

**Alabama**  
**Department of Mental Health and Mental Retardation**



Division of Mental Illness Services

**Regional Plans**

**Submitted to:**

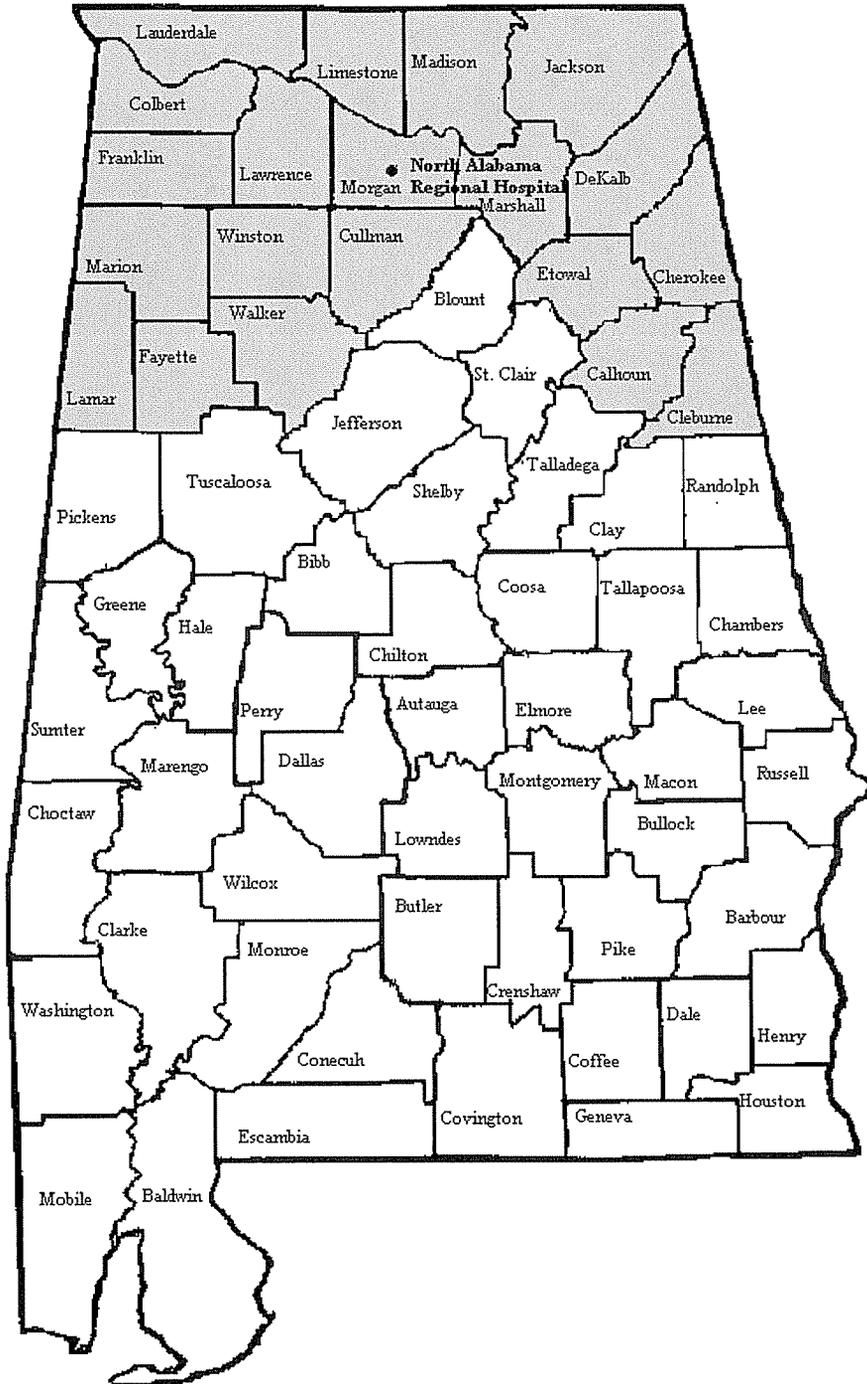
**Commissioner John Houston**  
**October 2006**

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# Region 1

## SMART Plan



## Mission

**To develop a regional plan for creating a community-based mental health system for acute care services for adults and long-term transformation of the mental health system.**

To accomplish the stated mission, this plan for Region 1 was collaboratively developed with a broad-based stakeholder group. This document is the beginning of a broad systems reform and improvement plan which should accomplish a much higher quality of service than currently available through the expansion and potential reallocation of resources. Members of the planning group included the following.

Nancy Jester, WINGS (Consumer Advocacy Organization)

Kielta Bagwell, WINGS

John Avera, National Alliance on Mental Illness of Alabama (NAMI)

Ann Denbo, NAMI

Jill Russell, DMHMR Advocate

Charles Cutts, Facility Director, North Alabama Regional Hospital

Emmett Poundstone, Mountain View Hospital

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Dennis Griffith, Decatur General West Hospital

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Bryan Libell, CEO, Riverbend Center for Mental Health

Captain Melissa Beasley, Florence Police Department

Marie Hood, Executive Director, Mental Health Center of North Central Alabama

Chris Van Dyke, Executive Director, Cullman Area Mental Health Authority

Brian Davis, Executive Director, Huntsville-Madison County Mental Health Center

Skip Newman, Executive Director, Northwest Alabama Mental Health Center

Mickey Turner, Executive Director, Calhoun-Cleburne Mental Health Center

Jerry Johnson, Mountain Lakes Behavioral Health Care

Shelia Hurley, Cherokee-Etowah-DeKalb County Mental Health Center

Bill Hays, Executive Director, Rapha House

Kathy West, Summit Health and Management Corporation

## Where are we now?

Region 1 of the Division of Mental Illness Services within the Alabama Department of Mental Health and Mental Retardation encompasses the 20 counties of Lauderdale, Colbert, Franklin, Marion, Lamar, Fayette, Winston, Walker, Cullman, Lawrence, Limestone, Morgan, Madison, Marshall, Jackson, DeKalb, Etowah, Cherokee, Calhoun, and Cleburne. Public mental health services are provided in the community by 8 mental health centers, Riverbend, North Central Alabama Mental Health Center, Huntsville-Madison County Mental Health Center, Mountain Lakes, Cherokee-Etowah-DeKalb County Mental Health Center, Calhoun-Cleburne Mental Health Center, Cullman County Mental Health Center, and Northwest Alabama Mental Health Center. North Alabama Regional Hospital in Decatur provides public inpatient psychiatric care for the region. According to the most recent census figures, the regional population is 1,388,806. The region served over 29,500 people in the community during fiscal year 2005. Using the 5.4% national prevalence rate for serious mental illness the penetration rate for the region seems to be around 40% which suggests an unmet need of about 60%.

Over 650 individuals were admitted to North Alabama Regional Hospital during FY05. Based on admissions per 100,000 people, Etowah County had the highest admission rate at 99.82 and Colbert County had the lowest admission rate of 12.81. The regional admission rate was 49.47. Inpatient mental health care is also provided within the region at Woodland Hills Behavioral Health, Mountainview Hospital, Decatur General West, Eliza Coffee Memorial Hospital, Huntsville Hospital, Baptist Walker Regional Medical Center, Gadsden Regional Medical Center and Northeast Alabama Regional Medical Center in Anniston.

An analysis of the service capacity and workload of the region was conducted. The results are indicated in the table below.

	<b>Region 1</b>	<b>Statewide</b>
Regional Population	1,388,806	4,557,808
<b>Community Capacity</b>		
Inpatient Bed Capacity (estimated)	203	686
Inpatient Beds Per 100,000 Population.	14.62	15.05
Residential Bed Capacity	442	1,417
Residential Beds Per 100,000 Population.	31.83	31.09
Supported Housing Units	205	775
Supported Housing Units Per 100,000 Population.	14.76	17.00
Psychiatrists (FTE)	19.25	81.70
Psychiatrists (FTE) / 100,000 Population.	1.39	1.79
CMHC Allocations from DMHMR - FY07	\$39,048,222	\$127,952,863
No. Served	29,850	102,243
Served as % of Population	2.13%	2.24%
Allocation Per Person Served	\$1,320	\$1,251
CMHC Amount Per Capita FY07	\$28.12	\$28.07

Seven of the eight mental health centers have an Assertive Community Treatment (ACT) team. There are currently 47.5 full-time case managers currently in the region with average caseloads of 48.5 clients each.

<b>STATE HOSPITAL</b>	<b>NARH</b>	<b>Total</b>
Acute Bed Capacity	74	376
Acute Beds Per 100,000 Population.	5.33	8.25
Mean Acute LOS FY05	46.44	68.35
Acute Patient-Days FY05	29,565	173,427
Acute Patient-Days / 100,000 Population.	2,129	3,805
Total Hospital Budget FY06	\$11,639,640	\$107,895,639
Acute Care Portion	\$11,639,640	\$61,078,767
Avg. Beds Occupied FY05	81	475.14
Cost Per Patient-Day FY05	\$393.70	352.19
Cost Per Episode FY05	\$18,283	\$24,072

Admission by county to NARH for FY05 is depicted below.

<b>CMHC</b>	<b>COUNTY</b>	<b>Population 2005</b>	<b>Probate Adm FY05</b>	<b>Adm/ 100k</b>
Riverbend	Colbert	54,660	7	12.81
Riverbend	Franklin	30,737	9	29.28
Riverbend	Lauderdale	87,691	29	33.07
North Central AL	Lawrence	34,605	8	23.12
North Central AL	Limestone	70,469	25	35.48
North Central AL	Morgan	113,740	45	39.56
Huntsville-Madison	Madison	298,192	189	63.38

<b>CMHC</b>	<b>COUNTY</b>	<b>Population 2005</b>	<b>Probate Adm FY05</b>	<b>Adm/ 100k</b>
Northwest AL	Fayette	18,228	4	21.94
Northwest AL	Lamar	14,962	8	53.47
Northwest AL	Marion	30,154	5	16.58
Northwest AL	Walker	70,117	21	29.95
Northwest AL	Winston	4,498	-	-
CED	Cherokee	24,522	20	81.56
CED	DeKalb	67,271	39	57.97
CED	Etowah	103,189	103	99.82
Calhoun-Cleburne	Calhoun County	112,141	47	41.91
Calhoun-Cleburne	Cleburne	14,460	8	55.33
Marshall-Jackson	Jackson	53,650	40	74.56
Marshall-Jackson	Marshall	85,634	33	38.54
Cullman MHC	Cullman County	79,886	47	58.83
<b><i>Region 1 Totals</i></b>		<b><i>1,388,806</i></b>	<b><i>687</i></b>	<b><i>49.47</i></b>

# Where do we want to be?

## Vision

We envision a seamless mental health system that is

- Consumer and family-driven

Characteristics should include processes that

- Are personalized
- Involve and listen to consumers and families in all facets
- Focus on mutual respect and responsibilities
- Measure satisfaction

- Wellness-oriented

Characteristics should include

- Services grounded on wellness concepts
- Prevention and early intervention driving the system
- The expectation of wellness not wellness as the exception
- The promotion of self-sufficiency
- The concept of “being the best that you can be”

- Accessible when the need arises

Characteristics should include

- Timeliness
- Responsiveness
- Interventions before a crisis
- Emergency services
- Broad-based services

- Family-driven

Characteristics should include processes that

- Keep families involved
- Recognize that perspectives sometimes differ between consumer and family

- Community-based

Characteristics should include

- A full continuum of care that is
  - ❖ Available

- ❖ Accessible
- ❖ Familiar
- ❖ Personal

- Outcome driven (Results-oriented)

Characteristics should include

- Services that are performance-based and adjusted according to need
- Best practices with proven positive outcomes
- Sensitive to geographic, cultural, and linguistic diversity
- Fiscally accountable

Characteristics should include

- Good stewardship principles
- “Getting the best bang for the buck”
- Proper reporting
- Prioritization of core responsibilities
- Utilize public/private partnerships

### **Values**

We value a planning process that is

- Participatory
- Inclusive of all stakeholders
- Continuing
- Focused on current issues, but within a long-term perspective

We value a regional plan that

- Places the consumer needs at the center of decision making and encourages family inclusion & support
- Is structured around recovery and continually striving for wellness for the individual
- Creates timely and seamless access to an appropriate full continuum of services in the least restrictive and most environment
- Provides for performance assessments and best practices based on favorable outcomes.
- Provides services that are sensitive to geographic, cultural, and linguistic diversity
- Creates fiscal accountability

# How do we get there?

## Critical Issues

(This are not listed in priority order.)

### *Continuum of Care Issues*

- There are an insufficient number of in-home teams within the region.
- Case management is critical to early intervention efforts as well as to efforts to keep people out of hospitals.
- Transition programs should prepare individuals for discharge from hospitals and extensive follow-up services should be available to ensure a successful transition into the community.
- There is a limited number of and geographically disparate medical and behavioral beds within the region.
- Individuals with a primary diagnosis of mental retardation are sometimes committed to the state hospitals and remain because discharge/outplacement opportunities are limited.
- The inconsistency between geographical regions between the Division of Mental Illness and the Division of Mental Retardation is a barrier for discharge/outplacement of individuals with mental retardation in the state hospitals.
- The residential system faces the issue of some people not wanting to move to lesser restrictive environments and some people not wanting to stay in the same environments.
- There are federal implications to the Medicaid Rehabilitation Program which, if implemented, would decimate the entire service delivery system.
- The distribution of community beds has been inherited. Regrouping and reallocating of existing beds should be explored. However, funding rates do not foster reallocation efforts.
- The Medicaid cap of 16 hospital days limits the assistance that private hospitals could provide to the system.
- The state hospital cannot control admissions and discharges as needed.

- Discharge planning should begin at admission.

### ***Substance Abuse Issues***

- People with substance abuse disorders are being inappropriately routed into the MI system.
- Inappropriate commitments dramatically affect the census at the state hospitals.

### ***Legal Issues***

- Probate judges are the current gatekeepers of the mental health service delivery system. Any system change must be with and through collaborative efforts with these officials.
- Community Mental Health Officers are not utilized in every county in the region.
- There is no standardized requirement that petitioners have contact with the local mental health center prior to commitment.
- Local and annual training by the CMHC's could establish and build relationships within the law enforcement community.
- Law enforcement dispatchers need specialized mental health training.
- Law enforcement personnel often have to wait inordinately long periods of time while a consumer is screened.
- Mental health parity at the local, state, and national level should be promoted.
- The department should conduct a cost/benefit analysis prior to any proposed certification standards change.

### ***Consumer/Family Issues***

- Local MHC Boards should have NAMI representation.
- Consumer directed services and supports are critical to recovery and are limited within the region.

### ***Workforce Issues***

- The pay scale for psychiatrists and other mental health professionals is not comparable to the private sector.
- Fewer professionals are seeking and entering into the mental health profession.

### ***Technology Issues***

- There is an inequity in local management information technology capacities with differing levels of sophistication among centers within the region.
- The VA system should collaborate with the department and the CMHS's to develop and implement standard electronic medical records.

Based on the identified critical issues, the planning body developed the following long-term goals.

### **CONTINUUM OF CARE ISSUES**

***Goal:*** Redesign the continuum of care for acute services using nationally accepted formulas for the distribution of bed capacity.

1. Expand crisis stabilization capacities by partnering with local inpatient hospitals with psychiatric beds. Encourage those hospitals to seek designated mental health facility status by ensuring that bed availability will be restricted to individuals within the region.
2. Expand the residential continuum of care by 241 beds within three categories.
  - a. Intensive Residential to include the following types of beds
    - Dual diagnosis
    - Therapeutic group
    - Specialized behavior
    - Specialized medical
  - b. Extended Residential to include the following types of beds
    - Specialized basic
    - Residential care
  - c. Supportive Residential to include the following types of beds

Foster home  
Assisted living/retirement  
Semi-independent

3. This plan reflects a minimal increase in MI/SA bed capacity but the expectation is that many more beds will be available for individuals who need this type of service.

**Goal: Within 4 years, ensure that support services such as case management, ACT, and/or in-home teams are available and accessible in each county within the region.**

1. Increase the number of case managers to achieve a maximum caseload of 1:30.
2. Establish in-home intervention teams in each county.
3. Establish an ACT team within each community mental health center.

### **LEGAL AND LAW ENFORCEMENT ISSUES**

**Goal: Advocate for the modification of the current commitment statute to include the following:**

- Designating local mental health centers as “gatekeepers”
- Strengthening of the outpatient commitment rules

**Goal: Advocate for the use of mental health courts as a potential longer-term system transformation goal.**

**Goal: Within 4 years, every county within the region will utilize a community mental health officer and the CIT model.**

**Goal: With 4 years, mental health training opportunities will be available and mandated in the following venues.**

- Law enforcement academies – at least, 8 hours mental health training
- Annual professional development – at least, 4 hours mental health training

**Goal: A mental health curriculum will be included in the criminal justice program in local community colleges and/or universities.**

### **CONSUMER AND FAMILY ISSUES**

**Goal: Local community mental health centers and NARH will remain above the national average on the MHSIP consumer satisfaction surveys.**

**Goal: Drop-in centers will be established and operated by consumers in each mental health center area.**

**Goal: Establish, at least, one peer support group in each CMHC area.**

### **WORKFORCE ISSUES**

**Goal: Collaborate with local statewide groups to develop and implement a workforce development plan that focuses on recruitment, training, retention, and licensure of all mental health professionals to include psychiatrists, nurses, nurse practitioners, therapists, and mental health workers.**

### **TECHNOLOGY ISSUES**

**Goal: Representatives from the community mental health system will be included on the department's Information Technology Steering Committee to develop a consistent and standard definition for the minimum data requirements for electronic medical records.**

**Goal: The region will explore the use of telemedicine as a means to increase access to services particularly for individuals in rural areas.**

To accomplish the stated goals, the following strategies are suggested to be implemented in two phases as indicated in the table below.

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
1. <b>Reduce the census and capacity of North Alabama Regional Hospital.</b>	See Phase I priorities			
2. <b>Redesign the continuum of acute-care services in the region.</b>				
a. <i>Partner with local hospitals that provide inpatient psychiatric services for additional crisis stabilization services in every CMHC in the region.</i>				
(1) Calhoun-Cleburne		\$ 273,474		
(2) CED		\$ 421,186		
(3) Cullman		\$ 172,564		
(4) Madison		\$ 644,133		
(5) Mt. Lakes		\$ 300,871		
(6) North Central		\$ 472,666		
(7) Northwest		\$ 341,212		
(8) Riverbend		\$ 373,892		
b. <b>Add 128 intensive residential beds.</b>				
(1) 20 Dual MI / MR beds in Jacksonville			\$ 1,080,000	\$ 233,600
(2) 12 Dual MI / SA beds as follows:				
6 female beds in Gadsden			\$ 324,000	\$ 219,000
6 male beds in Attalla			\$ 324,000	\$ 219,000
(3) 10 Therapeutic Gp beds in Mt. Lakes area			\$ 540,000	\$ 222,614
(4) 50 Special Beh. beds as follows:				
10 beds in Riverbend (NGRI)			\$ 900,000	\$ 365,000
10 beds in Huntsville			\$ 900,000	\$ 365,000
16 beds in Calhoun/Cleburne			\$ 864,000	\$ 584,000
6 beds in Mt. Lakes			\$ 540,000	\$ 219,000
8 beds in Cullman			\$ 720,000	\$ 292,000
(5) 20 Special Med beds as follows:				
16 beds in Northwest			\$ 2,400,000	\$ 718,320
4 beds in Mt. Lakes			\$ 600,000	\$ 179,580

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
(6) Two 3-bed homes as follows:				
1 in Riverbend			\$ 180,000	\$ 136,995
1 in Northwest			\$ 180,000	\$ 136,995
<i>c. Add 22 extended residential beds.</i>				
(1) 16 Special Basic beds in Cullman			\$ 1,920,000	\$ 256,902
(2) 6 Residential Care beds in Mt. Lakes			\$ 720,000	\$ 89,965
<i>d. Add 91 supportive residential beds.</i>				
(1) 36 Foster Home beds as follows:				
2 ea. 10-bed units in North Central			\$ 2,400,000	\$ 86,140
10-bed female unit in Huntsville			\$ 1,200,000	\$ 43,070
6 beds in Mt. Lakes			\$ 720,000	\$ 25,842
(2) 25 Assisted Living beds as follows:				
10 beds in Riverbend			\$ 600,000	\$ 109,500
15 beds in Mt. Lakes			\$ 900,000	\$ 164,250
(3) 30 Semi-Independent beds as follows:				
16 beds in Cullman			\$ -	\$ 105,529
14 beds in Mt. Lakes			\$ -	\$ 92,338
<b>3. Develop adequate support services.</b>				
<i>a. Add 33 in-home support staff (standard = 1:30).</i>		\$ 767,240		
(1) 2 in Mt. Lakes				
(2) 2 in Calhoun/Cleburne				
(3) 6 in North Central				
(4) 7 in Riverbend				
(5) 5 in CED				
(6) 9 in Madison Co.				
(7) 2 in Cullman				
<i>b. Add 7 ACT teams.</i>		\$ 672,000		
(1) 2 teams in Mt. Lakes				
(2) 1 team in Calhoun/Cleburne				
(3) 2 teams in North Central				
(4) 1 team in CED				
(5) 1 team in Madison Co.				
<i>c. Add 17 in-home staff (standard = 1:8.6).</i>		\$ 773,500		
(1) 1 in Mt. Lakes				
(2) 4 in Calhoun/Cleburne				
(3) 2 in Cullman				
(4) 2 in North Central				
(5) 4 in Riverbend				
(6) 4 in Madison Co.				

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT			
<b>4. Improve legal and law enforcement support.</b>							
b. <i>Modify the commitment law to designate CMHCs as "gatekeepers" and allow commitments to designated mental health facilities.</i>							
c. <i>Advocate for the use of mental health courts as a potential long-term system transformation goal.</i>							
d. <i>Utilize a community mental health officer and the CIT model in every county.</i>				\$ 148,200			
e. <i>Increase law enforcement mental health training to 8 hours in the academy and at least 4 hours of annual professional development.</i>							
f. <i>Provide a mental health curriculum in the criminal justice program of all colleges and universities.</i>							
<b>5. Improve consumer and family support.</b>							
a. <i>CMHCs and NARH will remain above the national average on the MHSIP consumer satisfaction surveys.</i>							
b. <i>Establish a consumer-run drop-in center in each CMHC.</i>				\$ 420,000			
c. <i>Establish a peer support group in each CMHC.</i>				\$ 5,250			
<b>6. Improve the mental health workforce.</b>							
a. <i>Collaborate with the Department and others statewide to develop and implement a workforce development plan for the recruitment, training, and retention of mental health professionals..</i>							
<b>7. Improve the use of technology.</b>							
a. <i>Achieve CMHC representation on the Department's IT Steering Committee to develop a consistent and standard definition for minimum data requirements for electronic medical records.</i>							
b. <i>Explore the use of telemedicine to increase access to services, particularly in rural areas.</i>							
	\$	-	5,212,740	\$	18,012,000	\$	5,438,090

Priorities were established within the Phase I projects that would most dramatically impact the census coverage at North Alabama Regional Hospital through discharges and admission diversions. The priorities within Phase I are indicated in the table below.

PHASE I PRIORITIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT
1. Partner with local inpatient hospitals for additional crisis stabilization services in every CMHC in the region.		\$ 3,000,000
2. Add 7 ACT teams.		\$ 672,000
3. Add 17 in-home teams (standard = 1:8.6).		\$ 773,500
4. Add 33 in-home support / case management staff (standard = 1:30).		\$ 767,240
TOTAL – PHASE I		\$5,212,740

Additionally, the planning group members recommend that the following goals be addressed beginning immediately on a statewide basis.

- Peer Support Specialists
- Legal and Law Enforcement Issues
- Workforce Development
- Telemedicine

## How do we measure progress along the way?

The success of the implementation of this plan will be measured incrementally to achieve at North Alabama Regional Hospital (NARH) a capacity of 50 and maintain a census of 50 individuals. The following targets are projected.

<b>Performance Objective</b>	<b>Beginning FY07</b>	<b>Beginning FY08</b>	<b>Beginning FY09</b>
NARH Census	110-115	74	50
NARH Capacity	86	57	50
NARH Admission Rate (regional)	49.47	32.65	29.00
NARH 30-day Recidivism Rate	4.25	4.00	2.50
NARH 1-yr. Recidivism Rate			
CMHC Consumer Satisfaction Level – NARH	81%	>=81%	>=81%
CMHC Consumer Satisfaction Level - Region	88%	>=88%	>=88%

The planning group for Region 1 has thoughtfully and deliberately crafted a plan that is interdependent on a variety of components – all of which are necessary to achieve the desired result. A fragmented implementation could result in unforeseen and differing and unpredictable degrees of success. The group is committed to continue this planning process meeting quarterly to evaluate progress through performance, redesign strategies, and continue to develop detailed plans to transform the mental health service delivery system.

# Region 2

## SMART Plan



## **Mission**

**To develop a regional plan for a recovery-oriented community-based mental health system.**

To accomplish the stated mission, this plan for Region 2 was collaboratively developed with a broad-based stakeholder group. Members of the planning group included the following.

Steve Puckett, WINGS (Consumer Advocacy Organization)

Shelia Scott, WINGS

Cindy Smith, Alliance for the Mentally Ill of Alabama (NAMI)

Greg Carlson, NAMI

Glenda Lee, DMHMR Advocate

David Bennett, Facility Director, Bryce Hospital

Gerald Faircloth, DCH Health System

Zelia Baugh, Brookwood Medical Center

The Honorable Jerry Pow, Bibb County Probate Judge

The Honorable Cindy Neilson, Marengo County Probate Judge

Delshonda Thomas, AL Disability and Advocacy Program

Richard Craig, Executive Director, JBS Mental Health Center

Melodie Crawford, Executive Director, Chilton-Shelby Mental Health Center

Pat Martin, Executive Director, Cahaba Mental Health Center

Jim Moore, Executive Director, Indian Rivers Mental Health Center

Connie Robbins, Clinical Director, Indian Rivers Mental Health Center

Kelley Paris-Barnes, Executive Director, West Alabama Mental Health Center

Jim Counts, Division of Substance Abuse Services, Fellowship House

Fred Armistead, Division of Substance Abuse Services, Pearson Hall

## Where are we now?

Region 2 of the Division of Mental Illness Services within the Alabama Department of Mental Health and Mental Retardation encompasses the 20 counties of Jefferson, Blount, St. Clair, Talladega, Clay, Coosa, Randolph, Chilton, Shelby, Perry, Dallas, Wilcox, Choctaw, Marengo, Sumter, Greene, Hale, Bibb, Pickens, and Tuscaloosa. Public mental health services are provided in the community by 6 mental health centers, Jefferson, Blount, St. Clair Mental Health Authority, Cheaha Mental Health Center, Chilton-Shelby County Mental Health Center, Cahaba Mental Health Center, West Alabama Mental Health Center, and Indian Rivers Mental Health Center. Bryce Hospital in Tuscaloosa provides public inpatient psychiatric care for the region. According to the most recent census figures, the regional population is 1,484,551. The region served over 34,000 people in the community during fiscal year 2005. Using the 5.4% national prevalence rate for serious mental illness the penetration rate for the region seems to be around 43%.

Bryce Hospital provides acute care, extended care, and adolescent inpatient care. Over 600 individuals were admitted to Bryce during FY05. Based on admissions per 100,000 people, Perry County had the highest admission rate at 70.35 and Bibb County had the lowest admission rate of 4.65. The regional admission rate was 42.57. Inpatient mental health care is also provided within the region at Northport Medical Center, Carraway Hospital, Brookwood Hospital, Trinity Medical Center, Hillcrest Behavioral Health, and the Center for Psychiatric Medicine at the University of Alabama Birmingham.

Further analysis of the service capacity and workload of the region was conducted. The results are indicated in the table below.

	<b>Region 2</b>	<b>Statewide</b>
Regional Population	1,484,551	4,557,808
<b>Community Capacity</b>		
Inpatient Bed Capacity	315	686
Inpatient Beds Per 100,000 Population.	21.22	15.05
Residential Bed Capacity	338	1,417
Residential Beds Per 100,000 Population.	22.77	31.09
Supported Housing Units	287	775
Supported Housing Units Per 100,000 Population.	19.33	17.00
Psychiatrists (FTE)	31.15	81.70
Psychiatrists (FTE) / 100,000 Population.	2.10	1.79
CMHC Allocations from DMHMR - FY07	\$36,690,599	\$127,952,863
No. Served	34,327	102,243
Served as % of Population	2.31%	2.24%
Allocation Per Person Served	\$1,069	\$1,251
CMHC Amount Per Capita FY07	\$24.71	\$28.07

<b>STATE HOSPITAL</b>	<b>Bryce</b>	<b>Total</b>
Acute Bed Capacity	126	376
Acute Beds Per 100,000 Population.	8.49	8.25
Mean Acute LOS FY05	92.30	68.35
Acute Patient-Days FY05	60,329	173,427
Acute Patient-Days / 100,000 Population.	4,064	3,805
Total Hospital Budget FY05	\$44,654,667	\$107,895,639
Acute Care Portion	\$20,653,701	\$61,078,767
Avg. Beds Occupied FY05	165.28	475.14
Cost Per Patient-Day FY05	\$342.35	352.19
Cost Per Episode FY05	\$31,599	\$24,072

Admission data by county to Bryce Hospital for FY05 is depicted below.

<b>CMHC</b>	<b>COUNTY</b>	<b>Pop. 2005</b>	<b>Probate Adm FY05</b>	
			<b>No.</b>	<b>Adm/100k</b>
JBS	Blount	55,725	9	16.15
JBS	Jefferson	657,229	381	57.97
JBS	St. Clair	72,330	10	13.83
Indian Rivers	Bibb	21,516	1	4.65
Indian Rivers	Pickens	20,178	3	14.87
Indian Rivers	Tuscaloosa	168,908	98	58.02
Cheaha	Clay	13,964	3	21.48
Cheaha	Coosa	11,162	5	44.79
Cheaha	Randolph	22,717	7	30.81
Cheaha	Talladega	80,457	24	29.83
West Alabama	Choctaw	14,807	10	67.54
West Alabama	Greene	9,661	5	51.75
West Alabama	Hale	18,316	4	21.84
West Alabama	Marengo	21,879	14	63.99
West Alabama	Sumter	13,819	7	50.65
Chilton-Shelby	Chilton	41,744	13	31.14
Chilton-Shelby	Shelby	171,465	15	8.75
Cahaba	Dallas	44,366	11	24.79
Cahaba	Perry	11,371	8	70.35
Cahaba	Wilcox	12,937	4	30.92
<b>Region 2 Totals</b>		<b>1,484,551</b>	<b>632</b>	<b>42.57</b>

# Where do we want to be?

## Vision

We envision a seamless mental health system that is

- Consumer and family-driven

Characteristics should include processes that

- Foster empowerment
- Demonstrate mutual respect
- Involve consumers and families in decision-making
- Build partnerships and relationships with caregivers

- Recovery-oriented

Characteristics should include

- Expectations of recovery
- Hope

- User-friendly accessible when and where the need arises

Characteristics should include

- Preventative services instead of reactionary services
- Immediate responses

- Community-based

Characteristics should include

- Hospitalizations considered as system failures
- Services that are close to home, flexible, and least restrictive
- Collaborative partnerships between public and private providers

- Measured through performance improvement indicators and outcomes

- Evidence-based in its practices uniformly providing the best level of care

- Tailored to geographic, cultural, and linguistic diversity

- Fiscally accountable

## Values

We value a planning process that is

- Participatory
- Inclusive of all stakeholders
- Continuing
- Focused on current issues, but within a long-term perspective

We value a regional plan that is

- Structured around recovery and wellness for the individual across the continuum of care
- Places the consumer and family at the center of decision making
- Creates access to appropriate services in the least restrictive environment
- Provides for performance improvements and evidenced-based practices
- Tailors services to geographic, cultural, and linguistic diversity
- Creates fiscal accountability

# How do we get there?

## Critical Issues

### *Continuum of Care Issues*

- There is a lack of permanent affordable, safe, and adequate housing.
- The needs of the aging population with mental illness are not being met – particularly relative to housing and day treatment.
- The lack of transportation impedes the availability and accessibility of employment.
- State hospitals should undergo a culture change to move toward more rapid stabilization of patients.
- The lack of diversion services contributes to the gridlock within inpatient settings.
- The time necessary to access services – public and private – does not promote recovery.

### *Legal Issues*

- There is an inconsistent interpretation of commitment laws by Probate Judges.
- The commitment statute does not allow outpatient transfers from county to county.
- A standardized gatekeeping function is not utilized in the probate court system.
- Crisis Intervention Training should be incorporated in curricula for law enforcement.
- Jails are becoming placement alternatives for people with mental illness who have committed misdemeanors. Medications and transportation, as well as a lack of knowledge about the mental health service delivery system, exacerbates the problem.
- The lack of mental health parity impedes the delivery of private inpatient services.

### *Consumer/Family Issues*

- Consumer-operated programs and peer support programs are an integral part of recovery.
- Consumer education will help alleviate fears and objections to placements and are needed to bridge the gap between consumer choice and clinical recommendations.

### *Workforce Issues*

- The shortage of psychiatrists, nurse practitioners, and other mental health professionals threatens the entire mental health service delivery system.

### *Technology Issues*

- Telemedicine and electronic medical records should be utilized to enhance the availability and accessibility of services.
- The department lacks consistency of data requirements among its service divisions.

Based on the identified critical issues, the planning body developed the following long-term goals.

### **CONTINUUM OF CARE – INCLUDING ACUTE CARE**

**Goal: Reconfigure the existing Bryce Hospital acute care capacity to allow easier and faster patient movement.**

1. Move patients from the admissions unit to the extended care unit as appropriate.
2. Reconfigure the extended care unit to include a 50-bed forensic ward to allow movement from the admissions unit.
3. Develop treatment plans within a 5-day maximum time limit.
4. Add an additional treatment team.
5. The rural counties will have first refusal for Bryce acute care beds when the targeted capacity of 48 is achieved.

**Goal: Reconfigure a continuum of care that includes acute care services to include the following expansions:**

1. 24/7 Regional Psychiatric Evaluation Clinic and related services within the American Psychiatric Association Guidelines for crisis/emergency services as described below.
  - 24/7 Regional Psychiatric Evaluation Clinic
    - Estimated LOS – 14 hours
    - Estimated 25 admissions/month with 75% discharged to community
  - Crisis Stabilization Unit ( 8-10 beds)

Estimated LOS – average of 4 days

Estimated 50 admissions/month

- Crisis Residential Unit (8-10 beds)
    - Estimated LOS – up to 10 days
    - Estimated 20 admissions/month
  - Crisis Helpline
  - Mobile Crisis Outreach Team
  - Crisis Counseling Unit
2. Assessment/Diagnostic beds with the following characteristics:
- Secure
  - Residential
  - Designated mental health facilities
  - Length of stay – maximum of 30 days
  - Public/Private partnerships
2. Short-term residential units (16-beds) with the following characteristics:
- Secure
  - Designated mental health facility
  - Length of stay – maximum of 90 days
  - In close proximity to the Assessment/Diagnostic unit and/or hospital
3. Intermediate Care with the following characteristics:
- Designated mental health facility
  - For those individuals with self-care capacity
  - Length of Stay – maximum of 90 days
4. Residential Supported Care with the following characteristics:
- Residential Care Homes
  - Specialized Care Homes
  - Community Extended Care
  - Extended care for the SMI aging population

- Similar to an assisted living facility

5. Home-type environmental care with the following characteristics:

- M.O.M. (1-bed apartments) with the following characteristics
  - On-site case managers with a caseload of 1:15-20
  - Services provided include monitoring, observation, and meals
- Independent Housing
  - Permanent
- AHFA HOME-type homes with the following:
  - “Bridge” teams (20 2-member teams) that assist the consumer for up to 120 days following discharge from hospital. The caseload would be approximately 1:8-12.

**Goal: In-home intervention teams (Assertive Community Treatment) should be available in each mental health catchment area in addition to those already located in the Birmingham area.**

**LEGAL AND LAW ENFORCEMENT ISSUES**

**Goal: Collaborate with the Department of MHMR to develop within six months one or more training curricula for legal, law enforcement, and local hospital personnel to enhance and standardize practices within the mental health system.**

- Target audiences: sheriff departments, police departments, district attorneys, guardians *ad litem*, circuit and district judges, local hospitals; associations representing the foregoing types of personnel
- Venues: continuing education (for credit) within each professional group, as well as regional workshops provided by CMHC personnel to develop and promote best practices

**Goal: Work with the Peace Officers Standards and Training Commission to enhance the MH training requirement to at least 8 hours for personnel going through Alabama's police academies.**

**Goal: Request that DMHMR along with Probate Judges Association consider proposing amendments the outpatient commitment law to allow the transfer of an individual on outpatient commitment from one county to another.**

### **CONSUMER AND FAMILY ISSUES**

**Goal: Encourage the appointment of consumers and family members to every 310 board in the region. Educate appointing authorities on the importance of consumer and family involvement on these boards.**

**Goal: Encourage development of consumer and family support groups in every CMHC area.**

**Goal: Encourage development of at least one drop-in center in every CMHC area.**

**Goal: Add a consumer component to every ACT team.**

**Goal: Every CMHC will have at least one consumer peer support specialist to provide education to consumers.**

**Goal: Establish a probate court liaison in every CMHC. For first-time commitments, a family support session will be conducted between petition and commitment hearings.**

### **WORKFORCE ISSUES**

**Goal: Collaborate with the Department of MHMR to develop a statewide plan to recruit more psychiatrists to Alabama. The plan should include amendment of the Board of Medical Examiners reciprocity rule to exempt psychiatrists wishing to come to Alabama from retaking Board examinations.**

**Goal: The Department of MHMR will work with UAB to expand the rural scholars program to include psychiatric medicine.**

**Goal: Advocate for the DMHMR to fund an independent Center of Excellence for evidenced-based practices.**

**TECHNOLOGY ISSUES**

**Goal: Require state hospitals to complete applications for Social Security, birth certificates, and other requirements for consumers to apply for Medicaid upon discharge.**

To accomplish the stated goals, the following strategies are suggested to be implemented in two phases as indicated in the table below.

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
<b>1. Reconfigure the existing Bryce Hospital acute care capacity to allow easier and faster patient movement.</b>				
a. Move patients from the admissions unit to the extended care unit as appropriate.				
b. Reconfigure the extended care unit to include a 50-bed forensic ward.				
c. Develop treatment plans within a 5-day maximum time limit.			-	
d. Add an additional treatment team.		\$ 800,000		
e. Rural counties have right of first refusal for Bryce acute care beds when targeted capacity is met.				
<b>2. Redesign the continuum of acute-care services in the region.</b>				
a. Add 65 assessment/diagnostic beds and a 24/7 psychiatric clinic & related continuum available to all counties within the region.				
(1) 24/7 Psychiatric Clinic in Jefferson County and related continuum	\$ -		\$ 1,000,000	\$ 6,071,800
(2) 30 beds in Jefferson County	\$ -	\$ 5,475,000		
(3) 35 beds in Tuscaloosa Co.			\$ -	\$ 7,665,000
b. Add 32 short-term residential beds.				
(1) 16 beds in Jefferson Co.			\$ 1,920,000	\$ 667,512
(2) 16 beds in Tuscaloosa Co.			\$ 1,920,000	\$ 667,512
c. Add 64 intermediate care beds.				
(1) 64 beds			\$ 7,680,000	\$ 2,670,048
d. Add 190 supported care beds.				
(1) 40 beds in residential care homes			\$ 4,800,000	\$ 600,761
(2) 60 beds in specialized care homes			\$ 7,200,000	\$ 1,435,151
(3) 90 beds in extended care homes			\$ 10,800,000	\$ 1,351,712

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
e. Add 500 home-type care beds.				
(1) 300 M.O.M. apartments (Phased-in, 100 / yr.)			\$	-
(2) 200 supported apartments with bridge teams	\$	-	\$	2,850,600
		\$		2,550,400
<b>3. Develop adequate support services.</b>				
a. Add 1 full and 4 partial ACT teams.				
(1) 1 team in JBS		\$		228,600
(2) 1 team in Cahaba (from in-home)		\$		114,300
(3) 1 team in Cheaha (from in-home)		\$		114,300
(4) 1 team in Chilton-Shelby (from in-home)		\$		114,300
(5) 1 team in West Alabama (from in-home)		\$		114,300
(6) PACT team in Tuscaloosa		\$		762,000
<b>4. Improve legal and law enforcement support.</b>				
a. DMHMR develops, maintains, and delivers training curricula for law enforcement personnel and other first-responders to enhance and standardize practices.				
b. Peace Officers Standards and Training Commission enhances MH training requirement for police academies to 8 hours.				
c. DMHMR Legal Division seeks probate judges' endorsement of an amendment to the commitment law to allow hearings to occur in other counties.				
d. DMHMR Legal Division seeks probate judges' endorsement of an amendment to the outpatient commitment law to allow the transfer of an outpatient commitment to another county.				
e. DMHMR develops, maintains, and delivers CIT training for law enforcement personnel. CMHCs advocate attendance by local law enforcement personnel.				
<b>5. Improve consumer and family support.</b>				
a. CMHCs and consumer and family groups encourage appointment of consumers and family members to every 310 board in the region.				
b. Encourage development of consumer and family support groups in every CMHC area.				
c. Develop at least 1 drop-in center ( 3 total for the region) in every CMHC area.			\$	165,000

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
d. Add a consumer component to every ACT team (6 people).		\$ 195,000		
e. Add a peer support specialist (9) in every CMHC to provide consumer education		\$ 292,500		
f. Fund a probate court liaison position (9) in every CMHC, and for first-time commitments, initiate a family support session scheduled by the probate judge between petition and commitment hearings, where possible.		\$ 409,500		
<b>6. Improve the mental health workforce.</b>				
a. DMHMR develops a statewide plan to recruit more psychiatrists to Alabama. The plan should include amendment of the Board of Medical Examiners reciprocity rule to exempt all psychiatrists wishing to come to Alabama from retaking the Boards.				
b. DMHMR works with UAB to expand the rural scholars program to include psychiatric medicine.				
c. DMHMR should fund an independent Center of Excellence for evidence-based practices.				
(1) Provide needed office/research space for Research and Evaluation of Assertive Community Treatment (REACT) Team.			\$ 150,000	
(2) Provide funding for a Co-Occurring Disorders Statewide Research and Training Center.				\$ 135,750
(3) Provide funding for space and operating costs for public psychiatry research.			\$ 1,000,000	\$ 446,875
<b>7. Improve the use of technology.</b>				
a. State hospitals complete applications for Social Security, birth certificates, and other requirements for consumers to apply for Medicaid upon discharge.				
b. DMHMR studies practical methods for applying telemedicine to system operations.				
	\$ -	\$ 11,170,200	\$ 35,470,000	\$ 24,727,720

Priorities were established within the Phase I projects that would most dramatically impact the census coverage at Bryce Hospital through discharges and admission diversions. The priorities within Phase I are indicated in the table below.

PHASE I PRIORITIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT
1. Add an additional treatment team at Bryce.		\$ 800,000
2. Contract for an additional 30 inpatient beds in Jefferson County		\$ 5,475,000
3. Secure 200 supported apartments with bridge teams		\$ 2,550,400
4. Add 1 full and 4 partial ACT teams and 1 PACT team.		\$ 1,447,800
5. Add a consumer component to every ACT team. Need 6.		\$ 195,000
6. Add a peer support specialist in every CMHC to provide consumer education. Need 9.		\$ 292,500
7. Fund a probate court liaison position in every CMHC, and for first-time commitments, initiate a family support session scheduled by the probate judge between petition and commitment hearings, where possible. Need 9 positions.		\$ 409,500
	\$ -	\$ 11,170,200

Additionally, the planning group members recommend that the following goals be addressed beginning immediately on a statewide basis.

- Peer Support Specialists
- Legal and Law Enforcement Issues
- Workforce Development
- Telemedicine

## How do we measure progress along the way?

The success of the implementation of this plan will be measured incrementally to achieve at Bryce Hospital an acute care capacity of 96 and maintain a census of 96 individuals. The following targets are projected.

<b>Performance Objective</b>	<b>Beginning FY07</b>	<b>Beginning FY08</b>	<b>Beginning FY09</b>
Bryce Census	189	126	96
Bryce Capacity	126	126	96
Bryce Admission Rate (regional)	42.57	40	30

The planning group for Region 2 has thoughtfully and deliberately crafted a plan that is interdependent on a variety of components – all of which are necessary to achieve the desired result. A fragmented implementation could result in unforeseen and differing and unpredictable degrees of success. The group is committed to continue this planning process meeting quarterly to evaluate progress through performance, redesign strategies, and continue to develop detailed plans to transform the mental health service delivery system.

# Region 3

## SMART Plan



## **Mission**

**To develop a regional plan for shifting the responsibility of adult acute care services from state psychiatric hospitals to the community-based mental health system.**

To accomplish the stated mission, this plan for Region 3 was collaboratively developed with a broad-based stakeholder group. Members of the planning group included the following.

Sylvia Richie, WINGS (Consumer Advocacy Organization)

Fannie Hicks, WINGS

Lynn Sharp, Executive Director, Alliance for the Mentally Ill of Alabama (NAMI)

Linda Champion, President, NAMI

Earvie Gandy, DMHMR Advocate

Allen Stewart, Facility Director, Greil Hospital

Deborah Owen, Director of Psychiatric Services, East Alabama Medical Center

Julia Ventress, Vice President, Baptist Health

Steve Shell, Director, Meadhaven

Jacques Jarry, Administrator, Bullock County Hospital

The Honorable Bill Stone, Pike County Probate Judge

The Honorable Bill English, Lee County Probate Judge

Will O'Rear, Montgomery County Probate Court

James Tucker, Chief Counsel, AL Disability and Advocacy Program

Don Schofield, Executive Director, East Central Alabama Mental Health Center

Carol Booker, Clinical Director, East Central Alabama Mental Health Center

Anne Penney, Executive Director, East Alabama Mental Health Center

Cyrilla Beveridge, Clinical Director, East Alabama Mental Health Center

Tommy Wright, Executive Director, Montgomery Area Mental Health Authority

Stan Barnard, Clinical Director, Montgomery Area Mental Health Authority

## Where are we now?

Region 3 of the Division of Mental Illness Services within the Alabama Department of Mental Health and Mental Retardation encompasses the 11 counties of Autauga, Elmore, Lowndes, Montgomery, Macon, Bullock, Pike, Tallapoosa, Chambers, Lee, and Russell. Public mental health services are provided in the community by 3 mental health centers, Montgomery Area Mental Health Authority, East Central Alabama Mental Health Center, and East Alabama Mental Health Center. Greil Hospital in Montgomery provides public inpatient psychiatric care for the region. According to the most recent census figures, the regional population is 669,505. The region served close to 16,000 people in the community during fiscal year 2005. Using the 5.4% national prevalence rate for serious mental illness the penetration rate for the region seems to be around 44%.

During FY05 581 individuals were admitted to Greil Hospital during FY05. Based on admissions per 100,000 people, Montgomery County had the highest admission rate at 169.21 and Russell County had the lowest admission rate of 16.22. The regional admission rate was 86.78 which is the highest in the state. Inpatient mental health care is also provided within the region at Bullock County Hospital, Meadhaven (Baptist Medical Center South), and East Alabama Medical Center.

An analysis of the service capacity and workload of the region was conducted. The results are indicated in the table below.

	<b>Region 3</b>	<b>Statewide</b>
Regional Population	669,505	4,557,808
<b>Community Capacity</b>		
Inpatient Bed Capacity	60	686
Inpatient Beds Per 100,000 Population.	8.96	15.05
Residential Bed Capacity	214	1,417
Residential Beds Per 100,000 Population.	31.96	31.09
Supported Housing Units	151	775
Supported Housing Units Per 100,000 Population.	22.55	17.00
Psychiatrists (FTE)	10.60	81.70
Psychiatrists (FTE) / 100,000 Population.	1.58	1.79
CMHC Allocations from DMHMR - FY07	\$18,511,044	\$127,952,863
No. Served	15,956	102,243
Served as % of Population	2.38%	2.24%
Allocation Per Person Served	\$1,160	\$1,251
CMHC Amount Per Capita FY07	\$27.65	\$28.07

<b>STATE HOSPITAL</b>	<b>Greil</b>	<b>Total</b>
Acute Bed Capacity	66	376
Acute Beds Per 100,000 Population.	9.86	8.25
Mean Acute LOS FY05	35.16	68.35
Acute Patient-Days FY05	23,405	173,427
Acute Patient-Days / 100,000 Population.	3,496	3,805
Total Hospital Budget FY05	\$11,296,850	\$107,895,639
Acute Care Portion	\$11,296,850	\$61,078,767
Avg. Beds Occupied FY05	64.12	475.14
Cost Per Patient-Day FY05	\$482.67	352.19
Cost Per Episode FY05	\$16,971	\$24,072

Admission data by county for Greil Hospital for FY05 is depicted below.

<b>CMHC</b>	<b>COUNTY</b>	<b>Pop. 2005</b>	<b>Probate Adm FY05</b>	
			<b>No.</b>	<b>Adm/100k</b>
EAMHC	Chambers	35,460	8	22.56
EAMHC	Lee	123,254	47	38.13
EAMHC	Russell	49,326	8	16.22
EAMHC	Tallapoosa	40,717	7	17.19
MAMHA	Autauga	48,612	8	16.46
MAMHA	Elmore	73,937	79	106.85
MAMHA	Lowndes	13,076	11	84.12
MAMHA	Montgomery	221,619	375	169.21
ECMHMR	Bullock	11,055	5	45.23
ECMHMR	Macon	22,810	26	113.99
ECMHMR	Pike	29,639	7	23.62
Region 3 Totals		669,505	581	86.78

# Where do we want to be?

## Vision

We envision a transformed, seamless mental health system that is

- Consumer and family-driven  
Characteristics should include processes that
  - Provide individualized treatment
- Oriented to wellness, recovery, and resilience
- Accessible through the community when the need arises  
Characteristics should include
  - A variety of appropriate services in the community are available
- Data driven and evidenced-based in its practices
- Measured through performance improvement indicators and outcomes
- Evidence-based in its practices uniformly providing the best level of care
- Tailored to geographic, cultural, and linguistic diversity
- Fiscally accountable  
Characteristics should include services that are
  - Coordinated
  - Highest quality

## Values

We value a planning process that is:

- Participatory
- Inclusive of all stakeholders
- Continuing
- Focused on current issues, but within a long-term perspective

We value a regional plan that:

- Is structured around recovery for the individual.
- Places the consumer and family at the center of decision-making.
- Creates access to appropriate services in the least restrictive environment.
- Provides for performance assessments and evidence-based practices.
- Tailors services to geographic, cultural, and linguistic diversity.
- Creates fiscal accountability.

# How do we get there?

## **Critical Issues**

### *Continuum of Care Issues*

- As the SMI population has changed (e.g. aging, dual diagnosed, young adults), the mental health services have become stagnated and not changed to meet the needs of the population.
- Supported recovery services such as employment, transportation, and housing should be flexible and measured against individual outcomes.
- Medicaid standard/reimbursements do not support recovery or the medical and dental needs of consumers in the community.
- Private hospitals should be included and represented on DMHMR planning and advisory groups.

### *Legal Issues*

- There is no standard protocol for commitment which includes pre-petition screening/evaluation developed and adopted by Probate Judges.
- The commitment statute should be reviewed in light of the proposed changes in the service delivery system.
- Crisis Intervention Training for law enforcement officers should be incorporated into law enforcement academies.
- The use of designated community mental health officers should be expanded.

### *Consumer/Family Issues*

- NAMI chapters should be active throughout the region and should consider broadening its scope through outreach to others especially private hospitals.

### *Workforce Issues*

- The shortage of psychiatrists, nurses, psychiatric nurse practitioners, and other mental health professionals threatens the entire mental health service delivery system.
- The state psychiatric licensure requirements (e.g. restrictive regulations regarding reciprocity) limit successful recruitment efforts.

- Recruit, training, and retention of all mental health professionals will continue to be a critical issue in the recovery process.

### *Technology Issues*

- DMHMR data systems requirements may alter current business models.
- Telemedicine and electronic medical records should be utilized to enhance the availability and accessibility of services.

Based on the identified critical issues, the planning body developed the following long-term goals.

The proposed inpatient services from the private sector and most of the residential facilities to be developed, with the exception of supported housing, should be secured, staffed 24/7, and designated mental health facilities. The designation of mental health facility will offer expanded regional capacity to individuals as well as to the probate court. Individuals may be committed, admitted, and discharged to and/or from one of these facilities. With increased capacity for acute/crisis care, Greil Hospital would then become the facility of last resort. However, it is important to note that this will only be successful if the designated mental health facility accepts individuals from this region exclusively.

## **CONTINUUM OF CARE – INCLUDING ACUTE CARE AND CONSUMER/FAMILY ISSUES**

**Goal: Establish a community-based continuum for acute care with a uniform protocol for access/movement thru the continuum.**

The envisioned acute care continuum is comprised of the following components with the described characteristics.

- Pre-Crisis
  - Respite
  - Case Management
  - Peer Support to include de-escalation
- Assessment Center Capacity

- First point of contact and/or entry for access to mental health crisis particularly by 911, CIT, Probate Court, ER, CMHC crisis lines, families, etc
- Includes medical and detox assessments/evaluations
- Secure
- 24/7 staffing
- <24 hr. hold capability
- Designated mental health facility
- Crisis stabilization units
  - May include mobile crisis stabilization teams
  - Designated mental health facility
  - Secure
  - Expected LOS 10 days
- Crisis Residential units
  - Short-term treatment
  - Designated mental health facility
  - Secure
  - Expected LOS <= 30 days
- Secure residential facility
  - Individuals who need protection while mastering basic living skills that will enable them to move to a lesser restrictive environment (i.e. group home, supported apartment, etc.)
  - May be behavioral and/or medical specialties with the expected LOS dependent on the type of facility
  - Designated mental health facility
- Community Extended Care
  - Extended care for the SMI aging population
  - Similar to an assisted living facility
  - Long-term residential
- Supported housing
  - Replacement for existing substandard living conditions where some consumers live.
  - Homeless
  - Consumers living with elderly family

Co-occurring capacity throughout the continuum should be provided.

**Goal: Establish the necessary supports to ensure that the developed continuum is consumer and family-driven, culturally and linguistically competent, and achieves the region's stated values.**

- Increase the number of case managers/ therapists by 50% to expand the system capacity for services.
- Integrate peer specialists throughout the continuum.
- Increase In-home interventions.
- Collaborate with other agencies to develop employment/transportation/housing options and opportunities.
- Develop, at least 3 drop-in centers within the region.
- Advocate for the expansion of the department's advisory/planning committees to include the private hospitals, probate judges, etc.
- Improve consumer and family support by advocating for consumer involvement in all aspects of a community program/s. Examples of opportunities for service may include
  - Quality Assurance Committees and sub-committee Advisory Boards
  - Planning Task Forces
  - Community Forum Planning Committees
  - Interagency Boards and Committees\
  - Hiring committees and interview panels
  - Grant Proposal Development committees
  - Grant Review committees
  - Clinical workgroups and/or treatment team reviews

**LEGAL AND LAW ENFORCEMENT ISSUES ( to be referred to the DMHMR Legal Task Force)**

- Develop a practical guideline for probate judges as they follow the legal commitment protocol.
- Advocate for

- community mental health officers
- ability for a physician to execute a 72-hour hold
- pre-court screenings
- Crisis Intervention Training (CIT) as a standard course in regional law enforcement academies.
- a standardized assessment/screening tool
- Mental health/mental illness topics should be incorporated into the training at the regular meetings of Probate Judges and similar training should be offered to attorneys who are involved in the commitment process through regional seminars that could offer CLE credits.
- Advocate for a revised commitment statute and administrative code regulations that is more consistent with the stated vision and values.

### **WORKFORCE ISSUES**

**Goal: Collaborate with statewide groups to develop and implement a workforce development plan that focuses on recruitment, training, and/or retention of psychiatrists but includes nurses and therapists.**

### **TECHNOLOGY ISSUES**

**Goal: Establish a standard uniform data system to include a regional electronic medical record and infrastructure capacity to utilize telemedicine.**

**Goal: Establish regional on-line training opportunities for staff.**

**Goal: Establish and/or expand the region's capacity for data analysis in order to demonstrate system effectiveness as well as to continue to improve the quality of the services that are delivered.**

To accomplish the stated goals, the following strategies are suggested to be implemented in two phases as indicated in the table below.

Goals and Strategies	Phase I Capital Requirement	Phase I Operating Requirement	Phase II Capital Requirement	Phase II Additional Operating Requirement
1. Reduce the capacity and census of Greil Hospital.	See detailed section entitled "Phase I Priorities".			
2. Redesign the continuum of acute-care services in Region 3.				
<i>a) Expand assessment capacity at each mental health center.</i>				
(1) 2 additional staff at East AL MHC		\$100,000		
(2) 1 additional staff at ECMHC		\$45,000		
(3) MAMHA: Psychiatric Assessment Center.		\$400,000		
<i>b) Increase community inpatient capacity (DMHF).</i>				
(1) Purchase additional inpatient services at East Alabama Medical Center.		\$300,000		
(2) Purchase services and assist with a 12-bed expansion at Bullock County Hospital in Union Springs. <i>The Bullock County Commission has agreed to match the \$200,000.</i>	\$200,000			
(3) Purchase inpatient services at Meadhaven (up to 32 beds)		\$1,200,000		
<i>c) Expand crisis residential/Brief Intensive Treatment Program (BIT) capacity in the community.</i>				
(1) Expand the East AL BIT program by 10-beds			\$1,200,000	\$900,000
(2) Develop 3 new 16-bed CRU/BIT unit in Montgomery catchment area. <b>NOTE: These costs could be considerably lower if existing resources can be utilized.</b>	2,000,000	1,100,000	\$4,000,000	\$2,300,000
<i>d) Add extended care residential beds.</i>				
(1) Add one 16-bed specialized medical unit. (2 beds reserved for respite care)		\$573,688		
(2) Add two 16-bed specialized behavioral care units (2 beds in each unit reserved for respite care)		\$651,892		
(3) Add two 16-bed retirement community extended care units (2 beds in each unit reserved for respite care).		\$651,892		
<b>**These beds are available at no capital cost and no significant start-up cost but may not be available after November. The daily cost per person in these facilities is about \$64. The units can be available and fully utilized within 30 days.</b>				
<i>e) Add residential capacity to address substance abuse and co-occurring acute care needs.</i>				
(1) Add 16-bed co-occurring unit at Greil.			\$900,000	\$750,000

Goals and Strategies	Phase I Capital Requirement	Phase I Operating Requirement	Phase II Capital Requirement	Phase II Additional Operating Requirement
<i>f) Add supported housing units/beds.</i>				
(1) Add HUD supportive housing beds .				
(2) Add additional AHFA apartment units when possible.				
(3) Consider expansion of apartment units at the Elks Center.				
<b>3. Develop adequate support services.</b>				
<i>a) Add Community Support Specialists to provide intensive care management for high-risk consumers to include but not limited to individuals from local inpatient units, residential facilities, crisis units, state hospitals, etc.</i>				
(1) East Central MHC: 3 community support specialists			\$84,000	
(2) East Alabama MHC: 5 community support specialists			\$140,000	
(3) MAMHA: 8 community support specialists			\$224,000	
<i>b) Add 1 peer support specialist per mental health center.</i>				
<ul style="list-style-type: none"> <li>• This should be a statewide project beginning with consultation from other states to develop a model for Alabama that will include certification standards and reimbursement criteria.</li> </ul>				\$60,000
<i>c) Add in-home teams (2 members).</i>				
(1) East Central MHC: 1 in-home team			\$70,000	
(2) East Alabama MHC: 2 in-home teams			\$140,000	
(3) MAMHA: 3 in-home teams			\$210,000	
<i>d) Establish a drop-in center in each catchment area within the region.</i>				\$150,000
<i>e) Add supportive employment, housing, transportation.</i>				
<i>f) Expand DMH/MR advisory/planning committees to include private hospitals, probate judges, etc.</i>				
<i>g) Improve consumer and family support by advocating for consumer involvement in all aspects of a community program/s.</i>				
(1) Develop planning tool for consumers/families to use.				

Goals and Strategies	Phase I Capital Requirement	Phase I Operating Requirement	Phase II Capital Requirement	Phase II Additional Operating Requirement
<b>4. Improve legal and law enforcement support (refer to DMH/MR legal task force).</b>				
a) <i>Develop a practical guide for probate judges as they follow the legal commitment protocol.</i>				
b) <i>Advocate for community mental health officers (6) in Montgomery county.</i>				\$ 30,000
c) <i>Advocate for the ability of a physician to execute a 72-hour hold.</i>				
d) <i>Advocate for pre-court screenings.</i>				
e) <i>Advocate for crisis intervention training as a standard course in regional law enforcement academies.</i>	\$50,000			
f) <i>Advocated for more training opportunities for probate judges and attorneys.</i>				
g) <i>Advocate for a standardized pre-screening assessment tool.</i>				
h) <i>Advocate for a revised commitment statute.</i>				
<b>5. Improve the mental health workforce.</b>				
a) <i>Collaborate with statewide groups to develop and implement a workforce development plan that focuses on recruitment, training, and retention of psychiatrists, nurses and therapists as well as training for current staff.</i>				
<b>7. Improve the use of technology.</b>				
a) <i>Establish a standard uniform data system to include a regional electronic medical record and infrastructure capacity to utilize telemedicine.</i>				\$300,000
b) <i>Establish on-line training capacity.</i>				
c) <i>Expand and/or develop capacity for data analysis.</i>	\$1,000,000			
	\$3,250,000	\$5,890,472	\$5,100,000	\$4,490,000

Priorities were established within the Phase I projects that would most dramatically impact the census overage at Greil Hospital through discharges and admission diversions. Phase I should realize an immediate reduction of the census at Greil from 74 to 44. That reduction should be maintained and/or further reduced throughout the 24-month time frame projected for Phase I. Furthermore, admissions to Greil should also decrease as additional inpatient capacity and assessment capacity is added within the region. The priorities within Phase I are indicated in the table below.

Phase I Priorities	Phase I Capital Requirement	Phase I Operating Requirement
1. Add residential capacity.		
a) Add one 16-bed specialized medical residential unit (2 respite beds).		\$573,688
b) Add two 16-bed specialized behavioral extended care units (2 respite beds).		\$651,892
c) Add two 16-bed retirement extended care residential units (2 respite beds).		\$651,892
2. Expand inpatient capacity.		
a) Purchase additional inpatient services at East Alabama Medical Center.		\$300,000
b) Purchase inpatient services and assist with a 12 bed expansion at Bullock County Hospital in Union Springs.	\$200,000	
c) Purchase additional inpatient services at Meadhaven.		\$1,200,000
3. Expand assessment capacity at each mental health center.		
a) Add 1 16-bed crisis residential unit within MAMHA.	2,000,000	\$1,100,000
b) 2 additional staff at East AL MHC		\$100,000
c) 1 additional staff at ECMHC		\$45,000
d) Psychiatric Assessment Center.		\$400,000
4. Add 16 Community Support Specialists to follow the person through the continuum.		\$448,000
5. Establish 6 additional 2-member in-home teams.		\$420,000
6. Increase capacity for data analysis.	\$1,000,000	
7. Offer CIT training throughout the region in law enforcement academies.	\$50,000	
<b>Total – Phase I</b>	<b>\$3,250,000</b>	<b>\$5,890,472</b>

Additionally, the planning group recommends that the following items continue to be addressed at the regional level and immediately on a statewide basis.

- Peer Support Specialists
- Legal and Law Enforcement Issues
- Workforce Development
- Telemedicine
- Forensics
- Technology

## How do we measure progress along the way?

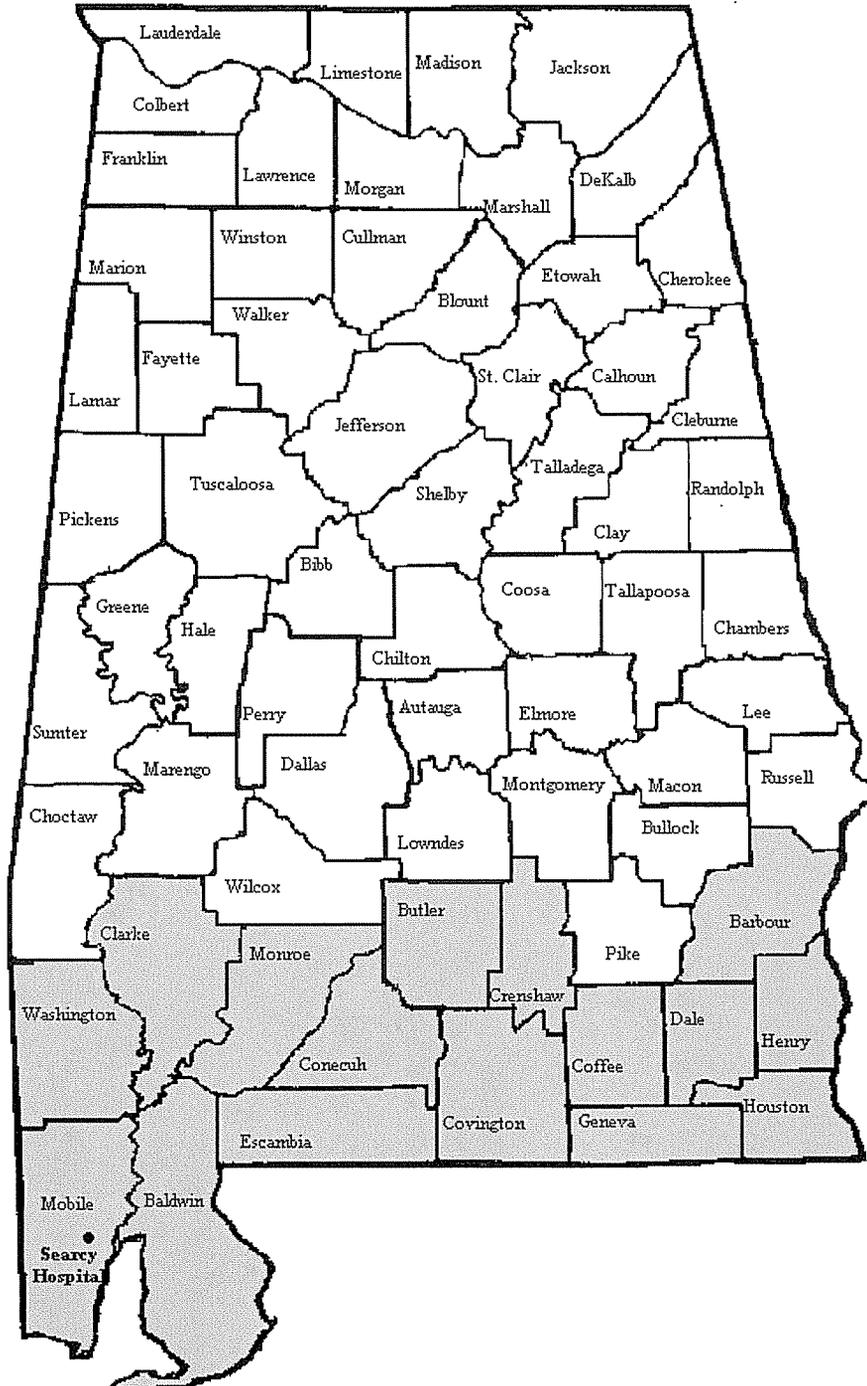
The success of the implementation of this plan will be measured incrementally to achieve at Greil Hospital a capacity of 50 and maintain a census of 50 individuals. The following targets are projected.

<b>Performance Objective</b>	<b>Beginning FY07</b>	<b>Beginning FY08</b>	<b>Beginning FY09</b>
Greil Census	74	50	50
Greil Capacity	66	50	50
Greil Admission Rate (regional)	86.78	40	20

The planning group for Region 3 has thoughtfully and deliberately crafted a plan that is interdependent on a variety of components – all of which are necessary to achieve the desired result. A fragmented implementation could result in unforeseen and differing and unpredictable degrees of success. The group is committed to continue this planning process meeting quarterly to evaluate progress through performance, redesign strategies, and continue to develop detailed plans to transform the mental health service delivery system. Furthermore, the region will continue monthly meetings with clinical directors and, if appropriate, expand the participants to better offer services to the people with mental illness within the region.

# Region 4

## SMART Plan



## **Mission**

**To develop a regional plan that provides community-based mental health services in a continuum of care focusing on the needs of the individual.**

To accomplish the stated mission, this plan for Region 4 was collaboratively developed with a broad-based stakeholder group. Members of the planning group included the following.

Ronald Hunt, WINGS (Consumer Advocacy Organization)

Sister Lucindia Claghorn , WINGS

Mary Elizabeth Perry, Alliance for the Mentally Ill of Alabama (NAMI)

Zoe Newby, President, NAMI

Zina May, DMHMR Advocate

Beatrice McLean, Facility Director, Searcy Hospital

Toni Greene, Mobile Infirmary

Vicki Darnell, Southeast Alabama Medical Center

Debbie Luttrell, McMillian Hospital

The Honorable Don Davis, Mobile County Probate Judge

The Honorable William Gammil, Coffee County Probate Judge

The Honorable Sherrie Phillips, Covington County Probate Judge

The Honorable Luke Cooley, Houston County Probate Judge

Aletha Pittman, AL Disability and Advocacy Program

Tuerk Schlesinger, Executive Director, Mobile Mental Health Center

Robin Riggins, Executive Director, Baldwin County Mental Health Center

Candace Harden, Executive Director, Southwest Alabama Mental Health Center

Robert Will, Clinical Director, Southwest Alabama Mental Health Center

Cindy Hataway, Executive Director, South Central Alabama Mental Health Center

Sheila Williams, Associate Director, South Central Alabama Mental Health Center

Melissa Kirkland, Executive Director, Wiregrass Mental Health Center

Angie Tribe, Wiregrass Mental Health Center

Phillip Drane, The Shoulder

## Where are we now?

Region 4 of the Division of Mental Illness Services within the Alabama Department of Mental Health and Mental Retardation encompasses the 16 counties of Mobile, Washington, Baldwin, Clarke, Monroe, Conecuh, Escambia, Butler, Crenshaw, Covington, Coffee, Barbour, Dale, Henry, Houston, and Geneva. Public mental health services are provided in the community by 5 mental health centers, Mobile Mental Health Center, Baldwin County Mental Health Center, Southwest Alabama Mental Health Center, South Central Alabama Mental Health Center, and Wiregrass Mental Health Center. Searcy Hospital in Mt. Vernon provides public inpatient psychiatric care for the region. According to the most recent census figures, the regional population is 1,014,946. The region served over 22,000 people in the community during fiscal year 2005. Using the 5.4% national prevalence rate for serious mental illness and the region's population of 1,014,946, it is estimated that the penetration rate for the region is around 41% which suggests an unmet need of about 59%.

Searcy Hospital provides acute care, extended care, and also has a psychiatric rehabilitation unit. Over 500 individuals were admitted to Searcy during FY05. Based on admissions per 100,000 people, Butler County had the highest admission rate at 77.05 and Barbour County had the lowest admission rate of 10.56. The regional admission rate was 50.25. 2005 data from the Mobile Probate Court also indicates 271 inpatient commitments and 148 outpatient commitments. Inpatient mental health care is also provided within the region at Bay Pointe Hospital, Mobile Infirmary, Crenshaw Co. Hospital, and Southeast Alabama Medical Center. In addition to these inpatient psychiatric units, the region diverts approximately 540 individuals from admission at Searcy Hospital by utilizing thirteen (13) facilities that are outside the region including 3 out-of-state facilities. Time and distance for consumers and families to travel can be upwards of 4 hours and 260 miles for a one-way trip.

Further analysis of the service capacity and workload of the region was conducted. The results are indicated in the tables below.

	<b>Region 4</b>	<b>Statewide</b>
Regional Population	1,014,946	4,557,808
<b>Community Capacity</b>		
Inpatient Bed Capacity	108	667
Inpatient Beds Per 100,000 Population.	10.64	14.63
Residential Bed Capacity	442	1,436
Residential Beds Per 100,000 Population.	43.55	31.51
Supported Housing Units	257	900
Supported Housing Units Per 100,000 Population.	25.32	19.75
Psychiatrists (FTE)	20.70	81.70
Psychiatrists (FTE) / 100,000 Population.	2.04	1.79
CMHC Allocations from DMHMR - FY07	\$33,702,998	\$127,952,863
No. Served	22,380	102,243
Served as % of Population	2.21%	2.24%
Allocation Per Person Served	\$1,506	\$1,251
CMHC Amount Per Capita FY07	\$33.21	\$28.07

Additionally, there are three ACT teams in the region with a caseload of 36 people per team.. There are, at least, seven (7) in-home intervention teams. There are 95 case managers with an average caseload of between 60-80 consumers. Mobile Mental Health Center has 80 case managers, and with the exception of Wiregrass Mental Health Center having 3 case managers, the other mental health centers in the region have 4 case managers each.

Hospital data	Searcy	State Hospital Total	Southeast Alabama Medical Center
Acute Bed Capacity	110	376	25
Acute Beds Per 100,000 Population.	10.84	8.25	2.46
Mean Acute LOS FY05	99.50	68.35	7.78
Acute Patient-Days FY05	60,128	173,427	8362
Acute Patient-Days / 100,000 Population.	5,924	3,805	824
Total Hospital Budget FY05	\$40,313,482	\$107,895,639	
Acute Care Portion	\$17,488,576	\$61,078,767	
Avg. Beds Occupied FY05	164.73	475.14	23
Cost Per Patient-Day FY05	\$290.86	352.19	\$484.85
Cost Per Episode FY05	\$28,940	\$24,072	\$3772

Admission data by county to Searcy Hospital for FY05 is depicted below.

CMHC	COUNTY	Pop. 2005	Probate Adm FY05	
			No.	Adm/100k
Mobile	Mobile	401,427	278	69.25
Mobile	Washington	17,773	9	50.64
Southwest Alabama	Clarke	27,269	8	29.34
Southwest Alabama	Conecuh	13,257	6	45.26
Southwest Alabama	Escambia	38,082	6	15.76
Southwest Alabama	Monroe	23,733	10	42.14
South Central	Butler	20,766	16	77.05
South Central	Coffee	45,567	20	43.89
South Central	Covington	37,003	21	56.75
South Central	Crenshaw	13,727	9	65.56
Wiregrass	Barbour	28,414	3	10.56
Wiregrass	Dale	48,748	16	32.82
Wiregrass	Geneva	25,735	5	19.43
Wiregrass	Henry	16,610	5	30.10
Wiregrass	Houston	94,249	50	53.05
Baldwin County	Baldwin	162,586	48	29.52
<b>Region 4 Totals</b>		<b>1,014,946</b>	<b>510</b>	<b>50.25</b>

# Where do we want to be?

## Vision

We envision a mental health system that is

- Accessible when the need arises

Characteristics should include

- Comparable levels of care – rural and urban environments
- Crisis services
- Consistency across the region
- Information regarding the services disseminated broadly across the region

- Recovery-oriented

Characteristics should include

- Services designed to treat the whole person
- Keeping in mind what is best for the individual
- Follow up to ensure compliance with treatment recommendations
- Goal-oriented
- Coordinated treatment for individuals with mental illness and substance abuse

- Consumer-driven

Characteristics should include processes that

- Give consumers a “voice” in their treatment
- Build systems focused on the consumer

- Family-driven

Characteristics should include processes that

- Keep families involved
- Recognize that perspectives sometimes differ between consumer and family

- A regional continuum of care based in the community

Characteristics should include

- Proximity of services to family and support networks
- Shared governance and accountability
- Collaborative in nature

- Outcome driven

Characteristics should include

- Avoiding treating individuals as objects
- Best practices based on research with defined metrics of success
- Sensitive to geographic, cultural, religious and linguistic diversity
- Stigma-free

Characteristics should include

- Building public awareness to dispel stigma\_especially within the educational system
- Fiscally accountable

Characteristics should include

- Affordability (e.g. sliding fee scale based on income)
- Use of technology
- Proper reporting
- Prioritization of core responsibilities
- Recognition of medical inflationary rates
- Utilize public/private partnerships

## Values

We value a planning process that is:

- Participatory
- Inclusive of all stakeholders
- Continuing
- Focused on current issues, but within a long-term perspective
- Creates fiscal accountability.

We value a regional plan that is:

- Structured around recovery and wellness for the individual across the continuum of care
- Places the consumer needs at the center of decision making and encourages family inclusion and support.
- Creates access to services in the least restrictive and most appropriate environment
- Provides for performance improvements and best practices based on evidence.
- Sensitive to geographic, cultural, religious, and linguistic diversity
- Creates fiscal accountability

# How do we get there?

## **Critical Issues**

### *Continuum of Care Issues*

- The current case load for the region is too high to effectively provide the supports to keep people out of hospitals and to assist people in recovery.
- The region lacks residential options particularly for those individuals with co-occurring diagnoses.
- Integrated treatment options for co-occurring disorders must be expanded within the region.
- There should be an emphasis on independent living with supports for consumers to define and realize individual recovery.
- Day treatment options should be examined to ensure that recovery is the end result and that result is achievable.
- Opportunities for employment should be developed and/or expanded.
- Travel distance to Searcy from some parts of the region is excessively long.
- There is a lack of appropriate services for the aging population.
- There is no access to detox services and minimal access to substance abuse treatment services within the region.

### *Legal Issues*

- Mental health training and ongoing education for probate judges, court clerks, and law enforcement personnel should be continued, supported, and in some areas developed and implemented.
- Efforts are needed to make the commitment process more sensitive to consumers.
- Mental Health Courts could divert incarcerations and possibly impact the admissions to state hospitals as individuals receive needed treatment in the community.
- Community mental health officers should be an option throughout the region. However, in order to fully implement and utilize, designated mental health facilities must be in the area.

### *Consumer/Family Issues*

- Peer support groups are a critical component of recovery and should be expanded.

### *Workforce Issues*

- There is a difficulty in recruiting mental health staff including psychiatrists, nurses, and therapists. Competitive wages are a contributing factor.

### *Technology Issues*

- IT infrastructure should be coordinated in its implementation and include the use of electronic medical records as well as telemedicine.

Based on the identified critical issues, the planning body developed the following long-term goals.

Services will be developed in three locations to afford easier access to service. Services in the Dothan area would be more accessible to consumers within the Wiregrass Mental Health Center. Services in the middle section of the region will be more accessible to South Central Mental Health Center and Southwest Mental Health Center areas. Services in the Mobile area would be more accessible for consumers within the Mobile Mental Health Center, and Baldwin County Mental Health Center areas.

The proposed residential facilities to be developed, with the exception of supported housing, will be secured, staffed 24/7, and designated mental health facilities. The designation of mental health facility will offer expanded regional capacity to individuals as well as to the probate court. The designation should include services only to people within this region. Individuals may be committed, admitted, and discharged to and/or from one of these facilities. With increased capacity for acute/crisis care, Searcy Hospital would then become the facility of last resort.

## CONTINUUM OF CARE – INCLUDING ACUTE CARE AND CONSUMER/FAMILY ISSUES

**Goal: Reconfigure a continuum of care that includes acute care services to include the following:**

1. Crisis Stabilization/Residential Units (8 beds – Mobile, 5 beds – Dothan, 8 beds South Central/Southwest). These units have the following characteristics:
  - Secure
  - Residential
  - Designated mental health facilities
  - Length of stay – expected - 5-10 days
6. Involuntary Probate Court Units (16-beds, 8 in Mobile and 8 in Dothan) with the following characteristics:
  - Secure
  - Designated mental health facility
  - Length of stay – expected - 7 days
7. Detox units
  - Length of stay – expected - 30 days

Advocate for a regional planning process within substance abuse division of DMHMR and prioritize funding for substance abuse residential services.

8. Intermediate Care Units of two types, with the following characteristics:
  - Short term residential – 64 beds in 16-bed increments
    1. Designated mental health facility
    2. Secure
    3. Length of Stay – expected - 90 days
  - Long-term residential -64 beds in 16-bed increments
    1. Designated mental health facility
    2. Secure
    3. Length of Stay – expected - 360 days
9. Specialized beds
10. Supported Housing
  - Apartments with Case managers available
  - Independent Housing

**Goal: Each rural county will have at least one in-home intervention team (2 members) with a case load of no more than 15 individuals per team.**

**Goal: Within the Mobile area, 4 additional “Bridge teams” (9.25 members) will be utilized with a caseload of no more than 10-12 individuals per team.**

### **LEGAL AND LAW ENFORCEMENT ISSUES**

**Goal: DMHMR will develop, collaborating with the mental health subcommittee of the Probate Judges Association and staff from the mental health centers, one or more training curricula for guardians ad litem to enhance and standardize practices within the mental health system.**

**Goal: The Department of MHMR will develop, collaborating with the mental health subcommittee of the Probate Judges Association; one or more training curricula regarding guardianship issues to better inform consumers and families.**

**Goal: Work with the Peace Officers Standards and Training Commission, Sheriff’s Association, and the Association of Chiefs of Police, in conjunction with the local probate judges, sheriffs, police chiefs, and local mental health center staff to enhance the Mental Health training requirement for personnel at two levels – those who are first responders to mental health crises and the general law enforcement workforce.**

**Goal: Establish, at least, two (2) community mental health officers within each county in the region.**

## **CONSUMER AND FAMILY ISSUES**

**Goal: Develop at least one consumer-operated supported group within each community mental health center.**

**Goal: Develop statewide certification standards for peer support specialists.**

**Goal: Establish at least fourteen (14) additional peer-support specialists throughout the region.**

**Goal: Ensure that each mental health center within the region continues or develops quarterly educational meetings for families and consumers as well as general public educational meetings to inform the public about serious mental illness including such concerns as new developments in the fields of medication, treatment, and recovery and strategies to reduce stigma.**

**Goal: Advocate with governmental entities who appoint board members to encourage appointments of consumers and/or family members.**

**Goal: Develop at least one supported work activity at each community mental health center within the region.**

## **WORKFORCE ISSUES**

**Goal: Encourage legislative supports that will foster psychiatric residency programs.**

**Goal: Develop, collaborating with the community college system, a statewide certification program for mental health technicians.**

**Goal: Begin recruitment efforts at all education levels for healthcare careers to include nurses, social workers, direct care, psychiatrists, nurse practitioners, and physicians' assistants.**

**TECHNOLOGY ISSUES**

**Goal: The Department of MHMR and all CMHC's will standardize electronic medical records so that data can be shared among all providers and appropriate stakeholders.**

**Goal: Federal grant opportunities will be explored to assist in the development of a standard electronic medical record.**

**Goal: Establish at least one telemedicine site in each county within the region.**

**Goal: A regional electronic referral database will be developed to ensure that regional resources are maximally utilized.**

To accomplish the stated goals, the following strategies are suggested to be implemented in two phases as indicated in the table below.

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
<b>1. Reduce the acute-care capacity and census stay at Searcy Hospital.</b>	(See Interim Step described below.)			
<b>2. Redesign the continuum of acute-care services in the region.</b>				
<i>a. Add 21 crisis stabilization beds. (Secure, DMHF, Staff 24/7)</i>				
(1) 8 beds in Mobile	\$	-	\$	1,169,460
(2) 5 beds in Dothan	\$	-	\$	730,913
(2) 8 beds in SC/SW				
<i>Discussions are currently underway for a public private partnership with the Crenshaw Co. Hospital. for this capacity which could reduce this cost.</i>	\$	-	\$	1,169,460
<i>b. Add 16 involuntary probate court unit beds. (Secure, DMHF, Staff 24/7)</i>				
(1) 8 beds in Mobile	\$	-	\$	1,314,000
(2) 8 beds in Dothan	\$	50,000	\$	1,314,000

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
<i>c. Add 76 detox beds. (Secure, DMHF, Staff 24/7)</i>				
(1) 25 beds in Mobile			\$ -	\$ 4,211,792
(2) 13 beds in SC and SW area			\$ -	\$ 2,190,132
(3) 25 beds in Baldwin			\$ -	\$ 4,211,792
(4) 13 beds in Dothan			\$ -	\$ 2,190,132

Note: Lease Payments are included in the operating requirement for the detox beds.

<i>d. Add 128 intermediate-care beds. (Secure, DMHF, Staff 24/7)</i>				
(1) 16 short-term beds in Mobile			\$ 1,600,000	\$ 600,002
(2) 16 long-term beds in Mobile	\$ 1,600,000			
(3) 16 short-term beds Baldwin	\$ 1,600,000			
(4) 16 long-term beds in Baldwin			\$ 1,600,000	
(5) 16 short-term beds in SC/SW	\$ 1,600,000	\$ 600,002		
(6) 16 long-term beds in SC/SW	\$ 1,600,000	\$ 600,002		
(7) 16 short-term beds in Wiregrass	\$ 1,600,000			
(8) 16 long-term beds in Wiregrass			\$ 1,600,000	\$ 600,002

Note: Capital costs of the intermediate-care beds and specialized beds are estimated at a maximum level and could be considerably lower depending on the real estate market at the time of implementation.

**While these facilities are being developed, an interim step includes the following.**

a. Open 32 long-term intermediate beds at Brewer-Baypointe (currently occupied by The Shoulder) to be operated by Baldwin County Mental Health Center.	\$ 200,000	\$ 1,500,000		
b. Open 16 short-term intermediate beds in SW (a lease will be explored to utilize a vacant hospital wing).	\$ 100,000	\$ 750,000		
c. Open 16 short-term intermediate beds in Dothan ( <i>Wiregrass MHC has located a facility that through the relocation of an existing program could realize this capacity.</i> )	\$ 100,000	\$ 750,000		

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
<i>e. Add 112 specialized beds.</i>				
(1) 16 beds in Mobile (medical)			\$ 1,500,000	\$ 584,000
(2) 16 beds in Baldwin (co-occurring)			\$ 1,500,000	\$ 584,000
(3) 16 beds in Southwest (co-occurring)			\$ 1,500,000	\$ 584,000
(4) 16 beds in South Central (transitional)			\$ 1,500,000	\$ 584,000
(5) 16 beds in Wiregrass (co-occurring)			\$ 1,500,000	\$ 584,000
<i>f. Add 120 supported housing unit beds.</i>				
(1) 30 units in Mobile			\$ -	\$ 284,700
(2) 20 units in Baldwin			\$ -	\$ 189,800
(3) 20 units in Southwest			\$ -	\$ 189,800
(4) 20 units in South Central			\$ -	\$ 189,800
(5) 30 units in Wiregrass			\$ -	\$ 284,700
<b>3. Develop adequate support services.</b>				
a. Add 8 2-member In-home intervention teams (Wiregrass, Baldwin, South Central, Southwest).		\$ 728,000		
b. Add 4 9.25 member bridge teams (Mobile).		\$ 570,000		\$ 570,000
<b>4. Improve legal &amp; law enforcement support.</b>				
a. DMHMR to develop training curricula guardians ad litem.				
b. DMHMR to develop training curricula on guardianship issues to better inform consumers and families.				
c. Work to enhance MH training requirement for personnel at two levels - first responders and general law enforcement workforce.				
d. Establish (2) community mental health officers in each county in the region.		\$ 1,050,000		
<b>5. Improve consumer and family support.</b>				
a. Develop at least one consumer-operated support group within each CMHC.				
b. Develop statewide certification standards for peer support specialists.				
c. Add 14 part-time peer support specialists.				
• This should be a statewide project beginning with consultation to develop a model for Alabama that will include certification standards & reimbursement criteria.	\$ 35,000			\$ 140,000

GOALS AND STRATEGIES	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT	PHASE II CAPITAL REQUIREMENT	PHASE II ADDITIONAL OPERATING REQUIREMENT
d. Ensure that each mental health center within the region continues or develops quarterly educational meetings.				
e. Advocate with governmental entities who appoint board members to encourage appointments of consumers and/or family members.				
f. Develop at least one supported work activity at each community mental health center within the region.			\$ 250,000	\$ 100,000
<b>6. Improve the mental health workforce.</b>				
a. Encourage legislative support that will foster psychiatric residency programs.				
b. Develop, collaborating with the community college system, a statewide certification program for mental health technicians.				
c. Begin recruitment efforts in the school systems and community colleges for nurses, counselors, and technicians.				
<b>7. Improve the use of technology.</b>				
a. DMHMR and all CMHCs to standardize electronic medical records so that data can be shared and compared across the system.				
b. Federal grant opportunities will be explored to assist in the development of a standard electronic medical record.				
c. Establish at least one telemedicine site in each county of the region. <ul style="list-style-type: none"> <li>• This should be a statewide project that begins with a task force to determine existing and available resources and partners as well as establishing a standard protocol for the provision of services via telemedicine.</li> </ul>				
	\$6,885,000	\$11,045,833	\$14,150,000	\$18,872,652

Priorities were established within the Phase I projects that would most dramatically impact the census coverage at Searcy Hospital through discharges and admission diversions. Phase I should realize a reduction of the census at Searcy from 165 to 110. That reduction should be maintained throughout the 24 month time frame projected for Phase I. Phase II should result in a further reduction of, at least, 30 in the census and capacity at Searcy. The priorities within Phase I are indicated in the table below.

Phase I Priorities	PHASE I CAPITAL REQUIREMENT	PHASE I OPERATING REQUIREMENT
1. Open 32 long-term intermediate beds at Brewer-Baypoint (currently occupied by The Shoulder) to be operated by Baldwin County Mental Health Center. Interim-basis only	\$ 200,000	\$ 1,500,000
2. Open 16 short-term intermediate beds in SW (a lease will be explored to utilize a vacant hospital wing). Interim-basis only	\$ 100,000	\$ 750,000
3. Open 16 short-term intermediate beds in Dothan (a lease will be explored to utilize a vacant hospital wing). Interim-basis only		
<i>Wiregrass MHC has located a facility that through the relocation of an existing program could realize this capacity.</i>	\$ 100,000	\$ 750,000
<b>4. Add 16 involuntary probate court unit beds.</b>		
8 beds in Mobile	\$ -	\$ 1,314,000
8 beds in Dothan	\$ 50,000	\$ 1,314,000
<b>5. Add 21 crisis stabilization beds.</b>		
8 beds in Mobile	\$ -	\$ 1,169,460
5 beds in Dothan	\$ -	\$ 730,913
8 beds in SC/SW area		
<i>Discussions are currently underway for a public private partnership with the Crenshaw Co. Hospital. for this capacity which could reduce this cost.</i>	\$ -	\$ 1,169,460
<b>6. Add 128 intermediate-care beds.</b>		
16 long-term beds in Mobile (operating costs included in #1 above)	\$ 1,600,000	-
16 short-term beds Baldwin (operating costs included in #1 above)	\$ 1,600,000	
16 short-term beds in SC/SW	\$ 1,600,000	
16 short-term beds in Wiregrass	\$ 1,600,000	
7. Add 8 In-home intervention teams (all but Mobile).		\$ 728,000
8. Add 2 bridge teams (Mobile).		570,000
Statewide beginning for peer support specialist initiative	\$ 35,000	
<b>Total for Phase I</b>	<b>\$6,885,000</b>	<b>\$11,045,833</b>

The planning group realizes that many important issues, as noted below, were not adequately addressed during these initial planning sessions. However, on a regional basis, the group is committed to continue, on a quarterly basis, to explore innovative and cost-effective solutions that will promote recovery.

Additionally, the planning group members recommend that the following be addressed beginning immediately on a statewide basis.

- Peer Support Specialists
- Legal and Law Enforcement Issues
- Workforce Development
- Telemedicine
- Planning for Substance Abuse treatment and Co-occurring treatment strategies
- Forensic Population Issues

## How do we measure progress along the way?

The success of the implementation of this plan will be measured incrementally to achieve at Searcy Hospital a capacity of 80 and maintain a census of 80 individuals. The following targets are projected.

<b>Performance Objective</b>	<b>Beginning FY07</b>	<b>Beginning FY08</b>	<b>Beginning FY09</b>	<b>Beginning FY10</b>
Searcy Census	165	110	80	80
Searcy Capacity	110	110	80	80
Searcy Admission Rate (regional)	50.25	45	40	40

When the census at Searcy reaches 50, a partnership should be explored with the University of South Alabama in Mobile to transfer the 50-bed acute care unit. The employees would remain within the state system and the unit could, while meeting the needs of the individuals, allow for further training of psychiatrists, nurses, mental health technicians, and therapists.

The planning group for Region 4 has thoughtfully and deliberately crafted a plan that is interdependent on a variety of components – all of which are necessary to achieve the desired result. A fragmented implementation could cause unforeseen and differing and unpredictable degrees of success. The group is committed to continue this planning process meeting quarterly to evaluate progress through performance, redesign strategies, and continue to develop detailed plans to transform the mental health service delivery system.