The Mental Health Block Grant Ten Percent Set Aside Study

BRIEF REPORT | Client Transitions and Discharges

OVERVIEW

CSC programs staff members expressed concern about clients' post-discharge outcomes and service trajectories following the specialized early intervention. Site visits to the 36 study sites included interviews with clinicians and administrators, who were asked questions concerning client discharge and step-down policy and practice. Interviews with participants also covered discharge experiences.

Program Length. Exhibit 1 summarizes program length policies for the study sites. The largest service length category was 2 years, with flexibility to extend services (reported by 19 programs). Variations in flexibility were considerable, with some able to extend a few weeks and others in fixed 6-month increments. Several sites noted greater flexibility in extensions when the program had open slots for new clients.

Exhibit 1. CSC Program Length

Program Length	Number of Programs
2 year service target with flexibility to extend on a case by case basis	19
Fixed 2 year service limit, very limited ability to extend	4
Maximum 3 year service period	4
Program regularly services clients beyond 3 years	2
5 year service period	4
Indefinite service period/no upper limit on service eligibility	3

Availability of Step-Down Programs. Almost half (16) of the programs were able to provide at least some internal continuity of care through agency services after discharge; however, none were able to serve all discharged clients within the agency. Of these 16, six provided some continuity of relationships with providers in the CSC programs. Two other programs reported that they provided formal early psychosis services for clients discharged form their 2-year CSCs; one of these served discharged CSC clients for up to an additional 3 years. Only two programs reported availability of formal early psychosis services for clients discharged from 2-year CSC.

MHBG 10% Set-Aside Study Methods

The MHBG 10% Study is a collaboration among the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Mental Health (NIMH), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The study includes 36 CSC programs that were selected from among the 250 CSC programs across the U.S. that use MHBG 10% set-aside funding. Data presented here were collected during two site visits conducted between January-June 2018 and January-May 2019. Site visits included semi-structured interviews with 1) a site administrator or program director; 2) the CSC team; and 3) between one to four program participants per site.

Selected Staff Concerns. Members of the CSC teams described a variety of their concerns about what happens to clients after they leave their programs.

- Standard outpatient clinics having limited engagement practices that don't fit with this population, e.g. automatic disenrollment after two missed appointments;
- Standard services reflecting a more traditional, pessimistic view of schizophrenia in contrast to recovery-oriented philosophy of a CSC framework;
- Being able to locate psychiatrists who are able to prescribe clozapine or long-acting injectables (LAIs);
- Being able to locate psychiatrists able to serve former CSC clients on Medicaid who were not and did not want to be enrolled in a case management program;
- Negotiating the excessive costs of medication co-pays (for on-patent medications including LAIs as well as clozapine) for clients with private insurance.

> *"The quality of treatment in [our city], and I would imagine in a lot of these large urban areas, is just not good. And so it's not good by itself, and then it's really not good when you've had such an amazing program like this wrapped around you for so long. You know you're gong somewhere that's not good. You feel it as soon as you walk in the door."*

Selected Client Concerns. Data on perspectives on discharge are available from 78 participants. Nearly half (37/78) described feeling sad, anxious, unready, and/or worried about post-discharge deterioration and loss of support and structure. Twenty percent communicated ambivalence or a mix of feelings (e.g., feeling ready, but nevertheless sad to leave the program, or uneasy and unsure overall). Eight participants were not sure how to respond and just under one-quarter expressed optimism, hope, excitement, relief or pride regarding future (or recent) program graduation.

Examples of Discharge Planning Strategies

- Begin planning from 3-12 months before estimated discharge
- Taper intensity of care in the final 3 to 6 months of services
- Personally meet with the client and their new service provider
- Develop a formal relapse plan
- Develop a discharge toolkit
- Keep clients in the program for 6 months following transition

> *"Right now, I'd rather not have to leave. I'd like to continue the program. I'm somebody that likes just to keep it the way it is, the schedule and everything. It helps me just to be able to come here, and be able to talk to people… so, I'm somebody that would vote to stay indefinitely if need be."*