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Homeward Bound: Moving Treatment from the Institution to the Community

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This study examined changes in the length of stay, cost savings, recidivism and community access when individuals with serious mental illness who were mandated into extended treatment were moved from a regional center institution to community treatment. Results showed significantly shorter length of stay, cost savings and no increase in recidivism when individuals were treated in the community program.

KEY WORDS: serious mental illness; treatment and community.

In 1999, the Olmstead Act passed by the U.S. Supreme Court provided judicial support for the growing body of clinical research that suggested individuals with serious mental illness (SMI) may be most effectively treated in their home communities. The passage of this act came on the heels of research that indicated promising results for people with a serious mental illness when they are able to experience high involvement in their community, and participate in treatment that enhances social and independent living skills.

Assertive Community Treatment (ACT) which involves the use of intensive community intervention and support, has been shown to increase satisfaction in family and consumer as well as reduce the number of inpatient hospitalization days (Burns & Santos, 1995; Phillips et al., 2001). The Social and Independent Living Skills Program at the West Los Angeles VA Medical Center (Kuehnel, Liberman, Storzbach, & Rose, 1990) also provided a model that focused on developing increased social support and independent living skills, with resulting increase in consumer and family satisfaction and reduced length of stay at the inpatient level of care. A follow-up program, the Sustained Treatment and Rehabilitation (STAR II) (Ashear et al., (1997) reduced the length of stay from 180 to 35 days with corresponding increases in consumer satisfaction. In an analysis (Hegedus, Copeland, Barry, Blow, 2002) of three enhanced treatment programs through the VA, Hegedus and colleagues found significant cost savings without decrements in functioning occurred in all enhanced programming. The authors noted that diagnosis other than schizophrenia and higher baseline functioning predicted the strongest results in cost reduction.

In addition to community support, consumers diagnosed with a serious mental illness benefit from social skill development and support. People with SMI often experience significant social and personal losses as a result of their psychiatric condition. The sense of loss may be exacerbated by additional hospitalizations, particularly those that are involuntary, as they restrict a person's choice, independence and freedom of movement. Townsend and Rakfedlt (1985) demonstrated that hospitalizations contribute to lowered self esteem in persons with SMI. When hospitalized outside of their home community, people with SMI have limited access to their typical social support. Yet, social support may be an important buffer in the experience of a SMI. Shahar and Davidson (2003) demonstrated that improved social functioning mitigated the effects of depression

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in the SMI population. Adjustment to SMI can be facilitated by the development of skills to improve social functioning (Birchwood, Smith, Cockrane, Wetton, & Copestake, 1990). The opportunity for social support may be more available in the person's community. Corrigan (2002) suggested treatment partnerships that are embedded in the community are likely to foster empowerment in the presence of SMI. Anthony (1993) conceptualized the recovery process in the treatment of people with SMI by emphasizing multi-modal intervention including social and work related skills as well as medication management. The access to a supportive social network appears to facilitate the process of recovery. Taking access a step farther, Davidson, et al., (2001) suggested that persons with SMI be encouraged to fully engage in society. They suggest that symptom presence should not preclude the engagement process and that it is important they be ''let in'' to experience social interaction and support at the same level as persons without SMI.

The need for an alternative to institutionalization was particularly acute in the area of Western Nebraska. The system established for mental health treatment dictated that individuals with SMI who were determined to be a danger to themselves or others, were committed to treatment by the local Board of Mental Health. After this decision to commit the person was made by the board, they were transported over 300 miles to a Regional Mental Health institution where their average length of stay was 121 days (Laura Richards, personal communication). The stress on the person was high as they had to leave their support system, family and friends. The distance made visits and participation in the treatment process difficult for most family members. The consumers often lost their apartments, furniture and household possessions when they were not in the community for the extended period. Furthermore, the extended in-patient treatment at the most restrictive and most expensive level of care raised concerns that some of the consumers may have been treated at an inappropriately high level of care to adequately meet their psychiatric treatment needs.

The stress on the community was significant as local law enforcement had to transport these consumers back and forth from the Regional Center, often leaving the smaller communities without law enforcement staff. The stress on the Regional Center was also high as they did not have access to discharge planning resources including options for outpatient treatment, AA schedules, vocational rehabilitation, appropriate housing resources or other community supports located 300 miles from their facility. Frequently, consumers experienced discharge without these integral community supports in place.

These program stressors negatively impacted consumer care to such an extent that the Regional group of mental health providers in Western Nebraska decided to propose to the state an alternative to the institutionalization of these consumers in the Regional Center. After a review of the literature and programs involving community resources, the providers proposed a short-term stabilization and hospitalization program (Homeward Bound) for the majority of the seriously mentally ill consumers that were currently sent to the Regional Center. We hypothesized that we could treat these consumers within a 45 day treatment stay and that they would be able to begin participation in community activities within 10 days of beginning the Homeward Bound Program. The hypothesized shorter length led to an additional prediction of cost savings of $500,000 for the treatment of these consumers. A final expectation for our program was that we would not exceed a 20% recidivism of re-hospitalization for these patients with one year of discharge. Although no specific data were available, anecdotal report speculated that recidivism was close to 30%. We expected that diagnosis would be a significant predictor for recidivism.

The timing of our proposal for state funding was advantageous as the state's mental health costs were exceeding budget, and there were time-limited tobacco funds available for innovative projects within Health and Human Services. After presentations to a variety of committees, the state Governor lent his support to the program and the first year of the program (7/2002–7/2003) was funded with a one-time $350,000 allocation.

METHOD

Participants

Thirty-four consumers who were ordered by the Board of Mental Health from 7/2002 to 7/2003 to receive extended mental health treatment were placed in the Behavioral Health Center of the Regional Hospital. Exclusion criteria were limited to

those consumers with an IQ below 70, those with a sole diagnosis of substance abuse and those with primary needs for a sexual offender program track. Participants ranged in age from 19 to 66. The average age was 37.7, representation by gender was unintentionally equal with 50% female, 50% male. According to the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders-TR (American Psychiatric Association, 1994), 14.7% were diagnosed with a major depressive disorder, 14.7% with a schizoaffective disorder, 5.9% with a bipolar affective disorder and 29.4 with schizophrenia. 35.3% of patients were dually diagnosis with a serious mental illness and a co-existing substance abuse disorder.

Intervention

Treatment included four core components; Minimum of 6 hours of daily clinical programming with emphasis on skill building using cognitive-behavioral interventions and social skill training; Intensive discharge planning beginning on the day of admission; Participation in community events (AA meetings, clubhouse, community support groups) as soon as possible; Involvement of family, social supports in weekly treatment meetings, family therapy and home visits.

RESULTS

The average length of stay range was 8–57 days with a mean of 28 days (see Table 1). This represented a significantly shorter length of stay than the previous average of 73 days (although original length of stay data indicated 121 days, when outliers were removed, the mean length of stay was shortened to 73 days) that occurred at the Regional Center. Cost savings based on the shorter length of stay were higher than expected with cost savings exceeding $905,930 (see Figure 1).

Table 1. Mean Length of Stay and Number of Consumers Treated by Quarter

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
No. of treated consumers	12	9	5	8	34
Length of stay	27	32	27	28	28

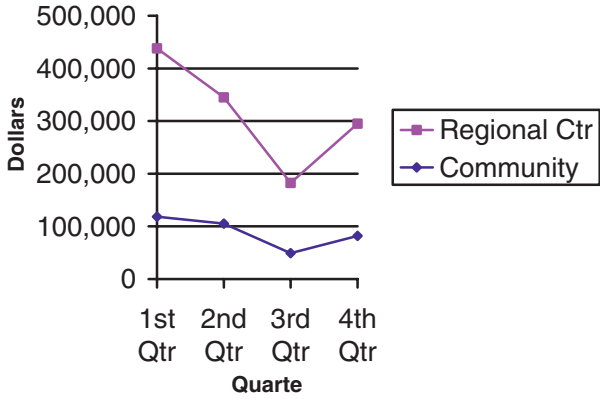

Fig. 1. Cost comparison per quarter based on average consumer's length of stay at regional center (73 days) vs. community hospital (28 days) at $365 per day.

Initial participation in community activities occurred between 6 and 30 days with a mean of 10. Recividism within 12 months post- discharge is 14.7% with 5 of the 34 consumers having been readmitted for short inpatient stabilization following discharge from the Homeward Bound Program. Recidivism was not significantly predicted by diagnosis $F(1, 32)=3.31$, $p=.078$.

DISCUSSION

These results suggest that persons with SMI who are treated in the community are able to stabilize and return to independent living with significantly fewer inpatient hospitalization days than when they were transported to the Regional Center Hospital over 300 miles from their home. We believe the dramatic difference between the average length of stay of 121 days at the Regional Center compared to the 28 days in the community inpatient facility increased the empowerment and independence of persons with SMI. The ability to stay in the community translated into a better quality of life as these consumers were able to maintain contact with their families, community support workers, living situations and employers. In addition, the increased independence and community support are likely to have been significant contributors to the low recidivism.

The financial savings of more than $900,000 was a secondary and added benefit. The cost savings

were largely a function of length of stay, rather than differential costs in programming or treatment.

The lack of predictive significance for recidivism as a function of diagnoses, may be attributable to several causes. The issue of co-morbidity may be a more powerful predictor than the primary diagnostic label that was used in this analysis. Furthermore, specific individual variables regarding age of onset, number of previous hospitalizations and family support may be stronger predictors than diagnosis, which we plan to explore in the future. As mentioned earlier, we did not have access to previous data regarding levels of recidivism in the past, so this year reflects the establishment of a baseline which will serve as a comparison for future research. A final consideration may be our need to expect re-hospitalization as part of a continuum of care for SMI, and the more relevant data may be related to the number and length of re-hospitalizations over time.

As a follow-up, the results related to reduced length of stay, access to community and family, and cost savings, led to a commitment by the state to refund the Homeward Bound program. Furthermore, the development of these types of services, which were designed to keep those persons with serious mental illness in their communities became an integral part of the Mental Health Reform Act that was passed by the NE legislature in 2004.

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