

**EXEMPLARY
RURAL MENTAL HEALTH
SERVICES DELIVERY**

Submitted by:

Edward L. Knight, Ph.D., CPRP

Vice President of Recovery,
Rehabilitation and Mutual Support, ValueOptions
Adjunct Professor, Rehabilitation Sciences, Boston University

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ABSTRACT:

Southeast Mental Health Services, in rural Colorado has successfully transitioned from a traditional model of maintenance and control to one focused on recovery and community integration. They moved from delivering day treatment, congregate living, assertive community treatment and no-choice therapy, to providing individuals with choice of goals and the supports needed to achieve and maintain their goals. As a result, consumers are now living independently. Currently, 38% of those with serious and persistent mental illness, are working, going to school or volunteering. The keys to this transition have been peer support networks, home health care aides, field case management and a crisis hostel with no threshold of symptoms for its use. Southeast Mental Health Services has achieved results and is a national example of the “transformation” called for in the *President’s New Freedom Commission on Mental Health* report.

EXEMPLARY RURAL MENTAL HEALTH SERVICES DELIVERY

Southeast Mental Health Services (SEMHS) is a model of rural mental health services delivery. SEMHS has a long history of providing services to rural Colorado residents, but since 2000, has transformed itself to become a visionary, recovery-based program. The services today embody the values of recovery and rehabilitation that are described in the 2003 *President’s New Freedom Commission’s* report on mental health.¹

In 1995, the state of Colorado capitated the provision of mental health services for its Medicaid eligible population. At that time, SEMHS became part of SyCare LLC, Inc., a group of four community mental health centers in southern and southeastern Colorado. SyCare joined ValueOptions, a Virginia-based managed behavioral health organization, to form SyCare-Options Colorado Health Networks, LLC, a 50/50 public/private partnership that currently holds the capitated contract with the State of Colorado. Moving to a capitated model enabled SEMHS to create additional services that were more relevant to its consumers and the community. This, coupled with managerial and executive shifts, helped to move the center to where they are today. In 1998, the new executive director, Bob Whaley, took over and provided the vision and leadership for many of the new and innovative programs that today mark Southeastern as a leading example of rural mental health service delivery.

SEMHS is a private, nonprofit corporation serving six Colorado counties. These counties are primarily rural and frontier and are sparsely populated. The counties cover 9,600 square miles with a total population of only 52,400 people. This represents nearly 10% of Colorado’s total landmass, but only 1% of its total population. In addition to geographic challenges, there are economic challenges as well. The median family income for these counties is significantly lower than the median family income for the state as a whole.

¹ 2003 APA Awards, Silver Award: Southeast Mental Health Services, LaJunta, Colorado—Serving People with Serious Mental Illness by Changing the Culture of Care. *Psychiatric Services*, November 2003, Vol 54. No.11.

SEMHS provides seven day-a-week, 24 hour-a-day emergency services for all six counties, with a centralized phone system. Consumers living in outlying areas can call the center using a toll free number. Transportation has always been a critical problem. Because of re-investment dollars saved under the capitation program, the center has been able to purchase vehicles to provide transportation to needed services.

SEMHS's caseload includes children, adults, couples and families who are served on an outpatient basis. People with severe and persistent mental illness receive a more intensive level of support designed to help them live successfully in the community. In addition to clinical services, the center provides innovative crisis services, housing and vocational assistance, self-help and increased consumer choice. Most consumers live in subsidized apartments in their own communities. SEMHS center recently transformed a board and care home into a crisis hostel, where consumers can go in times of need.

Significance of the Recovery Model

The term "recovery" is increasingly being used to describe a movement toward a more humane and ultimately more effective approach to the treatment of people with serious mental illness. The recovery model has some well-defined elements: hope, choice, support and education. A system that encourages recovery is based first and foremost on hope and the expectation of recovery. This approach includes helping the individual choose a meaningful goal in life, and providing appropriate social supports, with a particular focus on teaching goal-specific skills to help the individual move toward self-sufficiency.

An essential element is helping people set goals for themselves. In the recovery process people research the feasibility of their goals and then explore which skills and supports they need to achieve and maintain the goals they choose to pursue. This is the basic process of psychiatric rehabilitation. It is particularly important to people who became ill at a young age and did not go through a process of becoming emancipated from home and learning skills to live independently. It is also helpful in overcoming the "de-skilling" effects of institutionalization.² Even short periods of institutionalization, including many "community" placements, which are congregate or maintenance in nature, lead to loss of skills and goals.

In addition to individual goal setting and skills improvement, mutual support is fundamental to the recovery process. Mutual support works by enhancing self-efficacy. In self-help groups that exclude professionals, individuals learn that they can be successful in doing something new, even in the face of stress. This is the definition of self-efficacy. Mutual support is a life laboratory where consumers can test new skills in a supportive environment. Professional presence in these groups would destroy the need for self-reliance and would continue dependence.

Scientific data supports this notion. Four efficacy studies showed that adding mutual support groups to traditional treatment significantly reduced hospitalization.³ In another effectiveness

² Turkelson, K.: A Dialogue Between Psychiatrists and Recipients (videotape). New York, New York State Office of Mental Health, 1993.

³ Edmonson, E.D. Integrating Skill Building and Peer Support in Mental Health Treatment: The Early Intervention and Community Network Development Projects. *Community Mental Health and Behavioral Ecology*. A.M. Jeger and R.S. Slotnick. New York: Plenum Press, 1982: 127; Galanter, M. Zealous Self-Help Groups as Adjuncts to Psychiatric Treatment: A Study of Recovery, Inc., *American Journal of Psychiatry*, 1988: 145 (10) : 1248-1253; Kennedy, M. Psychiatric Hospitalization of GROWers. Paper presented at the Second Biennial Conference on Community Research and Action, East Lansing, Michigan 1990; Kurtz, L.F. Mutual Aid for Affective Disorders: The Manic Depressive and Depressive Association. *American Journal of Orthopsychiatry*, 1988, 58(1): 152-155.

study for persons dually diagnosed with serious mental illness and substance abuse, *Double Trouble in Recovery* significantly reduced substance abuse, mental illness symptoms and crises.⁴ *Double Trouble in Recovery* is a 12-step group run completely by those who are dually diagnosed.

Research has shown that self-help groups work because they provide a social network based on commonly shared experiences. Self-help facilitates moving people out of the role of being helped and into the role of being helpers. In self-help groups people share specific ways of coping based on their own experiences. Those who cope successfully serve as role models for individuals with less successful coping strategies. Finally, self-help groups provide self-generated meaningful structure. If such structure were imposed, it would be resisted.⁵

SEMHS's Transformation to a System Focused on Recovery and Rehabilitation

Until mid-2000, SEMHS operated on the traditional model, which included group residences based on what is called the *coercive housing model*, day treatment of six hours a day, five days a week, Assertive Community Treatment (ACT) teams⁶ and weekly counseling. It was a model strongly held within the milieu. Planning began in 1999 and in mid-year 2000, the center switched from the traditional model to a recovery model.

Management recognized that a shift in the center's culture was necessary to ensure the center's success. SEMHS was experiencing a 22% cash flow deficit, which meant that they would be bankrupt soon if some fundamental management strategies were not changed. Moving to a recovery model was consistent with the clinical as well as fiscal objectives.

Changes began with staff training in the Boston University Model of Psychiatric Rehabilitation. The management team re-engineered their management philosophy from a command/control style to a participatory model. Programs and job descriptions were redesigned to empower both staff and consumers to make decisions. The treatment staff began using individualized goal setting and skills teaching with consumers. Consumers were able to choose the problem, counselor, and length of time of therapy. The coercive group homes were shut down and replaced by individual housing based on a *housing first model*. People's housing was no longer contingent on attending day treatment, receiving services or any other requirements the mental health center staff had for consumers. Instead, consumers intentionally chose to live in the same apartment complexes, several to a complex, which allowed them to form informal support groups. Formal support groups also developed. A *Double Trouble in Recovery* group was formed and currently has an active membership of between 15 to 20 consumers.

Staff believed that it would take several years to make the shift, but the changes happened quickly. Within a few months people no longer attended day treatment and the program was closed. The ACT teams withered because people were doing so well that the teams were no longer needed. Outpatient commitment orders were successfully dropped on all consumers except those with criminal holds. After outpatient commitment orders were dropped, staff observed a spontaneous maturation process in consumers as they shed the infantile expectations that someone would be taking care of them full-time.

⁴ Magura, S. et al Medication Adherence and Participation in Self-Help Groups for Dually-Diagnosed Persons, accepted for publication in *Psychiatric Services*, in press.

⁵ Carpinello, SE and Knight, EL A Qualitative Study of the Perceptions of the Meaning of Self-help, self-help group processes and outcomes by self-help group leaders, members and significant others. Bureau of Evaluation and Service Research, New York State Office of Mental Health, 44 Holland Ave., Albany, NY, 12229, OMH contract #C0002529.

⁶ ACT teams are teams of mental health professionals focusing generally on maintenance, with caseworkers directed by a psychiatrist and nurse whose main aim is delivery at the sites where the consumer is located.

About 30% of the most disabled consumers at SEMHS receive home health care services. The home health care aides are supervised by a mental health worker who teaches the aides about the individualized needs of each person they serve. Services are provided in the consumer's home and natural environment. The Consumer Hostel is another program feature that enables consumers to take responsibility for their own well-being. The Consumer Hostel, staffed both by professionals and consumers, is a place where people may voluntarily go at any time of day or night for support without having to reach a predetermined threshold of dangerousness or distress.⁷ It is also the locus of several peer specialists who help isolated consumers develop social networks. The peer specialists' work under a consumer Director of Advocacy.

The center also recognized that community acceptance of people with mental illness was critical to re-integration. SEMHS set out on an aggressive education campaign to de-stigmatize mental illness. Staff provides on-going community education about mental illness to schools, human service agencies, and law enforcement. The staff also intervenes with the general public in local businesses. Three innovative staff introduced community outreach, adapted from the *person-centered planning model* to help create social niches for disabled persons by going into the community and working directly with community members.

Many of these changes would not have been possible without the move to a capitation model of financing. SEMHS' partnership with a managed care organization has enabled the center to develop alternative services. The center is now able to provide a wider array of services than was possible under the fee-for-service model, and can offer many of the individualized supports that people with serious mental illness need. Equally crucial was the shift in financial incentives away from fee-for-service. A fee-for-service model promotes delivering more and more services in order to maximize income, consequently making consumers dependent on ever increasing service arrangements.

This move to capitation changed financial incentives. However, pervasive staff cultural resistance remained. Authentic helping begins with the realization that valued roles in the community need to be opened for consumers. Mental health diagnoses are not only psychological categories, they are social categories. Receiving a diagnosis for most mental health consumers is tantamount to a social death sentence.⁸ This sentence is imposed by the fear of society, which has a need to differentiate itself from the "lunatic fringe". Staff resistance to authentic helping usually means that respect for the voice of consumers must be restored. To do this staff must confront their need to differentiate themselves from consumers as the "crazy" ones. Staff segregation such as having separate restrooms, or special spaces where consumers and their activities are confined need to be eliminated. Staff needs to acknowledge that consumers are equal and deserve the same respect as anyone else.

The initial resistance staff project when asked to empower consumers has to do with the perception of limited power. Staff are asked to "give up" the power they have over consumers, which may make them feel powerless, and has the potential to throw a system into a state of chaos. SEMHS managed the resistance by changing their own management style from one of command and control (similar to the command and control style staff previously used over consumers) to a management style of empowerment (mirroring the process of empowering consumers). SEMHS learned that when staff feel fully empowered by administration, it is much easier to turn power and control back to consumers.⁹

⁷ Dumont, J. Findings from a Consumer/Survivor, Defined Alternative to Psychiatric Hospitalization @ Annual Conference on State Mental Health Agency Services Research, Program Evaluation and Policy, Feb. 2001, National Association of State Mental Health Program Directors Research Institute, Inc Washington, DC.

⁸ Knight, E., Phelps, A., Harris, N. Mental Health Rituals, paper in preparation.

⁹ Ibid.

Another logical fear for staff is loss of job security. When administrators began to challenge the notion that consumers are debilitated and dependent, staff began to wonder what they would be doing when consumers became rehabilitated and independent, and if they would find themselves in the unemployment lines. During the transition, none of the staff at SEMHS was laid off. Instead they were re-assigned to new recovery-oriented jobs.¹⁰

Consumer Outcomes

The impact of the recovery model has been dramatic. These shifts have resulted in better outcomes for consumers and have improved the overall quality of services. A survey was completed in July 2001 of a random sample of individuals diagnosed with a serious and persistent mental illness receiving services from SEMHS. Fifty-seven clients were selected as the sample group, and 39 clients (68%) returned completed surveys. Areas evaluated included life changes, volunteering/work, therapy, crisis services, and social networks. Survey results are summarized below:

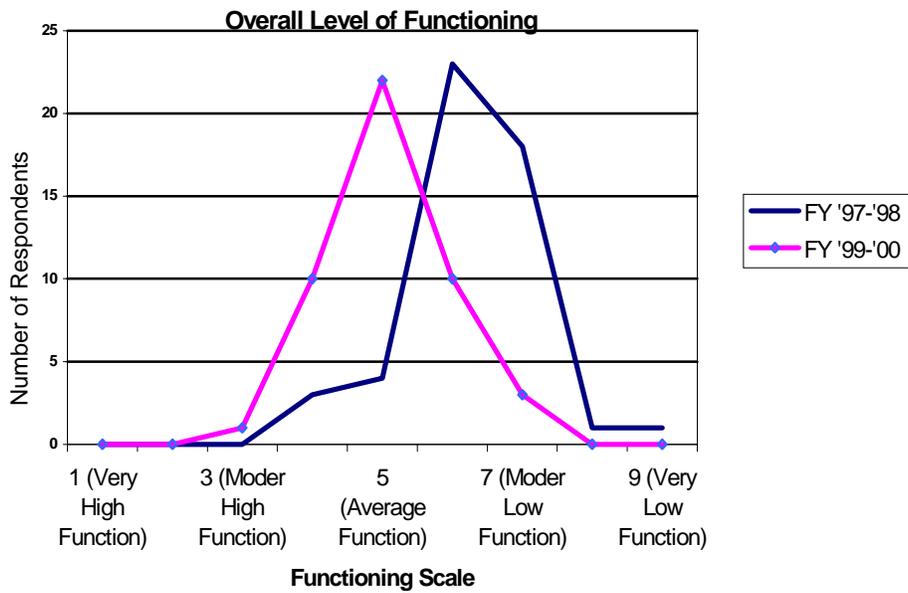
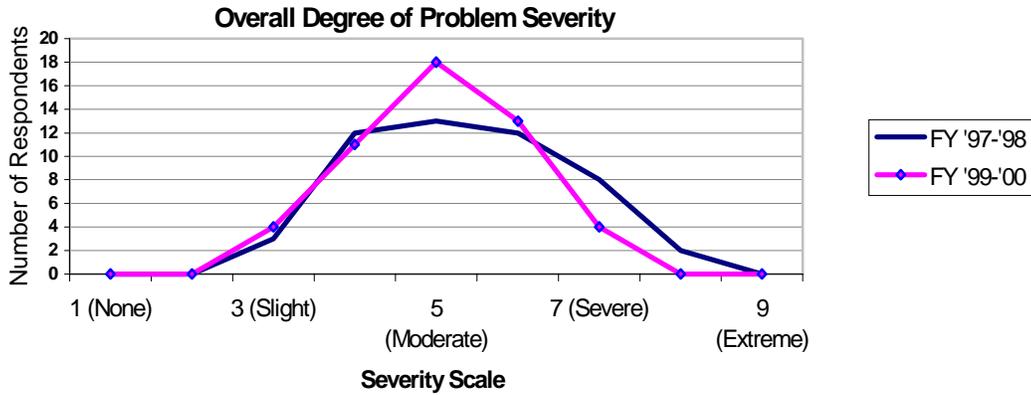
- 92% of the respondents have experienced some level of positive change in the last year;
- 36% have been employed or worked as a volunteer in the past year;
- 5% are going to school;
- 60% see a therapist as they need to as opposed to seeing a therapist for regularly scheduled visits;
- 46% responded that they decide when to see a therapist;
- 53% indicated they could usually choose the therapist they wanted to see;
- Almost 91% indicated that therapy sessions focused on problems the client defined;
- 64% found therapy helpful in addressing their problems;
- 29% of respondents have used the Crisis Hostel;
- 58% indicated that they talked with one or more consumers weekly; and
- 49% have more non-consumer friends now than they had two years ago.

The Colorado Client Assessment Record (CCAR) was another measure used to assess outcomes. On a five-point scale of overall functionality that the CCAR measures, scores have gone up a full point from below average functioning to average functioning. The Colorado Client Assessment Record (CCAR) is an assessment instrument required by the State and used to capture information in the following areas: diagnosis, functioning, employment, problem severity, level of care, strengths and resources. The CCAR has an algorithm used to calculate level of impairment and level of service. The instrument must be completed at least annually and has been used in Colorado for several years.

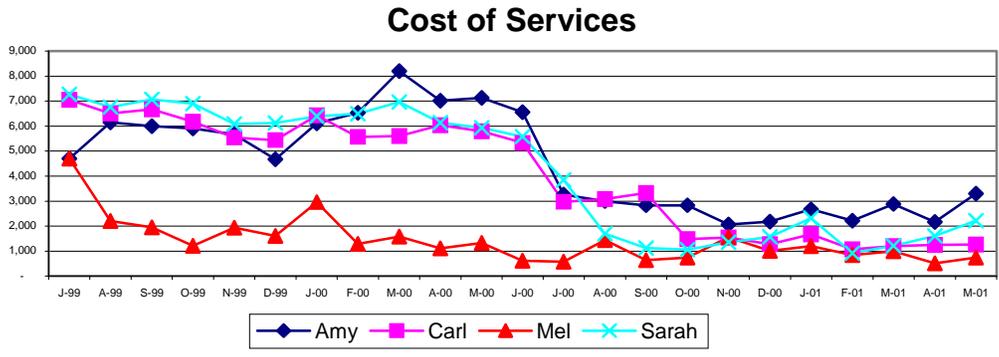
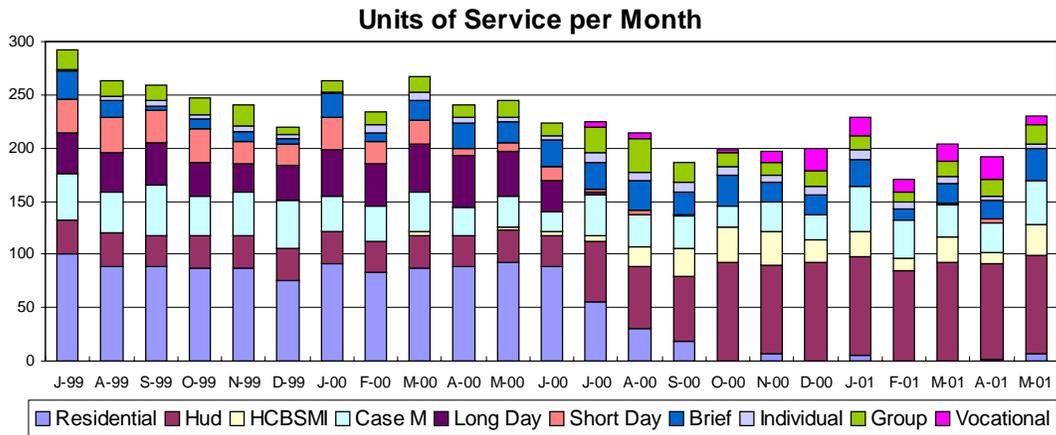
For evaluating change over time at SEMHS, a set of matching CCARs for 50 clients were selected for fiscal years 1998 and 2000 (pre- and post-change). Information was compared for each year in 11 categories. The graphs below illustrate comparisons in degree of problem severity and overall level of functioning, the latter reflecting a rather dramatic increase in level of functioning of about one point, from below average to average. An evaluation of other areas, including overall

¹⁰ Ibid.

strengths and resources, reflect a similar pattern: positive movement away from the more extreme outliers and toward the mean.



In addition to improving functional outcomes, this model also reversed a 22% cash flow deficit. Cost saving have been shifted to improving access and providing better services. The graphs below show how costs shifted before and after the recovery implementation in July 2000. HUD housing and vocational services increased and long and short day treatment was eliminated. Residential almost disappeared and its nature changed. Short stays in the crisis hostel are counted as residential which continues to operate under a residential license. Case management, individual and group counseling remain about the same. Finally, overall costs declined.



Conclusion

The program's ultimate accomplishment is best described in the words of an SEMHS board member:

“What we have here is a planned and controlled liberation of people diagnosed with mental illness.”

The changes have been so noteworthy, that SEMHS has won national awards. In 2002, they won the Lilly Reintegration Award Program, second place in clinical medicine. This award is given to organizations that implement innovative approaches to helping individuals with serious mental illness reintegrate into their community. In 2003, the American Psychiatric Association honored SEMHS with the Silver Psychiatric Services Award because of their outstanding programs. This is the potential transformation that can be achieved with the recovery model. This model can be replicated elsewhere, however training and supports are needed for both administrators and professionals in the values and principles of recovery and in developing the appropriate therapeutic and social supports.