MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN
MENTAL RETARDATION BULLETIN

COMMONWEALTH OF PENNSYLVANIA - DEPARTMENT OF PUBLIC WELFARE

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May 15, 2000	**Immediately**	**00-00-04**

SUBJECT: Guidelines for Identifying Persons with Mental Retardation and Mental Illness for State Mental Health Hospital Discharge

BY: **Deputy Secretary for Mental Health and Substance Abuse Services**

BY: **Deputy Secretary for Mental Retardation**

SCOPE:

County Mental Health/Mental Retardation Administrators
Base Service Unit Directors
CEO, State Mental Health Facilities
OMR Regional Offices
OMHSAS Regional Offices

PURPOSE:

The purpose of this bulletin is to formalize the procedure of identifying persons with mental retardation and mental illness (dual diagnosis) for State Mental Health Hospital discharge.

BACKGROUND:

Individuals with mental retardation who have mental illness are in need of both treatment and supports. Without the appropriate treatment and supports, individuals are at risk of inappropriate admission to and long term residency in State Mental Health Hospitals.

Collaboration between the mental retardation and mental health systems can minimize the occurrence of long term placement of individuals with mental retardation in State Mental Health Hospitals. Both systems need to assure that the treatment and supports that individuals need in the community are delivered so that they may live healthy, productive and inclusive lives.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Appropriate Regional Offices of Mental Retardation and Mental Health and Substance Abuse Services

DISCUSSION:

OMR and OMHSAS staff recognize the need for standard procedures to identify persons who require the services of both the mental retardation and mental health system to live successfully in their community. People who need the community-based habilitation and treatment services of both systems require a specialized plan of care that is developed and monitored by staff from both systems. Additionally persons who are identified for discharge from a State Mental Health Hospital require the same coordinated approach from both systems. A procedure has been jointly developed by both program offices and field-tested with success to promote these objectives.

PROCEDURE FOR ASSESSMENT OF DIAGNOSES AND NEEDED SERVICES FOR PERSONS WITH MENTAL RETARDATION RESIDING AT STATE MENTAL HEALTH HOSPITALS

Identification of persons with a dual diagnosis:

The purpose of this review process is to identify all persons in the State Mental Health Hospital system who have a mental retardation diagnosis, whether their mental illness is active or in remission, and whether or not they are judged to be currently ready for discharge to the community. The review includes:

1. Identify state mental health hospital patients who have a dual diagnosis (mental retardation and mental illness) as defined by the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*
2. Assess each person to determine the readiness for discharge, or the necessity for continued hospitalization.
3. Identify the individualized supports needed for each person to live in the community (physical health, mental health, adaptive living, etc.).
4. Identify the shared responsibilities of the Mental Health and Mental Retardation system and schools where appropriate, indicating specific program responsibilities.
5. Identify and solicit the involvement of the person and the person's family/guardian in the review process.

Guidelines:

Prior to conducting the review in each State Mental Health Hospital, county teams are encouraged to provide hospital staff with information on the full range of living options and services in the community.

Prior to Review:

State Mental Health Hospitals will identify people as possibly having a dual diagnosis. For each person identified, a hospital review team will be convened, and a hospital staff person will be named as the primary contact person. The hospital review team will minimally include nursing and social services staff, direct care staff, physician and psychiatrist.

A community review team is convened prior to each person's review. The community review team is comprised of County MH/MR representatives and members of the hospital review team.

Process for Review:

1. Prior to each person's review, the hospital primary contact person or county case manager should contact the person's families/guardians about the status of their family member and this process.

2. For each person identified as possibly having a dual diagnosis, a community review team of representatives from the County MH/MR, the County (or BSU) Mental Health case management program and the County (or BSU) Mental Retardation case management program will meet the person, complete a review of state hospital records, and meet with hospital review team members.

3. The entire review team together will complete the standardized review form for each person identified as possibly having dual diagnosis. (Attachment 1)

4. The names of the reviewers, the date(s) of the review, and the names of the state hospital staff providing information will be entered at the top of the review form.

Procedures for collection and recording of Review information:

1. Items #1-10 of the attached review form will be completed for each person. These include the person's name, date of birth, State Mental Health Hospital name and current ward assignment, the person's hospital number, any restrictions of the person (on a locked unit, must always be accompanied by staff, etc.), county name and county case number, and type of commitment.
2. The initial test of further inclusion in this targeted group as a person with dual diagnosis will be items #9 and 10, the verification of I.Q. scored and/or evidence of mental retardation prior to the age of 18 years. If the person has I.Q. scores above 70 and/or there is no verifiable evidence of mental retardation prior to 18 years of age, the review team will terminate their review(s). Relevant school records should be a part of this review based on release of information.
3. If the presence of mental retardation prior to 18 years of age can be verified, all team members will proceed with the review.
4. The complete State Mental Health Hospital record will be reviewed. Items #1-17 will be completed by the review team based on the record review.
5. All dates of admission, diagnoses at each admission, and reasons for each admission will be entered on the review form.
6. All current diagnoses, medical and psychiatric, will be entered on the review form. The most recent date of each diagnosis will be placed in parenthesis behind the diagnosis.
7. All current medications, the dosages, and the reasons for each medication will be entered on the review form. This section is to include ALL medications for ALL diagnoses (medical and psychiatric) and all PRN medication.
8. Additional medication history should be reviewed indicating the course of treatment for the previous two years, and should be attached to the review form as an addendum.
9. A brief summary of the state hospital treatment team goals and progress in these goals is to be entered on the review form. The date each goal was initiated will be placed in parenthesis behind each goal. Additional information can be attached to the review form, if needed.

10. The person's current adaptive skills will be entered on the review form. Information in this area is to include level of independence in personal care, activities of daily living, ambulation, method(s) of communication, use of adaptive/assistive devices, interpersonal relationships, and self-direction. Additional information can be attached to the review form, if needed.
11. The person's current work and employment activities are to be entered on the review form. Information about the person's work interests and any work assessment should be documented. Additional information can be attached to the review form, if needed.
12. Member(s) of the review team (preferably of the person's choosing) will meet with the person to learn more about him/her and talk about transition to community living, if appropriate, and his/her expectations for supports and services in the community. This is documented under "Additional/Significant Information" on the review form. Additional information can be attached to the review form, if needed.
13. The review team will discuss and clarify, when necessary, information obtained from the record and the interview with the person. This is documented under "Additional/Significant Information" on the review form. Additional information can be attached to the review form, if needed.
14. In the event of unresolved disputes, both the regional OMHSAS and OMR dual diagnosis point people will be involved in the final disagreement determination.

Planning for Hospital Discharge:

1. Based upon the record review and interviews, the review team will complete Item #18, which indicates the person's readiness for discharge, and enters this on the review form, inclusive of plans for communication of relevant information with home and host schools where appropriate. If the review team indicates that the person is **ready now for discharge,** a list of recommended supports that should be in place during and after transition is entered on the review form. For each person determined **ready now for discharge,** an individualized person-centered plan will be developed which will address the transition process from hospital to community and school where relevant and will identify the services and supports provided by the Mental Retardation and Mental Health system in the community. The planning and funding process needs to be expedited, and the person being evaluated need to be regularly informed of the timetable and progress. Some people may be very aware of the process, and talking about moving and then not having it occur may contribute to additional stress on them, or acerbate their psychiatric symptoms. Transitions should be person-specific. Some people may require more time, day visits, overnight visits, etc., while others may adjust quickly. Treatment plans at the hospital should be modified to reflect what each person needs for as smooth a transition as possible.

   Upon the determination that the person is ready for discharge now, the following steps should occur:

a. The county case manager should start the MA enrollment process for the person, if appropriate.
b. When appropriate, the hospital needs to develop a complete package of referral information for the potential Behavioral Health-Managed Care Organization (BH-MCO).
c. The county case manager and/or hospital social worker would ensure that the person goes through the Health Care physical Managed Care Organization selection process.

2. If the review team indicates that a person will be **ready for discharge at a later date,** brief explanations for the decision(s) should be entered on the review form, including the supports the team believes need to be in place to assist the person in discharge readiness. People with mental retardation and active mental illness may require continued state hospital treatment for now, but plans should be made for alternative community-based treatment and residential alternatives when their mental illness stabilizes. Again, relevant information should be shared in a timely manner with school's currently providing, or projected to provide educational programming for the individual.

3. For 304 Involuntary Commitment for Managed Care:
   a. If the person is in a community psychiatric unit and prior to filing a 304 commitment, the community hospital must notify the BH-MCO and provide a current psychiatric evaluation documenting the medical necessity for a long-term stay in a state mental hospital.
   b. If the person is living in the community and prior to filing a 304 commitment, the community provider must call the BH-MCO to request authorization for a psychiatric evaluation. The BH-MCO will determine whether the long-term stay is medically necessary.

4. Regional OMHSAS and OMR dual diagnosis point people and the County MH and MR point people will monitor the effectiveness of the review process in each hospital. Regional OMHSAS and OMR dual diagnosis point people should meet with the hospital administration as needed to discuss the progress of activities, their observations and to get feedback from staff, and to resolve disputes such as agreement on diagnosis, needed community supports (home, work, and/or school settings), or readiness for discharge.