

Allegheny County

II. HealthChoices Program

Involuntary Admissions

presented by



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AHCI is a contract agency for the Allegheny County Department of Human Services' HealthChoices Program

Involuntary Admissions of HealthChoices Members

Focus Quality Review

For the HealthChoices Behavioral Health Program

Prepared by
Allegheny HealthChoices, Inc.

Executive Summary

Involuntary admissions historically have been a topic of much discussion and debate. With the release of the Pennsylvania HealthChoices Behavioral Health Program Early Warning Care Management Report for the second quarter 2000, the issue resurfaced. The report documents that the rate of adult involuntary admissions for Allegheny County (5.3 per 1,000 adults) exceeded the rate of the state (3.1), the HealthChoices regions (SE was 1.6, SW was 3.7), and all other Southwest counties (ranged from 1.1 to 3.9).

The objective of the AHCI report was to evaluate consumers that were admitted voluntarily for inpatient mental health services to those who experienced at least one involuntary admission. Demographic variables and utilization patterns by level of commitment were compared and contrasted.

The majority of inpatient admissions occurred on a voluntary basis (81%) and the percent of involuntary admissions decreased as the level of commitment rose. The average number of admissions (ranged from 1.03 to 1.22/days) was essentially no different for the various commitment levels.

Analysis of the utilization patterns was remarkable in terms of the types of services received or not received before and after discharge. Forty-five percent of people admitted involuntarily did not receive any services within the 30-day period before their admission. Likewise, 35% of persons discharged from an involuntary admission did not receive services during the 30-day period after discharge. Distinct services that assist in the coordination of care and community-based services were, in general, utilized by less than 50% of the consumers discharged from an involuntary inpatient admission. This reflects utilization of services before and after discharge for involuntary mental health treatment.

The analysis helped to enumerate areas for more detailed analysis and areas for improvement. Trending the utilization patterns of individuals with involuntary admissions over time may be beneficial. This group of individuals could be targeted for intensive outreach and coordination of their care. Focus studies and education may contribute to identification of barriers and alternative approaches to accessing and providing care. These efforts may favorably influence the goal of reducing the rate of involuntary admissions and increasing the rate of maintenance within the community.

Introduction

The intent of this report is to examine the issue of involuntary admissions for individuals enrolled in the HealthChoices program. Many stakeholders have expressed concern over the admission rate of involuntary commitments to inpatient mental health services in Allegheny County. Others have indicated there is nothing inherently negative about the rate of involuntary admissions and that it may simply reflect the consistent application of the commitment criteria as they have been written. In response to these concerns, Allegheny HealthChoices, Inc. (AHCI) has conducted a review of services received during involuntary admissions in the second quarter of 2000. The goal of the report is to provide an overview of involuntary admissions experienced by HealthChoices consumers, the characteristics of those consumers who are admitted involuntarily and the service utilization pattern prior to and subsequent to an inpatient admission. It should be noted that the claims data utilized in this report was generated in November, 2000 (four months past the close of the second quarter) in order to allow lag in the claims submission process and ensure data integrity.

Types of Admissions

All admissions for inpatient mental health services require a commitment, whether it is voluntary or involuntary. A brief definition of each type of commitment is as follows:

- **201 (Voluntary Admission):** A person who is 14 years old or older (or the guardian of a child under age 14), signs a 201 commitment for voluntary admission to inpatient mental health services. Under a 201 commitment, the person may sign him/herself out prior to the attending doctor's release, but must give 72 hours written notice of intent to leave. When this written request to withdraw from treatment is received by the staff of the inpatient mental health unit, the person can be held up to 72 hours, at the discretion of the physician. This gives the provider time to further evaluate the person and initiate involuntary commitment, if needed, or finalize a discharge plan.
- **302 (Involuntary Admission):** A 302 commitment is petitioned to a county mental health delegate by someone who has first hand knowledge of a person who is dangerous to him/herself or others. Once the 302 is authorized, the person is subject to an involuntary psychiatric evaluation by a doctor. If the examining physician upholds the petition, the person is admitted to the hospital for up to five days. Within that five days, one of three things can happen: 1) the person is allowed to sign a 201 voluntary commitment; 2) the person is discharged by the attending doctor; or 3) an extended involuntary stay is petitioned to the court and a hearing is held to evaluate the clinical evidence for the petition.
- **303 (Involuntary Admission):** This is an extension of a 302 commitment. A 303 commitment is granted by a mental health hearing officer after hearing testimony from the person that petitioned the 302 commitment, the attending physician, and the person who was involuntarily committed. A 303 commitment is effective for up to 20 days.

- 304 (Involuntary Admission): This involuntary admission is effective up to 90 days, and is granted by a mental health hearing officer in response to a petition. The types of 304 commitments are as follows:
 - 304A: Commitment from community to state hospital;
 - 304B: Commitment from inpatient mental health to state hospital; and
 - 304C: Commitment to outpatient treatment.

Inpatient mental health is the primary service type in the HealthChoices program for which a person may be involuntarily admitted. A consumer might also be committed involuntarily to outpatient mental health services. In such a case, the commitment type would be a 304C. These commitments are not addressed in this report.

Voluntary and involuntary mental health admissions are governed by the Mental Health Act of 1972 and only apply to mental health services. Substance abuse treatment does not apply under this act. A person cannot be involuntarily committed to substance abuse treatment; however, s/he can be sentenced by the criminal justice system to substance abuse treatment.

Defining the Data

In looking at information on inpatient mental health involuntary admissions, it is important to note that each admission is counted only once as an episode of care (one continuous stay for inpatient mental health services). A consumer may have more than one episode of care within a given time period. If a consumer changes commitment status during his/her episode of care, s/he is counted once in the highest occurring commitment level. For example, during an inpatient mental health episode of care a consumer could be admitted on a 302 and converted to a 303 commitment. That consumer's admission would be counted as a 303, not a 302 commitment. If a consumer begins an admission on a 201 and during the course of the hospital stay, the provider petitions for and is granted a 304, that consumer's admission would be counted as a 304, not as a 201 commitment. Likewise, if a consumer had more than one admission, s/he would be counted once (in the highest occurring level of commitment) for each admission.

In analyzing the services consumers received prior to an involuntary admission or post-discharge, AHCI used a combination of authorization data to define an episode of care and claims data to determine the services consumers used prior to admission. This combination enhances the reliability that authorized inpatient mental health services are actually used for the specified date and time. There is less reliability when an authorization is made for other types of services (i.e., intensive case management or outpatient services) that the services are actually used at the prescribed date and time and in the amount prescribed. Using claims data to track utilization for services other than inpatient is more reliable since the provider is essentially confirming the consumer's receipt of service when submitting a claim. Therefore, both types of data were used to look at the services consumers received prior to and post-discharge from an involuntary admission.

Since the number of consumers represents a uniform measure between admissions (authorization data) and services (claims data), the service-related portion of this report is based on unduplicated consumer counts. Given that a consumer could have multiple episodes of care, the total number of involuntary admissions will slightly exceed the number of consumers.

Inpatient Mental Health Admissions

The following aspects of inpatient mental health admissions have been analyzed. This analysis include some comparisons to voluntary admissions for inpatient mental health services:

- Type of commitment;
- Number of admissions for inpatient mental health treatment compared to the number of unduplicated consumers;
- Demographic variables and tier assignments by commitment type;
- Admission rates by commitment type;
- First time inpatient mental health involuntary admissions;
- Number of consumers who did not receive services within 30 days prior to admission and 30 days after discharge; and
- Services received prior to and after discharge from involuntary admissions for inpatient mental health treatment.

Admissions for Inpatient Mental Health Services

During the second quarter of 2000, there were 1,685 inpatient admissions for mental health services under the HealthChoices program in Allegheny County. This includes both voluntary and involuntary admissions. Table 1.0 provides the breakdowns of admissions for inpatient mental health services by commitment type. This comparison is the first level of analysis.

Table 1.0

**Comparison of Inpatient Mental Health Admissions
by Commitment Type for Second Quarter 2000**

Type of Commitment	Number of Inpatient Mental Health Admissions	Percentage of Inpatient Mental Health Admissions
201	1,363	81%
302	203	12%
303	86	5%
304	33	2%
TOTAL	1,685	100%

Note: The raw numbers represent adult and children/adolescent admissions.

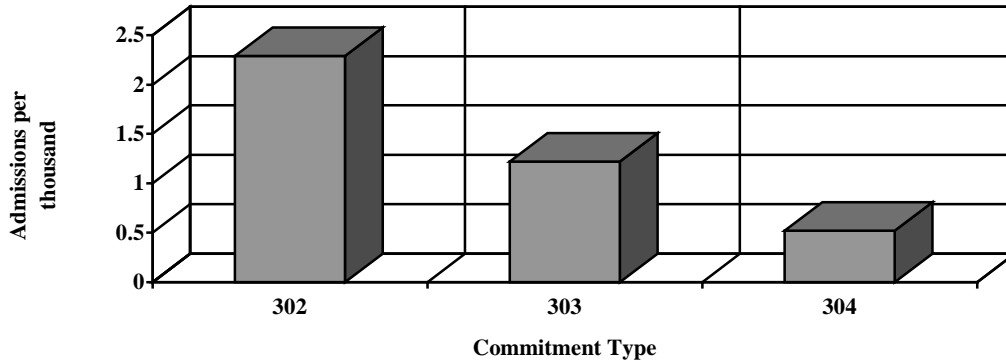
The number and percent of admissions by each commitment type are comparable to the three previous quarters. While the desired outcome would be a decrease in the percentage of involuntary admissions, the trend is favorable in that the number and percentage are not rising at this point in time.

Admission Rates by Commitment Type

Admission rates are calculated as admissions per 1,000 enrollees. Admission rates are included in this analysis to give a picture of the number of persons who are enrolled in the HealthChoices program in Allegheny County and have at least one admission for inpatient mental health services. From this point forward, the focus will be on the differences seen within the three types of involuntary commitments as illustrated in Chart 1.0.

Chart 1.0

Admission Rates for Inpatient Mental Health Services by Commitment Type



The total admission rate for inpatient mental health treatment was 14.15 admissions per one thousand enrollees. The admission rate for consumers on a 201 (voluntary admission) was 11.28. This is consistent with previous quarters and with the breakdowns seen in table 1.0 regarding inpatient admissions for mental health services by commitment. Involuntary admissions (302, 303 and 304) account for admission rates of 2.29, 1.22, and 0.52 respectively. The total admission rate for involuntary inpatient mental health treatment was 4.03.

The rate of involuntary inpatient mental health admissions is higher than the rates of other Pennsylvania counties. The Pennsylvania HealthChoices Behavioral Health Program Early Warning Care Management Report for the second quarter of 2000, reported an average rate for involuntary admissions of 3.1 per 1,000 adults in the state. The southeast region averaged a rate of 1.6 per 1,000 adults, while the southwest region averaged 3.7 per 1,000 adults. The average rate of involuntary admissions for Allegheny County was 5.3 per 1,000 adults while the rate for the remaining southwest counties was 2.4 per 1,000 adults. In addition, Allegheny County's rate "was the same as the prior quarter and remained the highest rate for all measured counties, as it had in the prior two quarters." ¹

The raw number of involuntary admissions reported by the Commonwealth was five episodes more than the number obtained from Community Care's data. This discrepancy is likely due to the timing of generating the data and substituting admission information for discharge information to represent the total number of inpatient admissions.

¹ Pennsylvania HealthChoices Behavioral Health Program Early Warning Care Management Report; Executive Summary; Quarter 2, 2000; page 4.

Inpatient Mental Health Admissions by Commitment Status

It would be expected that the number of admissions to the least restrictive commitment level would be higher than the other two levels, and that the subsequent commitment categories would show a proportional decrease. The breakdown of involuntary admissions by commitment type, as illustrated in Table 1.1, is consistent with previous quarters.

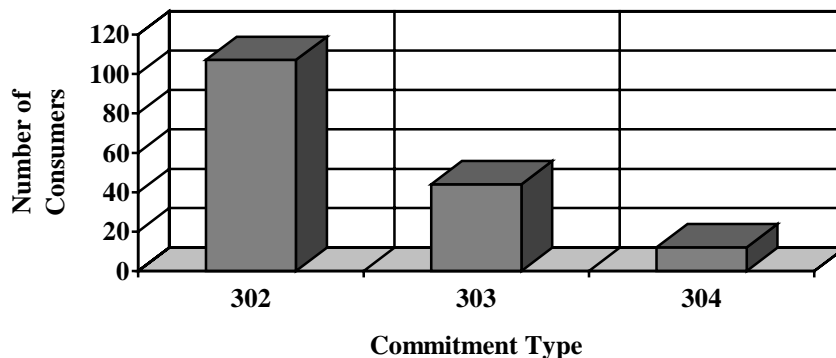
Table 1.1
Comparison of Involuntary Admissions for Inpatient Mental Health Services by Commitment Type

Type of Involuntary Commitment	Number of Admissions	Percentage of Involuntary Admissions
302	203	63%
303	86	27%
304	33	10%
TOTAL	322	100%

Consumers Without Previous Inpatient Mental Health Admissions

AHCI analyzed the number of consumers who were admitted involuntarily for inpatient mental health services without a previous inpatient mental health admission under the HealthChoices program. This analysis was performed to compare the number of unduplicated consumers without a previous inpatient mental health admission to the total number of unduplicated consumers admitted for inpatient mental health services.

Chart 1.1
Unduplicated Consumers by Involuntary Commitment Without Previous HealthChoices Inpatient Mental Health Admissions



For the second quarter of 2000, there were 1,685 admissions for inpatient mental health services. The total number of consumers who were admitted for inpatient mental health services on an involuntary basis and who did not have a previous inpatient mental health admission through HealthChoices, was 163. This represents 9.7% of all inpatient mental health admissions. A myriad of factors may contribute to this phenomenon including a lack of awareness, education, and access. Opportunities to improve include: strategic

outreach efforts, identify and target high-risk persons, and community events that promote awareness and benefits of outpatient mental health services including crisis management.

The number of consumers demonstrated in Chart 1.1 translates into 66% of consumers who had a 302 involuntary admission. Persons committed to a 303 and a 304 commitment level, represent 27% and 11% (respectively) of the total involuntary admissions for persons without a previous inpatient admission. These percentages compare to the overall breakdowns of involuntary admissions.

Unduplicated Consumers vs. Inpatient Mental Health Admissions

The next level of analysis looks at the number of unduplicated consumers and the number of inpatient mental health admissions. This allows the determination of the nature of the relationship between the type of commitment and recidivism. However, this does not present the full relationship of the two, since one consumer may have more than one admission, and may be listed in more than one commitment type. The consumer count is only unduplicated within each commitment type.

Table 1.2

Comparison of Unduplicated Consumers, Inpatient Mental Health Admissions, and the Average Admissions per Consumer

Commitment Type	Number of Unduplicated Consumers	Unduplicated Inpatient Mental Health Admissions	Average Admissions per Consumer
201	1,114	1,363	1.22
302	188	203	1.08
303	83	86	1.04
304	32	33	1.03
TOTAL	1,417	1,685	1.19

The commitment type that shows the highest average inpatient mental health admissions is 201 (voluntary). This category also has the highest number of consumers and inpatient mental health admissions. Maintaining focus on the three involuntary admission types, the number and average decrease proportionally, as the commitment type becomes more restrictive. By definition, the degree of restriction varies significantly between the commitment types, however, Table 1.2 illustrates that the average number of admissions per person only varied between one and two for each type.

In addition to a 304 commitment being the most restrictive, it is also the commitment type that is used to transfer a consumer from inpatient mental health services to state hospital care. Those consumers who are committed on a 304 can spend up to 90 days in the state hospital.

In some cases the length of a state hospital stay exceeds 90 days if extensions to the initial 304 commitment are granted.

Demographics and Commitment Type

In terms of demographic variables by commitment type, the following areas were analyzed:

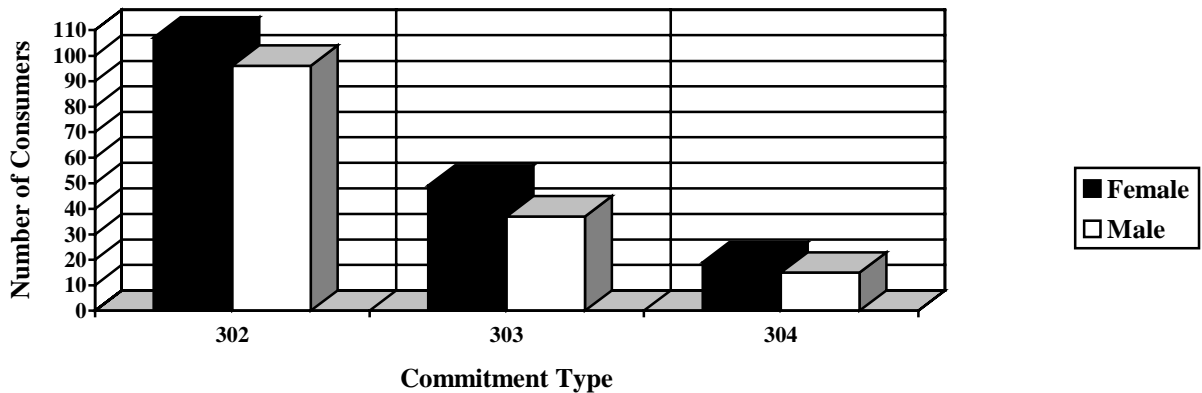
- Gender;
- Age;
- Race; and
- Tier assignment.

Gender and Commitment Type

Overall, female consumers tend to access inpatient mental health services more frequently than male consumers, however, the disparity between genders is relatively small. This pattern continues across all commitment types as illustrated in Chart 1.2.

Chart 1.2

Comparison of Gender by Commitment Type



The percent of females to males receiving inpatient mental health services under an involuntary commitment was 53% to 47%. There was little variance in these percentages across the commitment types.

Age by Commitment Type

The next demographic variable considered was age. It has been established in previous reports that the majority of HealthChoices enrollees, consumers of mental health services under HealthChoices, and consumers with inpatient mental health admissions tend to fall in the 22-44 year age group.

There are several reasons for this trend. First, this age group spans 22 years while the other groups cover a range of five to 19 years. The age group with the second highest number of consumers was 45-64 years, with a span of 19 years.

Another reason for the largest percent of consumers in the 22-44 year age group is the general age of onset for serious mental illnesses (especially schizophrenia) and serious substance abuse disorders. While these illnesses may actually ‘begin’ prior to the age of 22, the most visible symptoms often take a significant time to appear and interfere with baseline function.

Once a consumer graduates to the next age group (45-64 years), s/he may have lived with mental illness for up to 20 years. During this time, any denial may have been resolved and the consumer may be more accepting of treatment. Additionally, these consumers have potentially been in treatment longer, using more ongoing, community-based services, and less acute levels of treatment.

An increase number of involuntary commitments were seen between the 6-12 year and the 13-17 year age groups. One contributing factor is that when a child/adolescent reaches the age of 14 years s/he is able to refuse inpatient treatment. This ability to refuse treatment can necessitate the need for an involuntary admission. There are also limited educational efforts about mental illness and outreach through various child-serving systems such as education and juvenile justice.

Table 1.3

**Number of Unduplicated Consumers by
Age Groups and Commitment Types**

Age Group	201	302	303	304	Total in Age Group	Percentage of Total
0-5	11	0	0	0	11	0.6%
6-12	105	13	4	0	122	6.5%
13-17	104	49	7	1	161	10%
18-21	61	19	10	3	93	5.9%
22-44	712	96	42	23	873	52%
45-64	305	25	22	6	358	21%
65+	65	1	1	0	67	4%

Table 1.3 shows that 52% of persons with voluntary and involuntary inpatient mental health admissions fall within the 22-44 year age group. The second largest percent was persons in the 45-64 year age group (21%). The third largest percent was the 13-17 year age group with 10% of the total admissions. One exception to this is that the percent of 18-21 year olds exceeds the 13-17 year age group for 303 and 304 involuntary admissions. The difference in terms of volume is miniscule. The third largest percentage for 302 type commitments is the 13-17 year age group.

One of the contributing factors to low numbers of 13-17 year olds in the 304 category may be the absence of state hospital beds for consumers under the age of 18 years. These consumers may be placed in residential treatment facilities in lieu of state hospital facilities.

Race by Commitment Type

Overall, Caucasian consumers accounted for 55% of the total admissions for inpatient mental health services. African American consumers followed with 43% of the total admissions. This compares to Caucasian consumers accounting for 51% and African American consumers accounting for 47% of the involuntary admissions for inpatient mental health services. The only commitment type during the second quarter in which African American consumers exceeded the number of Caucasians was in the 302 category, however it should be noted that this is a difference of one consumer.

These percentages by race also compare to overall HealthChoices enrollment for Allegheny County for the second quarter of 2000. During this quarter, African American enrollees accounted for 47% of the total enrollment, while Caucasian enrollees accounted for 50% of the total enrollees.

Table 1.4

Unduplicated Consumers by Race and Commitment Type

Race	Type of Involuntary Commitment 302/303/304	Involuntary Inpatient Mental Health Admissions Total Number/Percentage of Total	Total HealthChoices Enrollees Who Access Any Service Type Number/Percentage of Total	Total HealthChoices Enrollment Number/Percentage of Total
African American	99 / 36 / 15	150 / 47%	5,241 / 37%	57,041 / 47%
Caucasian	98 / 48 / 18	164 / 51%	8,871 / 62%	60,672 / 50%
Other	6 / 2 / 0	8 / 2%	225 / 1%	3,088 / 3%

The number 302 and 304 commitments of African American and Caucasian consumers were similar as compared to 303 type commitments. Of the 1,363 inpatient mental health voluntary admissions, African American consumers accounted for 573 or 42% of the admissions. Caucasian consumers accounted for 761 or 56% of the voluntary admissions. The other races utilized two percent (or 29) voluntary admissions for inpatient mental health services.

Tier Assignment by Commitment

Another area that AHCI chose to focus on is the relationship of involuntary admissions for inpatient mental health services and tier assignment. Designed by Community Care, the tier system categorizes consumers into three levels of intensity based on their diagnosis, clinical risk factors, utilization rates, and their Medical Assistance eligibility category. The definition of each adult tier is as follows:

- Tier One (T1) members are the highest priority and include consumers who have had three or more inpatient admissions, receive a level of care other than outpatient, and have a diagnosis consistent with the Department of Public Welfare (DPW) standards for persons with Serious and Persistent Mental Illness (SPMI).
- Tier Two (T2) members include those who have a diagnosis of SPMI, one inpatient admission, and belong to either the Social Security Income (SSI) or Federally Assisted Medical Assistance for General Assistance Recipients (FGA) categories of aid.
- Tier Three (T3) members are consumers who are receiving outpatient services. These consumers may have one or two inpatient admissions, but do not meet the rest of the criteria for Tier Two.

The tier definitions for children/adolescents are very similar to the adult tier definitions, and are as follows:

- Tier One (C1) represents consumers age 18 years and younger with three or more inpatient admissions OR residential treatment facility admission OR two or more inpatient admissions and are currently receiving school-based partial, family-based or behavioral health rehabilitative services.
- Tier Two (C2) represents consumers age 18 years or younger who have received any service other than only outpatient and are not in Tier One.
- Tier Three (C3) represents consumers age 18 years or younger who have received only outpatient services and are not in Tiers One or Two.

Table 1.5 depicts the distribution of inpatient mental health consumers in Community Care's Tier System. The total number illustrated per tier assignment is not representative of all HealthChoices consumers. It only reflects those persons that received inpatient mental health services. Given this, the largest number of consumers should be assigned to Tier One (both children (C1) and adults (T1)) and should represent the largest percent of consumers managed on an inpatient basis. Likewise, Tier Two should have the second largest number and percent of consumers admitted.

Table 1.5**Unduplicated Number of Consumers by
Tier Group and Commitment Type**

Tier	201	302	303	304	Total for Tier Group	Percentage of Total
C1	93	27	7	0	127	8%
C2	121	34	4	1	159	9%
C3	0	0	0	0	0	0%
T1	783	80	42	25	930	55%
T2	364	62	33	8	467	28%
T3	1	0	0	0	1	<1%

Table 1.5 reflects these expectations, with the exception of an inverse pattern for children/adolescents in Tiers One and Two (C1 and C2). This variance may be due to the prolonged length of stay that children/adolescents experience with residential treatment facility placement. The intensity of service that a residential environment provides during an approximate 12 consecutive months or more of treatment may be sufficient to maintain the child/adolescent. An inpatient mental health admission would be less likely for a child/adolescent assigned to Tier One than a person assigned to Tier Two that does not receive prolonged, intensive services.

Consumers Without Services Surrounding Involuntary Inpatient Mental Health Admissions

It is also important to consider how many consumers do not receive services surrounding an involuntary inpatient mental health admission. The findings of the aggregate analysis suggest that member level analysis is warranted in a future report.

No Services Prior to Involuntary Admissions for Inpatient Mental Health Services

During the second quarter of 2000, 145 out of 322 (45%) total consumers admitted involuntarily for inpatient mental health treatment did not receive services in the 30 days prior to admission. Of these consumers, 96 out of 145 (66%) were admitted under the 302 category, 38 out of 145 (26%) in the 303 category, and the remaining 11 (8%) were in the 304 category. This is consistent with other breakdowns by commitment status. The demographic breakdowns for these consumers are as follows:

- Females accounted for 52% of these consumers;
- The age group of 22-44 years accounted for 50% of these consumers;
- African American and Caucasian consumers were equally represented.

This information is consistent with the preceding demographic breakdowns in this report.

No Services After Discharge from Involuntary Inpatient Mental Health Admissions

During the second quarter of 2000, there were a total of 112 out of 322 (35%) consumers discharged from an involuntary mental health admission who did not receive services covered by HealthChoices in the 30 days following discharge. There were 33 fewer consumers without services after an involuntary admission than before an involuntary mental health admission. While this is a favorable trend, one would hope to see a larger increase of consumers receiving services prior to and after admission. Limiting factors include: barriers to treatment (denial, transportation, and access issues) and services that address the needs of the consumer (i.e. issues that the consumer identifies as being important and meaningful).

Additionally, by virtue of the type of commitment, consumers on a 304 involuntary admission are usually admitted to a state hospital. State hospital admissions are not a covered service under HealthChoices and consumers tend to stay for more than 30 days. Therefore, no activity for HealthChoices in-plan services would be included in utilization data for persons who did not receive services 30 days after discharge. Of the 112 consumers, 74 or 66% were in the 302 category, 26 or 23% were in the 303 category, and 12 or 10% were in the 304 category. Again, this is consistent with other commitment breakdowns included in this report.

The demographic breakdowns for consumers who did not receive services during the 30 days following discharge from an involuntary admission include:

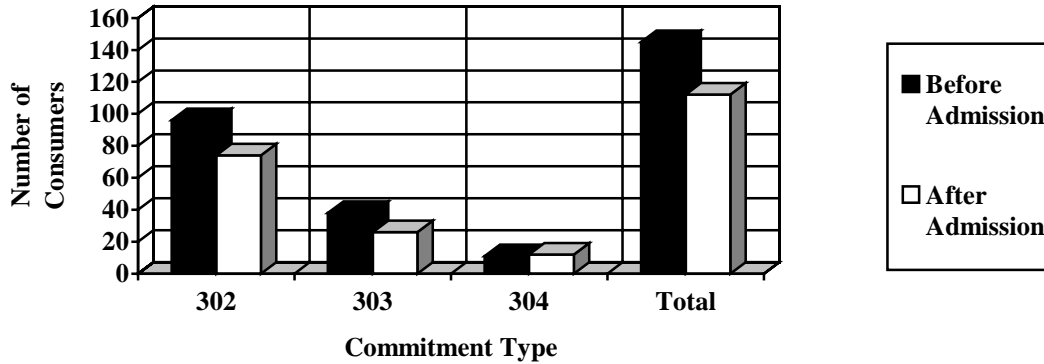
- Female consumers accounted for 55% of the total;
- Persons in the age group 22-44 years accounted for 50% of the total;
- African American consumers accounted for 52% of the total.

These findings are consistent with the overall findings of consumers who do not receive services after discharge from an involuntary inpatient mental health admission.

The following chart illustrates the comparison of consumers without services prior to admission and consumers without services after discharge from an involuntary admission. This comparison is delineated by commitment type.

Chart 1.3

Comparison of Consumers Without Services Prior to and After Discharge for Involuntary Inpatient Mental Health Services



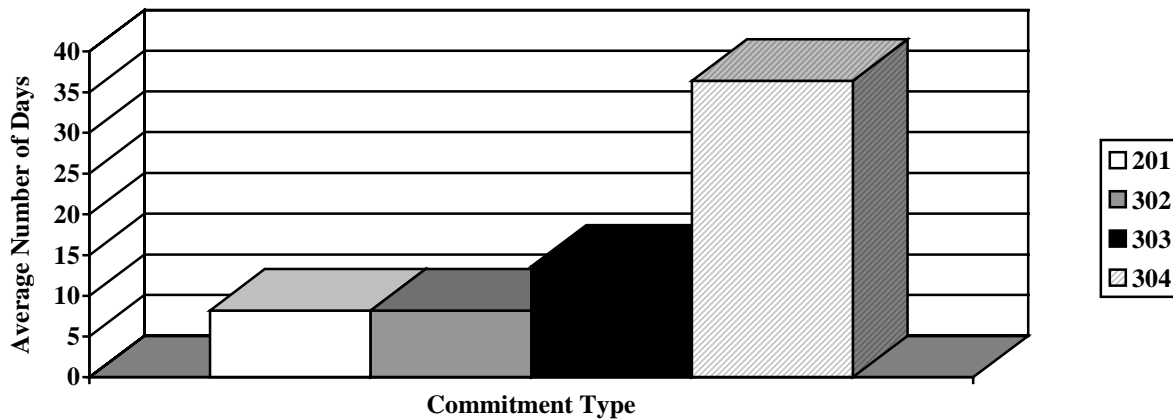
There were significant decreases in before and after admissions numbers for the total and the 302 commitment categories. A smaller, but notable difference in the 303 category, and a slight increase seen in the 304 commitment category. While the decrease is a positive trend for consumers without services, one would hope to see a larger difference going forward.

Average Length of Stay for Involuntary Admissions

The average length of stay for consumers on a 304 involuntary admission was considerably higher than the average length of stay for other commitment types. The average length of stay for the time period studied in this report is consistent with the average length of stay seen in previous quarters. Chart 1.4 illustrates the differences between commitment types.

Chart 1.4

Inpatient Mental Health Average Length of Stay by Commitment Type



Two percent (33) of all inpatient admissions with a 304 involuntary admission average a 28.2 day-stay longer than consumers under a 201 or 302 commitment and an average of 12.8 days longer than consumers under a 303 commitment. The differences in the average length of stay are due to the time a consumer waits to be admitted to the state hospital. For these consumers, inpatient mental health treatment is the only appropriate level of care to bridge the gap from an inpatient mental health to a state hospital admission. The average wait for a state hospital bed varies, but has typically remained between two and four weeks since the inception of the HealthChoices program.

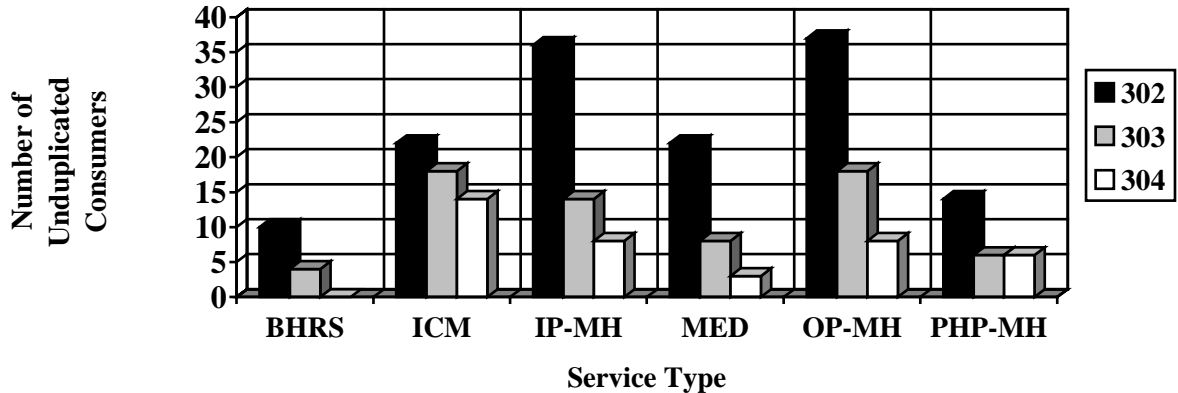
The length of time a consumer waits for a state hospital bed is tracked from the time that a 304 commitment is issued. Generally, the timeframes for a consumer to go through a 302 (up to 5 days) and a 303 commitment (up to 20 days) is 25 days. If the length of stay is 36.4 days for a consumer on a 304, and the first 25 days are used between the 302 and 303 commitments, that leaves 11.4 days on the average that a consumer stays on an inpatient unit awaiting a state hospital bed. This has considerable impact on the utilization of and costs associated with inpatient mental health care.

Service Mix Around Involuntary Inpatient Mental Health Admissions

AHCI compared the services consumers receive prior to and after discharge from an involuntary mental health admission. This comparison was done to analyze the effect services received after discharge has on subsequent care. When assessing the utilization of more intensive services (such as inpatient mental health), it is essential to also assess the utilization of the less intensive and community based services. Chart 1.5 summarizes the number of service types received by consumers before admission to an involuntary admission for inpatient mental health treatment. This chart only reflects the top six most utilized services. There were a total of 18 service categories observed in the data.

Chart 1.5

Service Types Received Prior to Involuntary Inpatient Mental Health Admissions



Key:
BHRS Behavioral health rehabilitative services **MED** Medication check
ICM Intensive case management **OP-MH** Outpatient mental health
IP-MH Inpatient mental health **PHP-MH** Partial hospitalization program

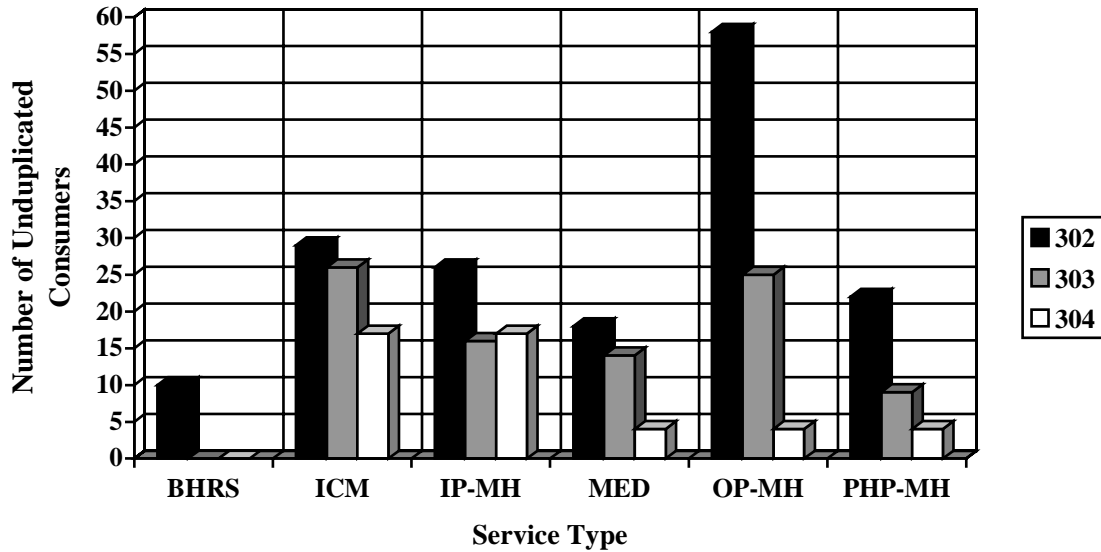
While outpatient mental health was the most highly utilized service prior to an involuntary admission, the number of consumers utilizing inpatient mental health services within the 30-day period prior to an involuntary admission was the second largest service utilized. The utilization pattern of inpatient mental health services was significant and may be a reflection of recidivism. Intensive case management represents the third largest number of consumers.

A consumer could receive more than one service type at any given time. One would hope to see an increase over time of not only outpatient mental health and intensive case management, but also services such as partial hospitalization, medication checks, etc. These patterns of service utilization appear to remain consistent across the three involuntary commitment types.

Chart 1.6 reflects the service utilization patterns for the 30 days following discharge from an involuntary inpatient mental health admission. Again, the chart illustrates the top six service types only. There were 18 difference service types observed.

Chart 1.6

**Service Types Received After Discharge From
Involuntary Inpatient Mental Health Admissions**



Key:

- | | |
|-------------------------------------------------------|-----------------------------------------------|
| BHRS Behavioral health rehabilitative services | MED Medication check |
| ICM Intensive case management | OP-MH Outpatient mental health |
| IP-MH Inpatient mental health | PHP-MH Partial hospitalization program |

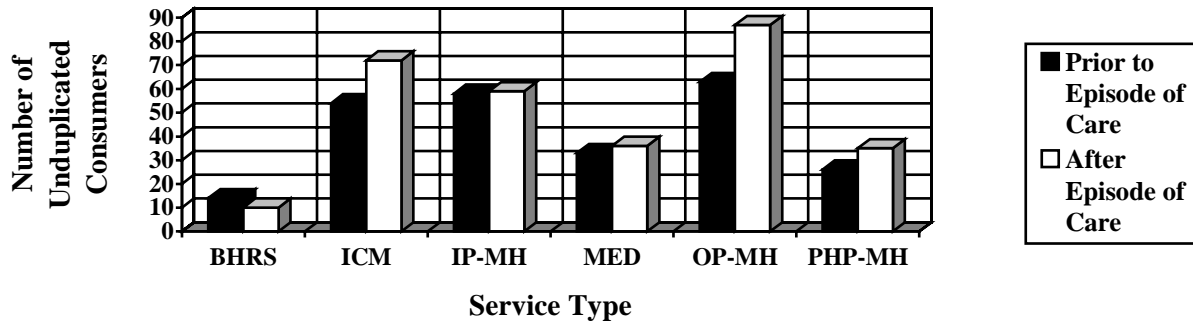
The most utilized service type during the 30 days following discharge from an involuntary inpatient mental health admission during the second quarter of 2000 was outpatient mental health. Intensive case management, inpatient mental health, and medication check followed respectively. One would expect that there would be higher utilization of intensive case management services, as this service type is instrumental in helping consumers attain and maintain recovery.

Persons admitted as a 304 commitment type would not contribute to an increase in outpatient services because their state hospitalization period overlaps the 30-day after discharge measurement period.

Chart 1.7 compares service types received during the 30 days prior to and following an involuntary inpatient mental health admission. One would expect that there would be higher utilization after discharge than prior to admission.

Chart 1.7

Comparison of Services Received Prior to and After Involuntary Inpatient Mental Health Admissions



Key:

BHRS Behavioral health rehabilitation services	MED Medication check
ICM Intensive case manager	OP-MH Outpatient mental health
IP-MH Inpatient mental health	PHP-MH Partial hospitalization program

More consumers utilized all of the service types included in the chart, with the exception of behavioral health rehabilitation services, after discharge than prior to admission. Only behavioral health rehabilitation services were slightly decreased after discharge than prior to admission. The main factor affecting this might be admissions to residential treatment facilities. If a child/adolescent consumer is not able to maintain his/her place in the community with the use of behavioral health rehabilitation services, and requires an involuntary admission for inpatient mental health treatment, admission to a residential treatment facility may be selected as the most appropriate discharge plan.

The use of drug and alcohol services is not as prevalent as mental health services; however, the analysis indicates the presence of dually diagnosed persons. Of the services received prior to admission, the following drug and alcohol services were consumed:

- Non-hospital rehabilitation services were utilized by the ninth largest number of consumers;
- Methadone services were consumed by the 11th largest number of consumers;
- Inpatient detoxification services were used by the 14th largest number of consumers; and
- The 17th largest number of consumers utilized outpatient drug and alcohol services.

For drug and alcohol services utilized after discharge, the pattern is as follows:

- Non-hospital rehabilitation services were consumed by the seventh largest number of persons;
- Methadone services were used by the tenth largest number of consumers;
- Outpatient drug and alcohol services were utilized by the 13th largest number of consumers; and
- The 19th largest number of consumers utilized inpatient detoxification services.

Over time, one would hope to see decreased utilization of inpatient mental health services (for all consumers) and increased utilization of community-based services. This utilization of services should not be limited to mental health services, but include drug and alcohol services as well.

Summary of Involuntary Admissions

This analysis provides an aggregate observation of involuntary commitments. The fundamental information about those admitted under involuntary commitments has remained stable across the quarters. There appears to be a relationship between persons at-risk and persons whose initial introduction to the mental health system is via an involuntary admission. These persons may not have received outpatient services in an effort to deter an involuntary admission because they have not been identified as at-risk enrollees. There exists an immense opportunity to increase awareness, educate, and conduct outreach.

A similar relationship exists between persons that do not receive services after discharge and the average number of admissions. This relationship is not contingent upon the commitment level. The relationship does impact mostly African American women between the ages of 22 and 44 years. Several economic and logistic barriers can preclude this group from receiving services.

Active outreach may be an effective mechanism to address the unfavorable consequences of the two relationships identified above. Traditional outreach methods may not be effective. Many consumers are not available by telephone or do not have a stable address. Outreach should occur within the community. Non-traditional places for outreach that can be very effective are churches, medical clinics, schools, etc.

An implied relationship exists between all commitment levels and recidivism. A consumer may require numerous inpatient mental health admissions before being exposed to sufficient education about mental illness and accepting his/her illness and treatment. Consumers need ongoing education about mental illness without regard to where they are within the process. Additionally, family members and the public at large also require additional education efforts.

Access to care may negatively impact a consumer's receipt of quality services. One measurement of quality is the degree to which a person's expectations and needs are met. Many traditional mental health services fail to meet expectations and needs by imposing barriers. These barriers include proximity to a consumer's neighborhood, childcare options, the hours (and days) during which treatment is available, and the availability of culturally relevant services. Quality also influences the breadth and intensity of engaging a person in less intensive services, thus reducing the frequency of readmission for inpatient services. Better methods to engage clients in treatment and help motivate them to participate in services should be developed. Participation increases because the client understands the value that the services can add to their lives.

AHCI will continue to track and trend the basic commitment data across the quarters. In addition, AHCI will conduct analysis to compare those consumers who have multiple involuntary admissions to those with fewer involuntary admissions, especially as they relate to service mix outside of inpatient mental health admissions. Issues that cannot be satisfied on an aggregate level will be analyzed at the member level. Going forward, AHCI would like to follow these consumers and analyze changes in their service utilization.