Services to Adults with Serious Mental Illness Standards

Standard 1: An agency receiving a grant to serve adults with a serious mental illness and that has been designated, as the comprehensive community mental health center for the catchment area must submit a plan to serve those adults in the catchment area. At a minimum, the plan must include:

1. A description of the population, including the number of adults with serious mental illnesses in the catchment area and their general situation - e.g. number homeless, number living alone, number living with families, number employed, etc.
2. An analysis of the treatment status of the population, including the number in treatment with the center and with other providers in the catchment area.
3. A description of an outreach plan to locate un-served consumers and help them get treatment and other services.
4. A description of the specific outreach, case finding, treatment and rehabilitation services to be provided. An agency with a grant as a single service or limited service agency must submit a description of the specific services it will provide to the population, and how those services are coordinated with the community mental health center, including the provision of data to the center for catchment area analysis.

Discussion: A designated community mental health center has the responsibility for the population of adults with serious mental illnesses in the catchment area. The population should be monitored to determine the penetration of catchment area services into the population, with a target of at least 50% of all adults with serious mental illnesses in treatment at any point in time. The center is also responsible to have a general knowledge of the portion of the population served by other agencies in the area. A grant agency that is not a comprehensive center is responsible for the specialty services it provides, and to link those services, as needed, to the services provided by the center.

Standard 2: A grant agency providing treatment services to adults with a serious mental illness must provide immediate response, either directly or through affiliated resources, to situations in which an adult with a serious mental illness is likely to decompensate – the person has not appeared for a medication renewal, has lost his/her medications, has lost housing, etc. The agency must allow for consumer choice, to the extent practical, in the manner of response and the choice of responders.

Discussion: Due to the nature of serious mental illnesses, appointments are often missed, meds are lost, and crises occur. Agencies need to be flexible enough to accommodate these events, and can usually do so by rearranging schedules. Rapid response outreach services should also be employed as needed.

Standard 3: All clinical records of adults with a serious mental illness must have a relapse plan, as part of the treatment plan, and that plan must be followed with each relapse. Failure to have a relapse plan, or to follow it, will be a QA exception. The consumer must be involved in the development of the relapse plan, and consumer choice in the development of the plan must be considered.

Discussion: Adults with serious mental illness tend to relapse in highly predictable ways. The first signs might be withdrawal, stopping medications, quitting work, dropping out of treatment, etc. After a few predictable steps, the person is in crisis and in the hospital. Hospitalization can be prevented if the treating agency plans for these events, and mobilizes its resources when the first signs appear.

Standard 4: Adults with serious mental illnesses may not be excluded from treatment because they do not agree with, or do not follow, one or more parts of their treatment plan. Adjustments must be made to accommodate the person in the areas of the treatment plan they do follow, until their situation becomes so unstable that inpatient care becomes necessary. Discharge of an adult with a serious mental illness, or failure to accept one for treatment, if the adult refuses to accept one or more parts of the treatment plan will be a QA exception.

Discussion: Adults with a serious mental illness often disagree with one or more parts of their proposed treatment plan, or do not follow the plan. Sometimes the issue is simply disagreement. At other times it may be due to confusion, or an attempt to deny the illness. If the treating agency refuses treatment unless the person is compliant with all parts of the treatment plan, that decision will guarantee that the person will fail in the community and have to be hospitalized. Agencies must work with the consumer to develop a treatment plan they agree with, and if that does not happen, help them with the areas in which they are compliant, and monitor the person's status so that crisis intervention can occur if it becomes necessary.

Standard 5: Adults with serious mental illnesses may not be excluded from treatment because they have a history of being dangerous to others. Adjustments must be made to accommodate the treatment of the person in ways that provide for the safety of the person, the staff, and other consumers. The treating agency may not refuse to accept, or discharge, a person with a history of dangerous behavior unless the agency can demonstrate an imminent risk that cannot be compensated for. If that risk is present, the agency must arrange for alternate placement. Discharge of an adult with a serious mental illness, or failure to accept one for treatment, if the adult has a history of dangerousness toward others will be a QA exception, unless the imminent risk is established and the agency has assumed responsibility for, and has arranged alternate placement.

Discussion: While relatively rare, adults with a serious mental illness may present with a history of violence, and may currently have some violence propensity. Such a person maintains a right to treatment that cannot be ignored by grant-funded agencies. The agency must plan to treat the person in ways that provide for the least risk, while meeting the treatment needs of the person. The person may be seen at a police station, or other setting that provides safety. The person may be excluded from group treatment activities, but seen individually. If the treating agency refuses treatment because the person presents with some violence risk, that decision will put the community at risk and guarantee that the person will fail in the community and have to be hospitalized, possibly after hurting someone. Agencies must work with the consumer and help them with the areas in which treatment can be safely delivered, and monitor the person's status so that crisis intervention can occur if it becomes necessary.

Standard 6: Centers must make an active effort to involve families of adults with serious mental illness in the treatment and support of the adult. The consumer should be encouraged to sign a release permitting communication with family (including unmarried significant others), and the clinical record should indicate that the discussion took place and what the consumer's decision was. The adult must be allowed to choose personal representatives from his/her natural support/family system that will be involved in the treatment process. The clinical record must also show active involvement of the family in the treatment process, unless the consumer chose to not have them involved, or the family member(s) declined the offer to be involved. Not attempting to involve the family, as above, will lead to a QA exception.

Discussion: Over half of all adults with a serious mental illness live with their families and/or receive the majority of their personal support from their families. At the same time, most families are not included in the treatment process. It is necessary to have families included in the treatment process to link treatment with the natural support system.

Standard 7: Adults with serious mental illness who live in Assisted Living Facilities must have the assisted living facility involved in the treatment and support of the adult to the extent permissible by law and practicality. There must be a release permitting communication with facility in each clinical record, or a statement that the adult refused after being actively encouraged to sign one. The treatment plan at the treating agency must include a description of the services to be provided at the assisted living facility and the expected outcomes. If the release is signed, the assisted living facility must be made a part of the treatment team, and a copy of the treatment plan must be located in the assisted living facility. The clinical record must also show active involvement of the facility in the treatment process, and communication between the treating agency and the facility, unless there is documentation the assisted living facility refused after being actively encouraged to be involved. Not attempting to involve the facility, as above, will lead to a QA exception.

Discussion: Many adults with a serious mental illness live in assisted living facilities, because they are unable to live independently. Most of their support comes from these facilities. At the same time, most of these facilities are not included in the treatment process. The lack of involvement and communication often leads to consumer problems that could have been prevented. It is necessary to have these facilities included in the treatment process to link treatment with this vital support system.

Standard 8: A grantee may not, as a matter of policy, exclude an adult with a serious mental illness from treatment because that adult has chosen that part of that treatment is to be provided by one or more other agencies. Grantee agencies must allow for this choice, and coordinate treatment planning with all involved providers. The collective treating agencies must develop a common treatment plan, which is shared by all agencies, and be present in the clinical record(s) at the grantee agency(s). Not allowing this choice will lead to a QA exception.

Discussion: Adults with serious mental illnesses sometimes choose a physician or case manager that is not employed by the agency providing most of the rehabilitation services. These consumers must be allowed to choose providers of services, even if those decisions result in treatment being shared by more than one agency, with resultant communication and billing complications. This issue is a matter of consumer rights.

Standard 9: The treatment plan of an adult with a serious mental illness must include those
individualized outreach services that are necessary to help maintain the adult in the community. The agency providing treatment to an adult with a serious mental illness must provide outreach services on an individualized basis to the extent necessary to meet the basic support needs of the adult. At a minimum, the outreach must occur under the following circumstances:

1. As an emergency measure to handle crises occurring with current clients or others in the community that are eligible for CSS services but have not yet chosen to accept active treatment.
2. As a way to monitor high-need consumers, or consumers who are not following their treatment plan, whether current clients, or those eligible who have not yet chosen to become clients.
3. As a way to do rehab work with consumers in their natural environment.
4. As a tool for case finding - locating eligible consumers who are in need of treatment and rehabilitation, but have not been referred, or have been reluctant to seek care.
5. As a way of providing training and support to families and other care givers

Discussion: Outreach is a vital part of services for this population, and must be within the repertoire of agency services. Needed outreach often makes the difference between staying in the community and hospitalization.

Standard 10: Adults with a serious mental illness must be provided with the opportunity to change therapists, case managers, or doctors if the adult cannot work effectively with the therapist, case manager, or doctor. It is recognized that a request to change workers can mean that the consumer has become frustrated with the treatment process, and the treating agency may request that the consumer try to work through the problems with the worker. However, a consumer has a basic right to change workers, even if that change is not necessarily in his or her best interest. To the extent practical due to staff availability, the agency must allow the requested change. The consumer request and the agency's response must be documented in the consumer's clinical record.

Discussion: This is a very controversial area. Consumers want the right to choose those with whom they trust their private lives. That choice may sometimes be made due to genuine inability to work together, sometimes due to frustration over temporary disagreements, and sometimes for other non-clinical reasons. Providers sometimes see the desire to change workers as "manipulation", "splitting", etc. The bottom line is that the consumer has a right to choose, even if the choice is not made with the best of perceived motivation.

Standard 11: Adults with serious mental illnesses who leave treatment for an extended period of time, and who return to treatment with the former treating agency, must be allowed, to the extent possible, to have access to the same therapist, case manager, doctor, etc. to ensure continuity of care. Efforts must be documented in the clinical record.

Discussion: If staff has left employment, there is obviously no way to provide the consumer choice. If the staff are still employed, but have full caseloads, the agency could possibly rearrange caseloads to move the consumer in, or have the former worker meet with the consumer and new worker to "bridge". The continuity is important, and should always be considered.

Standard 12: Adults with serious mental illnesses who present with dual diagnoses, whether
substance abuse or developmental disability must be given access to mental health services for their legitimate mental disorder. These consumers may not be excluded from treatment pending resolution of the co-occurring disorder, but must receive mental health treatment concurrent with any treatment for the other disorder. In addition, mental health treatment must be provided even if the consumer refuses treatment for the co-occurring disorder, unless the mental health provider can clearly document that the untreated co-occurring disorder has created a situation in which the mental health treatment cannot be delivered. That decision must be made on a case-by-case basis; the decision must be made clinically; and the decision cannot be made on the basis of a blanket exclusion policy. The QA section will review these cases.

Discussion: Fortunately, the exclusion of persons from treatment who have co-occurring disorders is becoming less frequent, but it does still happen. Consumers with co-occurring mental disorders and substance use disorders can still find themselves unable to access mental health care "until the substance abuse is under control" and simultaneously cannot access substance abuse treatment "until the mental illness has stabilized". This is not acceptable, and will not be permitted in grant-supported programs for adults with serious mental illnesses.

Standard 13: Adults with serious mental illnesses must be given flexible access to the treatment, rehabilitation, and support services offered at the treating agency. Consumer "level of functioning" may vary widely over the course of a few months, from very "high-functioning" to very much in need of intensive support, and back again. One way of assisting consumers in maintaining relative stability is to allow some self-selection of service elements they want to use. For example, a consumer who is "high-functioning" may want to drop-in periodically at clubhouses, day activities, etc., that are primarily intended for less stabile consumers. This type of contact assures the consumers that the services "are still there" and should be permitted, unless a specific service is very highly structured around a specific group of consumers, and the drop-in would be disruptive. That situation should be rare. Some of this contact may be in the treatment plan, and billed as it occurs. Other contact may be a courtesy service to the consumer, and as such not billed. This contact can help the consumer cope, and must be permitted. In addition,

some types of support given high-need consumers, like transportation, use of agency facilities, etc. must also be reasonably available to all adult consumers with serious mental illness while more natural supports are being developed.

Discussion: Some agencies tend do provide an "all or nothing" approach to care - the consumer either gets a full array of services, or is designated "high-functioning" and is excluded from most elements of service, especially if there is an expectation that all contact must be billable and billed. This jump is too much for some consumers, and does not allow for flexible services and supportive contact to meet individual needs.

Standard 14: All agencies with grant funds to treat adults with serious mental illness must submit a plan indicating how they will handle any aggressive acing out on the part of consumers. The plan must show a distinction between acting out due to fear and confusion, and deliberate, intentional acting out, and indicate how each will be handled. The plan must include staff training in the appropriate handling of aggressive behavior, and indicate the circumstances under which the agency, or an agency staff person, will initiate police involvement. The division must approve the plan. Any time an agency, or an agency staff person, has a consumer arrested, a complete description of the incident and the stated reason for arrest must be included in the clinical record. That report may be part of a quality assurance review.