Allegheny County HealthChoices Program

Community Treatment Teams: Implementation in Allegheny County since 2002

Presented by

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

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Executive Summary

Using principles of recovery to direct behavioral health systems is increasing in national prominence and acceptance. A recovery-focused system must involve empowering consumers to actively participate in their own treatment planning and goal-setting. A recovery-focused system must also involve services that can be flexible and individualized and that provide support in non-clinical areas including housing, peer support, and vocational and educational opportunities.

The behavioral health system in Allegheny County is increasingly promoting a focus on recovery. A recovery-influenced goal of Allegheny County's behavioral health system involves a shift in overall utilization from more intensive and/or restrictive services to less intensive services over time. In order to facilitate the accomplishment of this goal, Allegheny County chose to use HealthChoices reinvestment and County Community Hospital Integration Projects Program (CHIPP) funds to initiate Community Treatment Teams.

A Community Treatment Team (CTT) is a comprehensive service-delivery model that functions as the primary provider of services for people with serious and persistent mental illnesses. CTTs provide highly individualized services directly to consumers who are living in the community. These services are provided by team members who are on-call 24 hours a day, seven days a week, and 365 days a year. Beginning in 2002, four CTTs began accepting consumers who met the medical necessity criteria for admission: Mercy Behavioral Health, Residential Care, and Western Psychiatric Institute and Clinic each developed an adult CTT, and Western Psychiatric Institute and Clinic also developed a CTT for young adults. As of June 30, 2003, the four teams had a total of 266 consumers.

Allegheny HealthChoices, Inc. (AHCI) published a report in January of 2003 examining the early implementation of the teams. AHCI has developed this report to compare the teams during the early implementation stage, defined by the first and second quarters of 2002, through the first and second quarters of 2003. The report aims to track the evolution of the teams and changes in consumer outcomes over time, specifically focusing on:

- Composition of the teams (age, gender, and race of consumer participants);
- Changes in service utilization (CTT and non-CTT services); and
- Stability and community integration (living arrangements, employment, educational status, and utilization of natural support systems).

The main findings of this report include:

- Referrals to the teams are from multiple sources; many of the initial referrals were from the state mental hospital system (31%). The Residential Care Team has the highest percentage of referrals from the state mental hospital (42%), which appears to be related to the team's higher percentage of consumers with a diagnosis of schizophrenia, and the team's higher percentage of consumers residing in more structured living environments. Other referral sources include case managers, community hospital inpatient social workers, residential treatment facilities, and family-based providers.

- On average, most of the consumers on the four CTTs are diagnosed with schizophrenia (47%), bipolar disorder (20%), or major depression/depressive disorder (17%). Many consumers have an Axis II borderline personality disorder diagnosis (24%). This appears to be a factor in service utilization.

- A high percentage of CTT consumers (four team average of 70%) have a co-occurring substance abuse or addiction diagnosis. This is a factor in the services the CTTs provide.

- CTT services are paid for by the HealthChoices program (if a consumer is eligible for Medical Assistance) or by the County (if a consumer is not eligible for HealthChoices). Most CTT consumers are HealthChoices eligible. In all months examined, a small percentage of consumers did not receive CTT services. Multiple reasons for why CTT services are not being provided include:
    - The team may be unable to locate a consumer.
    - The team may be unable to engage the consumer in services.
    - A consumer may be incarcerated.
    - A consumer may have been enrolled with the team at the end of one month, but initial contact did not occur until the beginning of the following month.
    - Claims may have been submitted or processed incorrectly.

- There are differences between teams in terms of CTT consumer utilization of inpatient mental health services. Overall, total claims paid for inpatient stays have increased since the first quarter of 2002. However, the ratio of inpatient mental health days to the total number of CTT consumers has decreased. And, most importantly, consumers used inpatient mental health services significantly less in the six months after they are enrolled with a team, in comparison to the six months before their enrollment. On average for the four teams, 50% of consumers had one or more inpatient community hospital admission in the six months before their enrollment on the team; only 34% of consumers had one or more inpatient community hospital admission in the six months after their enrollment.

- With the implementation of the CTTs, CTT consumers' involvement with the state mental hospital has greatly decreased. On average for the three adult teams, 41% were in the state mental hospital within the six months prior to their enrollment with a CTT; only 6% of consumers were admitted to the state mental hospital in the six months after their enrollment with a CTT.

- Overall, the percentage of CTT consumers utilizing other HealthChoices and County-funded services has decreased or remained small. Many of these services compliment the services provided by the CTTs or are transitional services for consumers as they begin or end their treatment with a CTT. Therefore, this utilization is expected.

- More consumers live independently (between 24% and 31% in each of the four quarters examined) than in any other housing category. Many consumers still move regularly (between 17% and 21% within a three month period), and many still live in restrictive environments.

- A small percentage of consumers are employed (between 10% and 18%), and this percentage has increased only slightly over time.

Since their implementation, the CTTs have worked with consumers to help them stay out of the hospital, find stable housing, develop recovery goals, and improve their quality of life. Many individual consumers have had many successes. As the teams continue to evolve, the behavioral health system must support the CTTs through complementary services in housing supports, job placement, diversion from inpatient units, and forensic coordination. The teams must further enhance their recovery focus through the provision of substance abuse treatment and vocational counseling and support, and through facilitating consumers' development of their natural support systems.

Introduction

Nationally, the concept of using principles of recovery to direct behavioral health systems is growing in prominence and acceptance. While there are many individual aspects and interpretations of recovery, recovery-focused systems are based on several common principles. A recovery-focused system is committed to the vision that individuals with mental illnesses and substance abuse problems can and do recover. A recovery-focused system must involve empowering consumers to actively participate in their own service planning and goal-setting, with a strong emphasis on wellness. A recovery-focused system must also involve services that can be flexible and individualized and that provide support in non-clinical areas including housing, peer support, and vocational and educational opportunities. Over time, as individuals move towards their self-defined recovery goals, the system is expected to experience an overall decrease in the utilization of highly restrictive and intensive services, and an increase in less restrictive, community-based services, stable housing, and employment for consumers.

The behavioral health system in Allegheny County is increasingly promoting a focus on recovery. The Office of Behavioral Health stipulates in its contracts with providers that services be recovery-oriented. In its performance standards for providers, Community Care Behavioral Health* requires that services are recovery-oriented. A recovery-influenced goal of Allegheny County's behavioral health system involves a shift in overall utilization from more intensive and/or restrictive services to less intensive services over time. In order to facilitate the accomplishment of this goal, Allegheny County chose to use HealthChoices reinvestment funds for HealthChoices eligible consumers and County Community Hospital Integration Projects Program (CHIPP) funds for non-HealthChoices eligible consumers to initiate Community Treatment Teams. This allows both HealthChoices and non-HealthChoices consumers in the County to benefit from the service. This also provides a seamless approach to service since over time it is expected that the majority of these consumers will become HealthChoices eligible.

A Community Treatment Team (CTT), based on the assertive community treatment model, is a comprehensive service-delivery model that functions as the primary provider of services for people with serious and persistent mental illnesses. CTTs provide highly individualized services directly to consumers who are living in the community. These services are provided by team members who are on-call 24 hours a day, seven days a week, and 365 days a year.

CTTs are indicated for individuals in their late teens through adulthood who experience symptoms of their illness over a long period of time and experience impairments that produce distress and major disability in their daily functioning (e.g., employment, self-care, and social and interpersonal relationships). Consumers who participate in CTTs usually are determined to have a serious mental illness, and thus are people diagnosed with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and mood disorders (e.g., bipolar disorder, manic-depressive illness). They often have limited natural support systems, and/or have not benefited from the traditional service delivery system. Many of these individuals also have co-occurring mental health and substance abuse disorders.

* Community Care is the managed care organization that administers the behavioral health (mental health and substance abuse) component of the HealthChoices program for individuals receiving Medical Assistance.

Through a competitive bidding process, the County and Community Care selected three agencies to develop four Community Treatment Teams. These teams are staffed by Western Psychiatric Institute and Clinic (WPIC) (one transition age and one adult team), Mercy Behavioral Health (one adult team), and Residential Care Services (one adult team).

The teams began enrolling consumers in January of 2002. As of June 30, 2003, the four teams had a total of 266 consumers. AHCI published a report in January of 2003 that compared data from pre-implementation, defined as the first and second quarters of 2001, to early post-implementation, defined as the first and second quarters of 2002. This follow-up report compares the teams during the early implementation stage, again defined by the first and second quarters of 2002, through the first and second quarters of 2003. The report aims to track the evolution of the teams and changes in consumer outcomes over time, specifically focusing on:

- Composition of the teams (age, gender, and race of consumer participants);
- Changes in service utilization (CTT and non-CTT services); and
- Stability and community integration (living arrangements, employment, educational status, and utilization of natural support systems).

Background of the Community Treatment Team Model

Over the past 40 years, treatment approaches for persons with serious mental illness have been continuously changing. In response to the deinstitutionalization movement of the 1950's and 1960's and the introduction of more effective psychotropic medications, the locus of treatment has shifted more and more away from inpatient settings, particularly state hospitals, to community settings, specifically community mental health centers. As professionals began to understand more about the needs of individuals, these professionals recognized the need for a wider range of services to serve a diverse population (Mueser et al, 1998).

While the late 1960's and 1970's saw significant growth in the availability of community mental health services, there was increasing concern that these services were becoming too directed toward less seriously ill individuals, most of whom had never experienced a hospitalization, especially in a state facility, as a result of their mental illness. The federal government, which was the primary funding source for community mental health centers, established a new initiative, the Community Support Program (CSP). The primary function of the CSP is improving the coordination of community mental health services for adults with serious mental illness (Turner and TenHoor, 1978). At about the same time, federal dollars were converted to block grants and states were required to develop state plans that increasingly focused on establishing systems of care for adults with serious mental illness.

As systems developed, they became more complex and often difficult for consumers to navigate. This was particularly true for adults with serious mental illness. As a result, a new service function was developed - case management. Over the past several years, the role of the case manager has evolved although it has always included some core functions around ensuring that services for consumers are integrated and coordinated. There have been various models of case management developed and these models are reviewed in several publications (Mueser et al, 1998; Hodge and Draine, 1993).

One of the most effective models was developed by Stein and Test (1980) in Madison, Wisconsin. This program, the Program for Assertive Community Treatment (PACT), was designed as a specialized care model to meet the needs of adults with more severe mental illness. This approach is now more commonly known as assertive community treatment (ACT) and is designed to go far beyond traditional case management or treatment models.

Over time, the ACT model has gained popularity as an innovative and effective treatment for certain populations. Because the ACT model's effectiveness has been consistently demonstrated, this team model was identified by the Robert Wood Johnson Foundation as one of six evidence-based treatments for people with severe and persistent mental illness. It was also endorsed as an essential treatment in the Surgeon General's 1999 Report on Mental Health. Other proponents of CTTs include: the National Institute of Mental Health (NIMH) and the Agency for Health Care Policy and Research (AHCPR).

Allegheny County has had a system of case management for several years, but had not adopted an assertive community treatment approach until it made the decision to develop community treatment teams based on the ACT model.

Principles of Community Treatment Teams

The Assertive Community Treatment Association has developed the following as principles to use in operating community treatment teams. These principles reflect the model that has been implemented in Allegheny County, and clearly and completely incorporate the principles of recovery.

- **Primary Provider of Care:** The multidisciplinary team consists of Peer Support Counselors, a Psychiatrist, Nurses, Social Workers, Rehabilitation Specialists, Drug and Alcohol Specialists, and Vocational Specialists. The ideal ratio is one provider to ten or twelve consumers with a total capacity per team of 100 to 120 consumers. Both of these factors allow the team to provide most services with minimal referrals to other services or providers. Team members are not assigned a specific caseload; instead, the team accepts responsibility to meet all aspects of the consumer's needs.

- **Services Provided in Community Settings**: Seventy-five percent or more of the services provided by the team occur outside of the CTT office. Examples of community settings include: the consumer's home, bank, local stores, and neighborhood facilities, such as the park and library.

- **Highly Individualized Services:** The team helps each consumer to identify personal goals based on his/her strengths and hopes for the future. The plan is then updated continuously with input from the consumer as s/he moves through stages of recovery.

- **Assertive Approach:** The teams work proactively with consumers to help them live independently, engage in treatment, and move through the recovery process.

- **Long-Term Services:** Due to the long-term nature of these forms of mental illness and the severity of impairment, CTT services are intended to be used on a long-term basis. The CTT recognizes that recovery may occur over a period of years and that the illnesses, by their very nature, are cyclical. Therefore, they require long-term, titrated services, that is, services are available when consumers need them, where they need them, and at the level they need them.

- **Emphasis on Vocational Expectations:** The team expects and encourages consumers to participate in meaningful activity. Vocational services are considered a core element of the rehabilitation services provided by the CTT.

- **Specialized Services**: Many of the CTT participants encounter barriers and challenges as a result of having both a mental illness and problems with drug and/or alcohol abuse and addiction. The teams provide specialized treatment and services to address these issues.

- **Psycho-Educational Services**: The team establishes a collaborative relationship in the treatment process with the consumer and his/her family or significant other. Consumers are taught how to build upon their strengths to achieve their life goals. This includes teaching consumers about their mental illness and skills that will help them.

- **Family Support and Education:** The team works to include the consumer's natural support system, family members, or significant other, in the treatment process. This includes providing them with education about mental illness and the services the team provides. This approach often helps to improve family relationships by decreasing conflicts and increasing consumer autonomy.

When C. enrolled with a CTT in October of 2002, he was a patient in a community psychiatric hospital. He had just finished serving 17 years in the Allegheny County Jail. C. was homeless and had been spending time at several different hospitals since his release from prison. He was wary of the system; the CTT worked over time to build trust with him. They helped him find a placement in respite, and then visited him regularly to build the relationship and determine his needs and goals. With CTT assistance, he found an apartment in the community. The CTT also helped him purchase clothes and necessities for his apartment. Initially, he needed a significant amount of support from the team around drug and alcohol issues and medication adjustments. Over time, his level of supports has decreased. Now, C. occasionally attends CTT drug and alcohol groups and often spends time with CTT Peer Specialists in socialization activities. He is also working at a construction job.

- **Community Integration**: The team works with the consumers to reduce their social isolation by helping them participate more in community activities. Peer Counselors, as a part of the team, are often effective in this role.

- **Attention to Health Care Needs:** The team coordinates care for medical issues and provides health and wellness education.

The Implementation of Community Treatment Teams in Allegheny County

The Allegheny County community treatment teams began accepting consumers in 2002. Since that time, the teams have continued to grow and are approaching capacity, with an average of 67 consumers on each team as of June 30, 2003.

During implementation, the teams received extensive and in-depth training on a variety of topics. As part of Allegheny County's commitment to the education and support of the CTTs, a consultant continues to offer hands-on technical assistance to the teams and facilitates regularly scheduled meetings with team leaders, team specialists, Community Care, Allegheny County and AHCI staff. These meetings provide opportunities to discuss successes, share clinical and operational strategies, and problem-solve.

Additionally, Community Care led a collaborative process in 2003 for establishing CTT performance standards, which outline the performance requirements for the teams. The CTT staff, their supervisors, consumers, advocates, and family members provided input on the standards. The teams are already meeting most of the standards, and the remaining standards will be implemented by mid-2004. The standards insure the teams follow the general ACT model and principles of recovery:

- Staffing, services and supports provided by the teams, and team communication standards require that the teams as a whole are the primary providers of the variety of services.
- Team capacity, service intensity, hours of operation, and place of treatment standards require that the care provided by the teams is individualized, accessible at all times, and provided in the community.
- Assessment and treatment planning standards require that teams work in a partnership with consumers to comprehensively assess and plan psychiatric and substance abuse treatment, and to develop goals and interventions for physical health, relapse prevention, housing, and social, vocational, and educational functioning.

Because the performance standards require that the teams follow the ACT model and recovery principles, the standards support the favorable outcomes that CTTs have achieved in other locations. These outcomes include:

- Stable housing;
- Decreased utilization of hospitalization services;
- Decreased utilization of other non-CTT services;
- Increased employment; and
- Increased use of natural supports.

All of these outcomes are focused on sustaining people in the community by building on consumers' strengths to improve their functioning, and ultimately, their quality of life. Because of the long-term nature of the service, achieving these outcomes is expected to evolve gradually over time.

Methodology

AHCI analyzed demographic and utilization data to establish a picture of the evolution of the CTT program and progress toward achieving the expected outcomes. The timeframe for this study includes the first and second quarters of 2002 (defined as early implementation of CTTs), and the first and second quarters of 2003. Some analyses use monthly data that covers the entire time period (January 2002 through June 2003) to provide additional insight into consumers' experiences with the CTTs over time.

Data sources for this report include:

- **CTT Application** -- Prior to implementation, Community Care, Allegheny County, and representatives of the CTTs collaborated with AHCI on the development of a database[*] to house CTT consumer and other event information. Each team enters data into the application on a regular basis. AHCI manages the information contained in the application. Information extracted from the application for this report includes:
  - Demographic characteristics;
  - Living arrangements;
  - Employment status; and
  - Educational status.[**]

  For demographic analysis, the last month of each quarter was used as it more accurately reflects enrollment than the quarterly average.
- **Claims Data** – Data from adjudicated claims was used to provide information on diagnosis and utilization of HealthChoices funded services.
- **eCAPS** – The Allegheny County eCAPS data were used as the source for data on diagnosis and service utilization of County-funded (non-HealthChoices) services.
- **PsychConsult data –** PsychConsult is the care management database used by Community Care. Information on diagnosis was used to categorize diagnostic types. Authorizations data for inpatient community hospital stays was also used.
- **PCIS** – The state's PCIS (state mental hospital) data warehouse was used for information on the utilization of state mental hospitals.
- **CTT Staff** -- A meeting was conducted to receive feedback from CTT team leaders, Community Care, and County staff regarding AHCI's analysis of the data. The team leaders also discussed the successes and challenges they have faced since implementation of the CTT program. The team specialists also shared information on their roles, responsibilities, and challenges.

[*] The main focus of the application is to track changes in consumer status. Initially, teams enter a baseline status for each consumer and then modify the record whenever a change in status occurs.

[**] The application also tracks non-behavioral health supports and CTT crisis interventions. Because of difficulties and differences among the teams in accurately tracking these data elements during the earlier months of implementation, they are not included in this report.

Demographics

CTT Enrollment

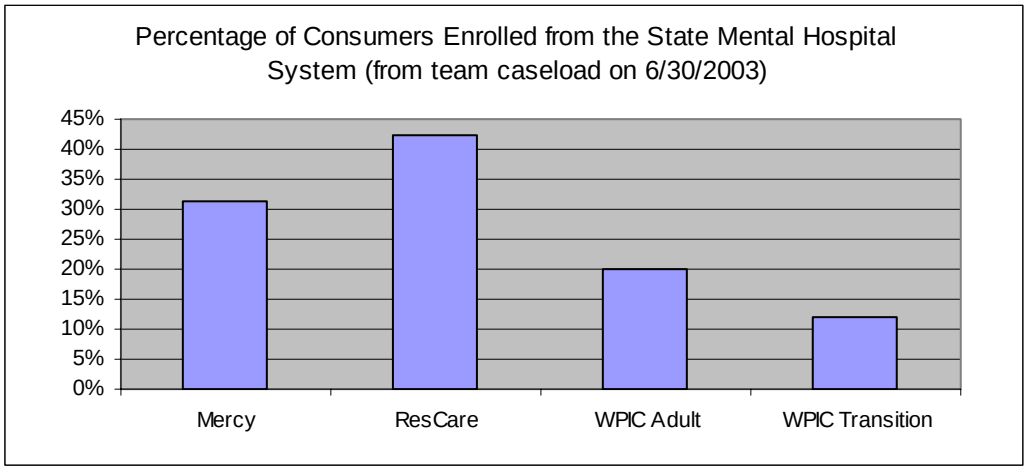
As of June 30, 2003, 266 consumers were enrolled in the four CTTs. The adult teams had 67, 67 and 64 consumers, and the transition age team had 68 consumers.

Of the total number of consumers enrolled in CTT, 247 consumers were HealthChoices eligible and 19 were not HealthChoices eligible at the end of June 2003. Participation in the CTT program is not contingent upon HealthChoices eligibility, although it is expected that many consumers will become eligible for HealthChoices over the course of their engagement with the CTTs.

Primarily two categories of aid are used by HealthChoices CTT consumers, Supplemental Security Income with Medicare (SSIM) and Supplemental Security Income without Medicare (SSI). Consumers qualify for SSIM if they are determined to be aged, blind or disabled for more than two years. During the second quarter of 2003, 69% of CTT consumers who received CTT services were eligible through SSI, and 25% through SSIM. The Residential Care CTT had by far the largest number of CTT consumers eligible through SSIM (45%). For consumers who are HealthChoices eligible through SSIM, inpatient mental health services are primarily paid for by Medicare.

Many referrals originate from the state mental hospital system. Chart 1 below illustrates the percentage of consumers that enrolled in CTTs while in a state mental hospital. Case managers, community hospital inpatient social workers, residential treatment facilities, and family-based providers are also sources of referrals. Community Care care managers also suggest that consumers consider CTT services. According to Community Care, many consumers choose a team that is part of a system with which they are already familiar, or based on their geographical preferences.

Chart 1.



Of the four teams, the WPIC Transition Age CTT has the smallest percentage of consumers who enrolled from a state mental hospital. This is expected, as fewer consumers in this age group are traditionally admitted to the state mental hospital system. The Residential Care Adult CTT has the highest percentage of consumers who enrolled with a CTT while they were in a state mental hospital. The Residential Care Team received the largest proportion of CHIPP funding from Allegheny County, which is funding designated to provide community mental health and support services to people who have been in the state mental hospital system. Because the Residential Care CTT received more of these funds, the team had a much larger percentage of referrals from the state mental hospital system.

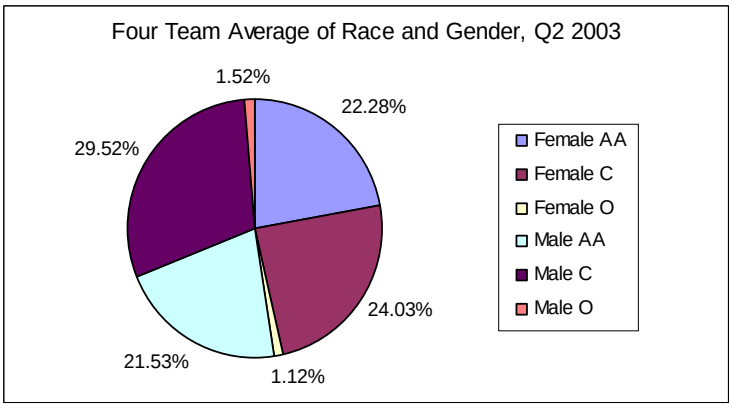
Presumably those who have had significant involvement with the state mental hospital system are likely to have more complex needs and less natural supports than consumers enrolling from other referral sources. As such, differences among the teams based on where consumers enroll from may be related to differences in other areas including housing, overall CTT service utilization, and utilization of non-CTT services.

Age, Gender and Race

The age, gender and race characteristics of the four teams have remained relatively stable since the first quarter of 2002. The three adult CTTs had similar age ranges for consumers enrolled on the teams at the end of the second quarter of 2003. Ages ranged from 22 years to 82 years, with an average age for the three teams of 42.2 years. For the transition age CTT, the ages ranged from 16 to 26 years, with an average age of 20.5 years.

Chart 2 depicts average gender and racial characteristics for the four CTTs, based on team enrollment at the end of the second quarter of 2003.

Chart 2.



When the teams are compared individually to the average, some notable differences emerge.

- The representation of male African-Americans on the WPIC Transition Age CTT is 10% lower than the four team average, and the representation of African-American females is 6% higher than the four team average. This may partially be attributed to an identification issue for transition age, male, African-Americans. Fewer younger African-American males are consumers in the behavioral health system, so fewer may be engaged and identified for referrals.

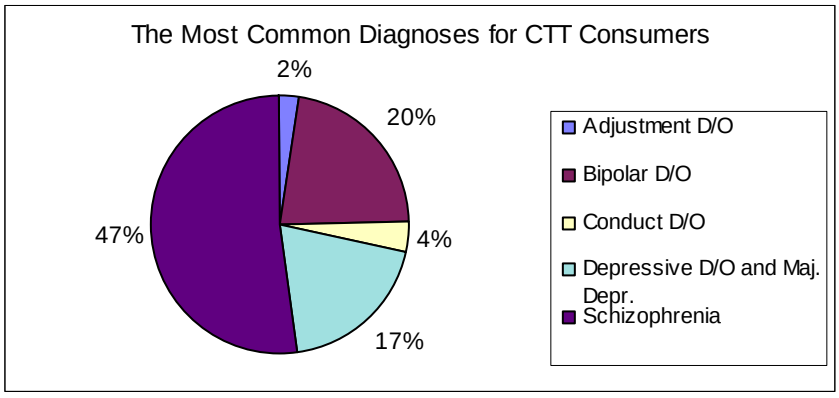
- The representation of African-American males on the Mercy CTT is 7% higher than the four team average.
- The representation of African-American females on the Residential Care CTT is 11% lower than the four team average.
- The representation of Caucasian males on the WPIC Adult CTT is 14% lower than the four team average, and the representation of African-American females is 10% higher than the four team average.

These gender and racial differences among the teams appear to have evolved over time with no specific explanation. Race is not a consideration in Community Care's referral process. Some of the variation can perhaps be explained by geography and personal preference of consumers. As mentioned previously, consumers who are familiar with or live in close proximity to a particular provider often choose to enroll with that provider's CTT. Therefore, the gender and racial composition of the CTTs is likely influenced by the gender and racial composition of the population served by the provider.

Diagnosis

Chart 3 depicts the four team average percentage for the most commonly utilized diagnoses for CTT consumers. This data is based on HealthChoices and County-funded (or base-funded) CTT services during the second quarter of 2003.

Chart 3.



Note: The percentages do not add to 100% because diagnoses associated with a small number of consumers are not graphed.

Schizophrenia is the most common diagnosis for all four teams. While the great majority of consumers on the three adult CTTs had a diagnosis of bipolar disorder, depressive disorder and major depression, or schizophrenia, the percentage of consumers with each diagnosis is different among the teams.

- The WPIC Transition Age CTT has a significant proportion of consumers with a primary diagnosis of adjustment disorder and conduct disorder, while the adult teams do not. These diagnoses are given primarily to children and adolescents and, given the age range of the Transition Age CTT, these diagnoses are expected. Also, this team has the lowest percentage of consumers with a diagnosis of schizophrenia (28%).

- The WPIC Adult CTT has the highest percentage of consumers diagnosed with either depressive disorder or major depression (31%). Forty-six percent (46%) and 15% of consumers have a diagnosis of schizophrenia and bipolar disorder, respectively.

- The Mercy CTT has 46% of consumers with a diagnosis of schizophrenia. Twenty-two percent (22%) and 10% of consumers have a diagnosis of bipolar disorder and depressive disorder or major depression, respectively.

- The Residential Care CTT has the highest percentage (66%) of consumers diagnosed with schizophrenia, which corresponds to the significant percentage of consumers on the team who were enrolled from the state mental hospital. Because of the complexity of schizophrenia as an illness, consumers with this diagnosis compose a large proportion of state mental hospital patients. This team has the smallest percentage of consumers with a diagnosis of depressive disorder or major depression (8%).

In discussions with the CTTs, the teams raised the issue of the considerable amount of time they spend working with people with borderline personality disorder. For CTT consumers who have had HealthChoices-funded CTT claims, it is possible to examine the prevalence of borderline personality disorder as part of the Axis II diagnosis in PsychConsult, Community Care's electronic care management system. On average for the four teams, 24% of CTT consumers have had an Axis II diagnosis of borderline personality disorder for at least one episode of treatment under HealthChoices (not necessarily during their participation in the CTTs). Between 19% and 23% of each of the three adult CTTs' consumers received this diagnosis at some point during the course of their treatment under HealthChoices, while 34% of the transition age CTT's consumers have received this diagnosis.

These numbers may overstate the prevalence of borderline personality disorder, as diagnoses may change over time, or may have been preliminary when entered into PsychConsult. For example, the WPIC Transition Age CTT believes that the number of consumers with a diagnosis of borderline personality disorder has decreased as consumers have joined the team, the team has developed relationships with the consumers, and further assessments have been completed. As treatment progresses, the team is better able to distinguish between behaviors common to adolescence and behaviors suggesting a borderline personality disorder.

In terms of different service utilization during the first and second quarters of 2003, the data confirms the teams' perceptions that the CTT consumers with a borderline personality disorder are receiving more service than those without, as Table 1 illustrates.

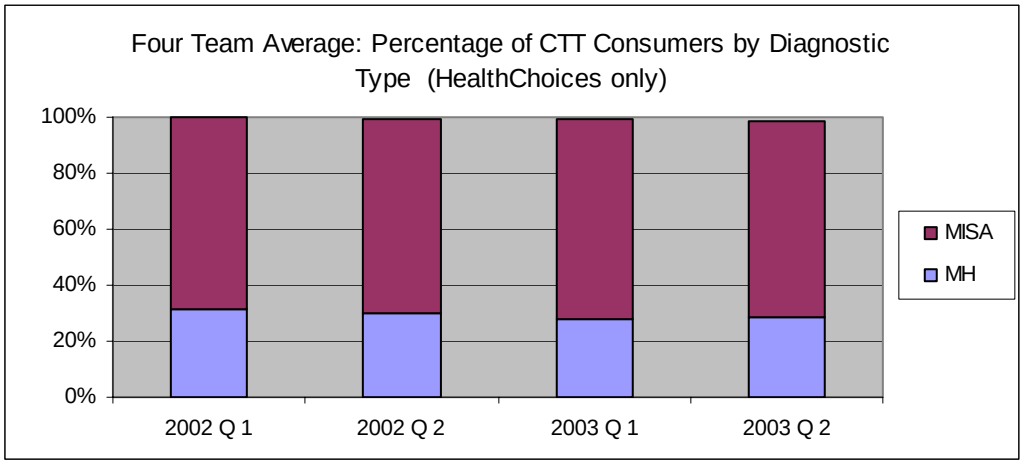
Table 1.

Comparison of Average CTT Units for Consumers with and without Borderline Personality Disorder Diagnosis (BPD)		
	Overall Average CTT units for Consumers with BPD	Overall Average CTT Units for Consumers without BPD
Q1 2003	102	73
Q2 2003	97	65

Diagnostic Type

Research has shown that the co-occurrence of substance abuse/dependence and mental illness is very common. The proportion of CTT consumers with co-occurring disorders, also referred to as mental illness/substance abuse (MISA), is therefore expected to be high for each of the community treatment teams. Chart 4 below illustrates the large percentage of the CTT consumers who have a co-occurring substance abuse disorder. This data is based on diagnosis information entered in PsychConsult, the clinical database tool utilized by Community Care, and therefore includes HealthChoices-eligible CTT consumers only in each quarter.

Chart 4.



As Chart 4 shows, approximately 70% of all CTT consumers have a co-occurring disorder; this has remained stable throughout the four quarters examined. However, the teams have differences in their percentage of consumers with each diagnostic type:

- In any quarter, the Mercy CTT has 87% or more consumers who fall within the MISA diagnostic category.
- The proportion of CTT consumers in the MISA diagnostic category on the WPIC Adult CTT is also very high, ranging from 77% to 83%.
- In contrast, the Residential Care CTT has between 56% and 69% of consumers with a MISA diagnostic type during these four quarters. One reason for this difference is the large percentage of the consumers on the team who were referred from the state mental hospital system, where they were less likely to have access to drugs and alcohol.
- The percentage of consumers on the WPIC Transition Age CTT with a MISA diagnostic type has grown from 28% in the first quarter of 2002 to 58% in the second quarter of 2003. This increase can be attributed to two factors: more recent referrals are including the MISA diagnosis, and some other consumers were not identified as having a co-occurring substance abuse disorder until they participated in CTT service and were further assessed.

Because of the prevalence of co-occurring disorders, an essential part of the recovery process for consumers is recognizing the impact and interaction of co-occurring disorders on their treatment and addressing them concurrently. With the implementation of the performance standards, each CTT must include a Substance Abuse Counselor on staff, and it is expected that CTT consumers will receive treatment from the team to address their substance abuse issues.

The CTTs are working to insure that they are providing adequate MISA treatment to support consumers in their recovery. Each team has approached incorporating MISA services differently, and thus the teams are at different stages in the development of MISA services for consumers:

- The Mercy CTT has recently hired a Substance Abuse Counselor who will provide both individual and group treatment. A 12-step MISA group is held once per week, and the team accompanies members to AA/NA meetings in the community. The team expects that the Substance Abuse Counselor will provide more focused assessment and treatment to support consumers in their recovery from substance abuse and addiction.

- The Substance Abuse Counselor on the WPIC Transition Age CTT conducts MISA groups three times per week. He also holds individual MISA therapy sessions and completes assessments at the request of other team members.

- Two members of the WPIC Adult CTT provide the majority of the MISA treatment. The full-time Substance Abuse Counselor and one of the team's case managers, conduct MISA groups and individual MISA therapy sessions, and also complete drug and alcohol assessments.

C. enrolled with a CTT as a diversion from the state mental hospital. He also had a significant history of drug abuse. When he enrolled with CTT, he was placed in a long-term structured residential (LTSR) program. Through attending both CTT MISA groups and individual MISA sessions, C. has been able to maintain his sobriety. While he occasionally has used alcohol and other substances, he has successfully practiced harm reduction and remained clean from heroin. He also has worked with the CTT psychiatrist on medication maintenance. He has since moved out of the LTSR and is living independently. He also worked with the Vocational Specialist on the team and is now attending cosmetology school.

- The Residential Care Substance Abuse Counselor conducts MISA groups as well. Daily groups were being held for a period of time; this schedule was scaled back because of other demands put on the Counselor's time. The Substance Abuse Counselor also conducts individual MISA work.

In discussions with the team leaders and Substance Abuse Counselors, several common themes related to MISA treatment emerged:

- The provision of substance abuse services through the CTTs is quite different from the traditional 12-step, abstinence-only substance abuse treatment model. The CTTs have the flexibility to use both harm reduction and abstinence principles in their treatment approach. Unlike traditional programs, consumers are not discharged from treatment if they relapse.

- While the Substance Abuse Counselors expressed a desire to have the time to do more individual, formalized treatment, they recognize that the informal contacts they have with consumers in the community (providing transportation or intervening during a crisis, for example) provide valuable and often effective opportunities for discussion of MISA issues.

- The Substance Abuse Counselors encourage consumers to use resources in the community for support in dealing with their addictions. The CTTs help consumers locate AA/NA meetings and often transport and accompany consumers to meetings. For example, on New Year's Eve, the Residential Care Substance Abuse Counselor took a group of consumers to a 12-step gathering.

- While the Substance Abuse Counselors take the lead in providing MISA treatment and are regarded as the MISA expert on the team, they all recognize that the rest of the team staff should and do provide substance abuse treatment.

- The Substance Abuse Counselors agreed that developing treatment strategies for consumers who chronically relapse is challenging. They agreed to meet as a group to discuss difficult cases and problem-solve.

Utilization of CTT Treatment and Services

As the primary service provider, CTTs provide consumers with recovery-oriented rehabilitation, support, and treatment services. The CTT model requires that the team work proactively with the consumers to engage in treatment, help them live independently, and move through the recovery process. CTT services are also necessarily long-term and cyclical, so services are available to consumers based on their individual needs at a particular time in their lives.

CTT services include both group and individualized services and are provided primarily in the community. Each week, the teams offer a variety of group sessions, including MISA groups, socialization groups, life skills groups, health and wellness groups, vocational groups, and dialectical behavioral therapy (DBT)* groups. On an individual basis, CTT staff help consumers find housing, teach daily living skills and money management, participate in treatment planning with other services, provide crisis intervention, individual therapy, and drug and alcohol counseling, and assist consumers in developing and achieving vocational and educational goals. The teams also deliver medications and accompany consumers to appointments and meetings.

> *W. was admitted to CTT while he was inpatient at a community hospital. A couple of days after admission he was released from the hospital with no prescriptions, at his request, to the street, as he had no housing. He stayed at the subway station most nights and the team had difficulty engaging with him and locating him at times. Then, the CTT began receiving his benefits check. This regular contact gave the CTT more opportunity to engage with W. Slowly he came around more often to the team and his interactions with the team have become more positive. After many months of building rapport and working with him, he permitted the CTT to help him move into an apartment.*

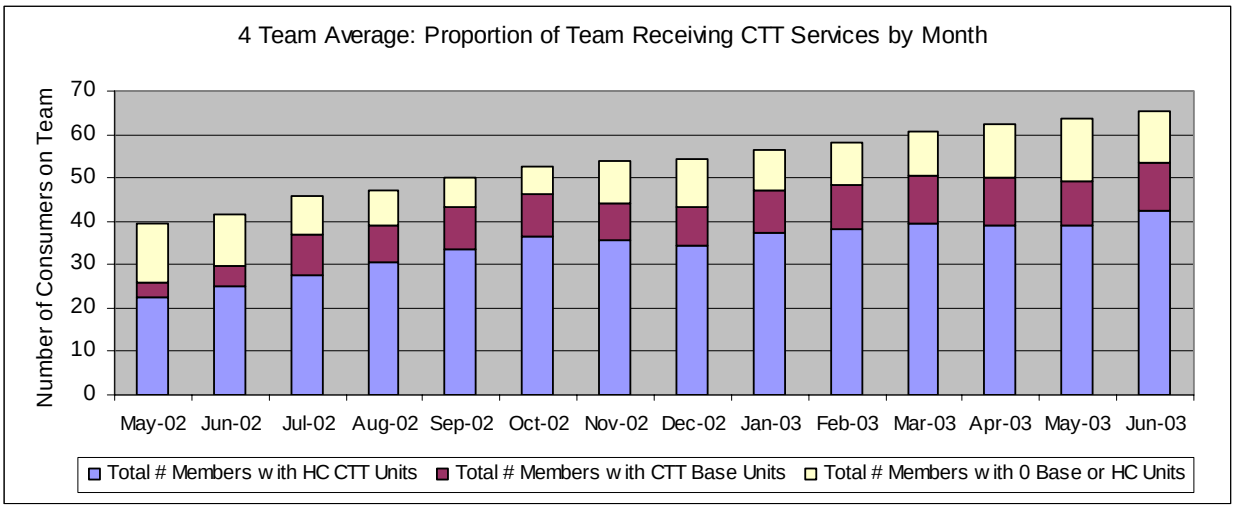
The individual consumer's experience with the team should vary over time, depending on their level of engagement with the team and their needs. Therefore, an established team will include consumers at various points in the recovery process. Generally, one third of consumers require a significant amount of crisis intervention and skill development, one third of consumers require a moderate amount of services, and one third require a small amount of services. CTT consumers who receive small amounts of services may have progressed through their recovery to a significant degree, or the teams may be having difficulty engaging them in services.

Overall, the teams believe their consumers generally fit this case mix profile. At times, the mix will vary, and a larger proportion will be high users of CTT services. Even when consumers have made significant progress in their recovery, they may relapse or have a crisis and require more intensive services for a period of time. Also, the teams recognize that some consumers may be receiving a low intensity of service because they are unwilling to accept more services at the time, despite the teams' attempts at engagement.

* Dialectical Behavioral Therapy (DBT) sessions involve skill-building to reduce behaviors that are self-injurious, behaviors that interfere with treatment, and behaviors that inhibit the individual's quality of life. While initially developed for individuals with a borderline personality disorder, consumers with substance abuse disorders have also had success using this treatment.

In the first two quarters of 2003, approximately $2.16 million in CTT claims were paid with HealthChoices and County funds. Chart 5 examines the patterns of utilization of CTT services as an average of the four teams over time based on this claims data. This analysis looks at data on a monthly basis (rather than quarterly) in order to better discern any fluctuations in the patterns of service delivery.

Chart 5.



As Chart 5 indicates, the majority of consumers receive CTT services under HealthChoices, although some consumers in each month on each team receive CTT services that are funded by the County. On average, the percentage of consumers who are enrolled on CTTs but do not receive any CTT services has decreased from 34% in May of 2002 (the first month that all teams filed claims for CTT services) to 18% in June of 2003. Generally, the number of CTT consumers receiving CTT services has increased as the total enrollment on the teams has increased over time. Each team has some variation around the average.

There are a number of reasons why a consumer may be enrolled with a team but not receive any services within a one month time period:

- The team may be unable to locate a consumer.
- The team may be unable to engage the consumer in services.
- A consumer may be incarcerated.
- A consumer may have been enrolled with the team at the end of one month, but initial contact did not occur until the beginning of the following month.
- Claims may have been submitted or processed incorrectly.

The CTT performance standards require that the team attempts to locate and engage a consumer a minimum of twice per week. While these attempts are documented in consumers' charts, the teams are often unable to bill for these attempts because they are less than 15 minutes. (In order to bill for one unit, the contact must last at least half the 30 minute unit length). Therefore, because the teams cannot bill for services or calls that are less than 15 minutes in duration, the

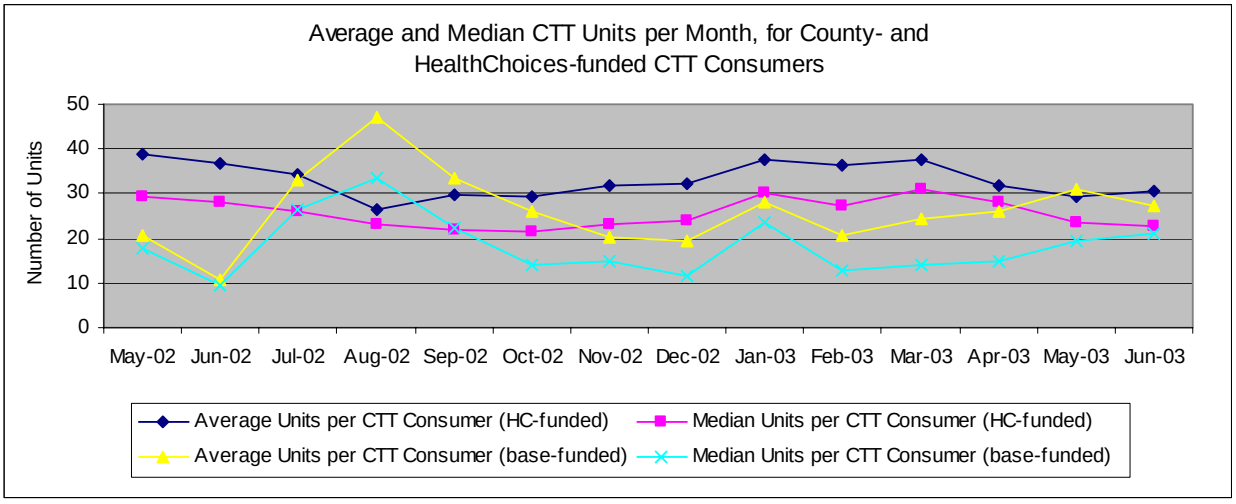
number of consumers with zero CTT claims does not necessarily reflect the attempts to engage consumers or the very short contacts that may be made.*

Also, although the CTTs can still bill for services when a consumer is incarcerated, accessing consumers while they are incarcerated has been a continual problem for the teams because of regulations at the jail. The County recently received a grant which will fund Forensic Specialists for each team. Some of the CTTs have hired individuals for the positions; the County will be training the Specialists for several weeks before they begin their work with the teams. With the addition of these Forensic Specialists, AHCI anticipates that the teams will be able to provide more services and support to CTT consumers who are incarcerated.

Chart 6 shows the average and median monthly units per CTT consumer. It is important to note that the average and median calculations only include consumers who had one or more 30-minute unit of CTT service within the month (i.e. the consumers represented in yellow in Chart 5 are not included in the average or median calculations). Excluding the consumers who did not have County- or HealthChoices-funded CTT units within the month from the calculations results in a description of the intensity of the CTT services provided for those who used CTT services.

The average measure is one way to describe the "middle" amount of CTT units consumers utilize on a monthly basis. Averages can be skewed by a very small number of unusual values. Therefore, it is important to compare the median amount to the average amount of CTT units consumers utilize. The median also describes the "middle" amount, where half of the values in the data fall above the median, and half fall below the median. If the average is greater than the median, more consumers are receiving a lower amount of CTT units within a month than the average might suggest, with a few consumers receiving a high amount of services and thus raising the average.

Chart 6.



Note: All data is an average of the four teams. One unit of service is 30 minutes.

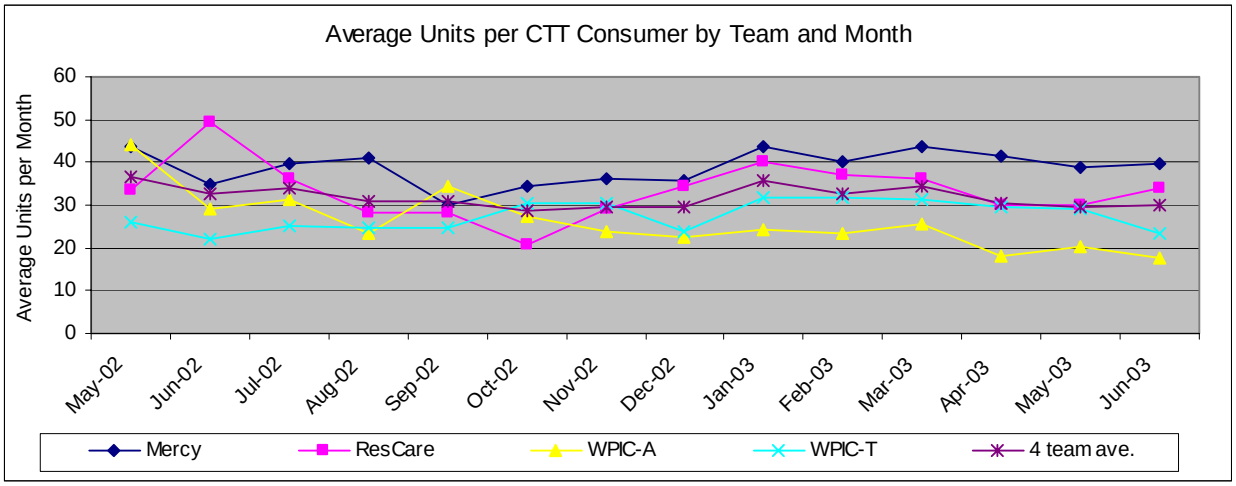
** As of January 1, 2004, the CTT unit designation returned to 15 minutes. CTTs can now bill for contacts that are longer than 7.5 minutes. This may result in fewer consumers appearing to have no units of CTT services.

As Chart 6 illustrates, the average number of CTT units per month for a consumer with HealthChoices funding is higher than the average number of CTT units per month for a consumer with County-funded services. (August 2002 is skewed by four Transition Age CTT consumers who had an unusually high number of CTT units of service.)

CTT consumers are typically covered by County funds at the beginning of their enrollment on a team, and become HealthChoices eligible during their transition onto the team. Therefore, those CTT consumers with CTT services paid for with County funds may be in the initial stages of their involvement with a CTT. They may not have transitioned fully from their previous level of care or engaged with the team and might therefore use fewer CTT services on average. Also, when a consumer is incarcerated or admitted to a state mental hospital, they are no longer HealthChoices-eligible. Therefore, any CTT services that are provided to consumers while they are incarcerated or in the state mental hospital are County-funded; the amount of CTT services provided while consumers are in these settings is less than when consumers are living in the community.

For both County- and HealthChoices-funded CTT consumers, the median units per month are lower than the average units per month. This indicates that the distribution of consumers' CTT units of service is skewed: more consumers are receiving fewer than the average number of CTT units per month. Chart 7 illustrates the average CTT units per month by team.

Chart 7.



Note: One unit of service is 30 minutes. As noted in Chart 5, the proportion of CTT consumers who receive County-funded CTT services is smaller than the proportion of CTT consumers who receive HealthChoices-funded CTT services. The average calculations in Chart 7 take these differences into account.

Between May of 2002 and June of 2003, the four-team average number of units per month per CTT consumer (including both County- and HealthChoices-funded) has fluctuated between 28.76 units per month and 36.44 units per month. (When County and HealthChoices are combined, the average fluctuates less than in the Chart above where they are graphed separately.)

- The Mercy CTT consistently has a higher average number of CTT units per month per CTT consumer than the other teams.
- The WPIC Adult CTT generally has a lower average number of CTT units per month per CTT consumer than the other teams.
- Since the end of 2002, the Residential Care CTT and the WPIC Transition Age CTT have followed the four team average more closely.

Clear explanations for the differences among the teams in terms of the amounts of service provision were not apparent from either the data or from discussions with the team leaders. Further analysis should be completed to examine the question of who is receiving low, moderate and high levels of service on each team, and why differences between the teams occur.

Utilization of Non-CTT Services

Because the CTTs provide comprehensive and individualized services to consumers, a reduction in CTT consumers' utilization of community hospital services, state mental hospital services, and other behavioral health services *that can be provided by the teams* is expected over time.

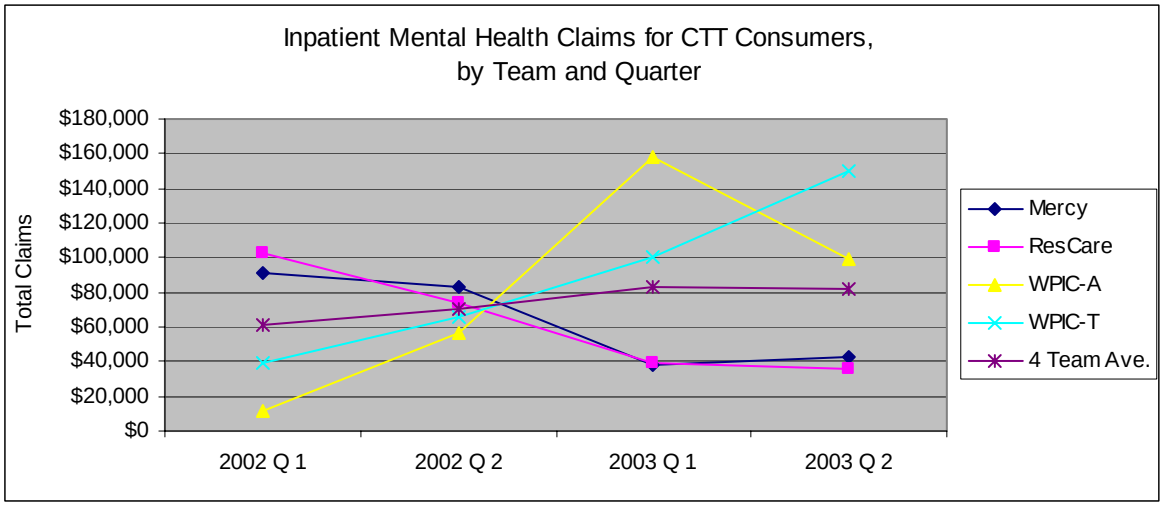
Community Hospital Services

To determine how CTT consumers' utilization of community hospital services has changed from the first and second quarters of 2002 to the first and second quarters of 2003, claims data and authorizations data were examined. The claims data reflects HealthChoices claims only, because only three community hospital inpatient stays were paid for with County funds for CTT consumers during the four quarters examined.

Inpatient Mental Health Claims by Quarter

Chart 8 graphs the total claims paid for inpatient mental health services by quarter and by team. (Total claims are not adjusted for the increases in team size over time.) This data suggests that, on average, the total claims paid for inpatient mental health hospital stays have increased somewhat since the community treatment teams began.

Chart 8.



While it is important to track these totals, relying on total claims paid data presents an incomplete picture of the CTT consumers' utilization of inpatient community hospital services in several respects:

- Each team's total enrollment grew over the four quarters examined. The claims data does not control for the increase in team size.
- Total dollars do not necessarily match the patterns of inpatient admissions and units. For a consumer who is eligible as Medicare primary (SSIM), the inpatient stay may not be paid for by HealthChoices. Therefore, actual dollars paid for inpatient stays may be under-reported in the data.

- The claims data is based on the dates of the inpatient stay, and does not allow for an examination of how consumers' utilization of inpatient hospitalization services changed depending on how long they are involved in treatment with the teams, or whether or not the average length of stay changed.

Table 2 presents the ratio of total inpatient mental health units used by CTT consumers to the total number of CTT consumers. Dividing the number of inpatient units by the number of consumers enrolled on each team controls for differences in the team sizes over time.

Table 2.

Ratio of Inpatient Mental Health Units to Total Number of CTT Consumers, by Team				
	2002 Q 1	**2002 Q 2**	**2003 Q 1**	**2003 Q 2**
Mercy	4.26	3.43	1.45	1.21
Residential Care	4.89	2.89	2.86	1.13
WPIC Adult	1.24	2.41	4.48	2.70
WPIC Transition	2.17	2.70	2.70	3.81
4 Team Average	3.53	2.86	2.89	2.21

Since the first quarter of 2002, the four team average of inpatient units per CTT consumer decreased, from 3.53 days per consumer to 2.21 days per consumer. Different patterns exist at the team level:

- The average number of inpatient units per CTT consumer for both the Mercy and Residential Care CTTs has decreased since the first quarter of 2002.
- CTT consumers on the WPIC Adult CTT have used more inpatient units per consumer over time, with the highest ratio occurring during the first quarter of 2003.
- The average number of inpatient units per CTT consumer for the WPIC Transition Age CTT has increased over time.

Inpatient Mental Health Average Length of Stay by Quarter

Analyzing authorizations for inpatient services allows average length of stays to be calculated. Table 3 provides data for the average length of stay for CTT consumers and for the HealthChoices population as a whole.

Table 3.

Average Length of Stay Comparison (measured in days per episode)				
	Q1 2002	Q2 2002	Q1 2003	Q2 2003
HealthChoices population	9.3	9.3	9.4	8.7
CTT Consumers	10.2	8.4	10.7	9.5

As Table 3 shows, the average length of stay, on average for the four teams, has remained relatively stable since the first quarter of 2002. Aside from the second quarter of 2002, the average length of stay for CTT consumers is somewhat higher than the average length of stay for the entire population.

Inpatient Mental Health Authorizations and Average Length of Stay by Enrollment Date

In order to examine if CTT consumers' utilization of inpatient hospitalization services has changed depending on how long they are involved in treatment with the teams, one additional analysis was completed. Using CTT consumers enrolled as of January 1, 2003, the six months before and after each individual's CTT enrollment date were examined for inpatient episodes. The results of this analysis are graphed in Charts 9 and 10 below.

Chart 9.

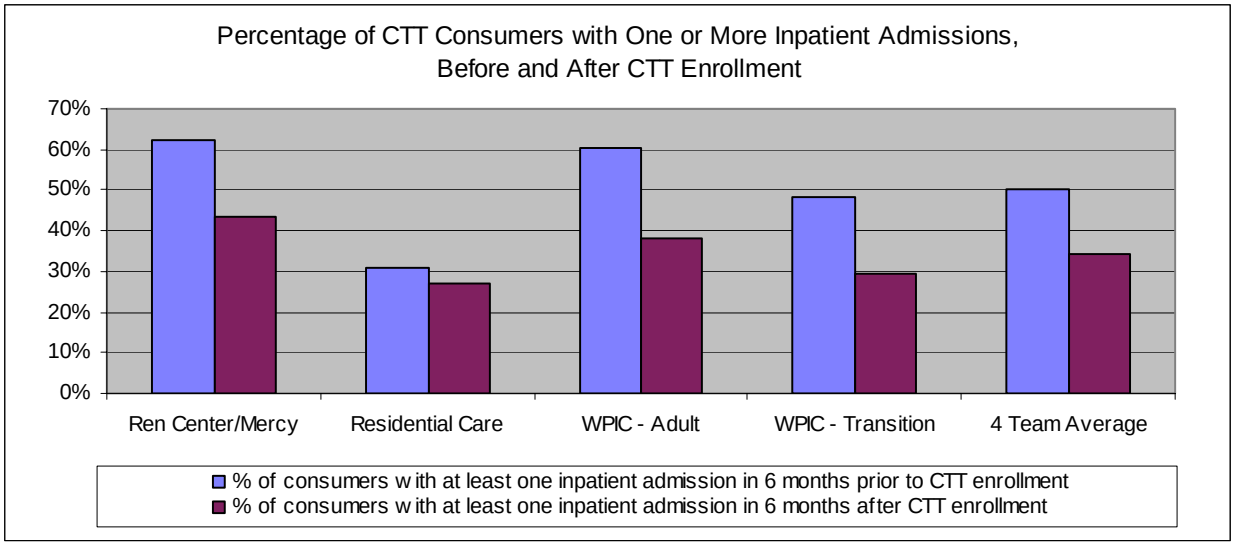
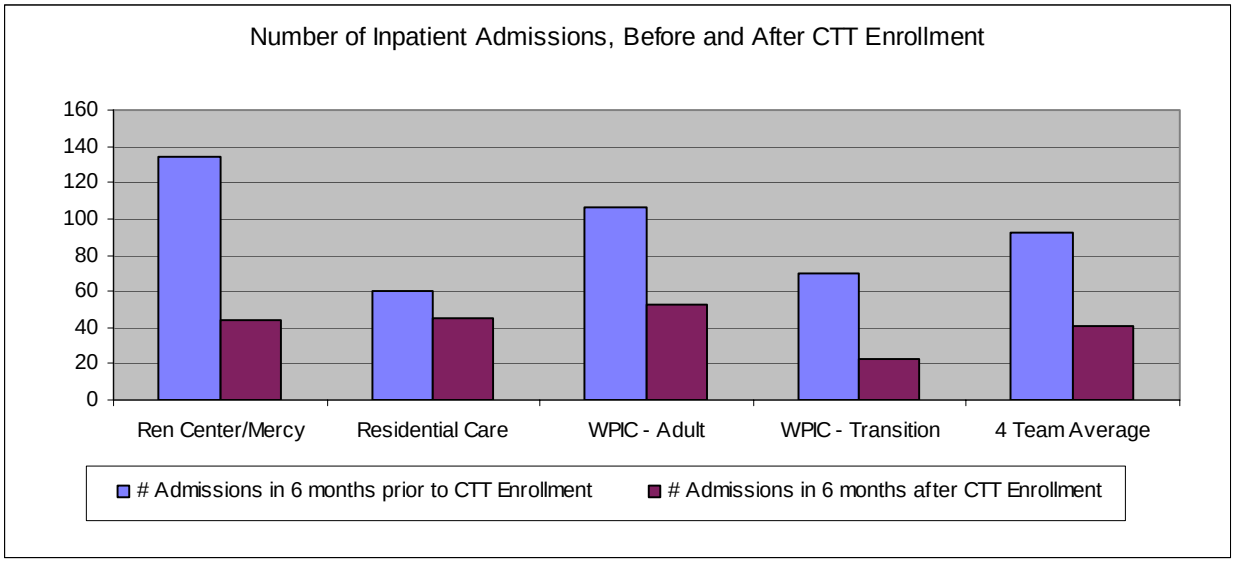


Chart 10.



Note: These graphs show HealthChoices inpatient mental health admissions (based on authorizations). Only 3 consumers (4 admissions) had inpatient mental health stays paid for with County funds in the six months prior to their admission to the teams. No consumers had inpatient mental health stays paid for with County funds in the six months after enrolling on the teams.

The percentage of CTT consumers with at least one inpatient admission decreased in the six months after CTT enrollment for each of the teams. On average for the four teams, 50% of CTT consumers had at least one inpatient admission in the six months prior to their enrollment with CTT, while only 34% of CTT consumers had at least one inpatient admission in the six months after their enrollment with CTT. The Residential Care CTT had the smallest percentage of consumers with an inpatient stay before enrollment, partly because so many of their consumers were in the state mental hospital before enrollment (discussed below). Also, the total number of admissions decreased in the six months after CTT enrollment for each team. On average for the consumers on the four teams, the total number of admissions decreased from 92.5 in the six months prior to admission to 41 in the six months after admission. Table 4 provides further analysis for the distribution of these admissions.

Table 4.

	Frequency of Multiple Inpatient Mental Health Admissions, before and after CTT Enrollment			
	Inpatient Admissions 6 months before CTT enrollment		Inpatient Admissions 6 months after CTT enrollment	
	% of team with at least one admission	% of these who had multiple admissions	% of team with at least one admission	% of these who had multiple admissions
Mercy	62%	75%	43%	61%
ResCare	31%	88%	27%	64%
WPIC Adult	60%	77%	38%	54%
WPIC Transition	48%	69%	30%	27%
4 Team Ave.	50%	77%	34%	52%

Both before and after enrollment with a team, a large percentage of CTT consumers with an inpatient stay had multiple admissions, although there was a decrease in the six months after enrollment with the teams. For each of the teams, and on average, fewer consumers had multiple inpatient admissions in the six months after their enrollment on the teams. This suggests that the CTTs are:

- Helping consumers plan for and manage crises;
- Working with consumers to identify symptoms of decompensation and stressors, and develop coping skills;
- Actively employing crisis diversion activities when possible; and/or
- Providing more individualized and flexible services and support to better meet consumers' needs.

T. frequently visits emergency rooms when she has a crisis. While these crises relate to issues in her life outside of her mental illness, she often was admitted for inpatient mental health services prior to her enrollment with the CTT. Since her enrollment, the CTT and two hospital emergency rooms have worked out crisis plans. The CTT is called immediately when T. presents at the ER. The ER staff provides her with a cot and a snack so she can be comfortable, but she is not admitted. The CTT staff picks her up or the ER provides her with transportation when she is ready to leave. To complement this crisis plan, her CTT therapist and the rest of the team are working with T. to develop her coping and interaction skills.

The teams work actively to stabilize and divert consumers from the inpatient units, and individual crisis plans are sometimes developed with consumers. During the early implementation of the teams, communication and coordination with the inpatient units was a challenge for the teams. The inpatient units are now required to alert the CTTs before a consumer is admitted so the team can attempt to divert the consumer, or if diversion is not possible, be involved in the admission and treatment planning process. Furthermore, Community Care is supposed to alert the CTTs when the inpatient unit calls for an authorization. Often, the CTTs were finding out about consumers' admissions to inpatient units well after they were admitted, especially for consumers whose primary coverage was Medicare.

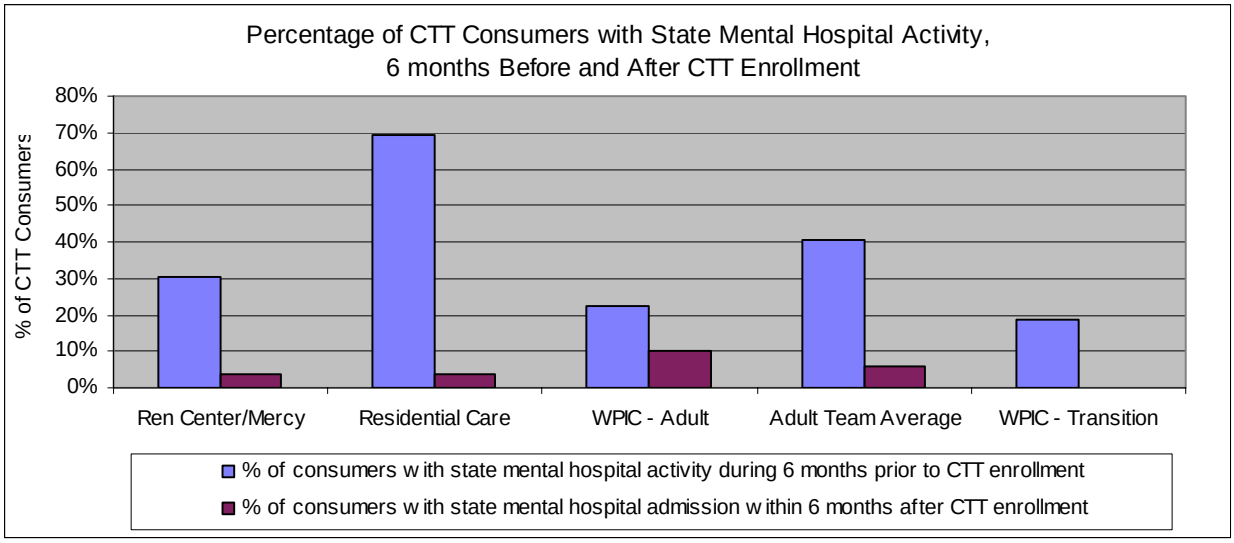
Generally the teams have experienced improvement in the communication and coordination with the inpatient units, although problems still persist. Community Care has changed their process with the inpatient units so they are more involved in an admission even if they are not the primary insurance (i.e. for consumers whose primary coverage is Medicare). Also, as the CTTs have developed relationships with the inpatient units, better coordination has resulted. In multiple instances, the CTTs have worked with inpatient units to develop crisis plans for individual consumers that have helped with diversion planning.

While consumers' utilization of inpatient services decreased in the six-month period after their enrollment with a CTT, significant utilization of inpatient services has continued. As coordination with Community Care and inpatient units improves, and the CTTs continue to improve diversion and stabilization efforts, AHCI expects inpatient utilization to decrease further.

State Mental Hospital Services

Because so many CTT consumers have significant histories of involvement with the state mental hospital system, it is important to determine if consumers are able to sustain living in the community with the support of a CTT. Using the January 1, 2003 population of the teams, the six months before and after each individual's CTT enrollment date were examined for state mental hospital involvement. The results are graphed in Chart 11.

Chart 11.

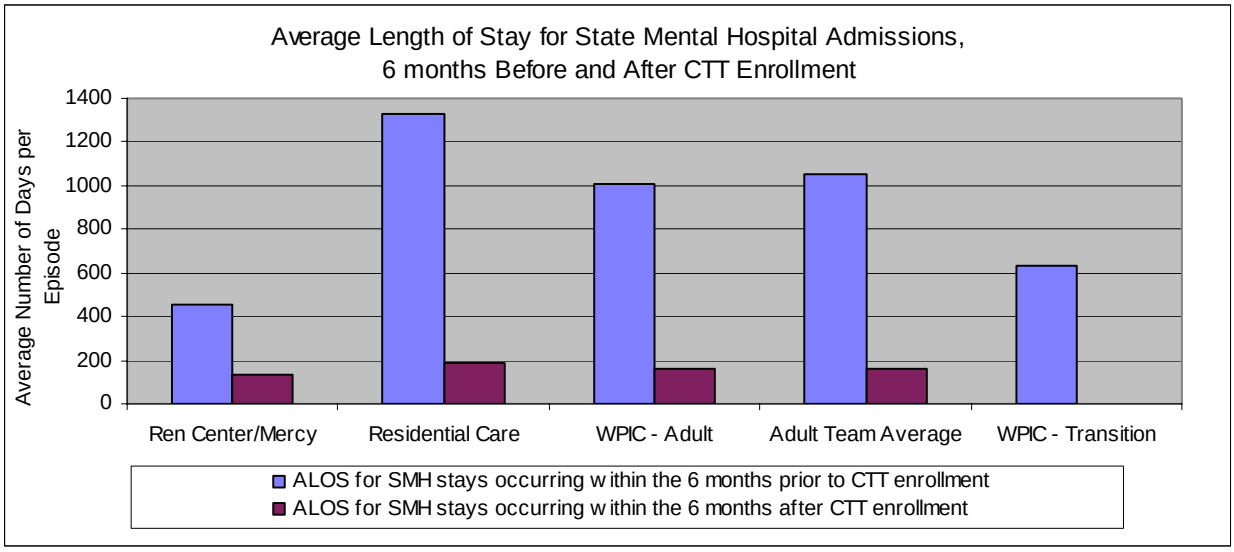


Note: Consumers who have been admitted to the state mental hospital since their CTT enrollment and who have not yet been discharged are included. Two consumers are not included because they were admitted to the state mental hospital prior to their CTT enrollment and have not been discharged, so no comparison can be made. Three other consumers are not included because of incomplete state mental hospital admission data.

As discussed previously in the Enrollment section, many CTT consumers were enrolled with a CTT while they were in a state mental hospital. As Chart 11 indicates, an even greater percentage of CTT consumers were in the state mental hospital system at some point within the six months before their CTT enrollment. The Residential Care CTT had by far the highest percentage (70%) of consumers who were in the state mental hospital within the six months before their CTT enrollment. Each team has experienced a very significant decrease in the percentage of consumers admitted to the state mental hospital six months after CTT enrollment (episodes beginning before CTT enrollment are excluded).

Furthermore, the average length of stay for a state mental hospital admission has significantly decreased for stays that occurred after a consumer's CTT enrollment. As illustrated in Chart 12 below, the average length of stay exceeded 2 ½ years (adult team average) for episodes that occurred before a consumer enrolled with CTT. The average length of stay for admissions that occurred after a consumer was enrolled with CTT is 158 days (adult team average).

Chart 12.



Note: The ALOS includes the entire number of days for each episode, regardless of hospital admission date or CTT enrollment date (so an episode could have begun earlier than six months before CTT enrollment and extended past CTT enrollment). Three episodes where a consumer has been admitted but not yet discharged are excluded from the ALOS calculation.

The teams take an assertive approach when working with consumers who are in the state mental hospital. When a referral is made to a team, the CTTs make face-to-face visits to the consumer at the state mental hospital at least once a week to begin the engagement process. Generally, the CTTs also call the hospital social worker on a weekly basis for updates and for treatment planning purposes. Teams also try to bring consumers to groups at the CTT office and to see consumers more often to further the transition process as the discharge date approaches.

B. had been a consumer at the state hospital for nine years when he enrolled with the CTT. Initially, the CTT visited him at the state hospital, and then began taking him off grounds for lunch. As his discharge approached, the CTT would bring him to CTT social groups with other consumers. Over this one year engagement process, the CTT gradually developed a strong relationship with him. On his discharge from the hospital, B. moved to an enhanced personal care home. Since being back in the community, B. participates in the team's socializing and recreational activities. He also regularly visits with the CTT Peer Specialists in the community.

The length of time the teams work with a consumer in the state mental hospital varies widely. For some consumers, there is a very short time period between the referral to CTT and discharge from the hospital. For others, there is a lengthy time period between the referral and discharge, sometimes caused by challenges in finding the consumer an appropriate living arrangement. In particular, consumers discharged to long-term structured residences may experience delays as they wait for an opening in this level of care.

Other HealthChoices Services

Because the CTTs provide comprehensive and individualized services to consumers, another goal of the teams is to decrease consumers' utilization of other behavioral health services *that can be provided by the teams*. Other services not provided by the teams may be used when medically necessary. The following charts depict the utilization by CTT consumers of the four most utilized levels of care (based on numbers of consumers, excluding inpatient mental health services) paid for by HealthChoices over the four quarters covered in this report: case management services, non-hospital rehabilitation services, partial hospitalization services, and respite services.

Chart 13.

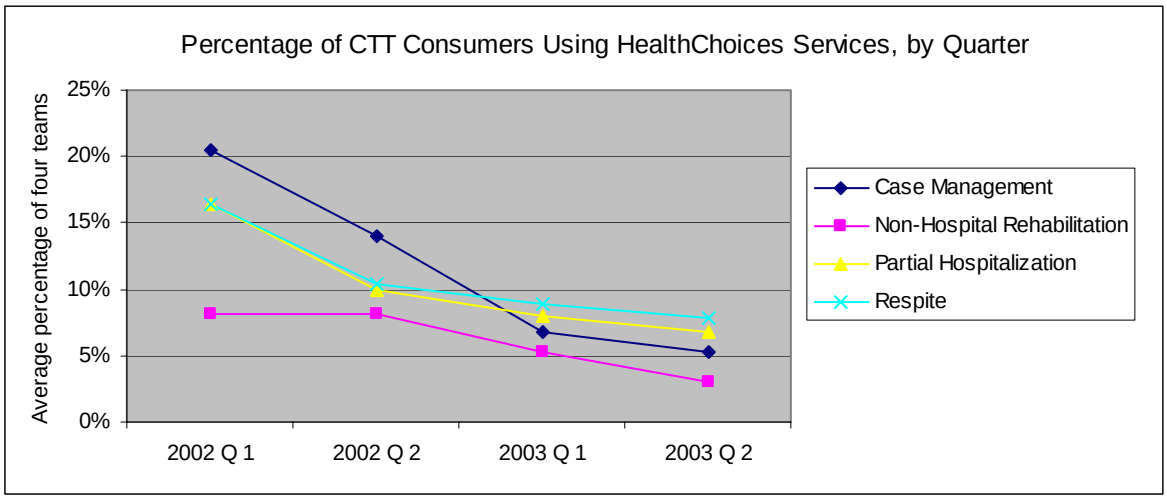
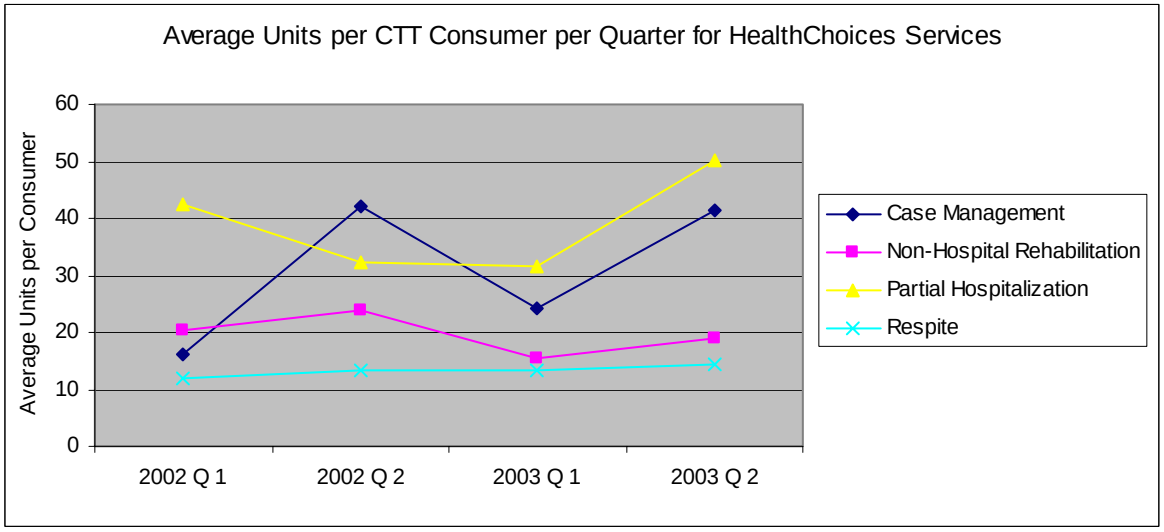


Chart 14.



Note: The average is calculated by dividing the total number of units by the number of consumers utilizing the service so intensity of services provided can be examined. It does not include consumers on the team who did not utilize any units of the service. (It is the average of the consumers of the team utilizing a particular service, not the team average.)

Chart 13 illustrates that the percentage of consumers on the teams utilizing each of these services has declined since the teams began enrolling consumers in the first quarter of 2002. Overall, the total claims paid for CTT consumers utilizing these levels of care have not increased significantly as the team enrollments have increased.

- It is expected that consumers will still utilize case management services as they transition on or off a CTT, so some percentage of a team could always utilize this level of care. Many referrals to CTTs originate with a case manager, so these consumers will often continue to utilize their case manager as they transition to the team. For those CTT consumers who use case management services, the average number of units per quarter has fluctuated (see Chart 14).

- Because CTT consumers have diverse and significant treatment needs, it is reasonable to expect that some consumers will need the services provided by non-hospital rehabilitation, partial hospitalization, and respite levels of care. Because the number of consumers with co-occurring disorders is so large, it is expected that some will need more intensive substance abuse treatment than can be provided by the CTTs. Thus, the utilization of non-hospital rehabilitation services can complement the CTT services and support consumers in their recovery.

> *J. had a chronic cycle of decompensating, going to a community psychiatric hospital, and finally going to the state hospital for stabilization. Recently, this cycle was about to repeat itself. CTT recognized this and was able to enhance services to a large degree: the team spent entire days with her, placed her in respite care, encouraged her to take her medications, and had someone stay 1-on-1 with her while in respite at night. Because of this intervention and support, J. was able to break the hospitalization cycle and is now stabilizing back in the community.*

- Consumers on all four teams use respite services. Respite services are often used as diversion placement from inpatient services, or as a step-down placement from inpatient services. The teams work assertively and creatively to insure that respite serves as an effective diversion. Respite programs may not be staffed to provide intensive one-on-one services needed by the consumer; the teams may provide one-on-one interventions themselves or contract with another service provider to support the consumers at the intensity required.

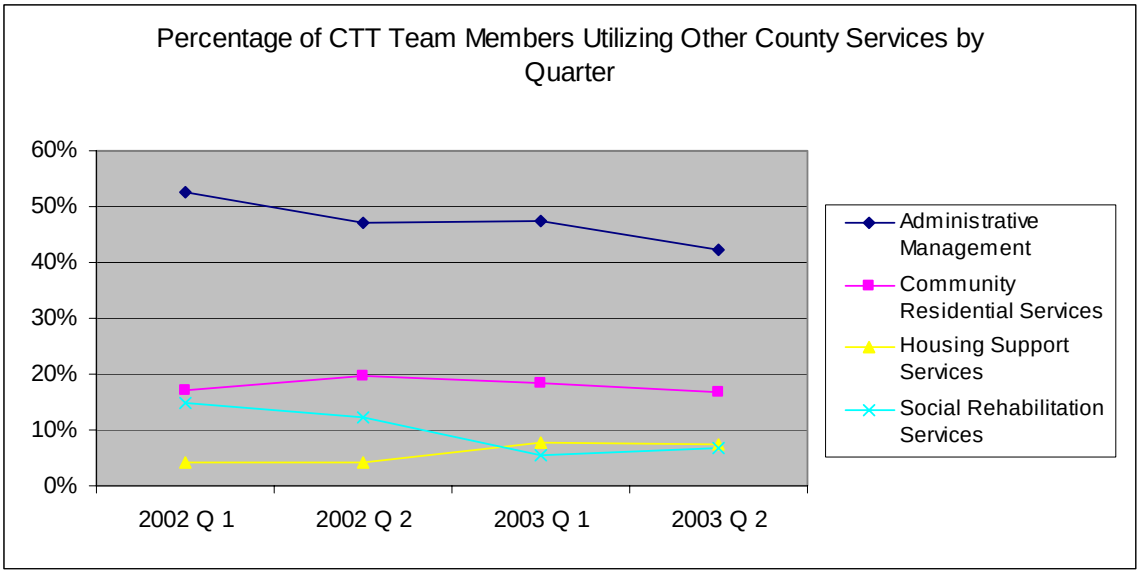
- Many respite programs also provide partial hospitalization services. In the four quarters examined, between 40% and 100% of consumers who used respite services also used partial hospitalization services. A CTT may also pick up a consumer in respite and bring them to the team offices for the day so they can attend groups and receive treatment while they are in respite. The teams and consumers have perceived that consumers could not remain at the respite program during the day. However, respite programs are staffed for consumers to remain during the day; clarifying this point with the teams could result in lower utilization of partial hospitalization services.

As the team enrollments have grown, the number of consumers utilizing these other levels of care has remained small. Therefore, the percentage of consumers on the teams utilizing these levels of care has logically decreased.

Other County-funded Services

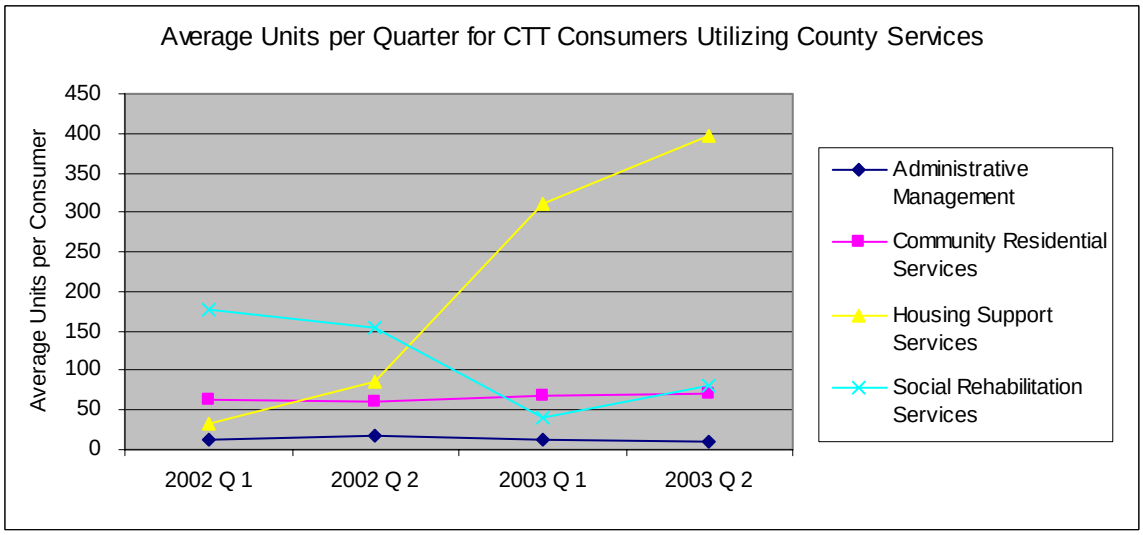
The following charts depict the utilization of the four most utilized levels of care by CTT consumers (in terms of number of consumers) paid for with County funds over the four quarters covered in this report: administrative management, community residential services, housing support services, and social rehabilitation services.

Chart 15.



Note: Four team average.

Chart 16.



Note: The average is calculated by dividing the total number of units by the number of consumers utilizing the service so intensity of services provided can be examined. It does not include consumers on the team who did not utilize any units of the service. (It is the average of the consumers of the team utilizing a particular service, not the team average.)

As Chart 15 indicates, on average for the four teams, between 42% and 52% of CTT consumers utilize administrative management services. The Mercy and Residential Care CTTs have

significantly higher percentages of consumers accessing administrative management services within a quarter (generally 20% higher than the two WPIC CTTs). For those CTT consumers who have received administrative management services, on average, they have received between 10 and 18 units per quarter over the four quarters examined. While the percentage of consumers using administrative management is high, the average number of units utilized is low.

The most common administrative management services provided to CTT consumers include case conferences (with a direct service provider or the client), case linking through phone contacts, monitoring conferences (with client and long-term care staff), and outreach. Administrative management tasks are performed by state mental hospital and forensic liaisons. Their direct involvement with the teams varies. Some teams have very little direct interaction with their liaisons while others collaborate with their liaisons more regularly. For example, the state mental hospital liaison for the WPIC Transition Age Team attends the CTT meeting once a week to coordinate information sharing and planning for consumers. Generally, the CTTs are not always knowledgeable about administrative management services and there is not a clear process for linking these services with the CTT services.

CTT consumers also use community residential services which provide funding for personal care homes, group homes, long-term structured residential programs, and supervised apartments. On average for the four teams, the percentage of consumers utilizing these services has remained constant over the quarters examined. The average units per quarter for those consumers who use the service has remained constant as well.

- The Residential Care CTT has experienced the most change in terms of the percentage of consumers receiving these services from the early implementation of the teams through the end of the second quarter of 2003. Initially, 38% of Residential Care's consumers were using community residential services, which decreased to 25% at the end of the second quarter of 2003.
- The Residential Care CTT also has had the largest percentage of consumers using community residential services. This may be related to the large proportion of the team that was referred from the state mental hospital. Consumers referred from the state hospital may have as a condition of their discharge, or recommendation in their discharge plan, for a referral to more structured living arrangements.
- The percentage of consumers receiving these services on the WPIC Transition Age CTT has grown from 7% during the first quarter of 2002 to 18% at the end of the second quarter of 2003.

Housing support services provide support services to a consumer living in the community. This service is an alternative to a more restrictive service (community residential rehabilitation, for example) or a step-down from it. The services are varied and include face-to-face contacts, rent subsidies, rent or other guarantees, and indirect services. On average, a very small percentage of the CTT consumers utilize this service. The Residential Care CTT has had the largest percentage of consumers utilizing this service, from 11% in the first quarter of 2002 to 18% in the second quarter of 2003. The average quarterly units of housing support services have shown a marked increase from the early implementation of the teams to the end of the study period. These numbers are highly skewed by one consumer on the Transition Age CTT, who receives 16 hours

a day of housing support services because of his high needs (his diagnosis includes pervasive development disorder).

The percentage of CTT consumers using social rehabilitation services has decreased from a four-team average of 15% in the first quarter of 2002 to an average of 7% in the second quarter of 2003. The average units per quarter for consumers who utilize these services have also decreased since the early implementation of the teams. Because the teams provide treatment groups and vocational services, social rehabilitation services may in some cases be duplicative for CTT consumers. However, social rehabilitation services are a source of peer support, and therefore may complement CTT services.

Community Integration: Housing, Employment, and Peer Support

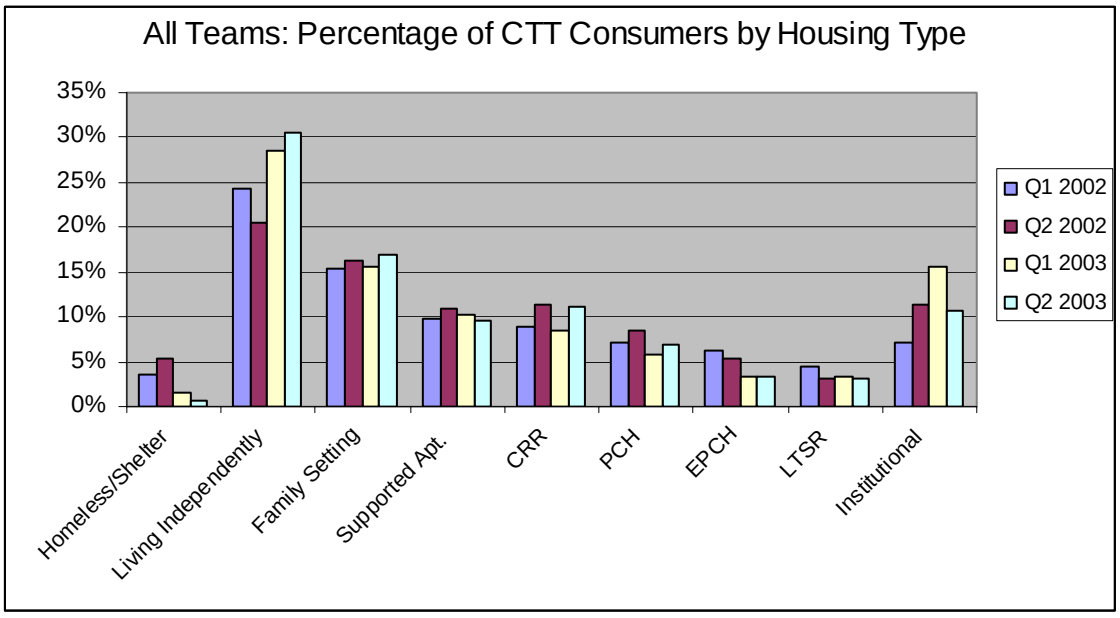
A recovery-oriented behavioral health system focuses not only on behavioral health and substance abuse treatment services. Providing supports to integrate consumers in the community, through their living arrangements, vocational and educational opportunities, and peer support networks is essential for rehabilitation and recovery. Because CTTs provide not only treatment but supports in these other areas, it is important to also examine outcomes in living arrangements and housing stability, employment and educational status, and peer support.

Living Arrangements and Residential Treatment Options

A major priority for CTT consumers is acquiring and maintaining safe and appropriate housing. Based on what type of living arrangement the consumer is interested in and what has and hasn't worked in the past, the consumer and the team work on securing the appropriate living arrangement.

CTT consumers utilized a variety of living arrangements throughout the report study period. Some settings include a treatment component, while others do not. Chart 17 depicts the average percentage (for the four teams) of consumers living in the nine most utilized housing categories (definitions for each category are provided in the appendix). The housing types are organized from less restrictive (e.g., living independently or in a family setting) to more restrictive (e.g., LTSR or institutional setting). The housing status on the last day of each quarter for each consumer is included.

Chart 17.



CRR: Community Residential Rehabilitation
EPCH: Enhanced Personal Care Home
LTSR: Long Term Structured Residences
PCH: Personal Care Home

For each of the four quarters, a larger average percentage of CTT consumers were in independent living situations than in any other housing category. While many of the categories appear to remain relatively constant over the four report quarters, differences exist when the data is examined at the team level.

- In general, the Mercy CTT has had a smaller percentage of consumers than the four team average in several of the more restrictive levels of care including CRRs, PCHs, and LTSRs. More have lived independently or in a supported apartment than the four team average, while fewer have lived in a family setting than the four team average. From the early implementation of the Mercy CTT, the distribution of consumers across the different housing categories has fluctuated only slightly, except for an increase from 9% (Q1 2002) to 17% (Q2 2003) of consumers living in a supported apartment.

- The Residential Care CTT has had a larger percentage of consumers than the four team average in more restrictive levels of care including CRRs, EPCHs, and LTSRs. Fewer have lived independently or in a family setting than the four team average, while more have lived in a supported apartment than the four team average. From the early implementation of the Residential Care CTT, the distribution of consumers across the different housing categories has fluctuated in several categories: decreases in the percentages of consumers residing in EPCHs (15% to 9%), LTSRs (12% to 6%), and supported apartments (24% to 16%), and an increase in the percentage of consumers living independently (3% to 11%). These trends are associated with the high number of initial referrals from the state mental hospital. Consumers referred from the state hospital may have as a condition of or recommendation in their discharge for a referral to more structured living arrangements.

- The WPIC Adult CTT has not had any consumers reside in an EPCH or supported apartment, and none in an LTSR during the first and second quarters of 2002. More consumers on the WPIC Adult CTT lived independently than the average. This may be related to two factors. First, fewer consumers were discharged from the state mental hospital, so fewer consumers had recent, lengthy institutional living environments. Second, more consumers have diagnoses related to depression; maintaining an independent living situation with these diagnoses (as opposed to schizophrenia or bipolar disorder) may pose fewer challenges.

- Between 36% (Q1 2002) and 40% (Q2 2003) of consumers on the WPIC Transition Age Team were living in a family setting, about double the four team average. Since this group of consumers is younger, they often have more family supports than older consumers. Because of the chronic and persistent nature of the illnesses for many older consumers, relationships with their families have been strained or seriously damaged over time. And, like the general population ages 16-26, many young adults choose to live with their families. The WPIC Transition Age CTT also had a somewhat higher percentage of consumers who resided in a CRR for each of the four quarters. While some consumers of this age need a more structured environment, CRRs are often not suitable for the needs of this age group.

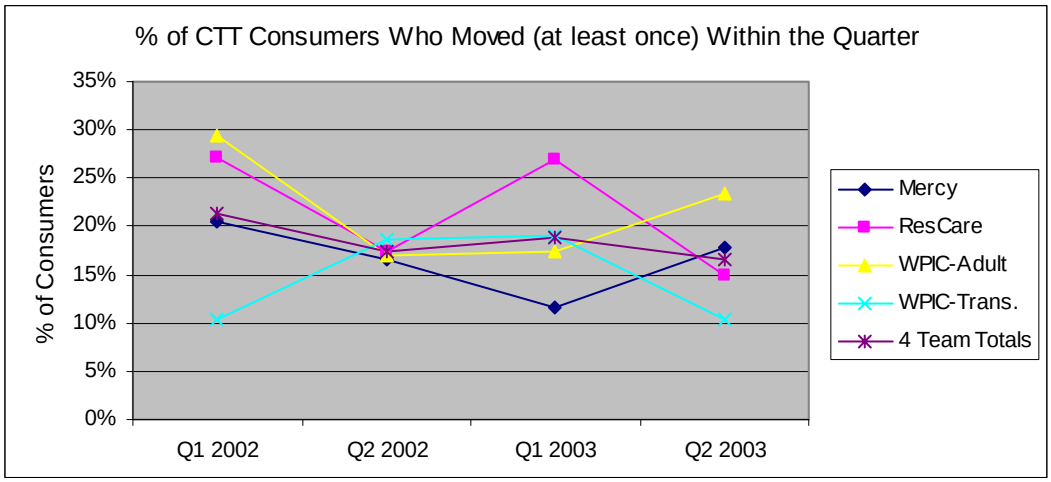
Conversations with CTT staff suggest the need for more independent and supported housing where services and supports are provided primarily by the team, rather than in a more restrictive environment. In addition, the CTT staff has expressed a need for “damp” housing. This type of housing does not exclude individuals who have been using alcohol.

Stability of Living Arrangements

The data in the previous section outlines the different living arrangements consumers have on each of the teams, differences between the teams, and how the distributions of team consumers in these different arrangements have changed. Two further questions regarding living arrangements must be examined: Are consumers' living arrangements stable, or do consumers move often? Are changes in living arrangements to a less restrictive setting?

Chart 18 illustrates the percentage of consumers on each team that moved at least once within each quarter examined. The percentage of all CTT consumers who moved at least once within a quarter decreased somewhat from 21.5% (Q1 2002) to 16.5% (Q2 2003). When the data is examined at the team level, the data fluctuates above and below the four team totals.

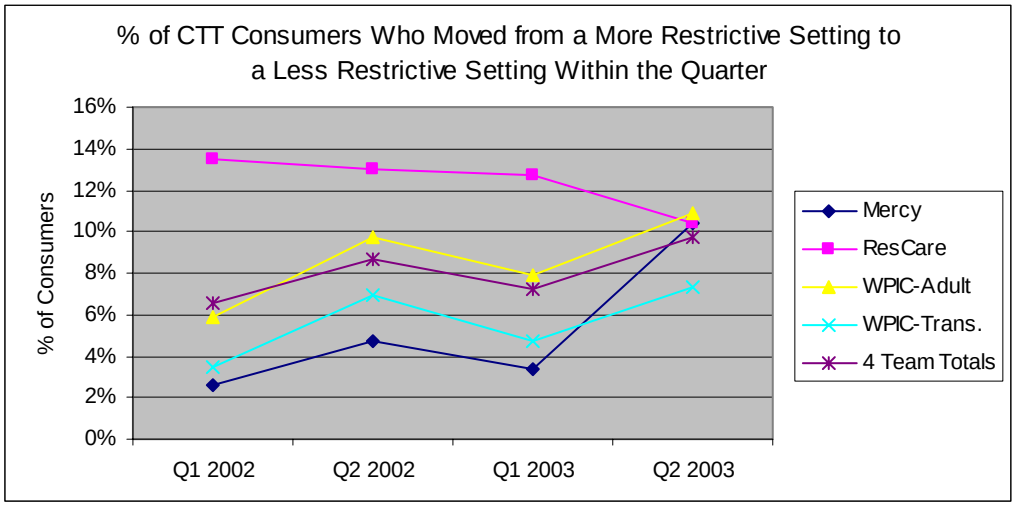
Chart 18.



Determining whether all these changes indicate that consumers are moving to an improved setting is more complicated. Changes from one living arrangement to another can be categorized as "more to less restrictive," "less to more restrictive," or "to the same level." Changes involving homelessness are not included in these categories. Generally, a change in living arrangement from more to less restrictive is considered a positive change, but this is not necessarily the case (if there is a move to a more restrictive setting that provides necessary drug and alcohol treatment, for example, it would be considered a positive).

Chart 19 shows the percentage of CTT consumers who moved from a more restrictive to a less restrictive setting within each quarter. The four team total has remained relatively stable over the four quarters examined. A larger percentage of the Residential Care CTT may have moved from a more to less restrictive setting because a larger percentage of consumers began their participation with the CTT in more restrictive settings.

Chart 19.



For each quarter examined, between 4.8% and 7.4% moved from a less restrictive to a more restrictive setting (not graphed). Between 2% and 6% of CTT consumers moved from their living situation into homelessness (not graphed).

As seen above in Charts 17 and 18, many consumers are still living in highly structured arrangements and a significant percentage move within a three-month time period. This partially reflects consumer-driven changes as they move through the recovery process. However, the team leaders acknowledge that challenges to supporting consumers in living arrangements do persist. The strict requirements of some treatment programs make it difficult for consumers to maintain their stability. For example, many require strict abstinence from alcohol even if alcohol abuse is not an issue for a consumer, again suggesting the need for "damp" housing. Transition age consumers may need a structured housing environment, but available placements may be more suitable to older consumers. Many landlords are also resistant to accepting additional consumers as tenants if they have had difficulties in the past.

When D. was admitted to the CTT program, he was a consumer at the state hospital. He was discharged to a Long Term Structured Residential program (LTSR) because both the hospital staff and D. believed he might need a more structured living environment. Several months later, the topic of discharge planning was raised at the LTSR. The LTSR staff was very resistant to discharging D. to the community to live independently, but the CTT encouraged D. He was discharged to his own apartment and the CTT provided extensive supports to ease this transition. Initially, the CTT staff did daily visits and medication deliveries. Over time, the level of contact with the team has decreased. Now, D. often joins the movie group and other socialization activities, and also has a weekly home visit from the CTT nurse for injections and medication checks. He has lived successfully in his own apartment for the last eight months.

All the CTTs have worked diligently with consumers to find safe and stable living arrangements, appropriate to the consumer's desires. The teams support consumers in independent living arrangements in a variety of ways beyond locating an appropriate placement. Based on the individual consumer's needs, the CTT may provide a housing stipend, help with the purchase of furniture, teach consumers cooking, shopping and cleaning skills, and

work with and educate landlords. Frequent visits, often including medication distribution, provide essential support and contact for consumers living independently or in supported apartments.

The CTTs support consumers living in more structured arrangements in different ways. CTT staff often participates in treatment team meetings at some facilities, and coordinate treatment with the facility. The CTTs visit consumers frequently at their places of residence, and often transport consumers to CTT groups, appointments, and errands.

Employment and Educational Status

An essential part of the recovery process for many consumers is identifying meaningful vocational and educational goals. Therefore, vocational services are considered a key component of the CTT model. Each team is required to have on staff a Vocational Specialist, who is charged with working with the consumers to establish employment and educational goals that fit in with the consumers' recovery plans.

The Vocational Specialist role on the team incorporates many activities. The Specialists:

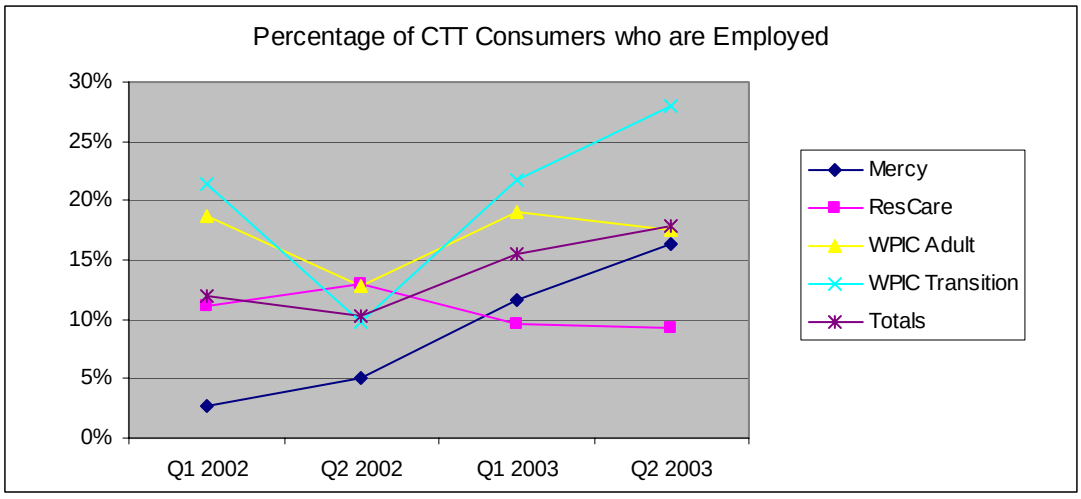
- Help consumers find work and go to school;
- Complete assessments with consumers;
- Educate consumers on job opportunities and appropriate workplace behavior;
- Conduct extensive job coaching and support for consumers while they are working;
- Educate consumers on navigating the benefits system;
- Serve as liaisons to schools and work supervisors;
- Cultivate relationships with vocational services and employers; and
- Educate employers on client-specific needs.

Over the four quarters of the study period, none of the teams has had much change in the percentage of consumers in school. On average, for the three adult teams, 4% of CTT consumers have been enrolled in either secondary or post-secondary education. For the transition age CTT, 27% of consumers are enrolled in either secondary or post-secondary education in each quarter. This larger percentage is expected, given the age of the Transition Age Team's consumers.

E. is a 19 year old with a history of hospitalizations and expulsion from schools. One symptom of his mental illness is severe anxiety with being in the community. The CTT worked extensively with him one-on-one in the community to help him overcome his anxiety. Working with the CTT psychiatrist on medication management also helped him address his symptoms. Since joining the team in March of 2002, he has moved into independent housing and recently got married. In January of 2004, E. began attending nursing school - the Vocational Specialist stays in frequent contact to provide support if he needs it.

A number of different employment categories from the AHCI application were summed to determine the total percentage of consumers employed: paid competitive employment, paid sheltered employment, paid supported employment, paid transitional employment, training, volunteer, and 'other.' The percentages of consumers employed on each team are illustrated in Chart 20.

Chart 20.

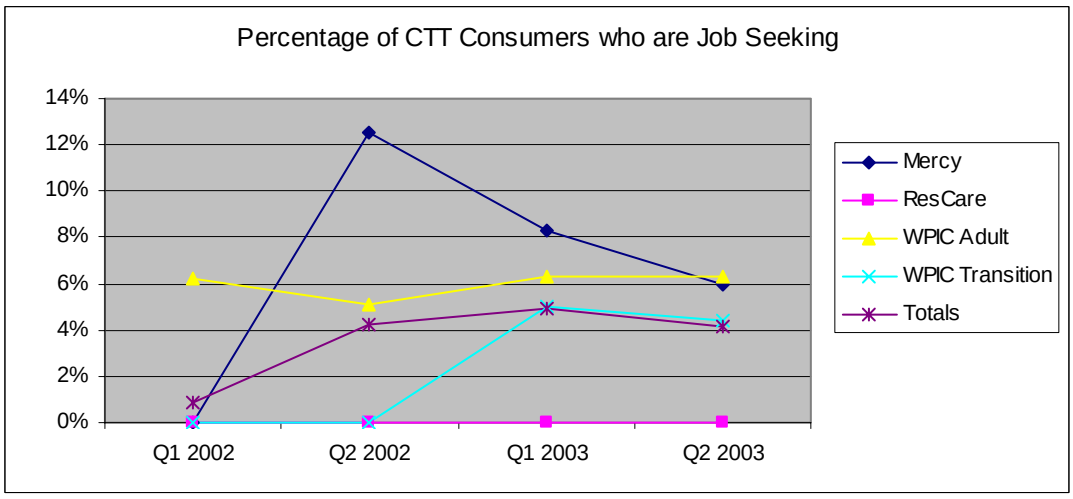


Since the first quarter of 2002, the four-team total percentage of CTT consumers that are employed has increased slightly, from 12% to 18%. There has been some variation by team.

- The WPIC Transition Age CTT has had the largest percentage of consumers employed for the first and second quarters of 2003, increasing from the second quarter of 2002.
- The WPIC Adult CTT generally has more consumers employed than the average.
- The percentage of Mercy CTT consumers working has shown a steady increase since the early implementation of the teams.
- Little change has been reported for consumers on the Residential Care CTT.

A number of CTT consumers who are not working are job seeking (Chart 21 below). This does not make up a significant portion of the team.

Chart 21.



The teams acknowledge that encouraging consumers to develop vocational goals and supporting consumers in reaching these goals has been very challenging. Teams have experienced some difficulties in recruiting and maintaining Vocational Specialists who have experience in not only finding jobs and developing relationships with employers, but also in working with the CTT population and the team structure. As the teams evolved, the Vocational Specialists were pulled in to perform case management duties to such an extent that it curtailed the time they had available to focus on vocational assessments and planning with consumers. Many consumers have difficulty maintaining their jobs, and many older consumers have felony backgrounds which makes finding jobs more challenging. Consumers often are concerned that working will result in a decrease in their benefits. Furthermore, the system as a whole has not pushed for the development of more vocational services and supports.

To support the Vocational Specialists in fulfilling their various roles, the team leaders have adjusted team scheduling processes to insure that the Specialists have more time to work with consumers on vocational development. Also, the Vocational Specialists will be meeting as a group to share information and resources, problem-solve, and coordinate vocational-related activities for consumers.

M was discharged from the state hospital to a Community Residential Rehabilitation program and enrolled with CTT. One symptom of M.'s schizophrenia is anxiety with being in the community. To help M. address this, CTT staff taught M. how to ride the bus by accompanying her on the route until she became comfortable with the bus system. Also, in her contacts with the CTT, M. expressed a desire to work. To support this goal, the Vocational Specialist helped M. get a job at Giant Eagle. M. is also working on a goal to walk to a local coffee shop independently a few times a week; CTT staff members treat her to dinner when she achieves this goal each month.

Since the early implementation of the CTTs, the teams have developed several creative employment opportunities where consumers can work while developing their readiness and goals for other employment opportunities. These opportunities also provide the Vocational Specialists a chance to assess consumers' strengths and interests. For example, the Mercy CTT has operated a moving service for other consumers and a car wash. The WPIC Transition Age CTT has run a BBQ for staff and consumers at the team's building. They will be opening a consumer-run store in their building, which will open once building renovations are completed.

Peer Supports

Many consumers do not have support networks beyond behavioral health professionals. The symptoms of their illness may interfere with their interactions with others, or the chronic nature of their illnesses may have strained and permanently damaged family relationships and personal friendships. Developing supports outside of behavioral health staff is an important part of community integration and recovery for consumers.

The CTTs are required to have a full-time Peer Specialist on staff to facilitate consumers' developing their network of peer supports. Peer Specialists provide support services which are highly individualized, and promote consumer self-determination and decision-making. They are individuals who are or have been a recipient of mental health services and are willing to disclose this to consumers; this disclosure helps to generate hope and gain the trust of consumers.

The WPIC Adult CTT is still in the process of hiring for this position, while the other teams currently have staffed this position. As with the Vocational Specialist role, the Peer Specialist role is evolving as the teams mature. The Peer Specialists have been pulled in to perform case management duties to such an extent that the time they have available to focus on peer support was reduced significantly. The teams are working to lessen these responsibilities so the Peer Specialists have more opportunities to work with consumers individually and in groups.

The teams support consumers developing interpersonal skills and peer supports in a variety of ways. Teams have initiated various groups, including parenting groups and socialization groups to facilitate skill-building and the opportunity for consumers to support each other. The Transition Age CTT Peer Specialist has started a cooking group. Consumers meet at one of the respite apartments and plan, shop, cook, clean and enjoy meals together. This Peer Specialist has also started a diabetes support group. Consumers meet at a local bookstore so they have access to books and resources on diabetes during their meetings.

The Mercy CTT consumers have started their own newsletter. The CTT consumers meet weekly to determine the content of the newsletter, as well as to appoint responsibilities for writing several articles. The first issue was published in December of 2003 with 12 consumer submitted articles, and shortly afterwards in January of 2004, the second edition was published with 21 consumer articles. Interest continues to grow. The newsletter is completely consumer-driven, as several consumers have been appointed co-editors and are responsible for making sure that assignments are given out and that other people turn in their articles by the publishing deadline.

AHCI expects that the teams will increase their focus on facilitating consumers' development of peer support networks over time, as the teams mature, the Peer Specialist role becomes more defined, and as the consumers move through the recovery process.

Discussion of Findings

The information in this report presents a comprehensive picture of the evolution of the CTTs and changes in consumer outcomes over time. Composition of the teams, changes in service utilization for CTT and non-CTT services, and stability and community integration are described using both data and direct input from the teams. The demographic analysis provides a description of the CTTs in terms of referral source, race, gender, age, and diagnosis, including dual diagnoses. The results suggest that the percentage of a team's consumers enrolled from the state mental hospital is related to both the diagnosis mix and living arrangements of a team. Most CTT consumers have diagnoses of schizophrenia, bipolar disorder, or major depression/depressive disorder; many also have had a diagnosis of borderline personality disorder. A high percentage of consumers have a MISA diagnosis.

Although the teams are still developing, it appears that the CTTs are working with consumers to bring about the desired outcomes of the program. In terms of community hospitalization, fewer consumers were admitted in the six months after their enrollment with the CTTs than in the six months prior to their enrollment. Many of the CTT consumers had experienced lengthy stays in the state mental hospital system. After enrolling with the CTTs, only a small proportion of consumers have been admitted to a state mental hospital.

The percentage of CTT consumers using non-CTT services, paid for by either HealthChoices or the County, decreased for some services and generally remains low. Furthermore, several of the most commonly used HealthChoices and County services, including respite, non-hospital rehabilitation, community residential services, and housing support services, complement and support the teams' services. The percentage of consumers receiving administrative management services remains high, although the average units used is relatively small.

As a recovery-oriented, comprehensive service, CTTs provide services not only in mental health and substance abuse treatment but in helping consumers integrate into the community as part of their recovery process. The CTTs have focused on making sure consumers have safe living environments. A percentage of the CTT consumers still moves each quarter, and a substantial percentage still lives in more restrictive environments. As indicated above, this may be part of individual consumers moving through their recovery. However, it is expected that over time fewer consumers will move frequently and more will live independently.

The inclusion of various specialists on the team (i.e. the Substance Abuse Counselor, Vocational Specialist, and Peer Specialist) facilitates and encourages recovery and community integration. When the data on employment is examined for all CTT consumers, the great majority of them are not engaged in any sort of employment, and very few are job-seeking. The data coincides with the teams' reported difficulty in hiring and maintaining Specialists in these positions, and in keeping the Specialists' case management responsibilities to a minimum so they can better focus on their core responsibilities. Therefore, the data suggests and the teams acknowledge that they should continue to focus more on these rehabilitative aspects of their services.

Recommendations

The data suggests that the CTTs are developing into the model envisioned by the County and Community Care when this effort was initiated. For example, consumers' use of the state mental hospital has been dramatically reduced, and teams report they are able to divert more consumers from inpatient admission. While results in many areas are positive, there clearly are areas in which enhancements to either the teams' capabilities or the system's resources and organization would further the work of the teams and the quality of services and support they offer to consumers. AHCI supports the following recommendations for the teams and the behavioral health system as a whole.

Housing
While more consumers live independently than in any other category, many consumers still move often and face challenges in finding appropriate living arrangements. Therefore, AHCI recommends that the County develop a comprehensive housing plan. Components of the housing plan should involve:

- The County facilitating and helping the CTTs develop relationships with landlords so that consumers can find apartments more easily.
- The development of a supervised apartment residence, with full-time staffing, for the transition age population.
- The development of "damp" housing.

Coordination with Forensic Services
AHCI recommends that the County continue the process of addressing the difficulties the teams have in meeting with their consumers while they are incarcerated through the Forensic Specialist grant.

Employment/Rehabilitation Services
Despite the importance of meaningful work and education in the recovery process for many individuals, the majority of CTT consumers are not working. AHCI recommends that:

- The teams, and the system as a whole, should increasingly focus on the important role that vocational goals play in consumers' moving toward their recovery.
- The team leaders and supervisors should insure the Vocational Specialists have the time and resources to perform their specialties.
- The Vocational Specialists should complete a thorough assessment with each consumer for the development of recovery-focused employment and educational goals.
- The Vocational Specialists should focus on job placement and support as immediate goals.

Service Utilization
While consumers are using inpatient mental health services less after they are enrolled with a CTT, a significant number of consumers still use inpatient services. AHCI recommends that:

- The teams continue to work with the inpatient units to successfully divert consumers from being admitted, including the development of coordinated crisis plans.

- Community Care continue to enforce its requirements that inpatient units coordinate diversion efforts and inpatient care with the CTTs. Community Care should also continue to notify CTT staff immediately when an inpatient unit requests an authorization for a CTT consumer.
- The County and CCBH expand the range of available crisis services.

Because a significant percentage of the teams receive administrative management services and the teams are not generally connected with this service, AHCI recommends that:

- The responsibilities of administrative management as they relate to CTTs should be clarified to avoid duplication of efforts and services.

Peer Support

Developing the role of the Peer Specialists further will enhance the recovery focus of the teams. AHCI recommends that:

- The team leaders and supervisors should insure the Peer Specialists have the time and resources to perform their specialties, and that they feel empowered and integrated with the team.
- The Specialists should continue meeting as a group to share ideas and resources and for skill-building.

Future Study

The CTT model requires that services be individualized and recovery-focused. To better understand the teams' provision of individualized services and recovery-focused treatment planning, a future study should include:

- An analysis of the characteristics of consumers receiving low, moderate and high levels of service on each team, and how this fluctuates.
- Record reviews examining recovery-focused treatment planning.
- Statistical analysis of factors associated with CTT outcomes.

In conclusion, the data suggests that many CTT consumers, through the teams' work, have made significant accomplishments in their recovery. The teams are still developing in terms of refining their internal processes to follow the CTT model and in taking on consumers to reach the team capacity. The institution of the performance standards will help to insure that the continued development of the teams follows the assertive community treatment model and recovery principles. Both the behavioral health system and the provider management staff must support the continued evolution of the services and recovery supports offered by the teams.

Appendix A

Housing and Residential Treatment Definitions

Definitions derived from the CTT Technical Manual and by the Allegheny County Department of Human Services, Office of Behavioral Health.

Institutional Setting
An involuntary setting such as a criminal justice facility, state mental hospital, or a community hospitalization that exceeds two weeks and places the individual at risk for losing their permanent housing.

Long Term Structured Residences (LTSR)
A highly structured therapeutic residential mental health facility for adults 18 years and older. LTSRs are designed to house people that do not meet medical necessity criteria for inpatient hospitalization but require mental health treatment and 24-hour supervision on an ongoing basis. Admissions may be voluntary or involuntary.

Nursing Home
A highly structured residence that provides 24-hour care for elderly people and those who are chronically ill.

Community-Based Drug & Alcohol Residential
An intensive drug and alcohol treatment program for adults 18 years and older that is staffed 24-hours. Detoxification services can be provided at licensed facilities.

Non-hospital Residential Rehabilitation
The same scope of services as provided by the community-based residential provider with the addition of a rehabilitation component.

Community Residential Rehabilitation (CRR)
A transitional residential program for adults 18 years and older with a mental health diagnosis. CRRs provide training and skill development to assist people to live independently in the community. A "full care" CRR provides 24-hour supervision and a highly structured therapeutic environment. A "partial care" CRR offers regularly scheduled visits by staff with a minimum of one-hour staff time and a maximum of eight-hours of staff time per day.

Personal Care Home (PCH)
A short term or long term living arrangement that offers shelter, food, and personal assistance in hygiene, nutrition, financial management, and administration of medications.

Enhanced Personal Care Home (EPCH)
A long-term living arrangement that exceeds the scope of the PCH by providing a variety of mental health services, social and recreational activities (twice weekly), and outreach team visits (twice a month).

Shelter or Mission
A temporary evening/night time shelter for homeless individuals. No daytime programming or treatment is provided.

Supervised Apartment
A provider-operated apartment with 24-hour on-site staff that provides assistance and support.

Supported Housing
An individualized housing model designed to assist individuals with a mental illness to live in the community and foster independence. The goals of supported housing include: to help an individual obtain safe, affordable, permanent housing; to improve community tenure; and increase reliance on natural and community supports.

Family Setting
Living in a private home of a friend or family for a period exceeding 24-hours. Food, cleaning, and laundry may or may not be provided.

Single Room Occupancy (SRO)
A provider-operated or an independent single room dwelling.

Living Independently
Living in an apartment or boarding room that was secured independently by the consumer.

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