



**Psychiatric Rehabilitation in the Community:  
A Program Evaluation of the  
Community Transition Program  
at the Heather**

**A Psychiatric Residential Rehabilitation Service  
Collaboratively Provided by:**

**Community Mental Health Center of Lancaster County**

**Lincoln Regional Center**

**OUR Homes**

# **Psychiatric Rehabilitation in the Community: A Program Evaluation of the Community Transition Program at the Heather**

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## EXECUTIVE SUMMARY

The Community Transition Program at the Heather (CTP-H) provides residential psychiatric rehabilitation for people with severe and persistent mental illness in a community setting.

Results of the program evaluation indicate the program serves a particularly impaired population.

Results of the program evaluation indicate the program is **highly effective** in providing a transitional continuum of care that maximizes and maintains peoples' stability as they move to greater independence following discharge from an inpatient psychiatric facility. This effectiveness is evidenced by:

- The very low psychiatric recidivism rate during CTP-H rehabilitation and after CTP-H discharge
- The high level of functional community activities (e.g., day rehab, work etc.) during rehabilitation
- The high rate of successful discharges to a less restrictive and more independent level of care
- The successful maintenance and stability of these discharges

## INTRODUCTION

The Community Mental Health Center of Lancaster County (CMHC) initiated a program evaluation of 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 areas for improvement. 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 residential rehabilitation program designed to assist people 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. CTP-H services are provided collaboratively by CMHC, Lincoln Regional Center (LRC) and OUR Homes. CMHC provides fiscal and administrative services and some technician staff; LRC provides program leadership and clinical staff; OUR Homes provides the physical facility and associated management duties.

Designed as a step away 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 people 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 the CTP-H is to help people achieve a level of functioning sufficient for success in a less supervised setting, requiring less intensive services.

The philosophy of the CTP-H is that people receiving mental health services are capable of functional, psychological and psychiatric recovery, and are entitled to opportunities for such recovery. Some people 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 people can achieve a greater degree of independence and a less restrictive level of care.

The program goals and objectives include:

1. To provide a transitional residential rehabilitation setting in which a person may transition from an inpatient intensive psychiatric rehabilitation program to the community to continue development of independent living skills and movement toward a less restrictive environment.
2. Assist people in making the transition from inpatient hospitalization to community living using the basic tenets of recovery.
3. Using the strengths identified in the assessments, provide education and skill training in areas of deficits as defined through assessment and rehabilitation planning process.
4. Assist people in the transition from psychiatric residential rehabilitation to less intensive levels of care.

***Description of Program Evaluation Procedures***

The program evaluation addresses the following questions:

1. Who are the people being served by CTP-H?
2. What is the impact of the program on peoples' functioning during CTP-H rehabilitation?
3. What is the impact of the program on peoples' functioning following discharge from CTP-H?

Information was gathered for people served by CTP-H from charts at CMHC, the CTP-LRC clinical database, questionnaires completed by CMHC community support workers and CTP-H staff, and CMHC hospitalization data.

As of September 2004 there were a total of 56 people who have been served by CTP-H and thus are included in this program evaluation. Of these 56 people, 13 were current residents at CTP-H. (It should be noted that while CTP-H is a 15-bed program, during the time of data collection for this program evaluation there were 2 empty beds). The majority of the remaining 43 people successfully graduated from the program and are included in the analyses of program outcomes.

Description of the people being served includes demographics (e.g., race, age etc.) and clinical characteristics (e.g., diagnosis, lifetime hospitalizations, legal status etc.). The total number of people for these analyses was 56 and includes both those people who were discharged as well as currently served. For certain analyses less data was available and is so noted.

Description of peoples' functioning during CTP-H rehabilitation includes rate of hospitalization and participation in functional community activity (e.g., work, day rehab program etc.). The total number of people for these analyses was 56 for evaluation of hospitalization rates during CTP-H rehabilitation and 13 (i.e., those people currently served) for participation in community activities while at CTP-H

Evaluation of outcomes of people discharged from the program includes hospitalization rate per six-month period after CTP-H discharge, discharge location, follow-up discharge location and participation in functional community activity. These analyses were conducted for those people who have been discharged from CTP-H (N=43) since the program's inception in 1998. Given the rolling nature of admissions and discharges, people have different lengths of stay at CTP-H and different lengths of post-discharge follow-up. On average the length of follow-up was 778 days (i.e., the average time from discharge to when follow-up information was gathered). The range of length of follow-up for these individuals was between 49 and 1961 days.

## **PART I: DESCRIPTION OF PEOPLE SERVED BY CTP-H**

### ***Summary of Description of People Served***

CTP-H serves people with particularly severe and persistent psychiatric disorders. This severity is apparent in the:

- high level of previous institutionalization both in number of lifetime hospitalizations and lifetime inpatient days
- severity of Axis I disorders, namely a high prevalence rate of schizophrenia spectrum disorders
- high comorbidity of Axis II disorders
- degree of medication resistant psychiatric symptoms
- degree of cognitive impairment
- degree of legal involvement

### ***Demographics***

With regard to the 56 people served by CTP-H thus far:

**Gender:** 29 (51.8%) have been men and 27 (48.2%) women

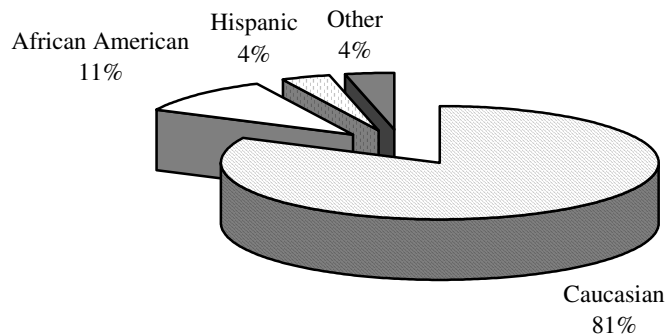
**Average age at admission to CTP-H:** 38.5 (range = 21 – 64.4)

**The average years of education:** 12.13 (range = 7-16 years)

**Race/Ethnicity:**

**Figure 1.**

#### **Breakdown of People Served by Race**



As seen in Figure 1:

**46** (81%) are Caucasian

**6** (11%) are African American.

**2** (4%) are Hispanic

**2** (4%) identified themselves as belonging to an “other” racial or ethnic category.



### ***Clinical Characteristics of People Served***

People 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 people 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 56 people served by CTP-H thus far:

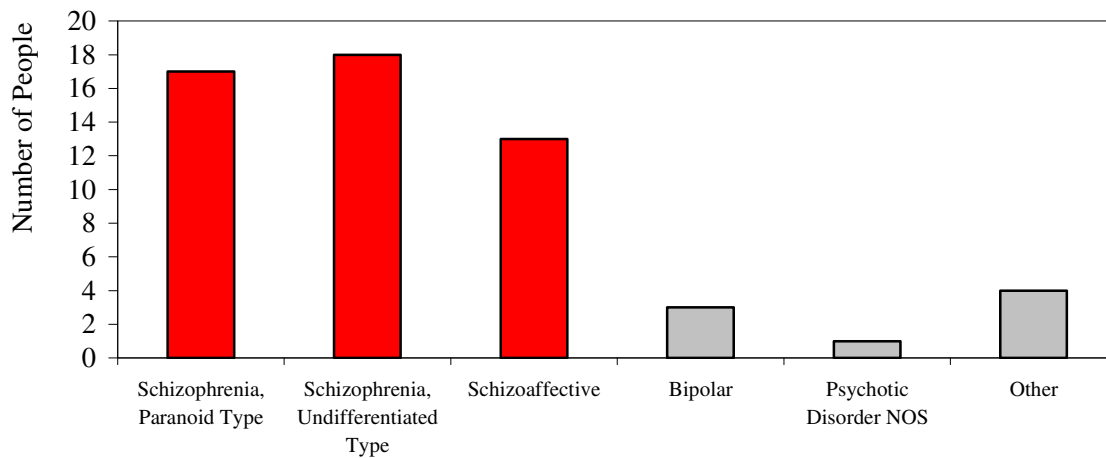
#### **Hospitalization History:**

- On average, people served by CTP-H have had **10.8 (range = 2 –33) psychiatric hospitalizations** during their lifetime.
- On average, people served by CTP-H have spent **1910.4 (range = 102 – 14,231) psychiatric inpatient days** during their lifetime.
- Average age of onset of psychiatric disorder is **19.6 years (range = 6 – 49)<sup>1</sup>**.

#### **Psychiatric Diagnosis:**

**Figure 2.**

#### **Primary Axis I Disorder**



As seen in the chart above, the majority of people served have a schizophrenia spectrum diagnosis as their primary Axis I disorder (red bars). Thus representing an especially severe portion of the SMI population.

<sup>1</sup> In Nebraska, psychiatric diagnosis can function to disqualify an individual for developmental disability services, so the average age of onset in the SMI population is sometimes unusually low.

### **Comorbid Psychiatric Conditions:**

- 35% of people served also have a secondary diagnosis on Axis I, primarily substance use disorders. 12 (21.4%) have a substance abuse diagnosis, 5 (8.9%) have a substance dependence diagnosis, 1 (1.8%) PTSD diagnosis, and 2 (3.6%) have another secondary diagnosis. The substance abuse comorbidity rate is clinically significant although it is considerably lower than prevalence estimates of 70-80% in the larger SMI population. It should be noted that based on chart review/interviews with community support staff that 65.1% have histories of substance abuse problems although do not necessarily carry a diagnosis of substance abuse.
- 36.8% of people served also have an Axis II personality disorder (PD) diagnosis: 7 (12.3%) have a borderline PD diagnosis, 2 (3.5%) have a paranoid PD diagnosis, 2 (3.5%) have an antisocial PD diagnosis, and 10 (17.5%) have a personality disorder NOS diagnosis. This is not an unexpected level of comorbidity although it should be noted that personality disorders tend to be unreliable diagnoses.

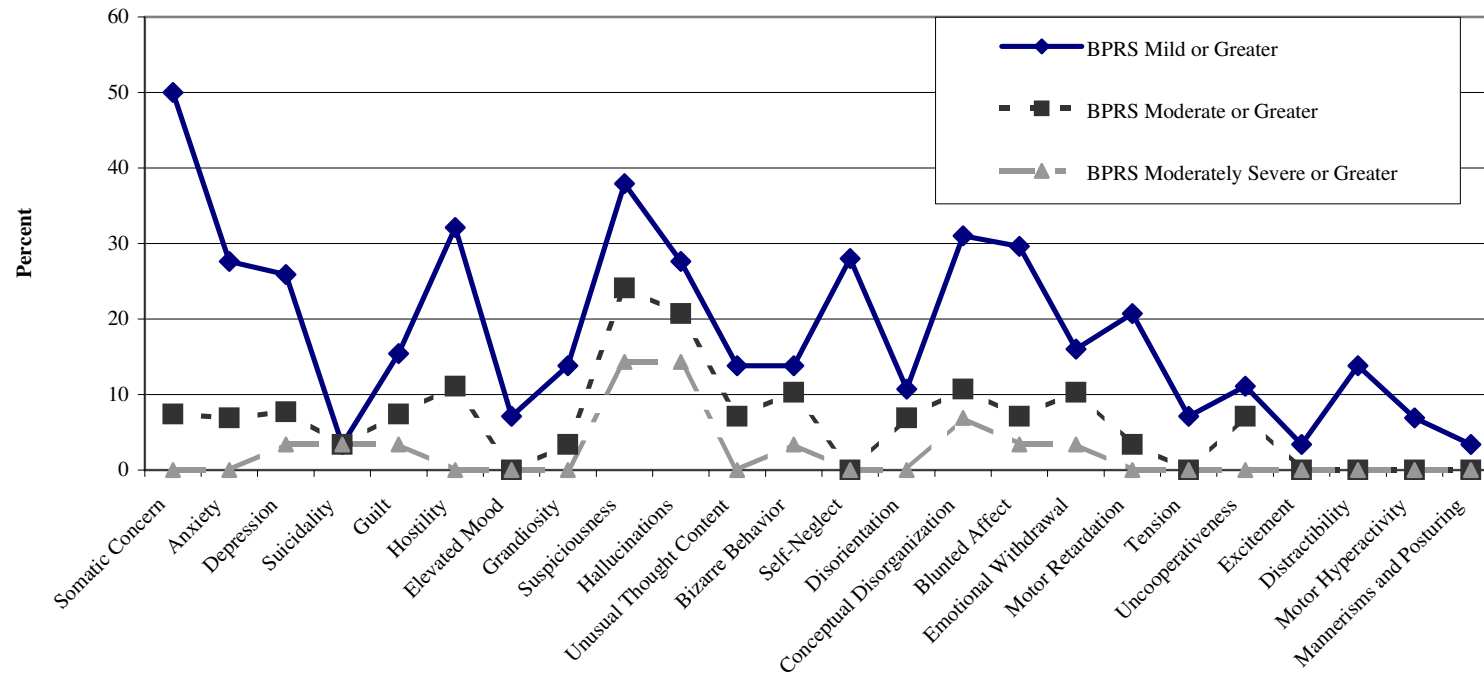
### **Psychiatric Symptomatology:**

A sample of people (N = 29) had inpatient psychiatric symptom data prior to their admission to CTP-H. To assess psychiatric symptoms, the Brief Psychiatric Rating Scale (BPRS)<sup>2</sup> was used. This measure is considered the gold standard for assessment of psychiatric symptoms and was administered by interviewers trained to a criterion level of reliability. On the next page is a detailed graphical account of the type and severity of symptoms experienced by these people. This graph indicates that at least 50% of individuals experience residual psychiatric symptoms at a mild, yet clinically significant level. Furthermore, 10-20 % of individuals experience residual psychotic symptoms, such as suspiciousness, hallucinations and conceptual disorganization (i.e., thought disorder) at a moderate to severe level. Overall, these data suggest that even while individuals are optimally medicated they still experience clinically significant psychiatric symptoms that are medication resistant.

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<sup>2</sup> Lukoff, D., Liberman, R.P., & Nuechterlein, K. (1986). Symptom monitoring in the rehabilitation of schizophrenic patients. *Schizophrenia Bulletin*, 12, 578-593.

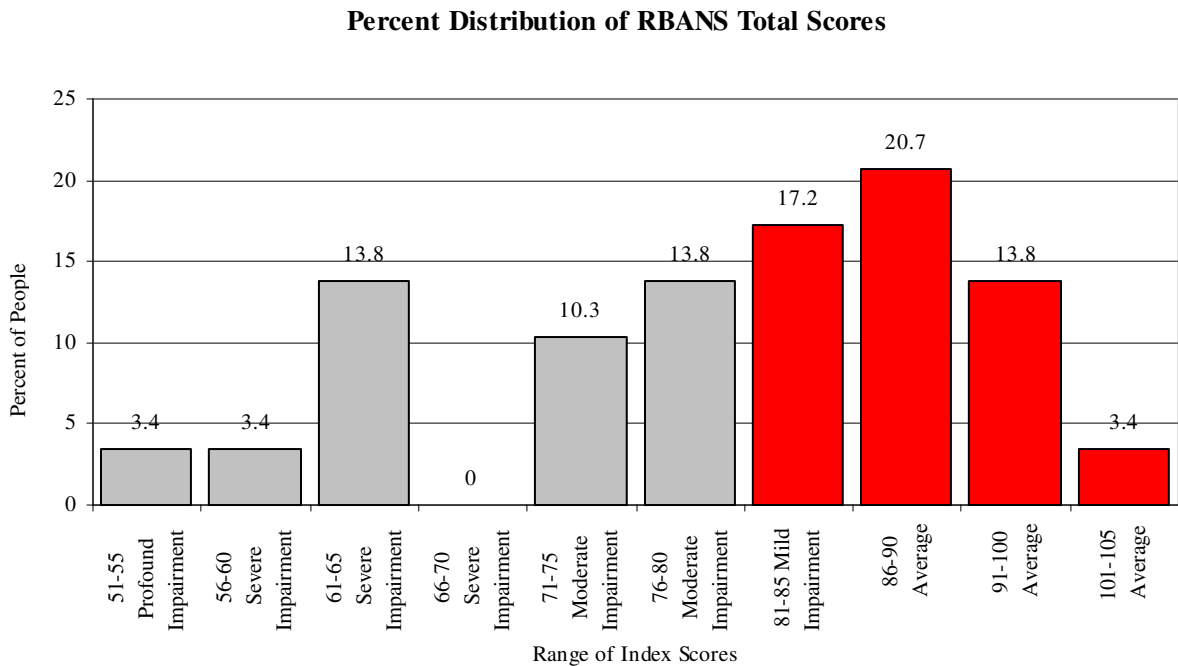
Figure 3: Percent BPRS Symptom Ratings by Severity



### Neuropsychological Functioning:

A sample of people (N = 29) also had neuropsychological assessment data available prior to their admission to CTP-H. The Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)<sup>3</sup>, a brief cognitive screening measure, provides a global index of neuropsychological functioning across several domains. People served by CTP-H demonstrate moderate cognitive impairment and perform at one standard deviation (i.e., an index score below 85) below the average for their age group in the general population (i.e., non-psychiatric population). These data are consistent with well-established research findings indicating that cognitive impairment is a pervasive aspect of severe mental disorders that can persist even after an acute episode has been resolved. Finally, this level of cognitive impairment is also consistent with the overall severity of impairment in people served by CTP-H. The graph below shows there is a considerable range in cognitive impairment with several people performing in the average range (red bars) yet a subset of people demonstrated significant impairment (solid bars). This also is consistent with published research on the heterogeneity of cognitive impairment in severe mental illness.

**Figure 4.**

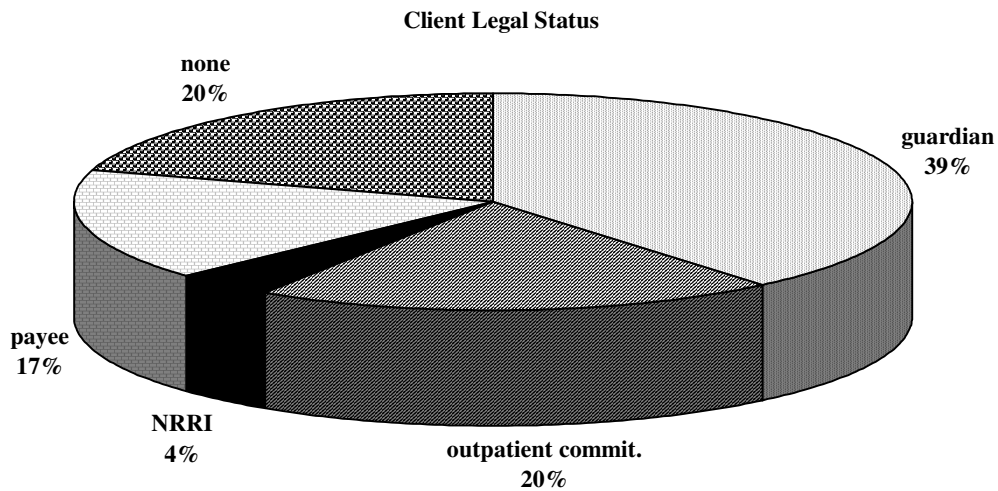


The 66-70 range was included to demonstrate the full range of potential scores in the impairment range. It should be noted that the 91-100 range is larger than other increments.

<sup>3</sup> Randolph, C. (1998). *Repeatable battery for the assessment of neuropsychological status (RBANS)*. The Psychological Corporation: San Antonio.

**Legal Status:**

As seen in the chart below, almost 80% of people served by CTP-H required some form of legal intervention in order to assist them in managing their disorder, treatment decisions and aspects of daily living. Twenty-one (39%) have a guardian, 11 (20%) have an outpatient commitment, 2 (4%) have NRRI court mandated treatment, 9 (17%) have a payee, and 11 (20%) have no legal involvement. This data is a further index of the severity of the population served. All of the people have had some form of legal involvement at some time (e.g., mental health board commitment).

**Figure 5.**

## **PART II: PEOPLES' FUNCTIONING DURING CTP-H REHABILITATION**

### ***Summary of Peoples' Functioning During CTP-H***

CTP-H provides a residential rehabilitation setting in which people can transition from an inpatient intensive psychiatric rehabilitation program to the community and to continue development of independent living skills and movement toward a less restrictive environment.

The data suggest the program is successful as evidenced by:

- the extremely low level of psychiatric rehospitalization
- the high level of functional community activities in which people participate. Of note, 69% of current CTP-H participants are presently employed in both supported (e.g, LRC Wagon Wheel Industrial Center) and in competitive jobs
- the number of people with a history of substance abuse who are engaged in community based substance abuse self-help groups and have a sponsor

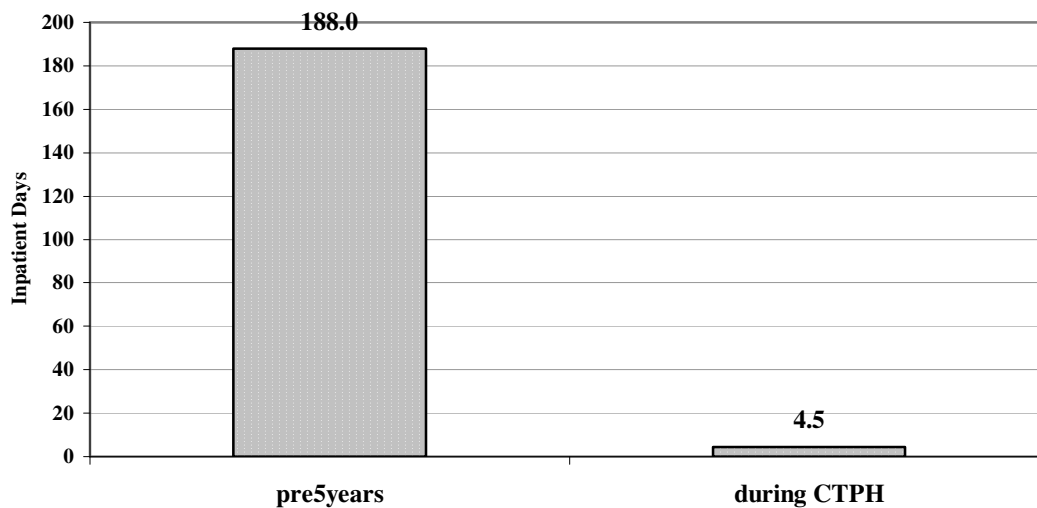
**Hospitalization Rate During CTP-H Rehabilitation**

*Analyses for both people discharged and those currently served N = 56*

Hospitalization rates during CTP-H rehabilitation (average length of rehabilitation = 608 days; range = 33 - 1628) were operationalized as the number of days spent in an inpatient psychiatric facility while at CTP-H. This included psychiatric units, regional center, or crisis center. This data was gathered from CMHC charts and hospitalization database from the time of discharge through September 2004.

**Figure 6.**

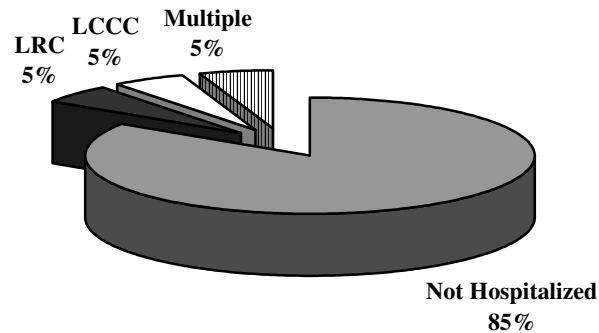
**Average Inpatient Days Per Year 5 Years Prior to Admission to CTPH and During CTPH Rehabilitation**



During the 5-year period prior to being admitted to CTP-H, people had spent an average of **188 days** per year in an inpatient facility. During rehabilitation at CTP-H, participants spent an average of **4.5 days** per year in an inpatient facility. It should be noted that the average duration of the regional center hospitalization immediately preceding CTP-H was **815.5 days**. Thus the majority of individuals served by CTP-H had spent 100% of the previous 2 years prior to CTP-H in an inpatient setting such as LRC.

Figure 7.

**Breakdown of Hospitalization Rate During CTP-H  
Rehabilitation**



**46 (85%) people had NO hospitalizations while at CTP-H.**

Nine (15%) people were hospitalized while at CTP-H.

Average # of admissions per hospitalized person = 2.6 (range 1 – 10).

Average # of total inpatient days per hospitalized person = 15.1 (range 1 – 86).

- Three (5.3%) people were directly admitted to LRC  
Of these three people, one had a brief stay and returned to an assisted living facility in the community and the other two still reside at LRC.
- Three (5.3%) people had brief stays at the Lancaster County Crisis Center (LCCC)  
Average # of admissions per person = 1.6 (range 1 to 2)  
Average # of days per person = 2.2 (range 1 to 3)  
Of these three people one is currently still at CTP-H and the other two are living in assisted living facilities. None have been hospitalized again.
- Three (5.3%) people had multiple admissions to LGH and LCCC  
Average # of admissions per person = 5 (range 2 to 10)  
Average # of total inpatient days per person = 41.7 (range 11 to 86)  
Of these three people one left AMA (and continues to be a high service utilizer) and two were eventually admitted to regional centers.

It should be noted that 2 people in the multiple admissions group account for 84% of all inpatient days for those hospitalized (total inpatient days for all hospitalized people = 136). Both of these people were diagnosed with borderline personality disorder comorbid with a schizophrenia spectrum disorder. They are high treatment utilizers and have spent on average 94.1% of all days post CTP-H in an inpatient setting.



### ***Participation in Functional Community Activities During CTP-H Rehabilitation***

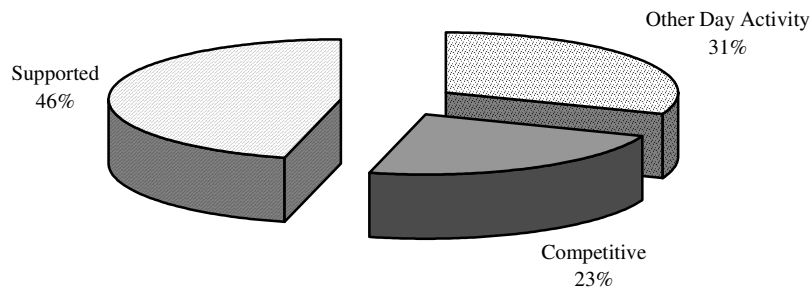
As an index of transition from inpatient care to CTP-H the nature and amount of functional community activities in which people participated was measured. These included employment, day rehabilitation program and adult day program. These analyses include those people currently served by CTP-H (N = 13).

As described below, consistent with the program's stated objectives of assisting in the transition from institution living to more independent community living, most people consistently participated in meaningful community activities during rehabilitation at CTP-H.

Employment. Peoples' employment status was examined in terms of the nature of the employment during CTP-H rehabilitation. The chart below indicates that 4 (31%) were not employed, 6 (46%) were involved in supportive employment (e.g., CMHC AWARE program, LRC Wagon Wheel Industrial Center), and 3 (23%) were involved in competitive employment. Overall, 9 (69%) were involved in some form of employment. On average people worked 19.7 (range = 9 -30) hours per week. It should be noted that the 31% not working were involved in other day programs.

**Figure 8.**

**Peoples' Employment During CTP-H Rehabilitation**



Day Rehabilitation Programs. Evaluation of peoples' participation in a daily rehabilitation program during CTP-H indicates that 2 (15.3%) people were involved in a day rehabilitation activity. They spent an average of 23.8 (range = 20 – 27.5) hours per week at the program.

Adult Day Programs. Evaluation of peoples' participation in an adult day program during CTP-H indicates that 3 (23.1%) people attend an adult day program. They spent an average of 19 (range 15 - 26) hours per week at the program.

Community-Based Substance Abuse Self-Help Groups. During CTP-H rehabilitation, some people participated in community-based substance abuse self-help groups (e.g., Alcoholics Anonymous). Of the 9 (63.3%) current CTP-H participants with a history of substance abuse, 4 (44.4%) participated in one of these groups. Of these four people, 3 had a sponsor in one of these groups. Thus, the program supports people's recovery from substance abuse. In the history of CTP-H, only one person has had a substance abuse relapse while a resident of CTP-H.

### 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, and more stable life for people with severe and persistent mental illness as evidenced by:

- 76% of people discharged from CTP-H experienced **no** hospitalizations during the evaluation period
- The majority of people transitioned successfully from CTP-H to a less restrictive level of care and are successful in maintaining at this level of care with some people moving on to an even less restrictive level of care (e.g., independent apartment)
- The majority of people continued to participate in at least 17 hours per week in functional community activities after discharge from CTP-H

The following analyses were conducted for those people who have been discharged from CTP-H (N = 43). Information for all people was not available due to factors such as elopement, moving from the CMHC service area, or death. For the majority of people still served by CMHC follow up information was gathered through a questionnaire survey of community support workers assigned to people discharged from CTP-H as well as a review of CMHC charts. On average the length of follow-up was 778 days (i.e., the average time from discharge to when follow-up information was gathered). The range of length of follow-up for these people was between 49 and 1961 days.

### ***Hospitalization Rate Post CTP-H Discharge***

As an index of successful transition from CTP-H to community living, rates of hospitalization were evaluated in terms of the number of days people spent in an inpatient psychiatric facility after discharge from CTP-H. The average follow-up period for people was 778 days. Hospitalization rates were operationalized as inpatient days in inpatient psychiatric units, regional centers, or crisis centers. This data was gathered from CMHC charts and hospitalization database from the time of discharge through September 2004. Analyses were conducted for people discharged to community facilities (N= 40).

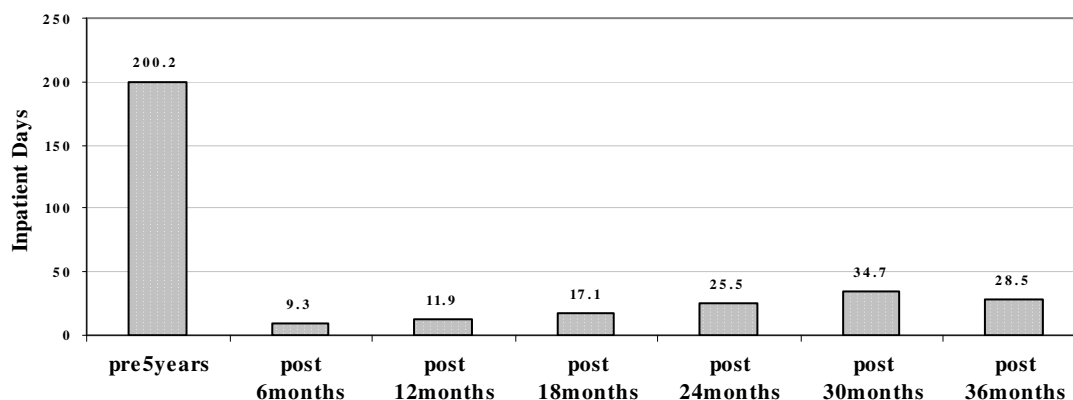
The low frequency and duration of hospitalizations after discharge indicate the program meets its stated objectives by providing a transition and continuum of care.

- During the 5-year period prior to being admitted to CTP-H, the discharged group of people spent an average of **200.2 days**<sup>4</sup> per year in an inpatient facility. It should be noted that the average duration of the regional center hospitalization immediately preceding CTP-H was **902.4 days**. Thus the majority of people served by CTP-H spent 100% of the previous 2 years prior to CTP-H in an inpatient setting such as LRC.
- Following discharge from CTP-H, **30 (76%)** people experienced **no** hospitalizations.
- **10 (24%)** people were hospitalized.
- On average, those people who were hospitalized after discharge had **375 days of continuous community tenure** prior to their first rehospitalization.

Below are charts depicting average inpatient days per six-month increment following successful discharge from CTP-H and a breakdown of those inpatient days.

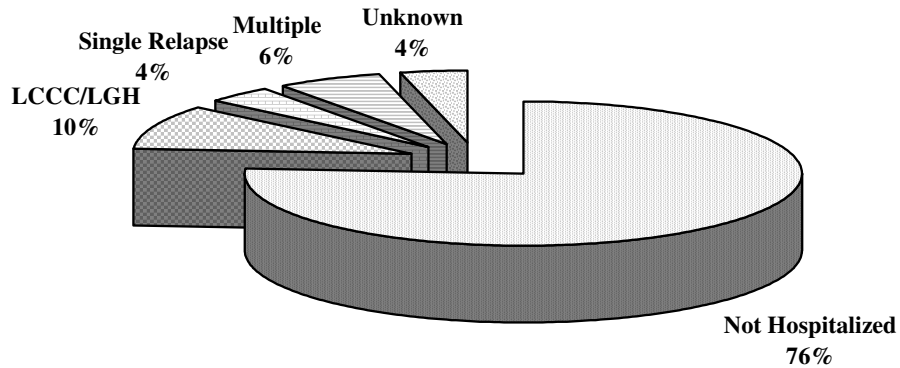
**Figure 9.**

#### **Average Inpatient Days 5 Years Prior to CTPH and Post CTPH Discharge**

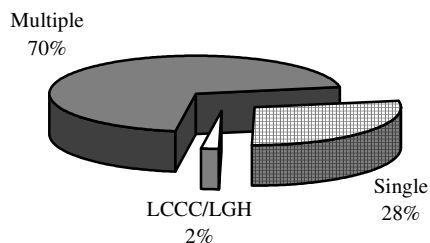


As shown, the number of inpatient days remains low for up to 3 years after successful CTP-H discharge.

<sup>4</sup> It should be noted that this number, which is slightly higher than the number reported on page 15, represents those people who have been discharged from CTPH as opposed to all persons served by CTPH.

**Figure 10.****Breakdown of Hospitalization Usage Post CTP-H Discharge**

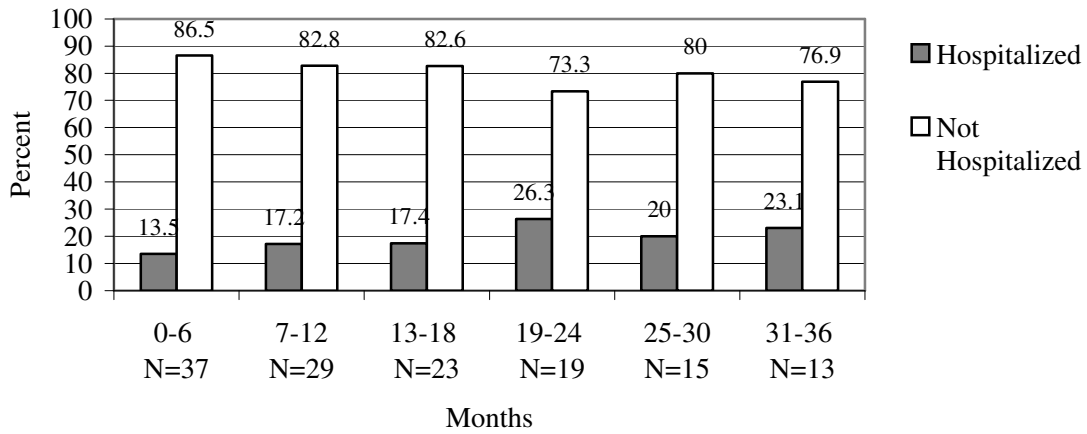
- **5 (10%)** had less than 20 inpatient days at LGH or crisis center
  - Average # of admissions per person = 2.2 (range 1 – 4)
  - Average # of inpatient days per person = 11.4 (range 6 – 19)
  - Average # of total days post CTPH discharge = 902.6 (range 121 – 1961)
  - Average # of days in community before rehospitalization = 475.8 (range 37 – 1395)
- **2 (4%)** had a **single** relapse with an LGH, crisis center and regional center admission
  - Average # of inpatient days per person = 469 (range 115 – 469)
  - Average # of total days post CTPH discharge = 1516 (range 1170 – 1862)
  - Average # of days in community before rehospitalization = 588 (range 489 – 687)
- **3 (6%)** had **multiple** LGH, crisis center and regional center admissions and are presently still at a regional center
  - Average # of admissions per person = 13.7 (range 7 – 26)
  - Average # of total inpatient days = 749.3 (range 199 – 1066)
  - Total # of days post CTPH discharge = 1025.7 (range 805 – 1250)
  - Average # of days in community before rehospitalization = 66.3 (range 1 – 169)

**Breakdown of Percentage of Inpatient Days Per Group**

As seen in the **Figure 11** to the left 3 people in the multiple group account for 70% of all inpatient days for those people who were rehospitalized (total inpatient days for those rehospitalized = 3345). Two of these three people were diagnosed with borderline personality disorder comorbid with a schizophrenia spectrum disorder. They are high inpatient treatment utilizers and have spent on average 94.1% of all days post CTP-H in an inpatient setting.

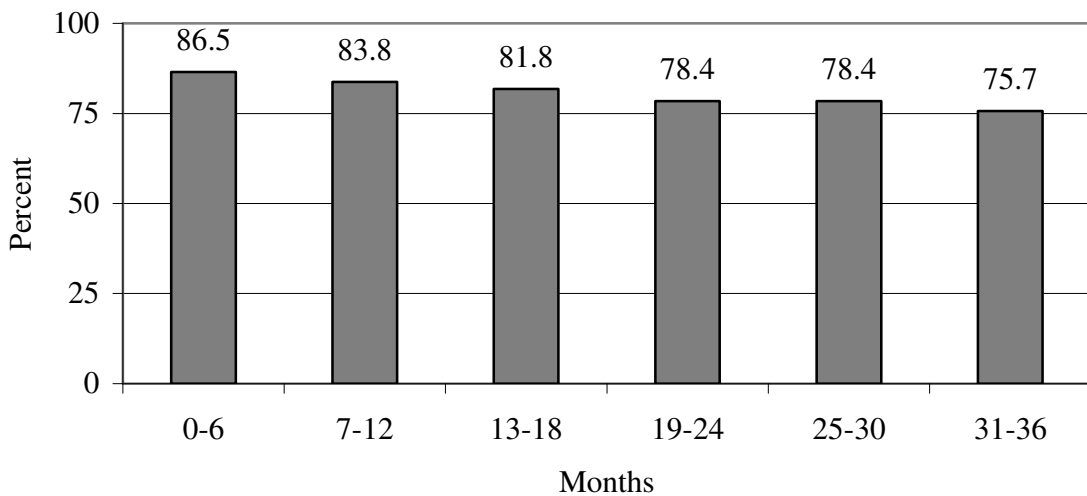
**Figure 12.**

**Non-Cumulative Percent Hospitalized Over 36-Month Period Following Discharge**



**Figure 13.**

**Cumulative Percent Not Hospitalized Over 36-Month Period Following Discharge**

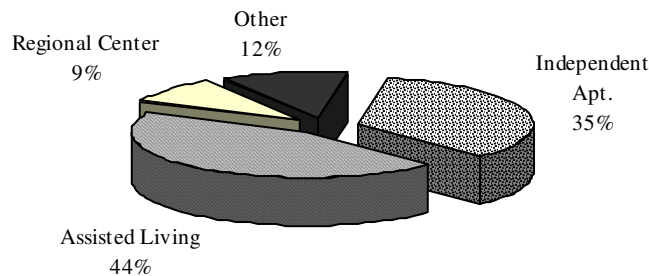


As shown in the two figures above, over a three year period of time 76% of those people discharged to the community from CTP-H are not hospitalized.

**Level of Care at Discharge and Follow-up**

Living situation was used as an index to determine if people moved to a less restrictive level of care following CTP-H discharge.

As can be seen in both the charts below, consistent with stated program goals **79%** of people are discharged to a less restrictive level of care. More importantly, at follow-up **75%** were successful in maintaining at this level of care and **10%** went on to an even less restrictive level of care (i.e., independent apartment).

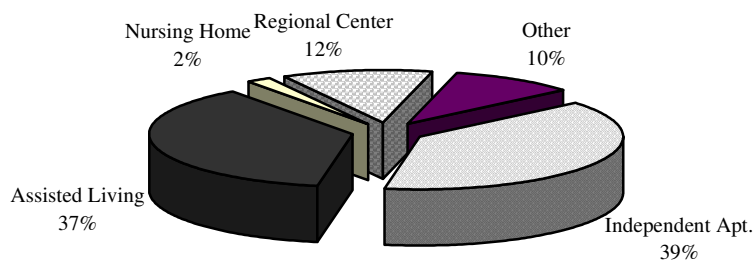
**Figure 14.****Living Situation at Discharge**

**15 (35%)** were discharged to an independent apartment

**19 (44%)** were discharged to an assisted living facility

**4 (9%)** were discharged to a regional center

**5 (12%)** were discharged to another setting (e.g., family home, eloped, deceased)

**Figure 15.****Living Situation at Follow-Up**

**16 (39%)** reside in an independent apartment

**15 (37%)** reside in an assisted living facility

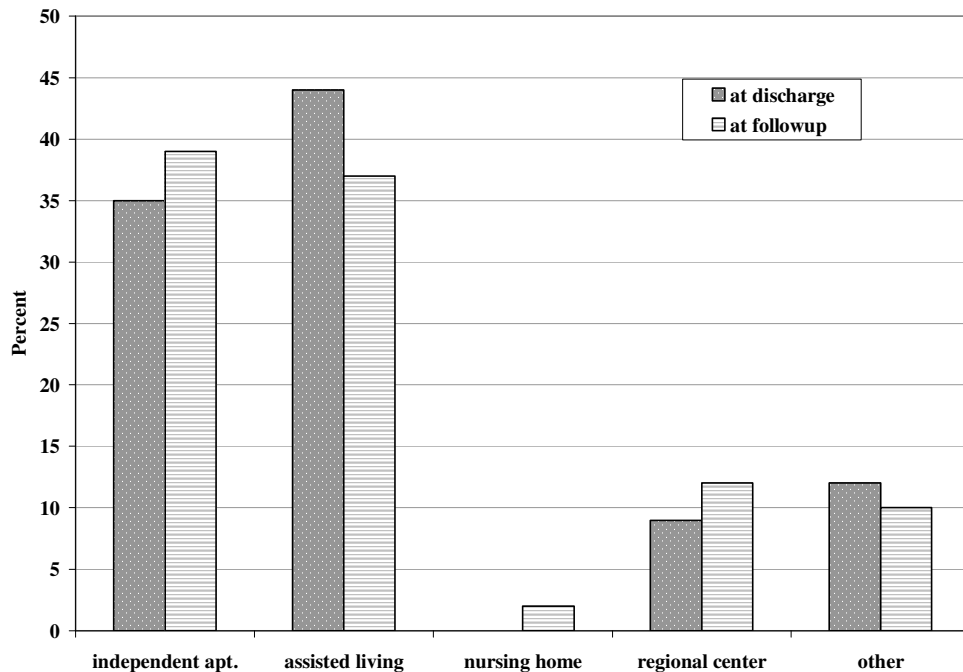
**1 (2%)** resides in a nursing home

**5 (12%)** reside in a regional center

**4 (10%)** reside in another setting (e.g., family home, eloped, deceased)

**Figure 16.**

Comparison of Level of Care at Discharge and at Followup



Comparison of discharge living situation to current living situation indicates that living situations remain remarkably stable:

**30 (75%)** remained in the living situation to which they discharged

**4 (10%)** became more independent by moving from assisted living to an independent apartment

**3 (7.5%)** moved from an independent apartment to assisted living facility

**3 (7.5%)** had another type of change (e.g., admission to regional center or substance abuse treatment facility)

It should be noted that the nursing home admission was required due to severe medical complications requiring a greater level of nursing care. This individual had 225 days of continuous community tenure post CTP-H in an assisted living facility before this nursing home admission.

Finally, it should also be noted that the 'assisted living' level of care represents a broad range of services that can include, among others, medication monitoring, housekeeping, cooking, and grocery shopping. Assisted living represents a residential option for people who choose not to or are unable to perform these activities. People require unique combinations of these services. In some cases few are required and the level of the person's independence and autonomy are high. In others, a need for extensive services is accompanied by a lower level of independence and autonomy. From a service delivery perspective this broad range of services warrants further study in order to clarify and specify these services and their contribution to outcomes (e.g., hospitalization rates, housing stability, community activity participation, etc.).



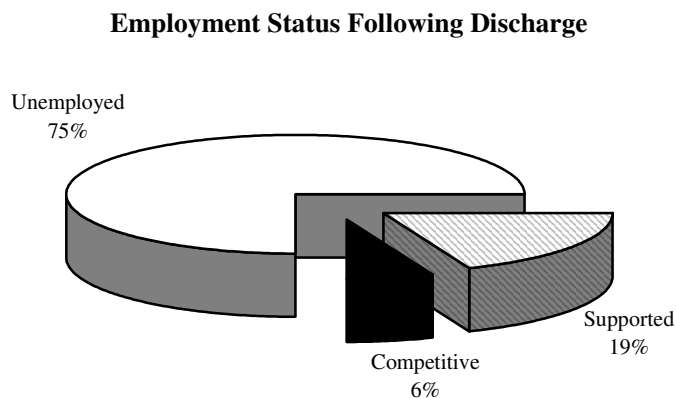
### ***Participation in Functional Community Activities***

As a further index of successful transition from CTP-H to more independent community living the nature and amount of functional community activities in which people participated was measured. These included employment, day rehabilitation program and adult day programs. These analyses exclude data from people whose status was unknown due to factors such as elopement. Data from people residing at the regional centers were also excluded.

As described below, consistent with the program's stated objectives of assisting in the transition from institution living to community living, most people consistently participated in meaningful community activities after discharge from CTP-H.

Employment. Peoples' employment status was examined in terms of the nature of the employment following discharge from CTP-Heather. The chart below indicates that 24 (75%) were not employed, 6 (19%) were involved in supportive employment (e.g., AWARE), and 2 (6%) were involved in competitive employment. Overall, 8 (25%) people were involved in some form of employment. On average, these people worked 12.8 (range = 3 -20) hours per week.

**Figure 17.**



Day Rehabilitation Programs. Evaluation of peoples' participation in a daily rehabilitation program following discharge indicates that 6 (25%) people were involved in a day rehabilitation activity. They spent an average of 17.5 (range = 5 - 20) hours per week at the program. Three of the 6 people that participated in a day rehabilitation program also participated in job duties at the day rehab program for an average of 7 (range = 1- 10) hours per week.

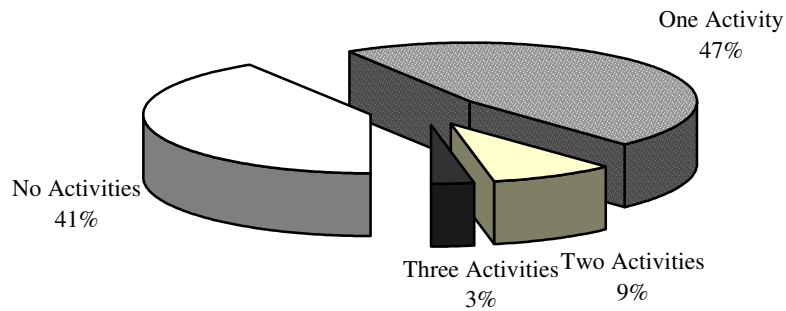
Adult Day Programs. Evaluation of peoples' participation in an adult day program following discharge indicates that 10 (40%) people attended an adult day program. They spent an average of 21.1 (range 15 - 25) hours per week at the program.

Overall, **59%** of those people discharged from CTP-H continued to participate in functional community activities and these people spent at least **17 hours per week** at this activity.

As seen in the chart below, 14 (41%) people did not participate in work, day rehab, day care, or volunteer work. 16 (47%) people participated in at least one activity, while 3 (9%) and 1 (3%) people participated in two and three activities respectively.

**Figure 18.**

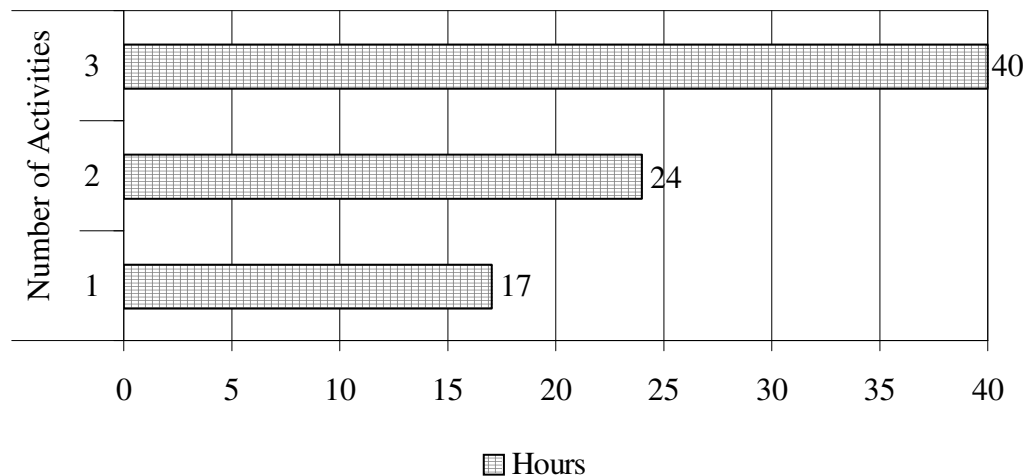
**Amount of Activities on a Weekly Basis Including Work,  
Day Rehab, Day Program, and Volunteer Work**



The amount of hours spent participating in the respective activity (i.e., work, day rehab, day care, and/or volunteer work) was analyzed across the varying quantities of activities. People who participated in one activity spent an average of 17 hours per week at this activity. People who participated in two activities spent an average of 24 hours per week at these activities. Finally, one person was involved in three activities for an average of 40 hours per week.

**Figure 19.**

**Average Hours Spent in Functional Activity by Number of  
Activities**



Community-Based Substance Abuse Self-Help Groups. After CTP-H, a small number of people continued to participate in a community-based substance abuse self-help group (e.g., Alcoholics Anonymous). Of the 19 (63.3%) people with a history of substance abuse, 3 (15.8%) were involved in one of these groups. Of these people, 2 had a sponsor in one of these groups. Compared to rates of substance abuse self help group participation during CTP-H rates of participation after CTP-H are lower (e.g., 44.4% during vs. 15.8% after).

## **CONCLUSIONS AND RECOMMENDATIONS**

Overall, the evaluation suggests that CTP-H is largely successful at facilitating the transition and recovery of people with severe and persistent mental illness. However, there are a few findings from the evaluation that warrant further study.

While people are served by CTP-H there is a high level of participation in functional community activities. After discharge this drops off, with 40% participating in zero functional community activities (e.g., work, day program etc.). Likewise, participation in AA/NA is higher during CTP-H than after discharge. These reductions in participation represent a risk for psychiatric and substance abuse relapse, which highlights the need for further evaluation of this phenomenon. Such an evaluation could elucidate the factors influencing this lack of participation and ultimately improve future outcomes. This may be an area for a continuous quality improvement project for CMHC Community Living Services.

More detailed assessment of outcomes as well as ongoing program evaluation may also further elucidate the program's effectiveness and improvements. There is some suggestion both by the data and anecdotal report, that there are two groups of people who are served: those who are more impaired and need a greater level of structure to ease their transition to the community and those who ultimately develop a greater level of independence. Further exploration of these group differences and general heterogeneity may facilitate different tailoring of the rehabilitation program.

From a service delivery perspective, a more systematic evaluation of the "assisted living" level of care category may be helpful in determining the range and types of services provided by these facilities and the needs that they address. Such an evaluation may help determine the impact of these types of services on subsequent outcomes.

## ACKNOWLEDGEMENTS

This program evaluation was conducted by Jason Peer, M.A., and Bryan Zolnikov, M.A., as part of a clinical psychology externship at the Lancaster County Community Mental Health Center. Supervision of and consultation for the project was provided by Joseph Swoboda, Ph.D. and William Spaulding, Ph.D. Additional consultation and feedback was provided by Mary Sullivan, MSW, Wendy Andorf, MSW and the University of Nebraska Severe Mental Illness Research Group.

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Below is a breakdown of the activities and hours of the CMHC clinical psychology externs associated with the project.

1. Gathered hospitalization data. This process involved individual chart reviews, cross-checking chart data with CMHC hospitalization database and tabulating this data for periods of time prior to CTP-H treatment, during CTP-H treatment and after CTP-H treatment for each person served by CTP-H. **30 hours**
2. Developed questionnaire to be administered to community support workers to assess individuals' community functional activities. Conducted focus groups with community support workers about this questionnaire. Distributed and collected completed questionnaires. **8 hours**
3. Development of database. **10 hours**
4. Data entry. **12 hours**
5. Data analysis. **55 hours.**
6. Compiling report, revisions and completion of final report. **110 hours**

**Total Hours: 225**