

March 31, 2006

MEMORANDUM

TO: John Houston  
Commissioner

FROM: R. Emmett Poundstone, III   
Chair, Acute Care Task Force

RE: Report from the Acute Care Task Force

Enclosed is the report entitled "The Transformation of Alabama's Mental Health Care System: The Crisis in Acute Care" developed by the task force which you recently established. The group heard from national experts in the field of mental health care as it carefully and deliberately developed this report. It is the anticipation of this broad-based stakeholder group that you will embrace the concepts and take further steps toward the implementation of the recommendations included in this report.

It has been my pleasure to assist you and the department in an endeavor that promises to truly transform Alabama's mental health service delivery system in a manner that focuses on consumers, families, recovery, and resiliency.

REP:ae

**The Transformation of Alabama's Mental Health  
Care System**

**The Crisis in Acute Care**

**A Report to the  
Alabama Department of Mental Health and Mental Retardation  
Commissioner John Houston**

**by  
Acute Care Task Force  
R. Emmett Poundstone III, Chair**

**March 31, 2006**

# **The Transformation of Alabama's Mental Health Care System**

## **The Crisis in Acute Care**

### Executive Summary

In June 2005, Commissioner John Houston established a broad-based stakeholder task force to address the issue of overcrowding in the state's psychiatric hospitals. The task force realized that the scope of the problem went far beyond the boundaries of the state hospitals. The task force deliberately developed a framework, rooted in the concepts of community and recovery, for transforming the mental health system of care in Alabama.

The state operates 376 acute care beds and 367 extended care beds in the state-operated hospital system. In December 2005, the patient census was 42 people over the system's capacity. The average census overage from March 2005 to March 2006 was 116 people. The acute care bed crisis can be attributed to the following.

- ◆ A 47% reduction in extended-bed capacity in the public system
- ◆ A 15% reduction of available beds in the private system
- ◆ An increased rate of admissions in the public system

To effectuate a long-term solution requires the development and maintenance of several components. The envisioned system must be

- recovery-oriented,
- dedicated to the use of evidenced-base practices and measured outcomes,
- consumer and family driven,
- culturally competent and linguistically appropriate, and
- fiscally accountable.

Additionally, the system must have the capacity to meet the individual's and community's needs. That is, there must be a balance of services available, from crisis (i.e. urgent and emergency), to inpatient (i.e. public and private), to supported recovery (i.e. housing, employment, and transportation).

In order for this envisioned system to come to fruition, the task force recommends that acute care services be shifted from the state psychiatric hospitals to the community-based mental health system. In order to accomplish this, the task force further

recommends formalized planning on a regional level that includes, at a minimum, state hospital staff, community mental health centers, private hospital representation, and consumers and families. Regional plans should be comprehensive, with strategies developed to focus on this report's stated goals related to legal issues, workforce development, technology, community capacity, and the forensic population. Strategies should also be developed to effectively provide treatment for individuals with co-occurring diagnosis. The department should provide concise, comprehensive, and clear guidelines for regional plans.

Finally, the task force recommends that the Commissioner review the submitted plans in order to determine a pilot area for the transformation of Alabama's mental health system to begin. Resources would then be made available, where possible, to implement the piloted regional plan with the goal of incrementally implementing the other regional plans.

Alabama is poised to be in the forefront of providing services to individuals with mental illness in a cohesive manner where recovery and resiliency are promoted. The work of this task force is the first step toward such a system of mental health care.

## **Acute Care Task Force Participants**

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## **The Transformation of Alabama's Mental Health Care System The Crisis in Acute Care**

***"Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."***

*National Consensus Statement of Mental Health Recovery*

### *National Crisis*

Mental illness can occur at any stage of life, from infancy to old age. It affects almost every American family regardless of its socio-economic status. No community is unaffected by mental illness. It is prevalent in our homes, in our schools, and in our workplaces. According the President's New Freedom Commission on Mental Health (herein referred to as the Commission), in any given year 5 to 7% of adults will have a mental illness and 5 to 9% of children will have a serious emotional disturbance. Mental illness ranks first among illnesses that cause disability in the United States, Canada, and Western Europe. In April 2002, President Bush identified a fragmented mental health service delivery system as a major obstacle that prevents Americans with mental illness from receiving the care needed to promote recovery and resiliency.

In its *Interim Report to the President*, the Commission confirmed, "... the mental health delivery system is fragmented and in disarray...lead[ing] to unnecessary and costly disability, homelessness, school failure, and incarceration." Additionally, the report concluded that the system is not oriented to the hope of recovery which should be the single most important goal of serving people with mental illness. The shortcomings of the system were not attributed to a lack of compassion or professionalism among workers but rather with the evolution over the past five decades of the community-based mental health system of care. The Commission further stated that in order to promote recovery and resiliency, institutional care should be replaced with efficient and effective community-based services.

### *Acute Care*

In order to fully review the mental health system and make recommendations to the President, the Commission established fifteen (15) subcommittees to provide preliminary policy options in key issue areas. The Subcommittee on Acute Care recognized that within the process of recovery, crises occur. During crises, people with mental illnesses sometimes must be evaluated in emergency settings and sometimes must be admitted to short-term inpatient settings. Acute care is a vital part of a comprehensive mental health service delivery system and has traditionally been defined as follows:

- Short-term (median length of stay of approximately 30 days or less), 24-hour, inpatient care, sometimes provided in hospital emergency rooms
- Short-term, 24-hour care provided in residential treatment programs for children
- Treatment in other crisis settings.

More recently other approaches have been identified that are more normalized and less costly alternatives to inpatient care. These include such options as crisis residential programs for adults, crisis family care and treatment, foster care for children, multi-systemic therapy for children and families, mobile crisis teams, assertive community treatment, and peer-based services. The most important role for acute care is to provide a safe setting to evaluate and assess the person in crisis. The Subcommittee identified access and availability of acute care services to be an essential component of a balanced system of mental health care.

## Where are we now?

### *Mental Health Care in Alabama*

The Alabama Department of Mental Health and Mental Retardation provides appropriate care and treatment for individuals with severe mental illnesses and children and adolescents with serious emotional disturbance. People typically come into the state's mental health service system through local community mental health centers, or probate and juvenile courts. Currently, when the severity of a person's illness requires intensive treatment beyond the scope of services offered within the community, psychiatric hospital care is available on a short-term basis. This type care is often referred to as "acute care."

There are four state-operated psychiatric hospitals (Bryce in Tuscaloosa, North Alabama Regional in Decatur, Searcy in Mt. Vernon, and Greil in Montgomery) that have acute care units (sometimes referred to as "admissions" units). The acute care bed capacity is as follows.

<b>Hospital</b>	<b>Number of Acute Beds</b>
Bryce	126
Searcy	110
North Alabama Regional	74
Greil	66
<b>Total</b>	<b>376</b>

Each hospital is assigned a geographical area (catchment) from which patients are admitted.

In some cases, longer term hospital care is necessary and provided, with the ultimate goal of the individual returning to their local community. This type of care is referred to as "extended care." Two of the state hospitals (Bryce in Tuscaloosa and Searcy in Mt. Vernon) provide this type of care and treatment. There are 367 extended care beds in the

state with 172 beds at Bryce and 195 beds at Searcy. Catchment areas have also been established for the extended care units to determine and manage the patient population.

The mental illness service delivery system also includes care and treatment to four (4) special populations: adolescents with severe emotional disturbances; acute geriatric; adults found by criminal courts to be “not guilty by reason of insanity” (NGRI) or in need of forensic evaluation to determine competency to stand trial or participate in their defense; and the elderly with severe mental illnesses and other health/medical conditions requiring basic nursing home care. Adolescents with severe mental illness are treated in a 20-bed adolescent unit at Bryce Hospital in Tuscaloosa. The Mary Starke Harper Geriatric Center, a 96-bed facility also located in Tuscaloosa, provides short-term mental health care for people 65 years and older with acute psychiatric conditions. The Taylor Hardin Secure Medical Facility, a 114-bed facility located in Tuscaloosa, is the state’s primary forensic unit, as well as providing forensic evaluations, acute, and long-term psychiatric care and treatment. A psychiatric nursing home, Alice Kidd in Tuscaloosa, operated by the department, has a capacity of 35 beds.

The community-based system of public mental health care is anchored by 25 community mental health centers (CMHC) which were established by local governmental entities. The CMHC's provide a comprehensive array of services including outpatient, day services, in-home services/interventions, a variety of residential options, and some inpatient and emergency services. The department monitors and certifies the quality of care rendered at each center. Additionally, the department provides funding to the centers through contractual agreements. Over 100,000 individuals per year are provided mental health services in this community environment.

Over the past 30 years, Alabama’s mental health and mental retardation system was primarily directed by judicial oversight as a result of the Wyatt V. Stickney lawsuit. The Wyatt case, as it is more commonly known, was filed in the 1970’s and continued for over 30 years. During this era, standards of client care, treatment, and habilitation were established and implemented in all state operated in-patient facilities in Alabama, which

also became the basis for many national accreditation and certification standards in the mental health and mental retardation fields. By the mid 1980's, the focus of the Wyatt case shifted from primarily that of institutional care to that of community-based treatment and care. As a result, for almost two decades, the Alabama mental health system has expanded its community-based system and moved thousands of individuals from institutional settings to more community integrated systems for care and treatment.

#### *Crisis in Acute Care*

As one condition of the Wyatt Settlement Agreement in 2000, 300 extended care beds within the system were closed by 2003. Based upon the assessed needs of consumers in the state facilities, additional community-based resources were developed to facilitate the bed closures. Furthermore, the expanded community resources were expected to result in a reduced demand on the remaining state hospital beds with a target of decreasing admissions by 20%.

Residential service availability would also be based on the needs of consumers. The needs and desires of consumers and families were accomplished through annual assessments and consumers' person-centered discharge plans. The expansion of residential services in the community was also expected to directly affect the admission rates at the state psychiatric hospitals. Residential service beds increased 13% from 2000 (1928 beds) to 2005 (2175 beds). The Black Belt catchment area (East Central, Cahaba, Montgomery, and West Alabama) saw a 42% increase in availability of beds from 219 in 2000 to 312 in 2005.

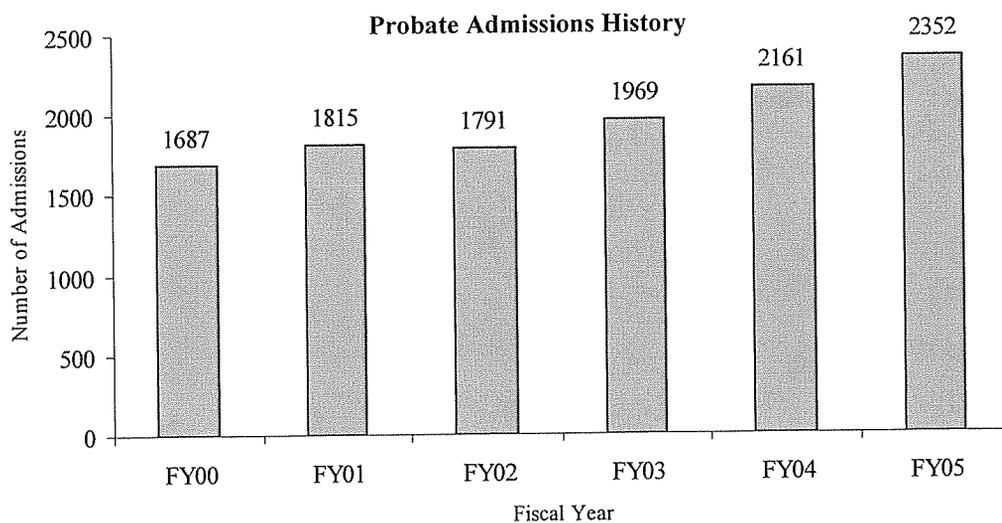
As the Division of Mental Illness was complying with the terms of the Wyatt Settlement Agreement and enhancing services in the community, the Alabama Hospital Association began to report a troubling trend in inpatient psychiatric units within its member hospitals. Many private hospitals were experiencing loss of revenues in their psychiatric units due to changes in Medicare and Medicaid reimbursement rates related to the Federal 1999 Balanced Budget Act. While the number of licensed psychiatric beds has

remained the same over a five-year period from 2000 - 2005 (1435 beds), the configuration of those beds has changed. In 2000, 68% of the psychiatric beds (918) were utilized for adults and children. In 2005, that percentage has declined to 62% (845 beds). At the same time, the number of gero-psychiatric beds increased by 69% (110 beds). These 110 beds had previously been accessed by adults and children with psychiatric needs. This reconfiguration of the utilization of private psychiatric beds has had a significant impact on the public acute care system.

To further compound the problem, the state hospitals were reporting increased admissions after years of declining admission rates. Nationally, admissions to psychiatric hospitals increased 11% in one year (2000-2001). Restated, the acute care bed crisis was attributed to the following.

- ◆ A 47% reduction in extended-bed capacity in the public system
- ◆ A 15% reduction of available beds in the private system
- ◆ An increased rate of admissions

The increased demand for beds remains. In fact, the 2000 projection of a 20% **decrease** in admissions was not realized. Admissions from probate courts have actually **increased** 39% over the past five years.



The crisis continued to grow. Since November 2004, the acute care census has ranged from 10 to 44% above the bed capacity. Additionally, two hospitals providing acute care have maintained a median length of stay of between 15 - 35 days over a four year period from 2002 through 2005 while the remaining two hospitals median length of stay ranged from 43 - 56 days over the same time period.

A variety of strategies have been employed to address this issue. The steps previously taken are illustrated below.

1. Since 2003, 20 new acute beds have been opened at Bryce Hospital and 20 additional acute beds have been opened at Searcy Hospital.
2. The service catchment areas of the state were realigned to more proportionately assign psychiatric hospital responsibility based on the current identified needs for acute and extended care services.
3. Since 2001, approximately \$4 million per year has been used in the community to expand crisis services in an ongoing effort to provide treatment that could prevent admissions.
4. Movement from the hospitals to community placements was facilitated by eliminating the catchment area restrictions on post-hospitalization placement. This means that a patient admitted from North Alabama had the option of being discharged to a program in South Alabama.
5. To effectively utilize community beds throughout the state, four Utilization Coordinators were employed to match vacant community beds with hospital discharge needs.
6. Twelve inpatient beds have been opened in the community (6 in Birmingham and 6 in Mobile).
7. Forty-two (42) additional residential beds have been opened in 2004 and 2005 throughout the state to accommodate patients being discharged from the hospitals.
8. Three (3) 16-bed Intermediate Care Programs have been established in the community to provide community treatment services for those individuals in the hospitals who are approaching discharge. These residential programs provide

supervision in a structured environment allowing the patient to begin a transition to the community.

The aggregate effect of these strategies is still unclear. In December 2005, the percentage of census overage was 6% (42 beds over capacity) which was the lowest since November 2004. However, in August 2005 the percentage of census overage had risen to 20% (150 beds over capacity). On average the percentage of census overage from March 2005 to March 2006 is 16% or 116 beds over capacity. While the short-term priority is to move the system toward operating at 100% capacity, the need to address a longer-term solution to acute care that promotes recovery and resiliency is evident to all stakeholders.

### **Where do we want to go?**

The issue of the acute care service delivery system has been discussed by various groups for many years. The Division of Mental Illness' Coordinating Subcommittee as well as the Mental Health Planning Council have assisted in the development and implementation of many of the strategies discussed earlier. Previous Commissioners have established groups to address the service delivery system including the acute care component. Commissioner John Houston charged an Acute Care Task Force in August 2005 to envision an optimal acute care delivery system for the state and develop strategies to move toward that vision. This group is chaired by a former Commissioner of the department and is composed of stakeholders, consumers and families members. Those represented on the Task Force include:

DMHMR

National Alliance on Mental Illness of Alabama

WINGS

AL Disability and Advocacy Program

Probate Judges

Council of Community Mental Health Boards

Community Mental Health Center

AL Hospital Association

The following framework was developed by the task force.

**MISSION:** To design a mental health acute care service delivery system that is built on public and private partnerships utilizing resources to seamlessly move individuals through a continuum of care in the most appropriate and least restrictive environment.

**VALUES:**

1. Recovery for the individual is the ultimate goal.
2. Individual choice and worth are respected.
3. Services are delivered in a culturally competent and linguistically appropriate environment.
4. Services are evidenced-based and outcome oriented.
5. Accountability of resources is a foundation of the system.

As the group heard from national consultants, several themes emerged. The acute care system of care is an essential component of the larger more comprehensive service delivery system. In order for an acute care model to be effective, the other components of the service system such as crisis and outpatient services, supported employment, supportive housing, and transportation services have to be rich and robust. To address simply acute care is not in the best interest of consumers and families and does not fully promote recovery. To fully address the issue requires a true transformation of the Alabama mental health system. The task force acknowledges a long-term goal should be a systemic shift and realignment of the mental health service delivery system. Additionally, short-term goals and strategies should continue to be developed and implemented to address the more immediate problem of overcrowding in the state acute care units. Therefore, this document should serve as a framework for the future development of short-term goals, strategies, implementation plans, and progress reporting specifically designed to move the system toward the achievement of the stated goal of acute care provided in local communities.

## *A System Transformed*

**Recommendation: Acute care services should be shifted from the state psychiatric hospitals to the community-based mental health system.**

### **How do we get there?**

Deciding on the destination of a journey is critical; however, equally important is defining a route to the destination. The task force identified goals across seven broad areas that will move the current system toward the envisioned transformation. From the top of the service delivery system to the bottom and all points in between, all stakeholders must embrace and understand a "recovery" system that is primarily anchored in the community-based system of care. The following goals were developed to be considered as the framework for transformation and should be in the forefront as policies and implementation plans are further developed.

#### **Goals related to Legal Issues**

1. Develop and implement on-going educational programs for the judicial, legal, and law enforcement communities
2. Review Rule 11 and Rule 25 (rules regarding competency to stand trial and NGRI) and make recommendations for changes to improve efficiency.
3. Review the "end-of-sentence" issues for mental illness facilities and DMH/MR's relationship with the Department of Corrections.
4. Examine the issues surrounding "conditional release", specifically, remaining indefinitely on that status and the response to non-compliance.

5. Develop a mechanism to ensure that local community mental health centers have involvement with the court during the commitment process in ways that maximize community services prior to state-operated hospital commitment.

### **Goals related to Workforce**

The scope of workforce development should be, at this time, limited to physicians, nurses, master's level social workers and counselors. The goals for workforce development center around 4 broad themes as described below.

#### Recruitment

1. Solicit legislative support to enhance Alabama's ability to recruit J-1 candidates.
2. Centralize recruiting efforts to shortage areas that have available J-1 and H-1 B slots.
3. Collaborate with the Alabama Nurses Association to recruit psychiatric nurses.
4. Develop strategies to recruit more LCSW/LPC into the private and public health care systems.

#### Retention

5. Re-examine salary ranges and flexible scheduling as methods to retain healthcare workers.

#### Training

6. Promote the expansion of nurse training programs.
7. Develop with private partners a nurse professional reentry program through scholarships and mentoring programs.
8. Explore innovative methods to produce more psychiatric nurses.

#### Licensing

9. Solicit support from all appropriate venues to urge the Board of Medical Licensure to establish licensure requirements to promote and not hinder recruitment efforts.

#### **Goals related to Technology**

1. Determine the financial and logistical requirements to develop a standard medical record for the Alabama public mental health system.
2. Determine the financial and logistical requirements to develop and deploy telemedicine capacity.

#### **Goals related to Community Capacity**

1. The responsibility for the provision of acute care services will be assumed by the community mental health centers. Acute care services, including local hospitalization, will be expanded in the community. The following implementation strategies should be considered.
  - Regional planning groups will develop regional plans to achieve the desired reduction in state hospital acute care census based on shifting acute care from state hospitals to local communities. The regional planning body should, at a minimum, consist of representatives from the local mental health centers, the state hospital, consumers and families. Other partners shall include private hospitals, local advocacy organizations, and interested community stakeholders. Input from these partners could be achieved through focus groups.

- The regional plan should consider local planning efforts and will be developed in accordance DMHMR specific timelines and guidelines.
- The plan should be prepared in accordance with evidence-based practice guidelines and promote recovery.
- The plan should address regional implementation strategies to address previously identified goals relative to legal, technology, and workforce development.
- The plan should include an evaluation component measuring the reduction in acute care census, the increases in community capacity, and family and consumer satisfaction.

Each regional plan is expected to be unique to the area. However, each plan is expected to reflect the common theme of shifting acute care services to the local community.

Based on the regional plans submitted, at least, one region should be selected to pilot the implementation of its plan. Financing of the pilot may be achieved through allocation of bridge funding and/or an outcome based payment methodology to the respective community mental health centers.

An example of a regional model is illustrated and described below.

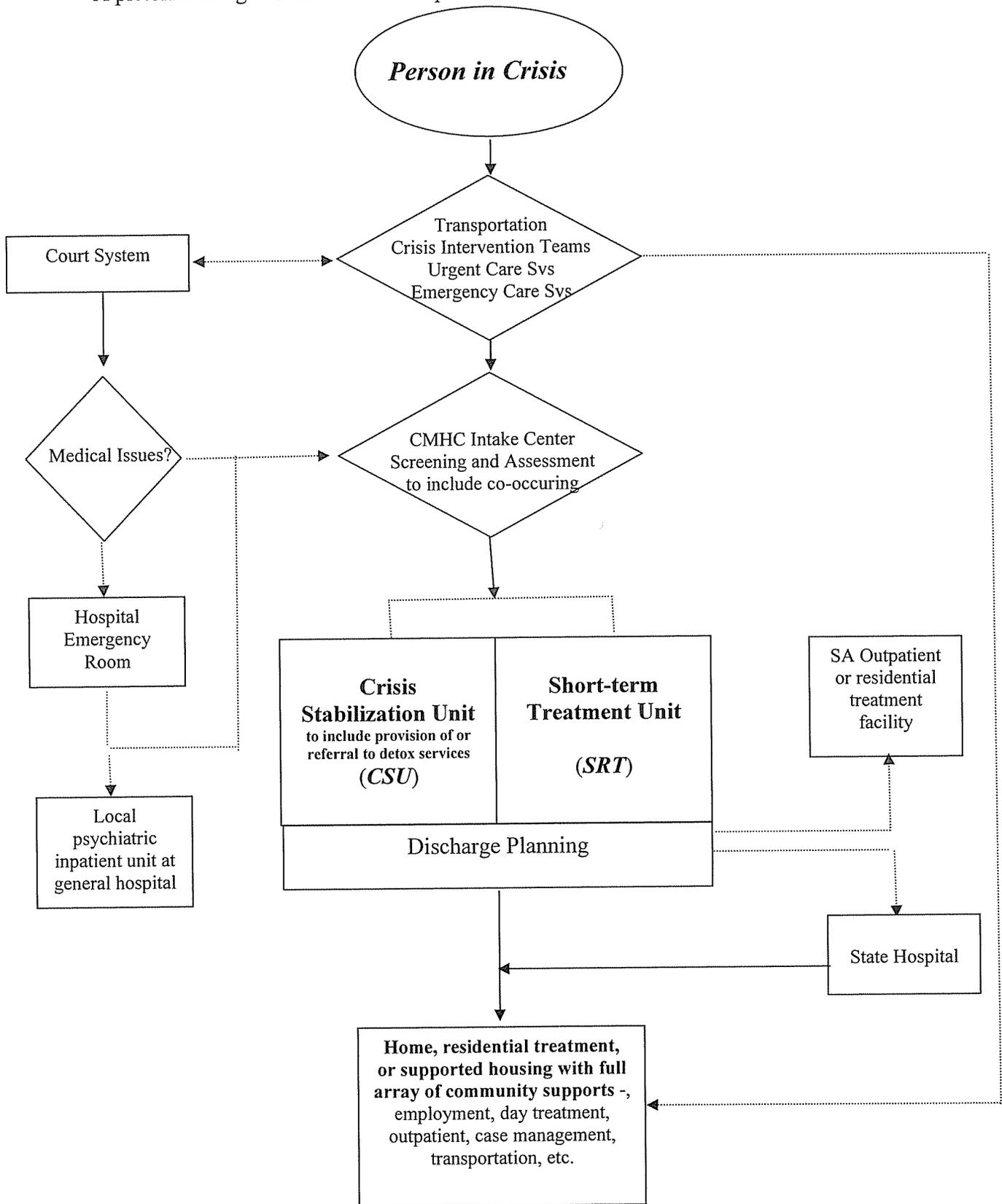
The community acute care system would be composed of the following components:

- A continuum of early intervention services in the community designed to prevent hospitalization for a person in crisis. These services would be developed consistent with the American Psychiatric Association Guidelines for crisis/emergency services and could include psychiatric facility-based urgent care,

psychiatric mobile emergency services, and /or psychiatric mobile urgent care services.

- CMHC Intake Services perform gatekeeper functions with screening and assessment capabilities for mental illness, mental retardation, and substance abuse and identify medical contributing factors.
- Crisis Stabilization Units (CSU) are short-term alternatives to inpatient psychiatric hospitalization. A CSU provides brief intensive services for individuals who are acutely mentally ill on a 24-hour-a-day 7-day-a-week basis, under the licensing authority of the department. The purpose of a CSU is to examine, stabilize and redirect people to the most appropriate and least restrictive treatment settings consistent with their needs. The CSU is a secure unit with no more than 15 beds. The expected length of stay at a CSU would be 3 - 5 days.
- Short-term Residential Unit (SRT) is an acute care 24-hour-a-day, 7-day-a-week residential alternative service, generally of 90 days or less. The purpose of an SRT is to provide intensive short-term treatment to individuals who are temporarily in need of a 24-hour-a-day structured therapeutic setting in a less restrictive, but longer-stay alternative to hospitalization. The SRT is also a secure unit with no more than 30 beds.
- Aftercare consisting of the full array of supports ranging from transportation, housing, employment, other residential options, case management, mobile crisis services, and assertive community treatment etc.

A pictorial design of this model is depicted below.



## **Goals related to the Forensic Population**

This group developed short and long-term goals as identified below.

### SHORT TERM GOALS:

1. Identify adult male forensic inpatients at Bryce and Searcy as a “special needs” group to help provide focus and direction in their care and discharge planning.
2. Establish a teaching facility a specialized treatment team trained in forensic issues to focus on evaluation and treatment and the special considerations in placement.
3. Develop specialized or separate programs/units at Bryce and Searcy to house forensic patients
4. Provide training, as needed, in the special needs and legal/clinical procedures for this population.
5. Reestablish a regular rotation of patient transfers from Taylor Hardin to Bryce and Searcy.

### LONG TERM GOALS:

6. Review the special subpopulations of forensic patients to assure appropriate housing and services are provided. These groups may include geriatric, mental retardation, adolescent, female, and medical.
7. Examine current bed capacity for forensic consumers and trends with the aim of having the right number of beds available and in the correct location. Factors include: facility or community, level of security needed, projected beds needed by evaluation/treatment/competency, special groups.

8. Explore the feasibility of expanding the outpatient evaluation function to all community contract providers.
9. Assess community resources for forensic consumers to project future needs. Look at assessment needs, forensic group homes, case managers, variability across mental health centers, community support.
10. Develop and implement a forensic database for consumers in facility and community to allow tracking and analysis.
11. Explore the concept of a Forensic Director and/or Forensic Services to coordinate assessment and service delivery throughout the system.
12. Create a “culture change” in facilities and communities to increase understanding and acceptance of forensic consumers.

## **How will we measure progress along the way?**

As described earlier, shifting acute care services from the state psychiatric hospitals to local community mental health systems, will be gradual, planned, and incremental.

Targeted objectives should be established to track and report, at least, the following:

- Increased community capacity
- Decreased census in acute care units within the state psychiatric hospital system
- Decreased admission rate to state psychiatric hospitals
- High rankings of consumer and family satisfaction at each step of the transformation process.
- Measurement of performance outcomes to avoid trans-institutionalization, e.g. jails, prisons, nursing homes, etc.

The Acute Care Task Force acknowledges that the work evidenced in this report is only the beginning of the transformation process. With the approval of the concepts in this report, additional plans should be developed and implemented to continue the advancement of retooling the Alabama mental health system.