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# The Central State Hospital Discharge Study Tracking Report – March 2005

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# THE CENTRAL STATE HOSPITAL DISCHARGE STUDY
# TRACKING REPORT -- November 1, 2003 - October 31, 2004

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## I. INTRODUCTION

This report is the sixteenth and final in a series of public reports on the Indiana University tracking service which is following former Central State Hospital patients into the community. This tracking project is performed as a service for the Indiana Division of Mental Health and Addiction. The tracking service collects monthly data on discharged clients' location, clinical functioning, treatment utilization, and special service needs and challenges. Our goal in this project is to document, as accurately as possible, the unfolding impact of the closure of Central State Hospital. A complete overview of the study methodology and instrumentation is provided in our first report (*The Central State Hospital Discharge Tracking Report--January 1994,* Wright, et al.). This report details the current location and status of the 389 former CSH patients during the period from November 1, 2003 through October 31, 2004.

This report does not advocate a position for ***or*** against the decision to close Central State Hospital. Our role is that of an outside, independent evaluator. The funds for this project are being provided by the Indiana Division of Mental Health and Addiction (IDMHA), and IDMHA staff has been actively involved in defining some of the research questions we address. In addition, former Central State Hospital personnel, consumers, family members, and representatives from other State agencies and mental health facilities have been extremely helpful and cooperative in offering us suggestions and assisting us in implementing the tracking program. Nevertheless, the responsibility for the collection and interpretation of these data is ours alone. Both the collection of the data and the data analysis are conducted *completely* independently of any interested parties.

## II. SUMMARY OF CURRENT LOCATION AND FUNCTIONING

The descriptive information presented below reflects only data gathered between November 1, 2003 and October 31, 2004. These data are provided as summary indicators of the current status and functioning of the former CSH consumers. Because these data reflect only a limited span of these consumers' community tenure, generalizations regarding long-term trends or outcomes for this population cannot be made. This report speaks only to the discharged patients' functioning and adaptation during this period.

### Location

Data on the locations of discharged patients are presented for the whole population and broken down by those with mental illness (MI) and those with both mental illness and some type of developmental disorder (DD). The classification of patients into these two sub-populations is made by IDMHA for administrative purposes. A glossary defining types of community settings referenced in this report is presented in Appendix A. All tables and figures for this report are presented in the order referenced in the text in Appendix B.

Figure 1 presents information on the current location of all patients. Of the 389 former Central State patients being tracked, the majority continue to reside in semi-independent living apartments (23.1%), private residences (17.0%) and supervised group living settings (9.5%). The remaining clients living in the community are distributed among a variety of settings which include: state-operated facilities (7.5%), nursing homes (4.4%), and licensed room and board homes (2.1%). As of October 31, 2004 eight clients (2.1%) are incarcerated, 27 clients (6.9%) are missing and 95 clients are deceased (24.4%).

M.I. Patients. Figure 1a lists locations, as of October 31, 2004, of patients with a MI diagnosis. Group homes and private residences are providing care for the largest group of MI patients (31.3%). Of the patients living in state-operated facilities, most are residing in Logansport State Hospital (40.9%), Larue Carter Memorial Hospital (40.9%), and Richmond State Hospital (13.6%). The second largest group of MI patients is currently staying in supervised living apartments (13.2%). The remaining MI patients are located in various community settings which include nursing homes (5.3%), and licensed room and board programs (2.6%). Since March 23, 1992, 78 MI patients have died (25.7%) and 25 are missing (8.3%).

D.D. Patients. Figure 1b depicts the variety of locations where individuals with a dual diagnosis have been placed. The largest group of DD clients continues to live in semi-independent living programs (58.1%). The second largest group of DD patients is living in private residences (5.8%). As of October 31, 2004, 8.1 percent of DD clients are listed as living in state-operated facilities. Of the DD clients currently living in state-operated facilities the majority live at Madison (28.6%), and an equal percentage live in Richmond State Hospital (22.2%), along with an equal percentage at both Logansport State Hospital, Muscatatuck State Hospital. An additional 14.3% of DD clients reside at Fort Wayne Development Center. The remaining DD patients continue to live in supervised group living facilities (3.5%), a Medicaid waiver home (1.2%) and in a nursing home (1.2%). Since March 23, 1992, 17 (19.8%) DD clients have died.

**Service Status**

The data on service status, at this point, are limited to provider reports of whether or not the client is still receiving services. A total of 35 (9.0%) clients are reported as living in the community and not receiving services. All 35 clients are listed as missing by their mental health service providers.

**Global Clinical Functioning**

Clinical information regarding the functioning of clients is gathered only on the sub-set of consumers receiving services in community treatment settings (N = 221). Further, because the clinicians responsible for providing this monthly information sometimes do not have sufficient time to complete the entire tracking form, there are some missing data. Reports also are often returned late, and the analyses reported here are based on data reported to us through October 31, 2004.

Our principal measure of clinical functioning is the Global Assessment of Functioning (GAF; American Psychiatric Association, 1995)[1]. During this reporting period, GAF ratings were reported on 155 (70.1%) of the former CSH patients being treated in community settings. This measure is a standard measure of psychiatric functioning used across the mental health system and is ideally part of a standardized psychiatric diagnostic profile. We use this measure as a global indicator of how well clients

[1]This scale is a revised version of the Global Assessment Scale (GAS) originally developed by Endicott, Spitzer, Fleiss, and Cohen (1976).

are doing in the community. Scores range from 1 (Very Poor Mental Health) to 100 (Perfect Mental Health) and represent a hypothetical continuum of mental health to mental illness. Users of the scale generally agree that scores ranging 35-40 and below indicate a need for inpatient care while ratings above 80 are used to characterize people with few mental health problems.

The average GAF score for the overall population for November 1, 2003 to October 31, 2004 was 43.8. Figure 2 shows average GAF scores by month for the overall former CSH population. GAF scores fluctuated some between November 1, 2003 and October 31, 2004. The highest average GAF score was 44.5 for the month of April, 2004 while the lowest score of 43.1 occurred in January of 2004. In general, these data suggest that, as a group, the former CSH clients were relatively clinically stable during this period, with the exception of residents in nursing homes, who did experience a significant drop in GAF scores during the reporting period.

Figure 3 depicts the overall average GAF for patients for November 1, 2002 to October 31, 2003 by type of community placement. Former CSH patients residing in supervised living apartments (M = 47.3) had the highest functioning levels. Clients living in private residences (M = 46.8) were reported as having the next highest level of functioning, while RBA's (M = 36.3), nursing homes (M = 36.6), and supervised group homes (M = 39.9) are reported as having approximately equal functioning levels.

Clients were not randomly placed across treatment settings, so no inferences can be made regarding the effectiveness of treatment setting on client functioning. The differences across the type of placement could be the result of either differences in the services provided at each type of facility or in the types of clients placed in the different facilities or both.

**Hoosier Assurance Plan Instrument - Adults (HAPI-A) Assessment**

As indicated in our March 1996 report, we implemented a change in our data collection protocol in January, 1996. The previous measures of psychological functioning were replaced with the pilot instrument developed for the evaluation of the Hoosier Assurance Program. This change was made to reduce the data collection burden on clinicians who were responsible for completing both our tracking instrument and the Hoosier Assurance Plan Instrument. With the assistance of IDMHA staff, HAPI-A data were matched with the tracking database for the analyses reported here and in future reports.

The HAPI-A is a 28-item instrument designed to jointly measure problem severity with the consumer's ability to manage the problem as it influences community functioning. Each item requires two ratings: One is the rating of severity/self-management, which can range from 1 (severe distress) to 7 (no distress). The second indicates the presence of observable behaviors that contribute to that problem's severity.

All ratings are completed by clinicians using information collected in personal interviews or from clinical charts. The severity/self-management ratings yield scores on six factors:

Symptoms of Distress and Mood (Factor 1): describes an individual's level of anxiety, depression, and overall sense of emotional distress. Scores on factor one can range from three to 21.

Health and Physical Status (Factor 2): describes an individual's level of physical health. Scores on factor two can range from one to seven.

Community Functioning (Factor 3): describes an individual's occupational functioning, ability to perform daily living skills, ability to learn and perform tasks, and his/her level of thought disturbance. Scores on factor three can range from four to 28.

Social Support, Social Skills and Housing (Factor 4): describes the closeness and supportiveness of interpersonal relationships, how satisfied an individual is with his/her housing situation, the extent to which the environment and people in it are dangerous and/or threatening, and the person's level of inappropriate/impulsive behavior. Scores on factor four can range from four to 28.

Risk Behavior and Substance Abuse (Factor 5): describes an individual's level of behaviors such as criminal activity, unsafe sexual practices and drug use/abuse. Scores on factor five can range from seven to 49.

Reliance on Mental Health Services (Factor 6): describes how much support an individual requires from the mental health provider/s in order to maintain adequate community functioning. Scores on factor six can range from one to seven.

The HAPI-A instrument is required for MI clients whose treatment is funded by the IDMHA and who are not being treated in state-operated facilities. The analyses reported here compare HAPI-A ratings of former CSH MI clients with other IDMHA funded MI clients in the state of Indiana. Copies of the HAPI-A are available from DMHA.

HAPI-A ratings were obtained on 82 former CSH MI clients who were living in the community during 2004. A HAPI-A rating could not be obtained on all CSH clients as HAPI-A ratings are not required to be completed by IDMHA for clients living in state-operated facilities, for clients living in correctional facilities, for clients who have moved out of state, or for clients being served by the Indiana Division of Aging and Rehabilitative Services. To determine if former CSH clients differed from other IDMHA-funded MI clients, former CSH clients were compared to a group of 147 IDMHA-funded clients similar in age and DSM-IV diagnosis. Figure 4 shows average HAPI-A factor scores for the former CSH clients and the other MI clients. When compared to non-CSH clients, the former CSH clients were rated as functioning at comparable levels on all HAPI-A factors.

Within the 82 former CSH clients, comparisons were made between male and female and Caucasian and minority clients. Figure 5 illustrates average HAPI-A factor scores for male and female clients. Comparisons between these two groups found that male and female clients were functioning at approximately equal levels on all factors. Analyses comparing Caucasian to minority clients indicate that both groups are functioning similarly to one another on all six HAPI-A factors. Figure 6 displays average HAPI-A factor scores for Caucasian versus minority clients.

Fifty-five of the 82 former CSH clients who had had a HAPI-A form completed in 2004 also had a HAPI form completed in 2001, 2002 and 2003. Comparisons across all four years showed no significant clinical changes in functioning on any HAPI-A factors. Figure 7 displays average 2001, 2002, 2003 and 2004 HAPI-A factor scores for these 55 clients.

**Medical Problems**

The former residents of CSH continue to be relatively free from health problems. During the period from November 1, 2001 through October 31, 2002, 46 out of 221 (20.8%) clients who are

currently living in the community were reported as suffering from a medical problem. The majority of the health problems described were fairly minor in nature and included such things as arthritis, reflux disease, obesity, side-effects from medication, high cholesterol, hypertension, and respiratory problems. A few clients were reported as suffering from more serious problems such as various forms of cancer, lung disease, pneumonia, renal failure, diabetes, osteoporosis, broken bones, stroke and congestive heart failure. All individuals who were reported as having medical problems were also reported as currently receiving treatment for these problems.

**Morbidity**

Our records indicate that ninety-five or 24.4% of the former CSH patients have died as of October 31, 2004. The average age at the time of death was 57.0. The average age of the 5 individuals who died between November 1, 2003 and October 31, 2004 was 51.5. Among those who have died, the most common causes of death were cardiovascular disease or heart problems, cancer and respiratory failure or other respiratory-related problems.

**Acute Care Psychiatric Hospitalizations**

Twenty-six (11.8%) of the 221 patients in community treatment settings were admitted into an acute care psychiatric hospital between November 1, 2003 and October 31, 2004. Of these 26 patients, twelve required multiple inpatient stays averaging 2.9 admissions over the 12 months with an average stay of 2.6 days per admission. The total number of separate admissions for these patients was 35 . Based on the 49 admissions with lengths of stay reported, the total hospital days reported was 354, while the average stay was 7.2 acute days.

**Contact with the Law**

During the period from November 1, 2003 through October 31, 2004, clinicians reported that seventeen (7.7%) individuals living in the community had contact with law enforcement, some individuals with multiple contacts. Two individuals were escorted by law enforcement officials to the hospital. In one other case, law enforcement was called on multiple occasions due to public intoxication. In two other cases, law enforcement was called when clients were accused of assault. In one case, the police were called when a client was in violation of probation orders. During November 1, 2003 to October 31, 2004, five (2.3%) clients have spent time in jail. The five who did spend time in jail were there for an average of 15.4 days.

## V. CONCLUSION

Our purpose in offering this report is strictly informational. The reader is cautioned against drawing substantive conclusions from these data. These data represent discharged patients' profiles for the period from November 1, 2003 through October 31, 2004. Conclusions about the long-term success or failure to serve these persons in the community should be made cautiously.

Finally, this report is the last annual report on the status of the former Central State Hospital patients. After a decade of following these patients, DMHA and the research team have agreed to discontinue tracking this patient population. While we will not continue to follow, the research team will continue to analyze the data collected both in the tracking project and in the follow-up interviews to better understand the long-term impact of the closing of Central State Hospital. Results of these analyses will

be made available through scholarly literature and the Central State Hospital Discharge Study website (www.iupui.edu/~amss/csh).

*Please direct all comments and questions regarding this report and the Central State Hospital Discharge Study to:*

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## APPENDIX A

### Glossary of Placement Definitions

Correctional Facilities: Prison facilities, including Women's Prison and juvenile correctional facilities.

General Hospital: This includes temporary stay on a psychiatric acute care unit in a general medical hospital. Most hospitals have an initial entry onto a more restrictive floor which can address both mental and medical problems. After individuals have improved they are usually transferred to a less restrictive environment to complete their stay.

Nursing Home: Most nursing homes prefer to be known as "health care facilities" due to a negative view by many of "nursing homes." Legitimate health care facilities are licensed and surveyed by the State. Most are Medicare and Medicaid certified. Any individual in the State of Indiana must go through a process known as "pre-screening" before admission to this type of facility. This process was started some years ago, to protect the rights of individuals. An individual who wants/needs to be placed ins pre-screened for level of care. They **must** meet either a skilled or intermediate criterion for level of care or they cannot be placed. Persons with a mental illness diagnosis, or persons taking psychiatric medications, go through a more strict pre-screening process. This is done mainly to determine that the individual meets the criterion for physical level of care and is not being "warehouse" due to a mental disability. Individuals in health care facilities receive 24 hour supervision. Their meals are prepared daily and medications are administered. Staff assists with bathing and dressing as needed. There is an activity person on staff who plans various activities for the residents. Many facilities have physical therapy available for those individuals who may need it. If individuals sight themselves into a health care facility they do not have to stay. However, if individuals have a guardian or are court ordered into the facility, they may not leave. They would be allowed to leave with a responsible person for visits, but this person would have to sign them in and out.

Private Residence: Individuals live independently or with family members. Some people living in private residences receive ACT services.

RBA or Licensed Room and Board Assistance facility: RBA settings fall somewhere in the middle of the service continuum between 24 hour supervised care and independent living. Individuals in these settings, although somewhat independent, require assistance with meal preparation, monitoring of medications and housekeeping. Residents are encouraged to their own laundry, but assistance can be given if necessary. All three meals are prepared for everyone in a communal dining setting. Housekeeping staff deliver fresh towels each day and empty trash. One time per week, housekeeping staff vacuum residents' rooms and change the bed linens. Although RBA's are not considered 24 hour care facilities, there appear to be staff available 24 hours a day. There is a full-time activity person available who plans social activities for the residents who wish to participate. Residents are free to leave the grounds: they are asked to sign out when leaving so that staff will know who is present in case of a fire or similar emergency. RBA's are residential facilities licensed by a State authorized health facilities council.

SGL-(Supervised Group Living) or Group Homes: SGL's or group homes house up to ten individuals who live together. Meals are usually communal and staff are required to be available 24 hours per day. Staff works with individuals on performing activities of daily living, work issues, and other skills which

enhance self-sufficiency. Residents are allowed to go out with responsible person. Medications are administered and some residents are trained to self-medicate. SGL's are not locked facilities.

S.I.L.P.-(Semi Independent Living Program) or Supported Living: Individuals in the program are usually house in an apartment/house that is community based. They receive case management services and staff supervision as needed. (Current S.I.L.P.'s must provide 24 hour care for DD individuals discharged from CSH). Individuals are encouraged to become fairly independent with regard to self-care, cooking, and cleaning skills, and many are employed in the community. There is assistance with shopping and banking for those individuals who require it. Only three individuals can live together in a house or apartment. Anything over three would be classified as a group home. Some clients live in special S.I.L.P.'s connected with ACT.

SOF (State-operated facilities): State-run hospitals are considered the most restricted environment for individuals. These facilities are intended for long-term institutionalization of the most disabled of mentally ill persons. Briefer hospitalizations lasting days or weeks are accomplished in other local acute care/stabilization facilities.

## APPENDIX B: TABLES AND FIGURES

**Figure 1**
Current Placement of Former CSH Patients
N=389

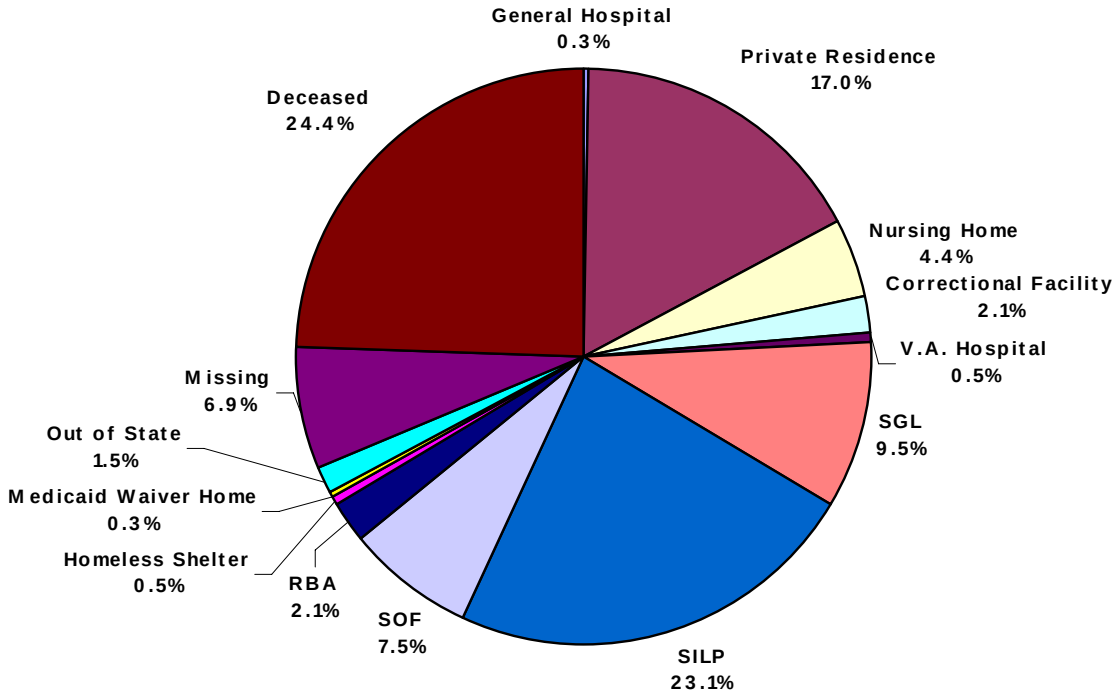

**Figure 1a**
Current Placement of M.I. Population
N=303

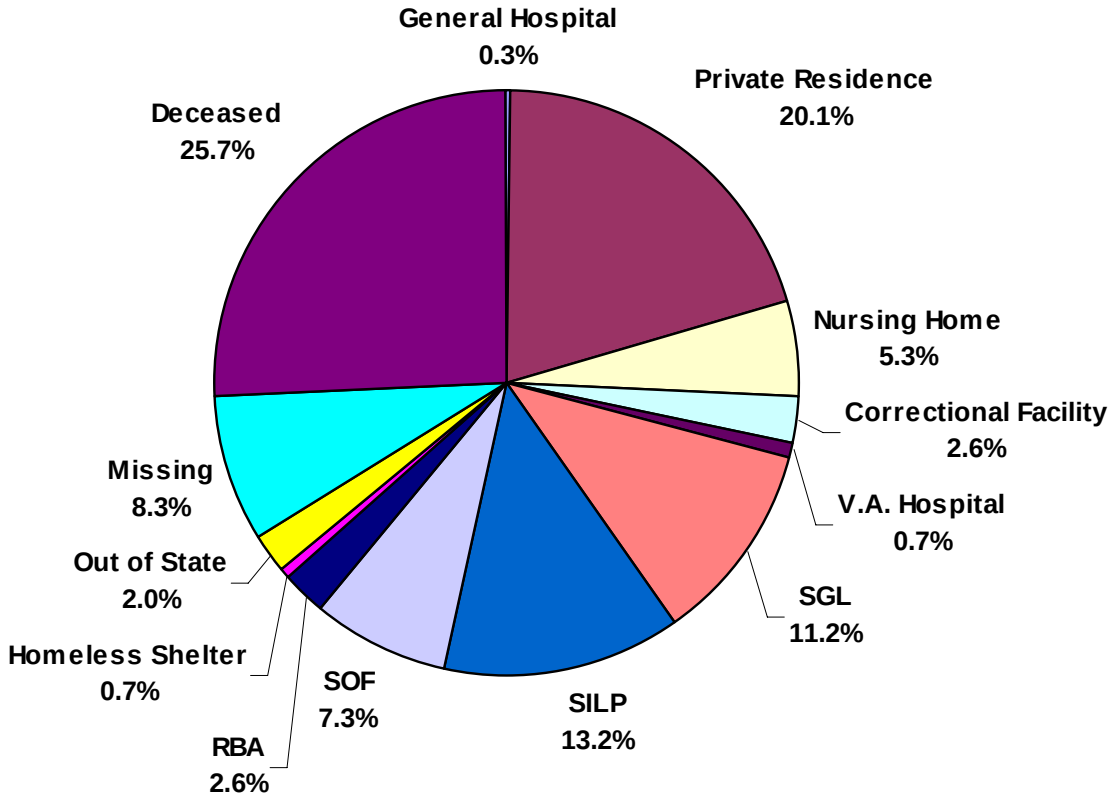

**Figure 1b**
Current Placement of D.D. Population
N=86

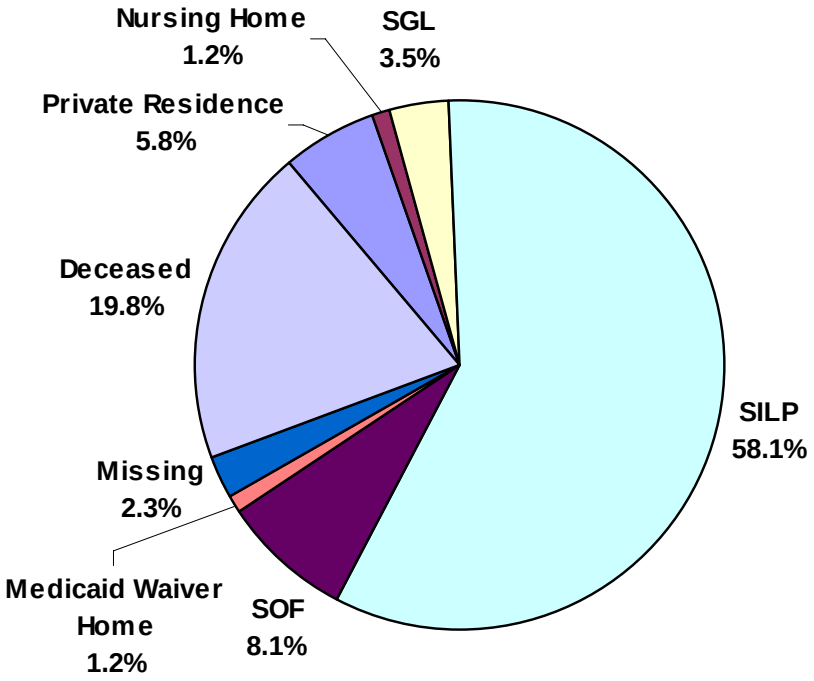

**Figure 2**
Average GAF Scores by Month

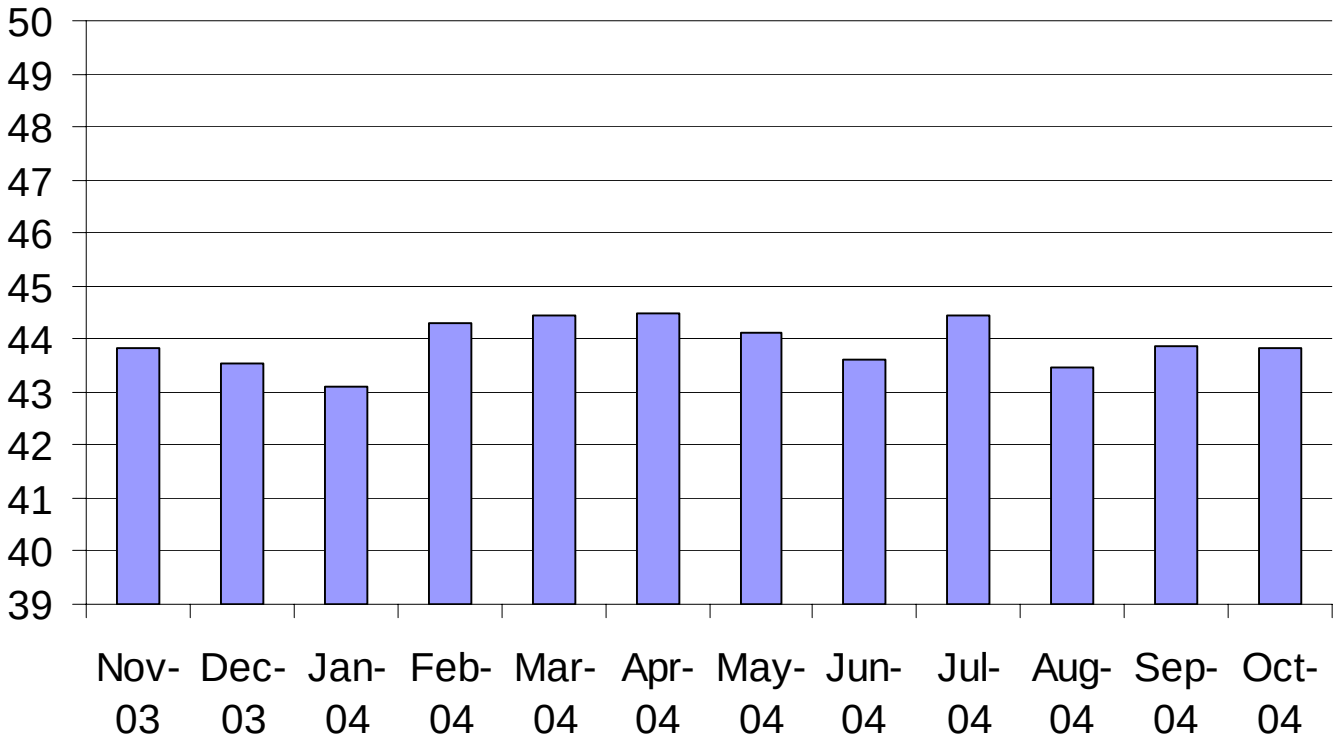

**Figure 3**
Average GAF Scores by Type of Facility

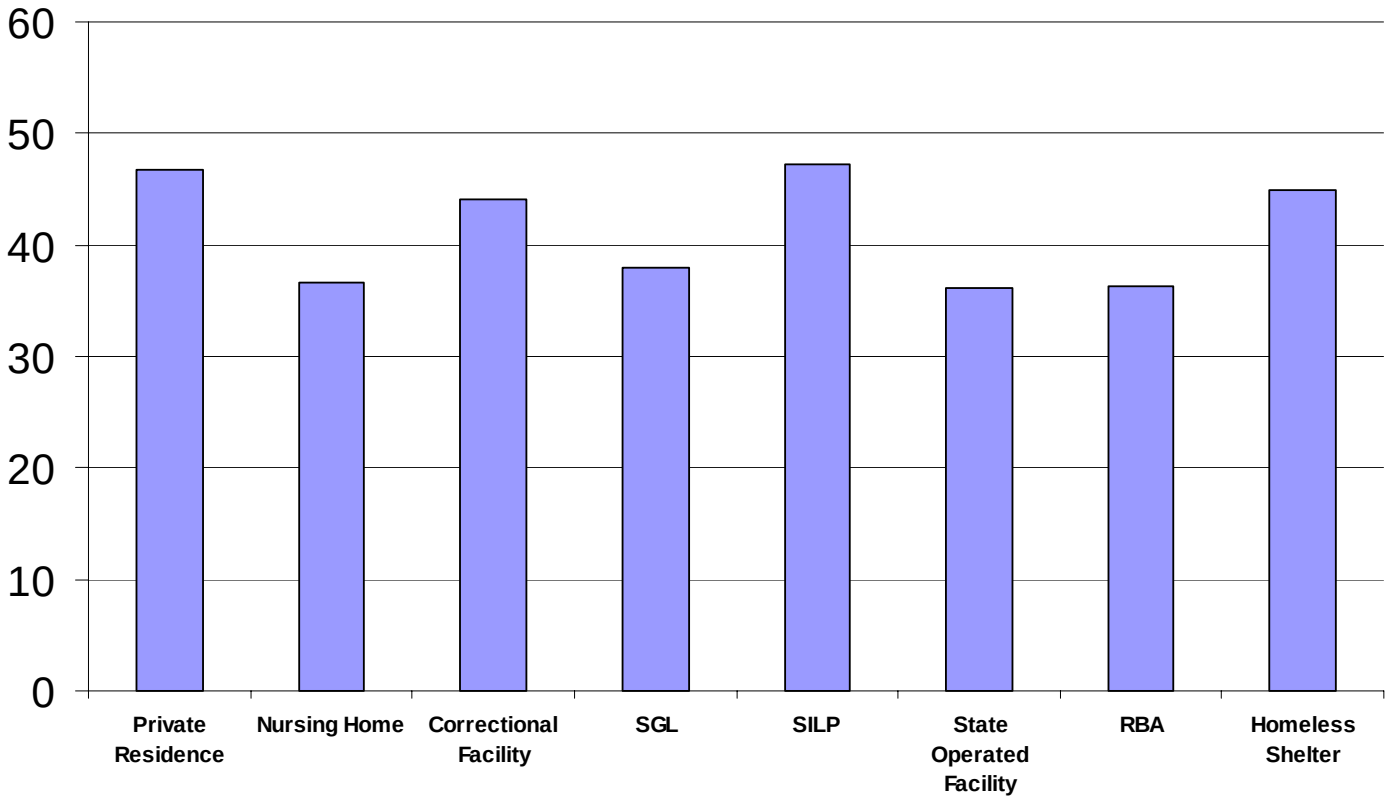

**Figure 4**
Average HAPI-A Factor Scores for Former CSH MI Clients and Other SMI Clients

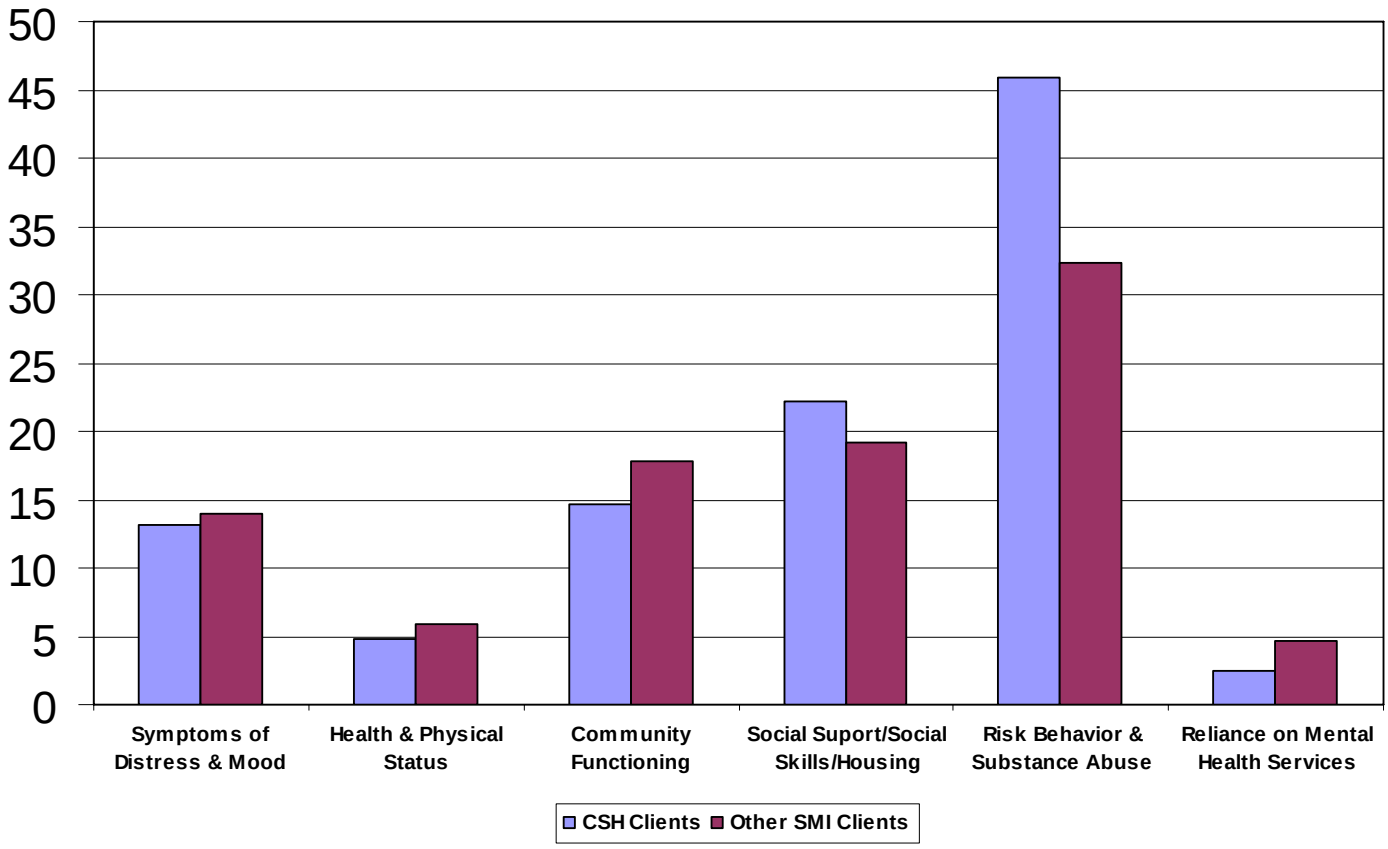

**Figure 5**
Average HAPI-A Factor Scores for Male and Female CSH MI Clients

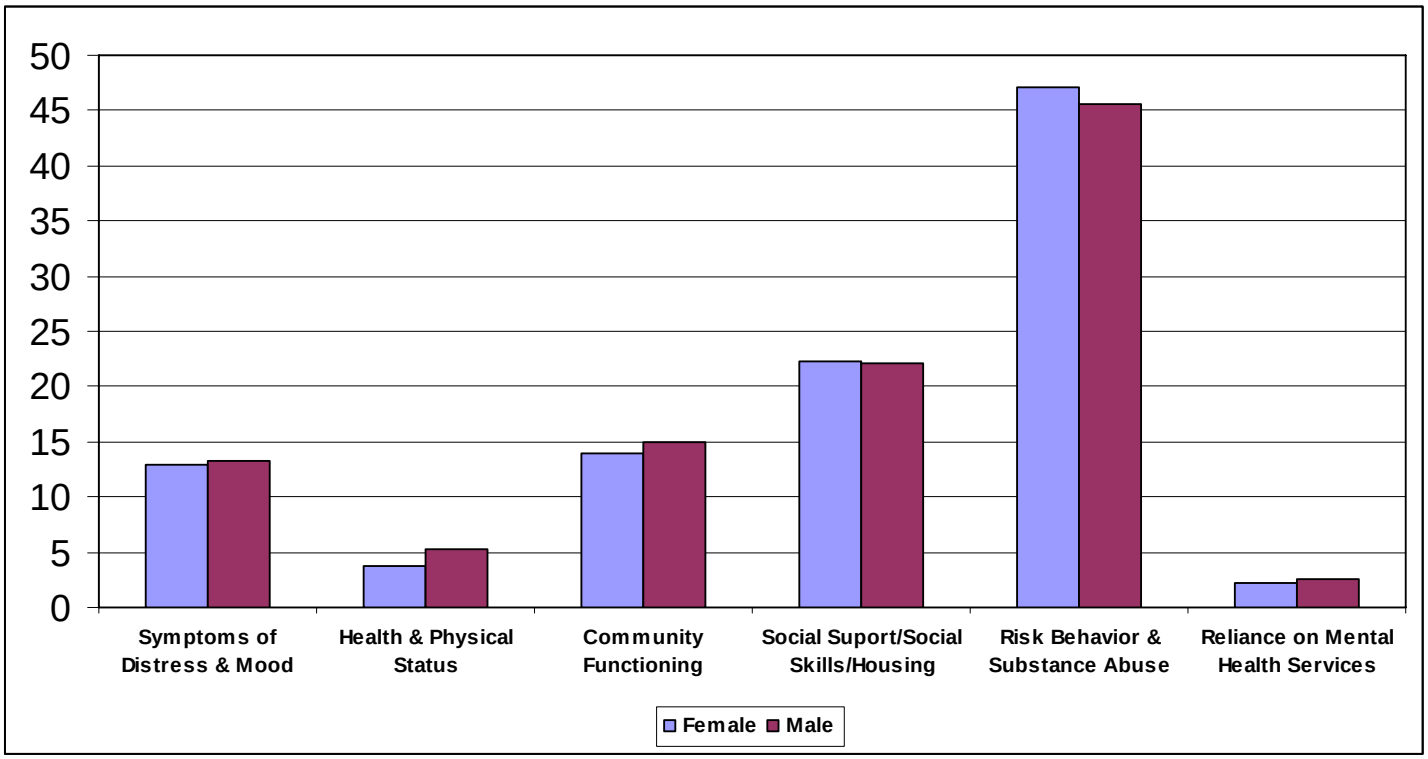

**Figure 6**
Average HAPI-A Factor Scores for White and Non-White CSH MI Clients

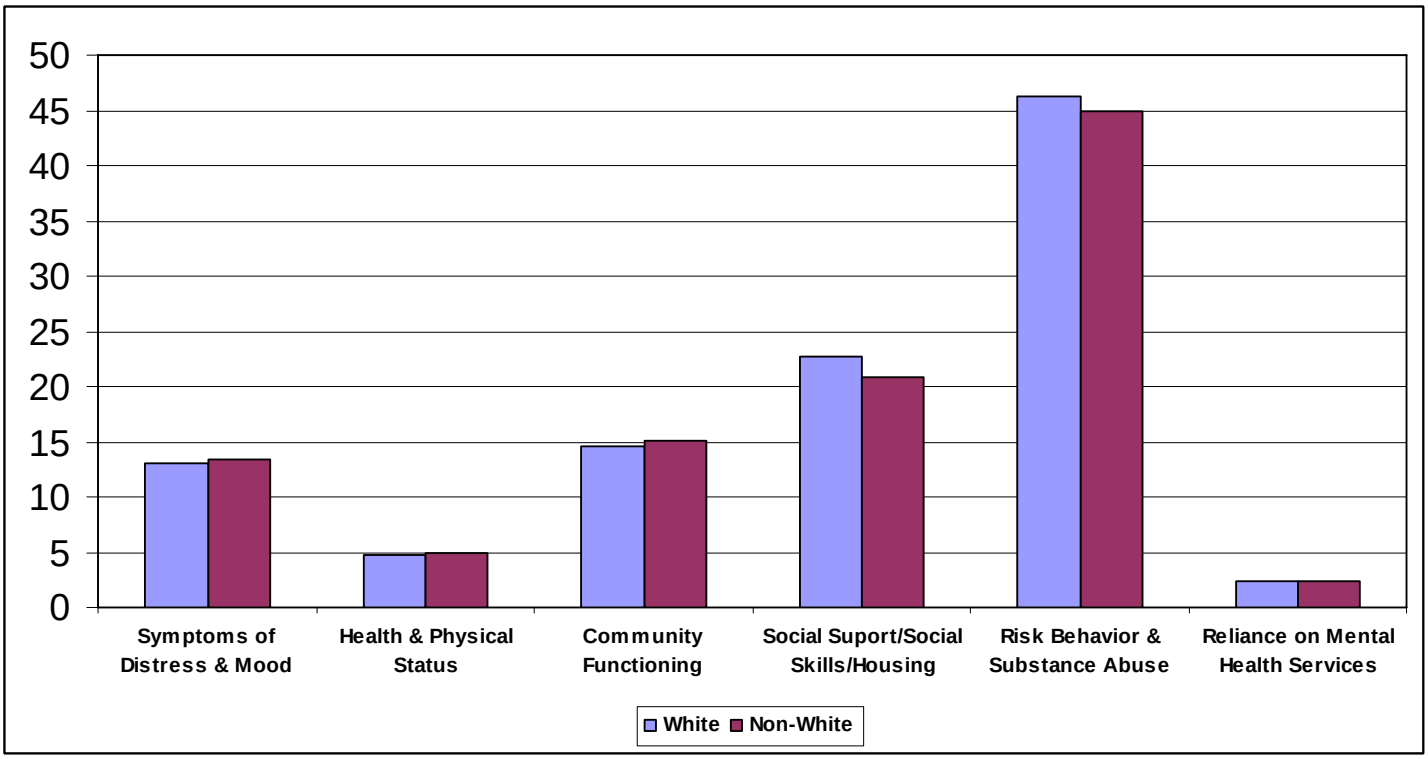

**Figure 7**
Average HAPI-A Factor Scores for CSH Clients with 2001, 2002, 2003 and 2004 Data