

## **Bridging the Gap - The Philadelphia Behavioral Health Collaborative: Moving from Programming to Supports** **by Amy Nemirow, PhD**

### **Improving Supports, the Consensus Panel Approach**

A diverse group of professionals has been working to increase awareness of the challenges faced by people in our community who are "dually diagnosed" with mental retardation and mental illness. Previously some efforts had been made to improve the ways in which people with a dual diagnosis are treated and services for them are provided, but many obstacles remained.

Two years ago, the Philadelphia County Office of Mental Retardation Services, in conjunction with Philadelphia Coordinated Health Care (the Southeast Region's Health Care Quality Unit) recognized the need to increase the system's responsiveness to people who have a dual diagnosis. In order to address the complexity of issues related to people with these disabilities, a new approach to the problem was set in motion. The Office of Mental Retardation Services and Philadelphia Coordinated Health Care cooperated in forming a Consensus Panel, bringing together a diverse group of stakeholders from across the city's various service systems to develop recommendations for improving services and supports.

The Consensus Panel first met in July, 1999, and included people who have disabilities, family members, residential provider agency staff, physicians, psychologists, nurses, behavior specialists, and representatives from Philadelphia's Offices of Mental Retardation Services (MRS) and Behavioral Health System (BHS). Philadelphia Coordinated Health Care (PCHC), Community Behavioral Health (CBH), the city's Behavioral Health Managed Care Organization, and the Southeast Regional Office of Mental Retardation were also represented. The whole group met monthly for eighteen months, and several concurrent workgroups were also formed to address issues and make recommendations regarding Family Values, Education and Training, Policy, Clinical Issues, Functional Assessment, and Behavior Specialist Standards and Practices.

All of the various workgroups' conclusions and the documents they produced were presented to the larger group for feedback and were then compiled and distributed in one binder. These conclusions represent the Consensus Panel's vision of Emerging Practices for improving services and supports to people with a dual diagnosis in Philadelphia. Some of the documents developed include: A Statement of Family Values; Policy Recommendations; Suggested Training Guidelines and Timeframes; Suggested Behavior Support Plan Format; Behavior Specialist Standards; Examples of Functional Assessment Tools; Team Expectations; Communication Standards for Prescribing Physicians; and a Suggested Format for a Historical Summary Document.<sup>1</sup>

## **Addressing the Issue of Frequent Hospitalization**

Another discussion topic that arose as the work of the Consensus Panel progressed was initially identified as Hospital Diversion, the importance of looking at why some people seem to use psychiatric in-patient facilities so frequently and how to reduce this need. The Consensus Panel concluded its work in December, 2000, and presented its recommendations to the Office of Mental Retardation Services (MRS) for system improvement. At that time, however, it was decided that the work of the Hospital Diversion group should continue. One of the Consensus Panel's recommendations to the Office of Mental Retardation (MRS) was to: "Develop a Hospitalization Diversion Plan, per existing committee recommendations when they are completed. Such a plan may include the development of guidelines for inpatient hospitalization to clarify expectations from the residential staff, providers and case managers. Such a plan may also include a pilot study to determine which factors are critical in minimizing the need for inpatient hospitalization and which factors contribute to the most successful inpatient treatment experience."

Working on the concept of creating a Hospital Diversion Plan became the ongoing mission of the workgroup, with the intent of running a small pilot project to put the group's ideas into action with a limited number of participants.

## **Taking a Broader View: Hospital Diversion Becomes Behavioral Health Collaborative**

Initially, the Hospital Diversion workgroup consisted of one representative from each of the following: the Office of Mental Retardation Services (MRS); the Behavioral Health System (BHS); Community Behavioral Health (CBH); and Philadelphia Coordinated Health Care (PCHC). In addition, there was a Behavior Specialist and a Program Director from a residential provider agency along with consultation from a Hospital Psychiatrist. We started by focusing on psychiatric hospitalization: what that experience was like for people; how it could be improved; and what could be done differently system wide to work toward those improvements.

We created a flow chart to illustrate the decision-making that would need to occur at every level of involvement when a person comes into contact with a psychiatric hospital in Philadelphia. For example, some questions would need to be answered, such as: Would the person be returning to a stable environment after hospitalization? Was the person known to the Mental Retardation or Behavioral Health System? Did the person have a Case Manager or Supports Coordinator? Was further evaluation, such as psychological testing, indicated? What community supports were in place for the person? What additional supports could be offered? How could support be coordinated most efficiently, and by whom? What people from which systems would need to be involved?

It became clear very quickly, that if we were to be successful, we would need to look at more than just the experience of hospitalization. It would be critical, in fact, to explore

the factors that led up to admission to a psychiatric in-patient unit for a person with a dual diagnosis. This would involve assessing the effectiveness of the supports and services being provided to people in the community and identifying where improvements could be made that might decrease the risk of a crisis requiring hospitalization. And most importantly, this would look different for every individual. Each person has his or her own critical issues, sets of experiences and triggers in unique combinations that increase the risk of crisis for that person. Instead of looking at existing community programs and trying to fit people's needs into what was already being offered, we wanted to promote the creation of truly individualized supports, tailored to the specific needs of each person. With no predetermined notions of what this would look like, we entered into the Pilot Project knowing that creativity and flexibility would be necessary components.

The most pressing concern identified by the workgroup participants was the importance of communication and collaboration, not just between the person and his or her circle of support/team (family, friends, residential staff, clinicians and other important people in the individual's life) but among all of the community systems supporting the person. We had all experienced the struggles of people and teams trying to "hang in there" when faced with challenging behaviors, psychiatric symptoms, medication changes or side effects and the frustrations of everyday life. These struggles can be compounded when teams are not even aware of the existence of many of the services that may be available to them.

At this point the mission of the workgroup was broadening in scope. We began to envision a new way of supporting people with collaboration and participation from the outset by all of the systems involved sharing information and offering solutions to the problems presented by each new situation. We invited representatives from all of the systems (Mental Retardation, Behavioral Health and Community Behavioral Health) that provide services to people, to attend our monthly meetings and we expanded the workgroup to include them. With our new vision in mind, we changed the name of the workgroup to the Philadelphia Behavioral Health Collaborative (PBHC).

### **Putting Ideas Into Action: The Pilot Project**

Now the mission of the group echoed the work of the Consensus Panel as a whole: to enhance the quality, effectiveness and coordination of the services and supports available to people in the community. Providing better services or coordinating existing services more efficiently, with the active involvement of the individuals and teams involved, would be one step toward improving the quality of people's lives in general. One desired outcome would be a decrease in the need for, or more importantly, a more efficient use of, psychiatric inpatient services. It is also worth noting that while we were concerned about quality assurance responsibilities, foremost we were trying to enhance the quality of the services and supports to people.

The Philadelphia Behavioral Health Collaborative (PBHC) moved forward with the development of a twelve-month Pilot Project, selecting the first five participants/teams to

whom we would offer support. Our primary intervention with these teams would be the promotion of a newly collaborative approach. Sharing information with key systems people was crucial. To that end, we developed a Psychiatric Emergency Face Sheet, which lists important information about the person that emergency personnel or hospital or insurance personnel would need to know, to be kept with the person's record. Some examples of the types of information listed on the two-page face sheet include: demographic information; names and phone numbers of important team members; hospitals used; diagnoses; medications; medical precautions/allergies; and any special instructions about the person, such as stressors, triggers, or unique communication styles. We are also developing a database with shared information from both the Mental Retardation and Mental Health systems.

A designated Pilot Project Coordinator will be the point person for communication among the teams and the workgroup and will track the data collected during the Project for purposes of determining outcomes at the end. We instituted a requirement that the Coordinator be notified within twenty-four hours if any of the participants are admitted to an in-patient unit during the course of the Project. The Coordinator would then convene a team meeting within five days, with representatives from all service systems attending, to address the reasons for hospitalization and a plan for discharge. We met with the psychiatrist from the designated in-patient facility where the Pilot Project participants are usually seen, to get feedback from him and to share the progress of the workgroup and the steps to be taken. We also conducted introductory meetings with all the participants and their teams to explain the Pilot Project, offer our support, and listen to their ideas about what they needed from us. We asked all of the teams to review the person's individualized plan and to improve or develop a Hospital Diversion Goal specific to the person's needs.

As another important component of this project, the Philadelphia Behavioral Health Collaborative (PBHC) is developing both individualized and system wide trainings to be offered to the participants of the Pilot Project and their teams. We will draw on the expertise of members of the Consensus Panel and we also hope to bring in outside consultants to offer trainings on specific clinical issues, such as Mood Disorders or The Impact of Trauma. Broader systems issues will also be covered, such as Cross-Systems Collaboration, the foundations of our work in Positive Approaches, and Comprehensive Integrative Approaches to Supports.

### **Some Interesting Developments: Progress Report**

So far, the Philadelphia Behavioral Health Collaborative (PBHC) has become involved in planning and coordinating supports for two individuals, both of whom have been hospitalized several times in the two months since the Pilot Project began. We have been privileged to meet teams that include residential staff who have shown great perseverance and commitment to their relationships with the people they support. These staff have been receptive to new ideas despite the challenges they have faced, including being physically attacked by a person in the throes of an emotional crisis. Both of these teams are struggling to figure out what to do, what resources are available, and

what new territory can be explored. At the urging of the in-patient facility's psychiatrist, the Philadelphia Office of Mental Retardation Services (MRS) conducted planning meetings for each team. These meetings were held at the hospital and involved participants from every aspect of the system including: Behavioral Health Systems; Community Behavioral Health; Office of Mental Retardation Services; Philadelphia Coordinated Health Care; residential staff and administrators; Behavior Specialists; hospital staff including the Psychiatrist; and staff from the Crisis Response Center. They all came to the table to talk specifically about how best to support these two people. The participation and cooperation of all of the systems at these meetings made for a unique and hopeful experience; however, the outcomes were very different for the two people involved.

The first person is a woman in her early thirties who lives in an apartment by herself and currently has two staff with her at all times. She struggles with depression, at times experiencing such severe self-loathing that she wants to hurt or kill herself. She is also a survivor of sexual abuse and a chaotic, sometimes violent family. At times she feels fearful, unsafe, angry and overwhelmed and occasionally she lashes out at the same people she looks to for support and comfort. Her direct care staff find her frequent mood shifts and unpredictable behavior to be challenging and exhausting. Additional community resources were identified which might help her and her team, including: increased frequency of outpatient counseling; a partial-hospitalization program; facilitation of team process by a consultant; and increased individual and group supervision for staff. Her staff were also made aware of additional community resources that they could make use of for crisis prevention and intervention, including a mobile crisis response unit available through the community's Behavioral Health service system. As a result of the additional supports and information, as well as having the opportunity to engage in a dialogue with others about their struggles, this team is motivated to continue to "hang in there" with the person they support. They are energized by new possibilities and practical suggestions that they can use every day.

The other person is also a woman in her thirties in a residential program, but she has a roommate and fewer staff available to her. Before moving into this program she had been in an institutional setting for more than ten years. She is not always able to express her feelings verbally and when she gets upset, she sometimes hurts herself or others or runs out of the house into the street, risking injury. The team supporting this person is also quite frustrated and currently have little expectation of being able to continue to support her safely. Unfortunately, the plan being considered by the team at this time involves a move to a higher level of care in an institutional setting. This situation only strengthens our resolve to continue our efforts.

### **Where Do We Go From Here? Envisioning Brighter Futures**

The work of the Philadelphia Behavioral Health Collaborative (PBHC) has reinforced our belief that our most important task is to increase and streamline communication and collaboration among service providers. Even though all of the individuals we support have been identified as having both mental retardation and mental health needs, people

involved with or supported by one system are often unaware of the services and supports offered by the other system. And when the two systems do talk to each other or about each other, it seems that each system uses its own terminology. Even more striking is the revelation that each system has a different understanding of their shared terminology. For example, the concept of Case Management is very different in the Behavioral Health System than it is in Mental Retardation Services.

Through our attempts to improve services and supports for people in our community, we discovered the necessity of addressing the emergence of a common language. This new terminology may not necessarily fit either the Mental Health or Mental Retardation systems exactly, but it will express the ideas of a new and improved approach for providing supports to people. This new system will be based on meeting the needs of each person, instead of trying to fit people into pre-existing programs that don't consider their uniqueness and individuality.

The Philadelphia Behavioral Health Collaborative (PBHC) Pilot Project is scheduled to run through September 2002.

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*1 For further information or a copy of the Consensus Panel binder, contact Philadelphia Coordinated HealthCare, 123 S. Broad Street, Philadelphia, PA 19109, (888) 546-0300*