

Intentional Collaboration: Addressing Transitions in Care for People with Severe and Persistent Mental Illnesses

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This commentary explores transitions in care for people who have severe and persistent mental illnesses and reside in long-term care communities. Challenges and historical approaches as well as barriers to successful transitions are examined. Recent policy changes in North Carolina are discussed and contextualized in emerging evidence-based practices that emphasize intentional collaborative efforts.

Perhaps one of the greatest challenges in the deinstitutionalization of people with severe and persistent mental illnesses lies in creating and sustaining supports for those who cannot live independently. There are certainly people who have histories riddled with multiple or long-term hospitalizations who, upon discharge, seem to transition back into a living situation either with family or alone with some form of support. In these cases community-based services seem to be key in sustaining the ability to live independently and avoiding re-hospitalization. However, there are other people who, despite community-based services, are unable to live alone or with family because of the complexities of their mental illnesses. In many cases, these people are discharged from the hospital setting to assisted living facilities, nursing facilities, or group homes [1, 2]. In other cases, people end up in homeless shelters or on the streets. The legal system often becomes another stop on the journey taken by many people who are struggling with mental illness, which can inhibit options for supported or independent living. The challenges are great for people whose mental illnesses stand in the way of independence, particularly as the system of care in North Carolina continues to struggle with redesign and shrinking budgets. Recent legal challenges have highlighted the fact that long-term care communities have been providing living environments for those who are mentally ill and there is much debate about whether or not this is effective or appropriate. What does seem evident is that an array of living environments is necessary and important for those citizens of North Carolina whose lives are challenged by mental illnesses. Further, it is vital to consider the gravity of planning for transitions between and among services that support those with mental illnesses. People simply cannot be passed from service to service without careful coordina-

tion and collaboration. Poor transitions in care often become the first step in the failure of the system to support people who depend on the expertise and professionalism of others.

Historically, the burden of planning for transitions in care involving long-term residential communities has fallen solely on the staff of the facility that is discharging the person in need of services (see 10A NCAC 13F/G .0902(d) (2)). For instance, if a person residing in an adult care facility experienced behavioral, mental, or emotional complications as a result of a documented or perceived mental illness (eg, the person becomes behaviorally disruptive), a determination about the person's ability to remain in the facility is made by facility staff persons who then have to plan for discharge to another setting. In best-case scenarios care coordination between and among service providers occurs voluntarily as a result of positive working relationships that have evolved over time. In other cases the director and staff of the assisted living care facility bear the sole responsibility for finding alternative placement, often with little to no input from providers that served the person affected by the transition in care. In many cases facility staff lack training or experience with people who have severe and persistent mental illnesses, and situations that may have been manageable with appropriate training and intervention instead result in the disruption of care. Such incidents often create the need for immediate discharge and the person in need of services finds him or herself being relocated to a new living environment or in the emergency department of the hospital. Often notification about the change in living environment to community-based mental health service providers is either delayed or does not occur at all, creating risks for the person in need of services to fall through the cracks of the service system. This risk is particularly great when the new living environment is located outside the service system currently working with the person, such as a new geographic location

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served by another system of care. Additionally, the incident that created the disruption may preclude other assisted living or long-term care communities from offering admission to the person in need of services, creating a period of service limbo as staff persons attempt to locate an alternative living situation. This unfortunate scenario often results in the person being lost in the service system, which creates further risk for exacerbation of his or her mental and/or physical illnesses.

People with mental illness face many challenges and this is certainly true for those who do not have families that can support their needs or for those who cannot live independently. People who have mental illnesses often experience more social isolation and financial hardship compared to people who have other disabilities or those who have no identified disabilities. Additionally, people with mental illnesses have higher demands for services and report unmet service needs compared to those with other disabilities or no identified disabilities [3]. Housing concerns regarding people with mental illnesses have become more prominent since deinstitutionalization began. In the past few years there has been a focus on independent housing options for those with mental illnesses and there seems to be a notion that the more independent the living arrangement the better. Some research related to the inference that independent living is best practice reveals the importance of supports from family, friends, and professionals and more traditional supported living options are preferred by some people with mental illnesses [4]. Not surprisingly there are calls for more research as housing options seem to shift toward independent supported housing models for people with mental illnesses [5]. Additionally, review of the literature reveals that a needed area of focus for future research is the array of appropriate housing options for people with mental illnesses [6].

A 2007 review of the literature regarding housing and supports for people with mental illnesses revealed that the best outcomes were realized when housing was combined with a mix of supports and services from family, friends, and professionals compared to housing with assertive community treatment team services only (that ranked as the next best outcomes), or housing combined with case management only [7]. Another study supports the notion that a broader range of service and housing options is necessary to reduce costs of repeated hospitalizations and to enhance recovery outcomes [3]. One of the existing and possible future housing options for people with mental illnesses is the adult care home or assisted living, including group homes. A recent, unpublished qualitative study completed by the author reveals that factors that support recovery models are present in adult care homes that intentionally train staff about mental illnesses and co-occurring disorders and engage residents in a mix of community provider-based service options that are co-located in facilities (J.P., M. Keever, J. Roberts, unpublished data). What seems to be

emerging as the research continues is the importance of a variety of supports and services including options for housing [8, 9]. Of course, as housing options are explored and people are transitioned from one option to another, it is vital to coordinate care.

Recent research indicates that best practices for transitioning people between and among housing and other service options rely on collaborative approaches. A recent British study asserts that close collaboration between all levels of service providers is necessary to enhance quality of care [10]. Care coordination seems to extend beyond working with those in the mental health system alone, as illustrated by a study based in Australia that emphasizes the need for care providers to work closely with general practitioners in the coordination of services in order to enhance quality and avoid gaps in clinical knowledge about the people being served [11]. An article by Latimer suggests that the greatest difference in terms of quality of care for people with mental illnesses and co-occurring disorders lies in effective communication, defined as collaborative and intentional efforts to coordinate care [12]. Further, the National Transitions of Care Coalition (NTCC) offers a wealth of information including best practice models that are based in empirical research. Of particular note are the seven essential elements in a successful transition of care [13] and interventions with very strong trial or evaluation data [14]. At this point, the evidence seems to support that intentional, collaborative efforts that focus on involvement of the person served, service providers, family, and others important to the case produce the best outcomes including reduction in hospitalizations and reduction in gaps in service. Recent policy changes reflect collaborative and intentional approaches in North Carolina.

As of October 1, 2011 local Departments of Social Services (DSS) and Local Management Entities (LME) must take lead roles when a person living in an assisted living community needs to be transitioned. The assisted living community administrator/s and staff are no longer solely responsible for locating options and coordinating transitions in care. Session Law 2011-272 (House Bill 677) requires that DSS or the LME (in the case of unmet needs being related to mental health, substance abuse, or developmental disabilities) establish a team that includes but is not limited to the Local Long-Term Care Ombudsmen, those who are knowledgeable about housing options, service provider representatives, and others who have a vested interest in the transition. The new policy specifically requires that the team have standing members and alternates who can meet on short notice once the adult care community staff make the request for a transition in care. Additionally, the actions of the team must be documented and kept confidential.

The following case example illustrates a comparison of the old policy on transitions in care and describes how the new policy should be implemented. The example also demonstrates what outcomes may be expected. Jane is a

48-year-old woman who has been living at the XYZ assisted living facility for the past 6 months. Prior to her admission, Jane had lived at home with her aging mother until her mother became ill and was admitted to a skilled nursing setting. Jane has a complex clinical resume that includes diagnoses of bipolar I disorder, polysubstance dependence, early onset dementia (possibly linked to her drug use), and borderline personality disorder. Jane's first psychiatric hospitalization was at age 20, secondary to a suicide attempt. She has been hospitalized 12 times during the course of her illnesses and, despite all efforts to engage her with community-based services including assertive community treatment and psychosocial rehabilitation, she is unable to live independently. Jane has a history of making threats to herself and others and, this has not abated since she has been residing in the assisted living facility. In her current living environment, she has made threats to other residents, striking one of the older residents on the arm. Despite efforts to better train staff and to continue frequent engagement with assertive community treatment, the administrator and staff have made the decision to discharge her due to volatility. If this situation had occurred prior to the implementation of the new policy, the assisted living facility would have been solely responsible for Jane's disposition.

Jane was admitted to her current residence with only a minimal plan for services. Now that she is being transitioned again, she and the staff members are faced with the challenges of coordinating services. Under the old system, it would be very difficult for the assisted living staff to develop a care transition plan for Jane because of the lack of involvement of other partners in her care. The focus of the transition plan would have been locating a placement as opposed to intentional collaborative efforts to support Jane. Under the new policy, the assisted living administration and staff would contact the transition team, led by the LME, and a planning meeting would be arranged. The team could include staff from the assisted living community, service providers in the mental health system, medical service providers, other appropriate stakeholders, and family members. Jane's mental health care would become a focus in planning her transition and, intentional coordination of services driven by outcomes focused on supporting Jane's recovery would occur (eg, establishing goals that reflect reduction of symptoms, improvement in functioning, and movement toward optimal levels of independence). Hopefully, Jane would be transitioned to a living environment that can support her in the achievement of her goals. The level of involvement of Jane's family in the past is unclear, but attempts would be made to re-engage her family in her service plan. The promise of the new policy lies in the evidence that intentional care coordination is a best-practice model.

This new policy clearly reflects collaboration and inten-

tional planning, which is in line with best practice models. Perhaps as this policy is put into practice, the experiences of people who are affected by mental illnesses and co-occurring disorders will be improved as they transition within the complex system of care on which they depend. After all, the goal is to enhance quality of life and, if intentional collaborative efforts related to transitions in care do this, we have all succeeded. **NCMJ**

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