Moving from Legislation to Implementation:
A Call to Action for Secure Residential Treatment

White Paper

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By

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CALL TO ACTION:

There is a clear gap in the current system of care for the subpopulation of Chronically Seriously Mentally Ill adults. The good news is that the Arizona House of Representatives has recognized their needs and passed House Bill (HB) 2754 with $3.5 million dollars appropriated for Secure Residential Treatment. The legislation has materialized. This paper now calls on state leaders to release the dollars identified by the Arizona State Legislature to AHCCCS, the Department of Housing and Managed Care Organizations so that an RFI/RFP process is started. The time is now to move Secure Residential Treatment from legislation to implementation.

EXECUTIVE SUMMARY:

Arizona offers a diverse system of care whose purpose is to meet the clinical needs of those challenged with a serious mental illness (SMI). For most SMI adults, there is likely a service level designed to meet medical necessity criteria for that need. However, there is a sub-population of SMI adults for whom this paper refers to as "Chronically Seriously Mentally Ill" who are not being successfully served by the existing system of care. This sub-population is estimated to be around 5% of the total SMI population. This sub-population is characterized by some of the most debilitating mental illnesses such as schizophrenia and bipolar disorder; in addition, many also suffer from a co-occurring substance use disorder. The combination of this complex clinical presentation, within the existing SMI system of care, creates a perfect storm for about 5% of our SMI adults to cycle in and out of inpatient and residential levels of care and into the criminal justice system, acute medical care facilities and homeless "systems". This cycle of unnecessary arrests, incarcerations, acute hospitalizations and homelessness can be mitigated by implementing a new level of care recently funded by the Arizona State Legislature called Secure Residential Treatment. This paper calls on state leaders to release the dollars identified by the Arizona State Legislature to the Arizona Health Care Cost Containment System, the Department of Housing, Managed Care Organizations or other organizations such that a Request For Information/Request For Proposal (RFI/RFP) process can be initiated and move Secure Residential Treatment from legislation to implementation.

CHALLENGES:

There are approximately 25,000 individuals enrolled in the publicly funded behavioral health system in Maricopa County who have been determined to have a Serious Mental Illness (SMI). Of those, there is a small percentage of that population who have not responded to the wide variety of recovery-oriented treatment interventions that are available throughout the current continuum of care. In this paper, we refer to this group of individuals as Chronically Seriously Mentally Ill.

This Chronically Seriously Mentally Ill population continue to exhibit chronic and severe symptoms, and often go homeless. They have a history of repeated admissions to emergency rooms, urgent psychiatric centers, psychiatric inpatient settings and medical facilities. They, tragically, are often involved with law enforcement and end up in jail for petty survival crimes. Due to their psychiatric symptoms, they often spend long periods in isolation while in jail. If released from jail, they often end up with additional charges, serious felonies that may result in spending years or decades in prison. In addition, they may end up with additional legal charges due to violations of the rules while incarcerated. Occasionally their encounters with police, and their poor judgment

which arises out of their acute psychiatric symptoms, can lead to injury or death due to officer-involved shootings; a tragic outcome for the individual, their loved ones, and the officer.

Because of their symptoms, they also experience frequent crisis episodes and are often evicted from supported housing and residential programs due to frequent "elopements"; e.g. wandering off the premises or failing to make progress. Families and friends often hear that the individual "just isn't a good fit for" a given program. But currently there are not alternatives. Elopements and wandering off can result in risky behaviors that may be unsafe and detrimental to their health and wellness. Many become homeless, which further exacerbates their psychiatric deterioration. In addition, a high proportion of this group have severe challenges with substance and alcohol use along with their serious mental illness.

Kennedy, et al. (2014) reported that 20%-30% of individuals with a serious mental illness fail to respond to treatment and a similar fraction of individuals who are treatment non-adherent eventually relapse. They indicated that individuals who are "Treatment Resistant" or "non-adherent" incur significantly greater treatment costs compared to individuals who have been responsive to treatment. Costs associated with treatment responsive individuals range from $15,550 - $22,300 per year while treatment non-adherent individual's costs vary from $66,360. - $163,795 per year. Interestingly, hospital costs were 45% of the total costs indicating that the treatment resistant group had more repeat admissions and longer stays.

The Chronically Seriously Mentally ill also do not seek or adhere to their medical care. A recent article by the Lancet Psychiatry Commission (2019) indicated that there is a high rate of physical co-morbidity which often is poorly managed in the population with serious mental illness. This causes a drastic reduction in life expectancy and increases the personal, social and economic burden of this illness across the person's lifespan. According to the World Health Organization's Information Sheet/Key Facts: *Premature death among people with severe* mental *disorders; People with severe mental disorders on average tend to die earlier than the general population. This is referred to as premature mortality. There is a 10-25 year life expectancy reduction in patients with severe mental disorders.* Additionally, the group as a whole is non-adherent to traditional modalities of treatment and often do not engage in services. As a result of their untreated mental illness and/or exacerbation of their symptoms, they often engage in behaviors that put them at risk and negatively impact their health and wellness. With respect to general medical care, high treatment adherence predicts better clinical outcomes (DiMatteo, et al. 2002). The same factor applies to mental health treatment. Rates of disengagement can be quite high in mental health care. Doyle, et al. (2014) reported above 30% disengagement in first episode psychosis.

<u>BACKGROUND:</u>

While Arizona has many services to address the needs of those challenged by a serious mental illness, there remains a gap in the continuum of care for those whose mental illness is severe, chronic and who therefore refuse or are unable to avail themselves of services that are available. The current continuum includes the Arizona State Hospital, a number of community inpatient psychiatric hospitals or hospital units (both public and private), residential settings and a variety of supported housing programs. The Arizona State Hospital (AzSH), which is structured to provide longer term care, is limited to 55 Civil Patients/Residents from Maricopa County, if they are not there as part of a criminal process; this was established as part of a long running law suit (Arnold v Sarn).

While this setting may be an appropriate longer term setting for many of the individuals we are discussing, the capacity limit makes it extremely difficult to gain an admission. Additionally, AzSH is the most restrictive, least integrated place for anyone to receive services. Using AzSH as the only option for chronically seriously mentally ill is not clinically appropriate because many of these persons could "make it" in a more integrated

setting like secure community-based housing with treatment services. They should not have to wait and wait for entry into the most restrictive place for help.

Due to cost and pressure from insurers, the community psychiatric hospitals are designed for short term acute treatment and are not capable of providing longer term care or comprehensive holistic services. Spaulding, et al. (2016) stated that the "inpatient time frame is too short for meaningful rehabilitation or recovery, but acute hospitalization may be a key starting point for both (p15). In contrast, residential settings are designed to be temporary living environments with program requirements that many of the individuals whom we are discussing refuse to follow, and since they are unsecured settings, many individuals quickly leave. Supportive housing programs provide a varied level of support depending on the person's needs. Individuals who live in these settings have their own lease with Landlord-Tenant agreements. The individuals who we are discussing (i.e.: the CMI) rapidly break these agreements even with the support services that are available and are quickly evicted.

What is missing from the current array of housing and treatment options is a hybrid, that is *residential, not institutional*. The **Secure Residential Treatment Facility** that ACMI proposed and the legislature funded is this kind of model that provides for longer-term stabilization in a safe and secure setting with 24/7 on-site supervision, monitoring and supports. It provides the safety and stability of a secure setting from which people cannot wander or choose to leave with the benefits of comprehensive services and supports. It fills those gaps in the current continuum through which so many chronically severely mentally ill individuals fall.

Understandably, the concept of secure community-based residential treatment is not without controversy. Some industry voices believe that a secure facility absolutely violates the basic tenets of the recovery model; in fact, it fully supports recovery principles. The ACMI strongly agrees that recovery is possible.
ACMI believes that secure community-based residential treatment in fact fully supports the recovery model and brings the recovery road back within reach of people who today are on a dangerous detour. Secure, but community-based treatment can enhance the ability of the system to more fully and equitably meet the needs of those who currently suffer the greatest burden of mental illness. ACMI believes that secure residential treatment is far more integrated and highly preferable to incarceration, hospitalization and early death.

Currently, a large number of individuals have achieved their clinical and personal recovery by availing themselves of the services that support their recovery. Others have done it on their own without any services or supports. For many, it includes medications, some inpatient care, therapy, counseling, peer support, housing, employment and many other potential support services. The person and his or her treatment team are able to choose services that work for them. As mentioned earlier in this document, there is a relatively small group of individuals who lack any insight or desire to change potentially harmful and sometimes deadly patterns of behavior and, while services and supports are available, they decline all efforts to provide them with needed services. These individuals deserve new options to create their recovery journey.

The ACMI is focused on improving care for these individuals who are too sick and do not avail themselves of the recovery services that are available. The time frame needed for meaningful recovery to occur varies widely, and some, such as the Chronically Mentally Ill, require and deserve a longer period of time in a secured setting in order to have a meaningful chance to recover sufficiently to be successful in unsecured settings in the community. ACMI works on behalf of this group, and it is for this group that the ACMI took up the challenge of helping to create a model that offers a fair shot at a recovery journey.

<u>SOLUTION:</u>

Secure Residential Treatment setting can offer a safe setting for stabilization of persons who have a primary diagnosis of a serious mental illness that presents as chronic and severe. The individual served has not been successful in other settings and often will have experienced homelessness and justice system involvement. This newly licensed setting will add to the continuum of care and requires the Department of Health Services (DHS) to license secure behavioral health residential facilities (secure health facility) to provide secure 24-hour onsite supportive treatment and supervision by staff with behavioral health training. DHS already licenses "secure" settings for adolescents, children, individuals with Dementia and Alzheimers. The Secure Residential Treatment setting will address the needs of individuals who:

- Have been determined to have a serious mental illness
- Are chronically non-adherent to treatment or supports for a mental disorder while in the community
- Are placed in the setting/facility pursuant to an Arizona court order for mental health treatment based on current COT regulations
- Have repeat admissions to inpatient settings for behaviors that have been dangerous to themselves or others and have impacted their health and wellness
- Repeated relapses which have affected the person's overall health, both psychiatrically, physically and medically
- No longer meet medical neccesity criteria for an inpatient level of care
- Have been incarcerated and involved with the legal system as a result of untreated mental illness and/or an exacerbation of their symptoms
- Have a history of homelessness or leaving treatment facilities against medical advice (AMA)
- Have substance and alcohol use challenges
- Not considered to be a significant risk of violence towards others while living in a secured setting with 24 hour support and supervision
- The person has demonstrated an inability to reside in an unsecured setting and has been challenged by "wandering off or eloping" which leads to engaging in behaviors that are dangerous to themselves or others and have impacted their health, wellness and safety.

HB 2754 requires DHS to license secure behavioral health residential facilities (secure health facility) to provide secure 24 hour on site supportive treatment and supervision by staff with behavioral health training for persons determined to be seriously mentally ill, are chronically non-adherent to treatment for a mental disorder and are placed/referred to the facility pursuant to a court order.

HB 2754 allows the secure facility to provide services only to persons placed in the facility pursuant to a court order and the facility may not provide services to any other person on their premises. The Provisions also state that the secure health facility may not have more than 16 beds and "secure" is defined as a premise that are able to limit a person's egress in the least restrictive manner consistent with the person's court-ordered treatment plan. In addition, the Provisions provide that if the court finds that the person meets the criteria for court ordered treatment, the court may approve placement in a secure health facility and this level of care is not considered inpatient treatment.

More specifically, admission requirements for secure residential treatment require the court's findings to be based on clear and convincing evidence that establishes all of the following:

The person received treatment in the preceding 24 months in other less-restrictive settings, including unsecured treatment settings with on-site 24-hour supportive treatment and supervision by staff with behavioral health training:

- The treatment was unsuccessful or is not likely to be successful due to the person's expressed or demonstrated unwillingness to cooperate with treatment in other less-restrictive or unsecured treatment settings;

- The person's non-adherence to or nonparticipation in treatment over the preceding 24 months resulted in one or more of the following:
  - Serious harm to self
  - Serious harm or threats of serious harm to others;
  - Recurrent periods of homelessness resulting from the mental disorder;
  - Recurrent serious medical problems due to poor self-care or failure to follow medical recommendations; or
  - Recurrent arrests due to behavior resulting from the mental disorder; and
  - Any other evidence relevant to the person's willingness or ability to participate in and adhere to treatment in a licensed secure residential setting to ensure the person's compliance with the court ordered treatment.

RESPONSE TO OBJECTIONS:

While some people may react to the use of the term "secure facility" implying that it cannot be "recovery oriented", William Anthony, from Boston University, is one of the prime supporters of the recovery movement and is said to have quipped, "It's the focus, not the locus". Over the course of meeting with stakeholders, the ACMI has become aware of some potential objections to the new level of care.

Some of the objections are addressed below:

1) *"Isn't this just institutionalizing people all over again?"*
   No. A secured residential treatment program is not a hospital and will have no more than 16 residents. The treatment provided is individualized and personal choice will be a preserved, to the extent possible while also preserving the safety of the resident and others in the program. Living spaces will be as home-like as possible, and the program will include community integration, and preparation of the resident for discharge to a less restricted setting as soon as skills necessary for success in such a setting are demonstrated.

2) *"Won't this just be a way for teams or families to put people away instead of providing the specialized services they need to live in their own home?"*
   No. In order to be eligible for the secured residential treatment program, the person must have been unsuccessful in an unsecured setting with similar breadth and intensity of treatment services, or (if referred from a hospital), be expressing an unwillingness to participate in such services in an unsecured setting. Placement in the secured residential treatment setting will occur pursuant to a treatment plan ordered by the court, and the person will have due process rights and legal representation at a hearing at which this placement might be ordered, with an opportunity to present evidence to demonstrate that he/she does not need this type of placement. The court will review the need for this placement periodically, as part of the current court ordered treatment review process.

3) *If the person keeps leaving placements due to severe substance abuse issues, how will time in this*

program make any difference? Won't they just relapse as soon as they are discharged to an unsecured setting?

Those admitted with an identified substance use disorder will have evidence-based treatment during their time in the program which is intended to decrease their chances of relapse after discharge; a primary goal will be to integrate them into a support system of others who are substance and alcohol-free and can continue to support them in a substance and alcohol-free lifestyle after discharge, and to develop a detailed and individualized relapse prevention plan. Many studies show that changes in the brain as a result of use of substances and alcohol can persist for prolonged periods after sobriety is achieved, and placement in a secured setting for a longer period than is possible in current acute "detox" and subacute or residential substance use treatment will allow the person to solidify his/her recovery in order to help stop the cycle of repeated brief stays in "rehab" and relapse upon release. The efficacy of secured residential treatment for individuals with co-existing serious mental illness and a severe substance use disorder vs. current standard treatment should be an active focus of research once the program is in operation.

The principles of recovery can and should appear in all the potential treatment environments. Singh, et al. (2016) published a compendium of articles describing how recovery principles are being used in inpatient settings. A recovery orientation will be deeply ingrained in the secure residential program. Shared Decision-Making and Self-Determination principles will be employed in all the services that are offered. The only restriction of these concepts will be that the setting is secure and the individuals will not be able to leave AMA by virtue of the Court Order. Recovery is both a process and an outcome, the secure facility will ensure that recovery will be built into all of the services offered at the facility and will work with each individual to identify and support their recovery vision in order to facilitate the individuals attainment of their personal vision of a meaningful life. In fact, research supports that individuals who are seriously mentally ill and court-ordered for treatment have better outcomes compared to those who are voluntary for treatment (Kortrijk, H. E., et al. 2010). The persons to be served require longer term stabilization in a secure and safe setting where their mind, body and spirit can recover.

Bellack and Silverstein (2008) suggest that supporting recovery requires access to comprehensive, coordinated and continuous treatment combined with social supports. For the chronically ill population, the comprehensive, coordinated and continuous supports for recovery that do exist are of no interest to them. The person will generally lack insight into their illness or, in other words, have a medical condition due to their underlying psychiatric illness known as *Anosognosia,* which is a neurological brain disfunction . *Anosognosia* is not just stubbornness or outright denial which is a defense mechanism some people use when they receive a diagnosis difficult to cope with, it is actually a symptom of the illness. In fact, *Anosognosia* is central in conditions like schizophrenia or bipolar disorder.

The person will reside in a non-institutional, non-incarceration type residential setting with 24/7 on site treatment and supervision provided by staff who are behavioral health professionals, clinicians, behavioral health technicians and peers. The staff will have a background in behavioral health, physical health, integrated care, recovery principles, the SAMHSA 8 dimensions of health and wellness and will create an environment that is person centered, strengths based and individualized. There will be high emphasis on community integration, family support and the person's voice and choice.

The Secure Residential Treatment setting will be designed to provide interventions that will assist individuals in achieving optimal functioning in their personal life and in their community. Services are designed to build upon

strengths, decrease hospitalizations and provide community supports while minimizing behavioral health crises and a recurrence of symptoms. The services are person focused and individualized to meet the specific goals and needs of the individual served.

The staff will assist the person in designing and implementing an individually tailored Integrated Indiviudal Service Plans (IISP) that will address both behavioral health and physical/medical health needs; the IISP will include social determinants of health as well. A strong focus of program services be on overall health and wellness in order to live a happy and healthy lifestyle. The Secure Residential Treatment setting will provide active on-site services and treatment and may include the following as determined by the individual needs of each person and their IISP:

- Preservation of the person's ability to make choices in daily living consistent with treatment in a secure and safe environment
- Meal planning/grocery shopping
- Counseling Services to include indivudual, group and family and Specialty Counseling Services as applicable
- Substance use services to include evidenced based practices (EBP) such as Integrated Dual Disorders Treatment (IDDT)
- Resiliency building interventions inlcuding verbal and nonverbal evidenced based modalities
- Observation of self-administration of medication
- Personal hygiene skills development and self care
- Housekeeping skills
- Life Skills Training
- Community Integration Skills Training
- Safety and hazard recognition
- Stress Management
- Applied Behavior Analysis (ABA)
- Chronic Disease Self Managment
- Holistic health, exercise and wellness activities; indoor and outdoor activities
    - Yoga
    - Meditation
    - Therapeutic Arts/Art Therapy
    - Alternative modalites as prescribed and indicated on the IISP
- Utilizing public transportation and community integration activities

<u>General Supportive and Rehabilitation Services:</u>

- Education of client's rights and participation in treatment planning and development
- Individualized, person centered and evidenced based treatment planning
- Case Management/ service coordinator
- Peer Supports
- Health and Wellness activities
- Goal development
- Physical Health Coordination of Care
- Recreational/Socialization opportunities
- Crisis Intervention
- Wellness Recovery Action Plan (WRAP)
- Family Supports

Referrals will come through the Court in collaboration with the Health Plans/Managed Care Organizations and admission criteria will be established, monitored and audited. The Secure Residential Treatment setting/facility will not use physical, mechanical or chemical restraints. The only intervention used is an Emergency Safety Response which is used to protect staff and other residents from injury.

All staff will be trained in Crisis Intervention Training (CIT) and non-invasive types of interventions. If an individual demonstrates more aggressive or self-injurious forms of behavior, an assessment for a higher level of care will occur and coordination of care will be facilitated in an expeditious manner.

Thus, filling this gap will result in positive overall health/wellness outcomes for the chronically mentally ill subset of individuals who remain untreated and positive outcomes include:

- Reduction in psychiatric and medical conditions
- Reduction in mobile crisis services
- Reduction in incarcerations
- Increase in safe and stable housing
    - Decrease in homelessness
- Increase in employment
- Improved health and well-being of individuals
- Decrease in human suffering and increase in the quality of life to include joy and happiness
- Overall cost savings by reducing utilization of higher costs and levels of care

OUTCOME MEASURES:

The program outcomes will be measured on an ongoing basis in order to determine the program success and to identify structures, process and outcomes that need to be addressed:

Structure:

Based on the number of residents in the facility, the number of staff assigned to each shift meets the needs of the individuals served.

Staff who work at the facility have appropriate training to serve the individuals who reside there.

The facility meets all licensing inspection requirements and staff ensure that all safety standards are met on a daily basis.

The staff at the facility respect the resident's rights as stated in Statute.

All incident and accident reports will be thoroughly reviewed by the agency QM Committee.

Process:

Each resident has an up to date Assessment and IISP and progress notes are entered to ensure that objectives are being worked on a daily basis.

Each resident's IISP includes participation by the individual and their family if requested and the goals, objectives and methods are developed in a shared fashion.

Each resident of the facility has a daily schedule of meaningful activities.
All appointments off the grounds of the facility are kept as scheduled unless a rationale for an exception is documented by the team.

Outcome:
Outcomes will be measured using a nationally utilized, validated and reliable measurement tool called the DLA-20 (Daily Living Activities). The DLA-20 is designed to assess a person's functioning in 20 different areas that cover 10 general domains. The 10 functional domains include: Health Practices, Relationships, Household Stability, Alcohol & Drug Use, Safety, Nutrition, Personal Care & Hygiene, Communication, Managing Time, & Sexual Health and Behavior. This tool will provide a clear baseline of where individuals are when they are admitted, the progress they are making while engaged in services and help indicate when a person is ready for discharge.

Client Directed Outcome Informed (CDOI) surveys will also be implemented to measure the relationships between staff and individuals; this enables individuals to provide feedback on their perceptions of their progress in achieving their therapeutic goals and to give real time feedback to their care team members.

In addition, data will also be maintained for each individual on the following outcome measures. It will be analyzed by person and in the aggregate.

Based on an analysis of psychiatric hospitalization rate for two years prior to admission to the facility, individuals will demonstrate a reduction in hospitalization after residing in the facility.
Based on an analysis of medical hospitalization rate for two years prior to admission to the facility, individuals will demonstrate a reduction in hospitalization after residing in the facility.

Based on an analysis of emergency room usage for two years prior to admission to the facility, individuals will demonstrate a reduction in emergency room after residing in the facility.

Based on an analysis of time periods of homeless or unstable housing for two years prior to admission to the facility, individuals will demonstrate an increase in periods of stable housing after residing in the facility.

Based on an analysis of physical health assessments and preventive testing for two years prior to admission to the facility, individuals will demonstrate an increase in engaging in physical health preventative services after residing in the facility.
REFERENCES AVAILABLE ON REQUEST