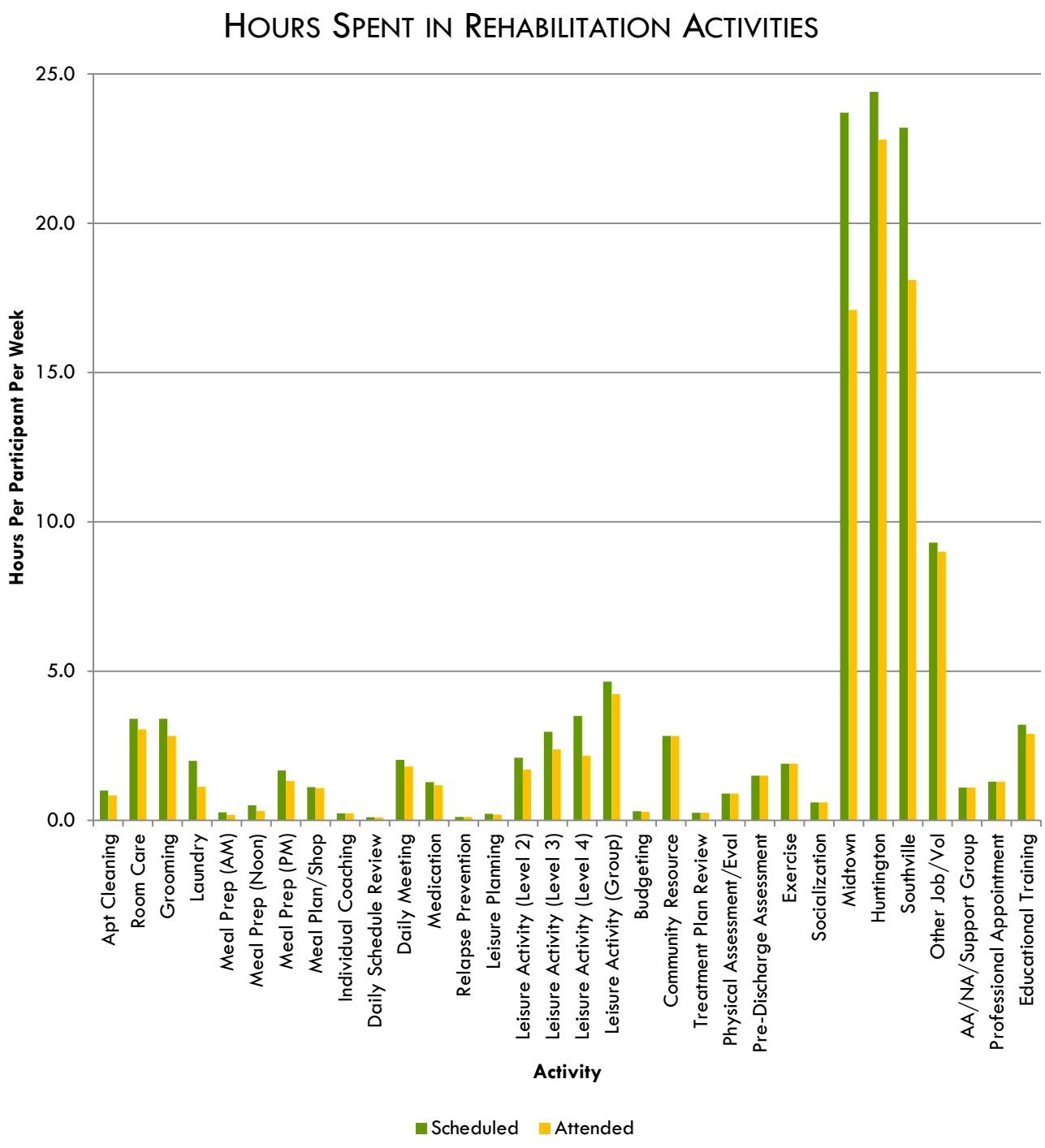
Overall Program Performance

(as measured by weekly TAC [Therapy/Activity/Class] scores)

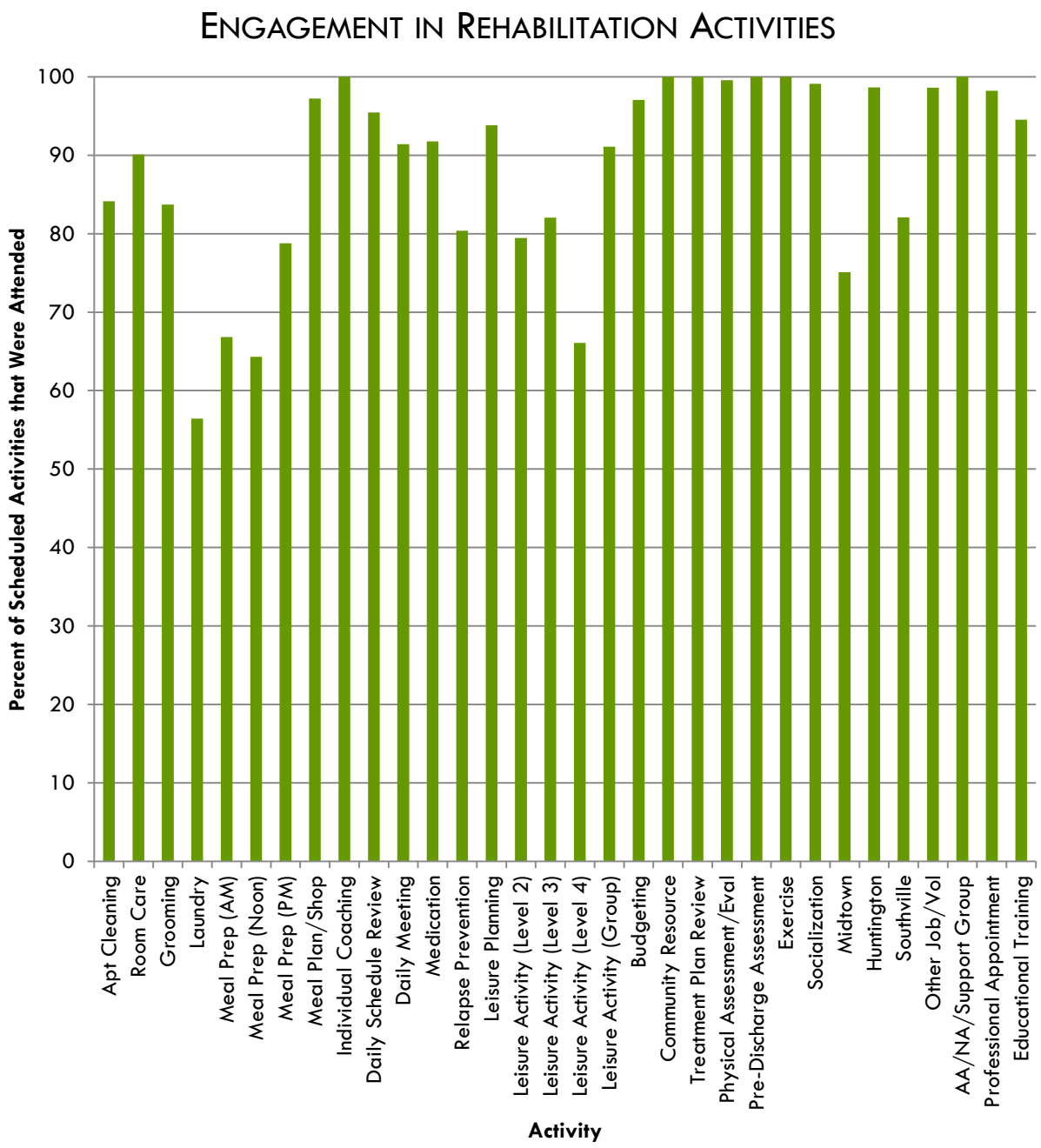
This analysis includes only participants served by the program in the last half of 2012 (N=18).

The TAC system is a clinical decision support system that tracks provision of therapy and rehabilitative services to participants and serves as a record of their participation in treatment and rehabilitation modalities provided by the CTP-H program and, as such, is an ongoing record of "active treatment." Treatment and rehabilitation modalities include activities such as meal planning, grooming, room care, and leisure planning that are part of activities of daily living necessary for independent functioning in a less restrictive environment for which the CTP-H program prepares its participants. TAC ratings, overall, are an important indicator of how well individual participants do in their rehabilitation as it encompasses major skills areas necessary for independent functioning. The rating includes the amount of hours an individual has scheduled for weekly activities, the amount of time activities were actually attended, as well as the quality of involvement (level of independence) in the activities. As such, TAC provides a comprehensive tracking system, providing information regarding quantitative as well as qualitative involvement in the CTP-H program. Overall, TAC ratings indicate a very high level of independent involvement in activities. This is especially notable as engagement and attendance in treatment activities is often a serious problem among people with SMI.

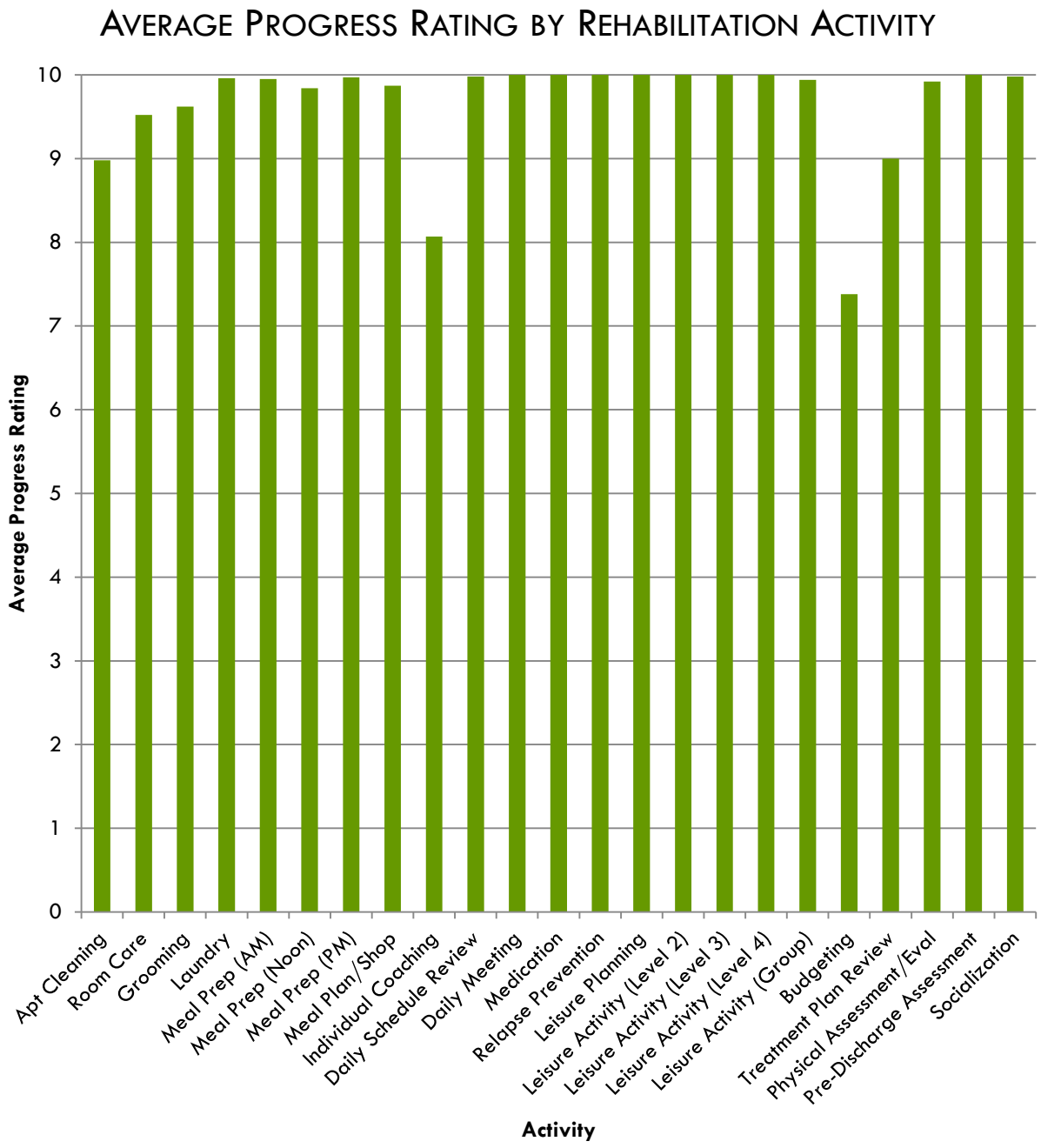
As mentioned above, CTP-H staff rates all participants using the TAC system on a weekly basis. On average, participants were scheduled for 37.1 hours of activities per week, of which 30.4 were attended. The chart below outlines the hours scheduled and attended for various rehabilitation activities. [Note: Midtown Center is an adult day rehabilitation program; Huntington and Southville are adult day care programs] Participants spend most of their time at day programs and are involved in various other rehabilitation activities as indicated.



Overall, CTP-H participants attended an average of 84.0% of rehabilitation activities per week (range: 19.6% to 100%). The chart below indicates the proportion of scheduled rehabilitation activities that were attended each week, a proxy for engagement in rehabilitation. The lowest scores were obtained on laundry, meal preparation, and Level 4 leisure activities. Staff indicate that it appears participants are completing laundry and meal preparation that is not accounted for due to noncompliance with the reporting requirement; thus, the reported figures may underestimate participants' engagement in these activities. Level 4 leisure activities are leisure activities completed independently by participants on Level 4 (the highest level) of the program.



The TAC scale measures progress in a rating scale that ranges from 1 ("does not demonstrate skills needed to complete the task") to 10 ("demonstrates skills needed to adequately complete the task [skill area] without staff teaching or prompts"). The overall average progress rating was 9.76 (out of 10; ranging from 8.3 to 10), indicating independent performance of activities of daily living. The activity with the lowest independence performance was budgeting, consistent with independent living skills deficits in this area (see ILSI, page 12).

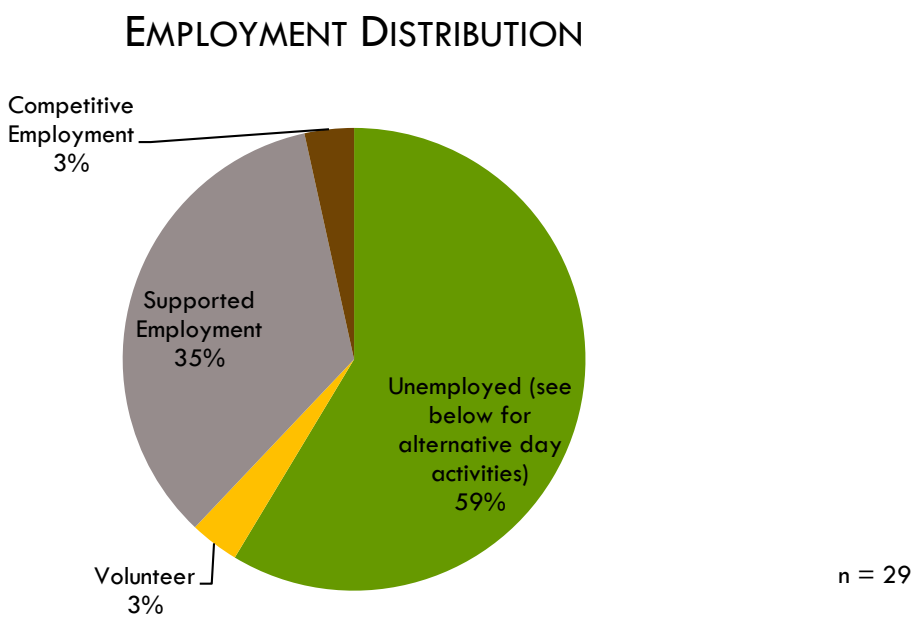


Participation in Functional Community Activities During CTP-H Rehabilitation

As an index of transition from inpatient care to CTP-H, the nature and amount of functional community activities in which participants were involved was measured. These included employment (competitive, volunteer, and supported) and attendance of an adult day program (either an adult day care program or an adult day rehabilitation program.) These analyses include all participants (N = 29). As described below, consistent with the program's stated objectives of assisting in the transition from institution living to more independent community living, most participants consistently participated in meaningful community activities during rehabilitation at CTP-H.

Employment.

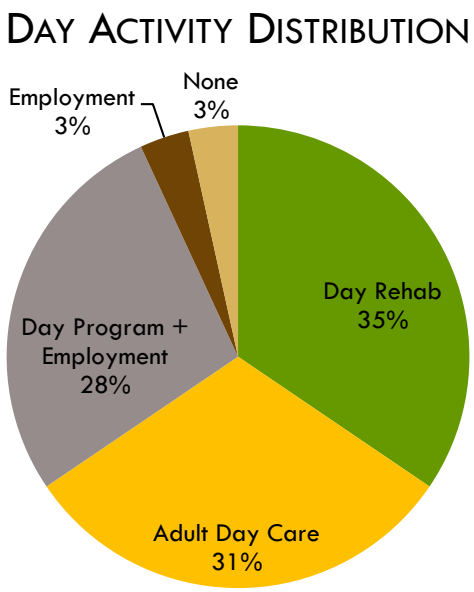
Participants' employment status was examined in terms of the nature of the employment during CTP-H rehabilitation. The chart below indicates that 17 (58.6 %) were not employed. Of the 12 (41.4%) who were employed, 1 (8.3% of those with employment) was competitively employed, 10 (83.3% of those employed) were involved in supportive employment (e.g., aware), and 1 (8.3% of those employed) was employed on a volunteer basis. On average, participants worked 9.7 hours per week (range = 2-30 hours per week). It should be noted that participants not working were engaged in some other form of meaningful day activity (see below).



Day Activities. The following analysis includes all CTP-H participants (N=28)

Nearly all CTP-H participants (96.6%) were engaged in one or more meaningful day activities. The majority (19 participants) attended either an adult day rehabilitation program (10 participants, 34.5%) or an adult day care program (9 participants, 31.0%). Eight CTP-H participants (27.6%) were engaged in some form of employment while they also attended either an adult day rehabilitation program or adult day care program.

One participant (3.4%) held a job for a day activity. One participant (3.4%) chose not to pursue a day activity.



n = 29

ADULT DAY ACTIVITY HOURS.

Evaluation of participants' involvement in an adult day program and/or employment during their CTP-H stay indicates that participants spent an average of 26.38 (range 0 - 37) hours per week at their program and/or work place.

Length of Stay at CTP-H

The average length of stay at CTP-H for participants served between January 2011 and December 2012 (n = 13) was 662 days (standard deviation = 401 days). There were 2 participants whose stay was much beyond the distribution and could thus be considered outliers. When those participants were removed from the analysis, the average length of stay at CTP-H became 521 days (standard deviation = 205). This figure falls within the state service definitions which define an expected length of stay between 9 months (274 days) and 18 months (548 days). The range of length of stay at CTP-H was from 243 days to 1630 days during the time covered by this evaluation.

In the figure below, the dark line represents the average length of stay for participants admitted in each of the years since CTP-H opened. There remain in the program 10 participants admitted between 2008 and 2011 who have not yet been discharged: one participant admitted in 2008 whose length of stay is presently 1499 days, one participant admitted in 2009 whose length of stay is presently 1408 days, three participants admitted in 2010 whose average length of stay is presently 884 days, and five participants admitted in 2011 whose average length of stay is presently 603 days. The lighter line represents what would be the average length of stay for participants admitted after 2008 if those 10 participants were discharged on the date of the analysis. When those participants do eventually discharge, the actual length of stay for participants admitted after 2008 will be greater than the figure shown.

The present results regarding average length of stay (662 days) represent a significant increase from an average of 325 days during the time period covered in the most recent program evaluation (2004-2007) and represent a return to the figures from the first program evaluation (1998-2004). Because of its intensive structure, CTP-H serves as a step down from the Lincoln Regional Center, allowing some individuals to be discharged to a community setting rather than remaining in the more restrictive inpatient setting. The program's functioning in this way results in its serving a unique population whose level of clinical acuity and impairment in skills required for successful community functioning is quite severe. Consequently, the gradual transition to less restrictive settings takes considerable time with this population.

Until 2009, many CTP-H participants were referred from an inpatient psychiatric rehabilitation unit at the Lincoln Regional Center. These individuals received intensive psychiatric rehabilitation in a secure inpatient setting and were then referred to CTP-H to continue their rehabilitation in the community. The decline in average length of stay observable in Figure 10 is in no small part attributable to that intensive rehabilitation. In 2009, the inpatient rehabilitation unit was closed. Participants referred to CTP-H since that time have not had any psychiatric rehabilitation and consequently require more rehabilitation at CTP-H and therefore a longer length of stay.

It is also important to note additional factors influencing length of stay, such as court restrictions for NRRI participants or restrictions for Medicaid waiver services. The level of care needed by some of the participants is higher than can reasonably be accomplished through Assisted Living/State Rate and potential discharge providers refuse admission without some additional funding for supervision and one-on-one care. However, changes in available housing assistance programs (e.g., Region V's Rental Assistance Program) may have helped reduce length of stay for some individuals as it decreases waiting periods for supplemental rental funds for persons with disabilities and as such allows for a more efficient discharge process from CTP-H to a more independent setting in the community.

PART III: OUTCOMES AFTER CTP-H DISCHARGE

Summary of Outcomes after CTP-H Discharge

CTP-H provides an effective transition to a less restrictive, more independent life for participants with severe and persistent mental illness as evidenced by:

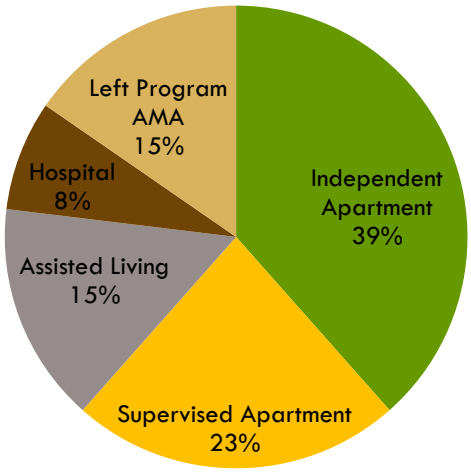
- The majority (76.9%) of participants transitioned successfully from CTP-H to a less restrictive level of care (independent apartment, supervised apartment, or assisted living).

The following analyses were conducted for those participants who have been discharged from CTP-H (N = 13). Very limited information was available regarding functioning after CTP-H discharge, so no analyses were conducted.

Level of Care at Discharge

Living situation was used as an index to determine if participants moved to a less restrictive level of care following CTP-H discharge. As can be seen in the chart below, the majority of CTP-H participants (76.9%) moved to a less restrictive setting after being discharged from CTP-H, including 5 (38.5%) to an independent apartment, 2 (15.4%) to assisted living, and 3 (23.1%) to a supervised apartment. One participant (7.7%) was hospitalized and 2 (15.4%) left AMA.

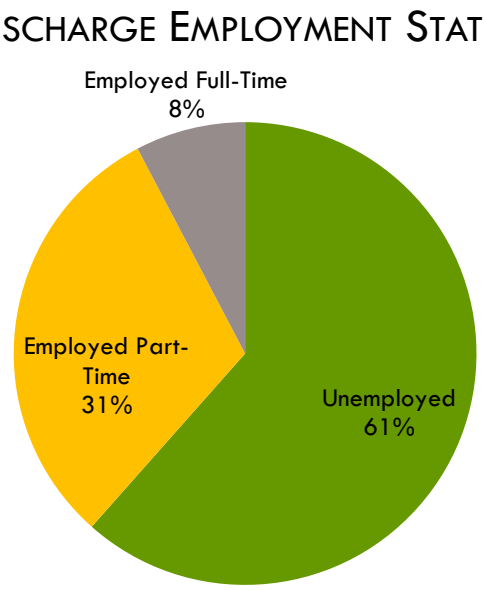
DISCHARGE LEVEL OF CARE



n = 13

Employment Status at Discharge

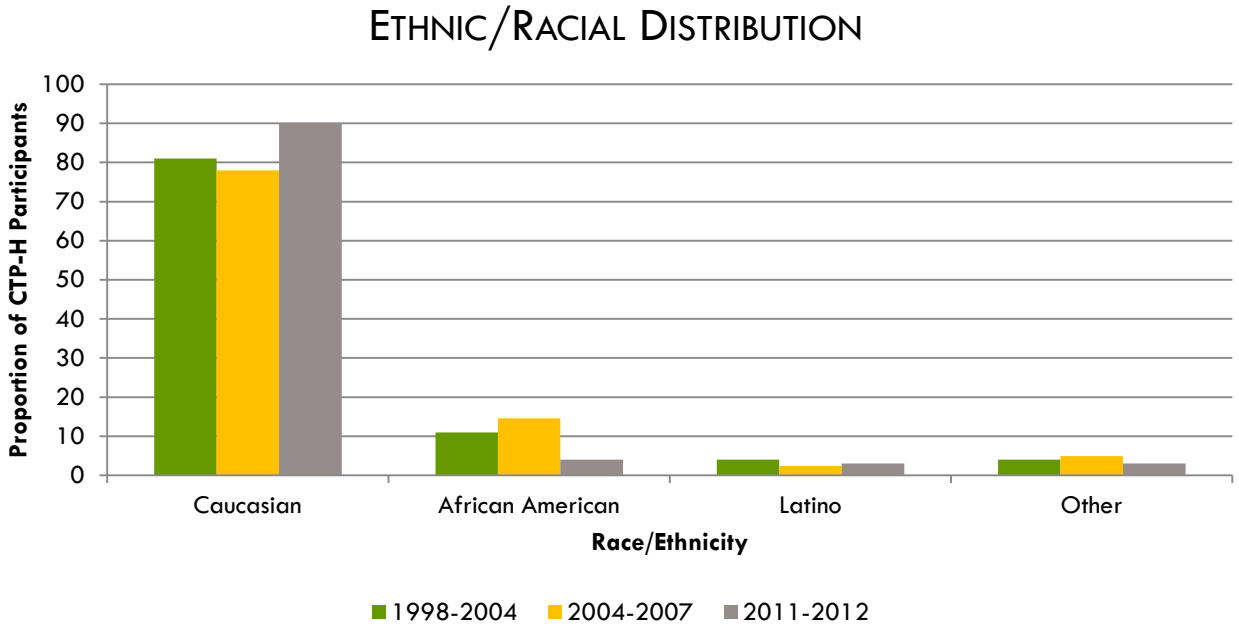
Most participants (61.5%) were unemployed at discharge. However, discharge planning included scheduling alternative day activities, such as participation in an adult day program. Four participants (30.8%) were employed part-time and one participant (7.7%) was employed full-time at discharge.



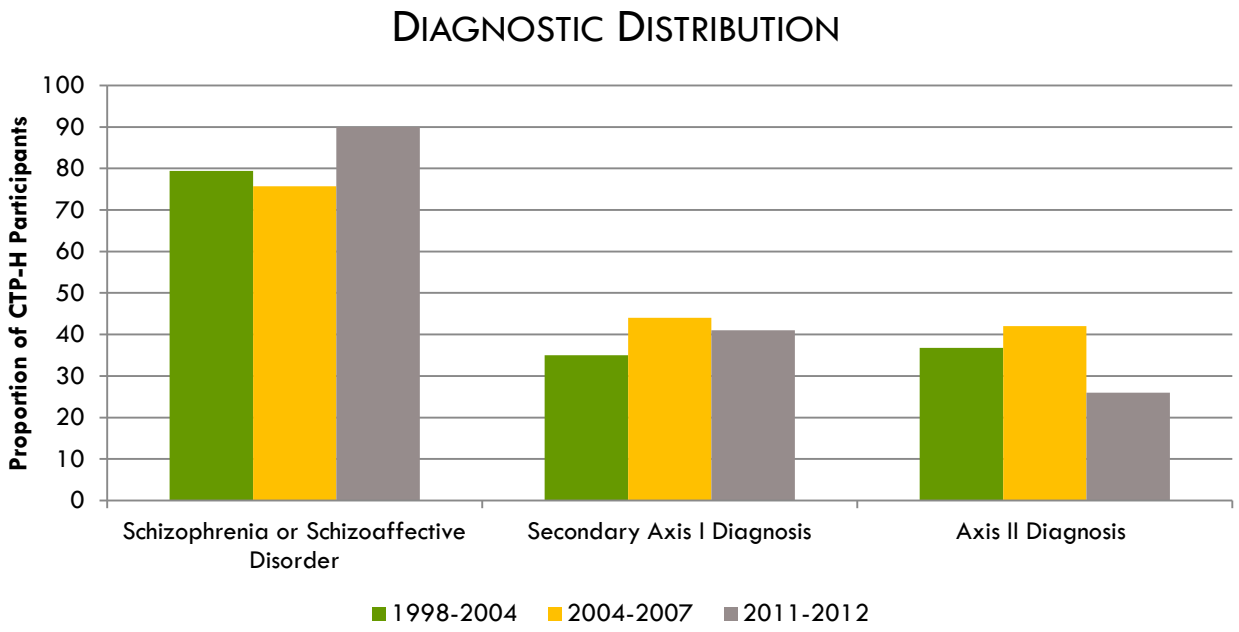
n = 13

COMPARISON OF PROGRAM EVALUATIONS

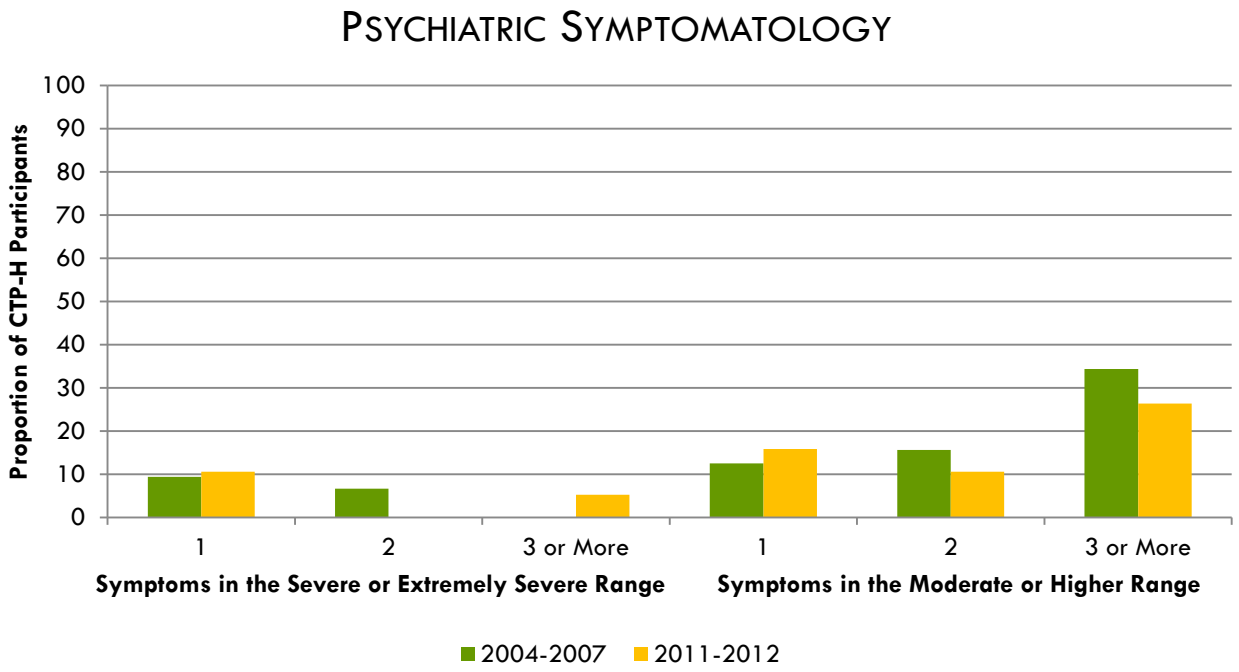
Since its inception in 1998, CTP-H has served a total of 140 participants. Overall, the demographic composition of participants served remained similar, with the racial distribution being representative of the larger Lincoln, NE, area.



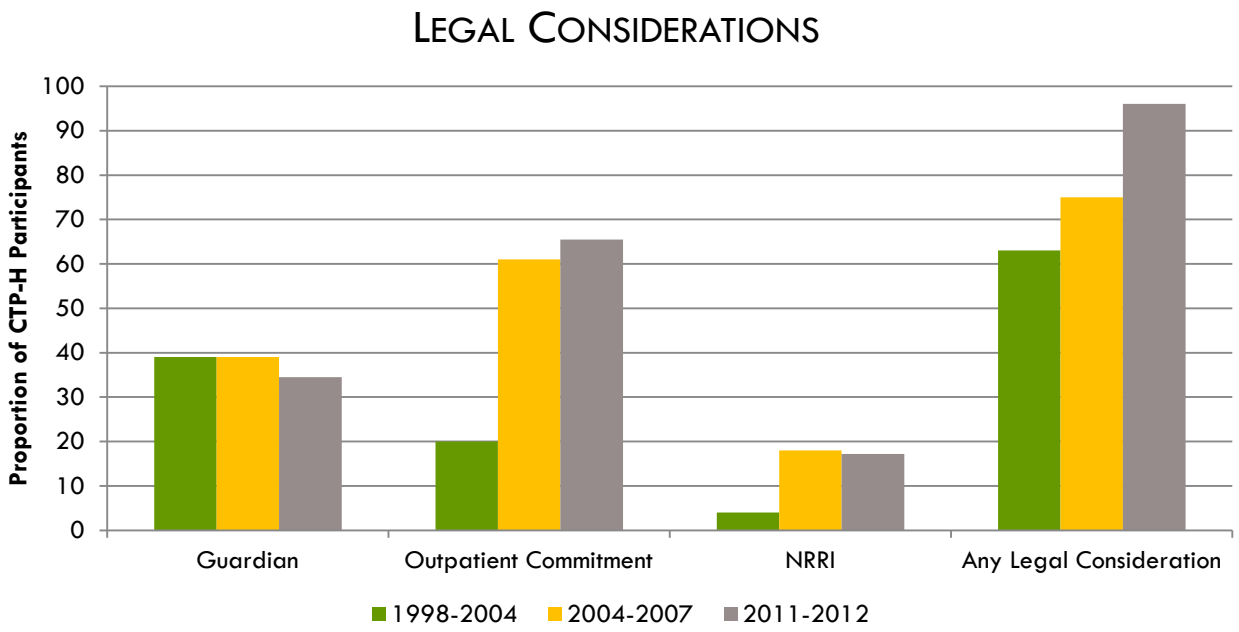
In terms of psychiatric diagnosis, CTP-H continues to serve a severely mentally ill population with the majority of diagnoses being schizophrenia or schizoaffective disorder. The incidence of both secondary Axis I diagnoses and Axis II diagnoses has remained fairly consistent across the evaluations, though a decrease in Axis II diagnoses was observed in the present evaluation.



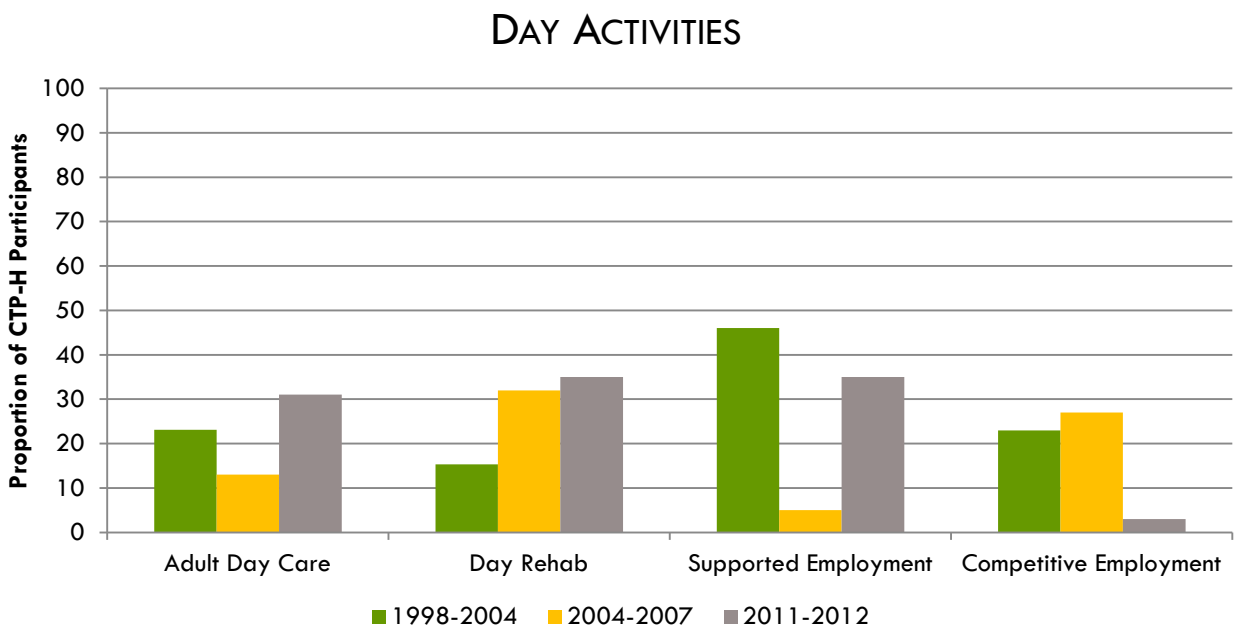
Overall level of psychiatric symptomatology as measured by the BPRS has remained the mild level across the evaluations. Very few participants experience symptoms in the severe or extremely severe range. This symptomatology level is consistent with participants stabilized on medications and compares to the overall level of symptomatology observed for CTP-H participants in the previous evaluations.



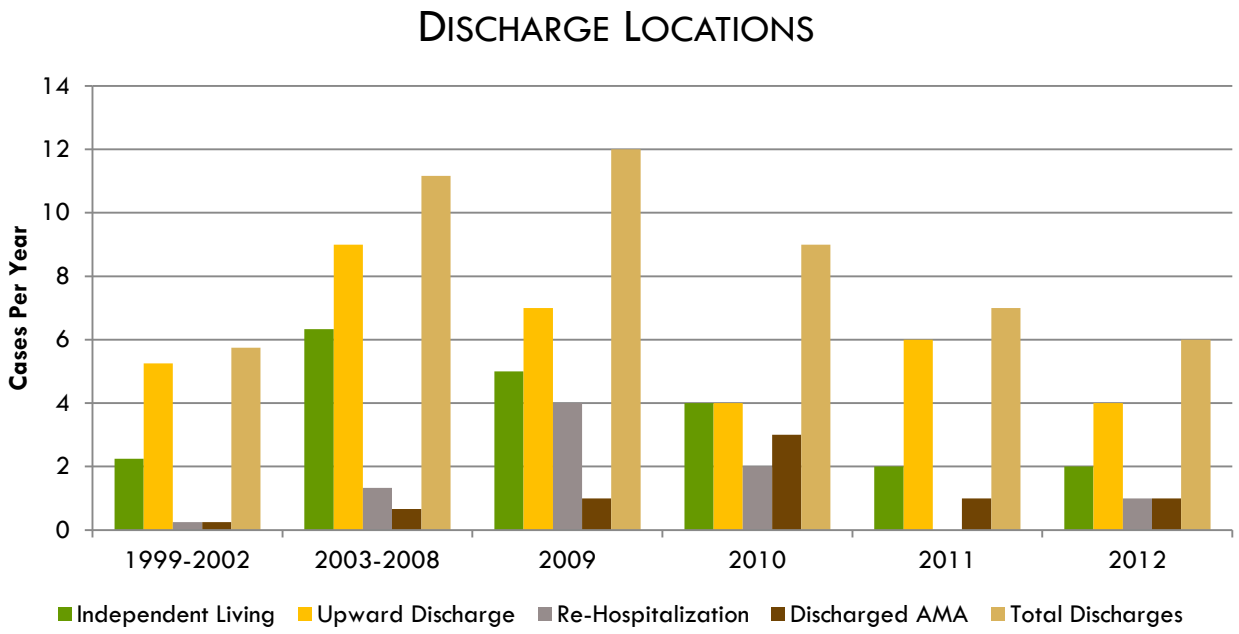
Changes were noted regarding participants' legal status at the time of admission to CTP-H. While the proportion of individuals with legal guardians has remained fairly constant, there was a dramatic increase in the number of individuals with an outpatient commitment or NRRI status in the 2004-2007 evaluation, which remained relatively stable in the present evaluation. However, there has been an overall increase in the proportion of participants with legal considerations even when compared to the previous evaluation.



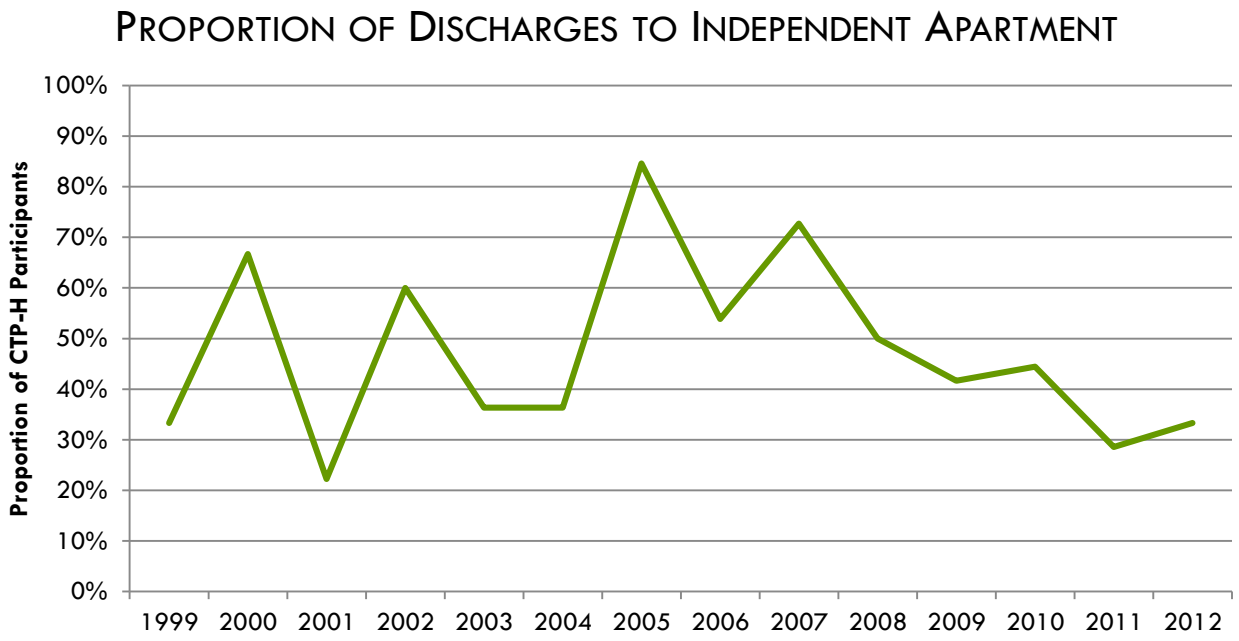
Other changes noted during this evaluation period include the decrease of number of participants engaged in employment activities. From 1998 to 2004, 69% of participants were employed, which decreased to 32% in the 2004 to 2007 evaluation and 38% in the present evaluation. There has been an increase in participants engaged in supported employment since the most recent evaluation, perhaps because of supported employment opportunities at O.U.R. Homes. However, there has been a dramatic decrease in participants engaged in competitive employment. This may be due, in part, to a more competitive job market in general with striking economic changes since the 2007 evaluation. With fewer participants engaged in employment, more participants are engaged in adult day care and day rehabilitation programs.



Perhaps the most interesting findings regard discharge. In the first evaluation, 35% of individuals were discharged to an independent apartment. This figure increased considerably in the most recent evaluation to 69% and has since decreased to nearly the original figure at 39%. The distribution of living situations at discharge in the present evaluation is very similar to what was obtained in the first evaluation, the early years of CTP-H. However, it is quite different from what was obtained in the most recent evaluation, when there was an inpatient psychiatric rehabilitation program preparing participants for community living and a variety of community-based mental health services for follow-up care. The figure below aggregates the discharge locations across 1999-2002 (the early years of CTP-H), 2003-2008 (years of improvements in the surrounding community system), and then yearly since 2009, the year the inpatient psychiatric rehabilitation program at LRC, CTP, was closed.



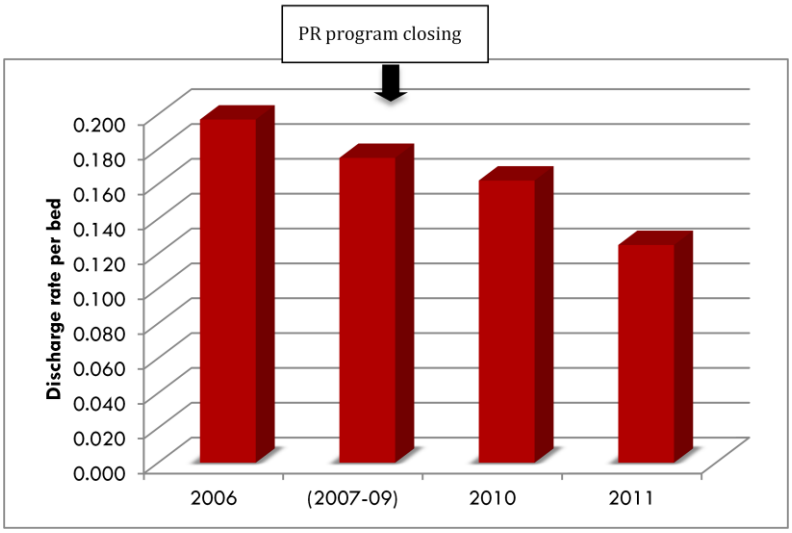
In addition to there being a decrease in total discharges per year in recent years, there has also been a decrease in discharges to independent apartments. This may be attributable to greater functional impairment on admission to CTP-H that is not rehabilitated in a timely fashion or to a change in community supports for independent living.



The changes in CTPH outcome reflect the change in its role in the surrounding service system precipitated by the closing of the LRC rehabilitation program. Before the closing, it was the step-down destination for the most disabled graduates of the LRC program. Today it is the only psychiatric rehabilitation program serving that population in the region. Without previous rehabilitation in the secure LRC program, current admissions to CTP-Heather require substantially more time to reach more independent levels of functioning, and with less reliable success.

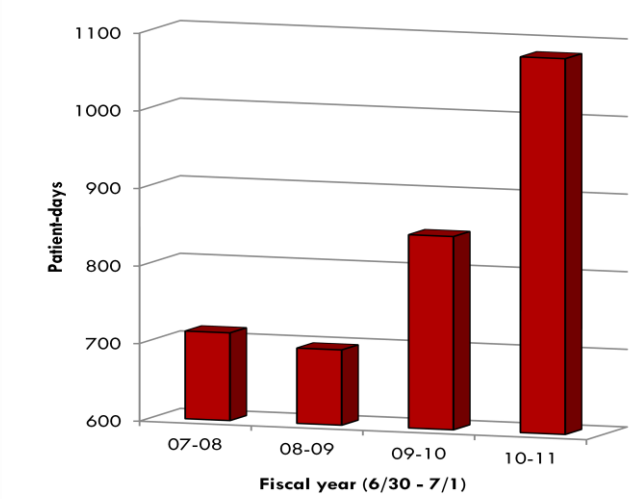
Changes in CTP-H outcome reflect related changes in the functioning of the surrounding mental health system. Within LRC, there has been substantial increase in use of restraint and seclusion and a general degradation of treatment. This is reflected in turn in the LRC discharge rates, which have decreased steadily since the LRC program was closed (below). Although the outcome of CTP-H has suffered from the closing, its presence in the system has buffered against some of the impact. For example, although the length of stay has doubled over the past 18 months for patients from Region V, it has more than tripled for patients from the adjoining region, which has no residential program comparable to CTP-H.

Lincoln Regional Center non-forensic discharge rates before and after closing



The slowdown in LRC discharges has had a profound effect on community services beyond CTP-H. A key indicator of system stress is the number of days patients remain in the county crisis center after they have been adjudicated for commitment to LRC. That number has increased dramatically since the LRC rehabilitation program was closed.

patient days spent in the crisis center after civil commitment, waiting for a state hospital bed



CONCLUSIONS AND RECOMMENDATIONS

Overall, the evaluation suggests that CTP-H is largely successful at facilitating the transition and recovery of participants with severe mental illness. The most striking finding from this evaluation is a return to the discharge profile of the early years of the program. When the local mental health system had an inpatient psychiatric rehabilitation program preparing individuals for community living *and* community-based services for follow-up care (i.e., 2003-2008), CTP-H was able to discharge more individuals and to more independent locations. Following the closure of the inpatient psychiatric rehabilitation program in 2009, individuals were admitted to CTP-H with more functional impairment and less development of independent living and illness management skills. Consequently, the average length of stay at CTP-H has increased to allow for time to teach these skills. The results of this evaluation are consistent with the results of the evaluation published in the article referenced above (Tarasenko et al., 2012) in indicating that without a secure psychiatric rehabilitation program, there are widespread effects throughout the surrounding mental health service system, including at CTP-H. The recommendations that follow from such a conclusion are policy-oriented, as research and this series of program evaluations all indicate that psychiatric rehabilitation is beneficial at an individual and system level.