J. Psychosoc. Rehabil. Ment. Health (2018) 5:213–222
https://doi.org/10.1007/s40737-018-0126-0

REHABILITATION FACILITY & SERVICES

A Program to Discharge Individuals with Long Term Psychiatric Hospitalizations

Tom Bartholomew

Received: 25 September 2018 / Accepted: 15 November 2018 / Published online: 28 November 2018

Abstract Despite a substantial decrease in the number of people confined to state psychiatric hospitals in the last decade, some individuals remain hospitalized who are no longer determined to be a danger to themselves, property or others but for whom discharge has been problematic. The clinical issues that affect the discharge of these individuals generally fall into four categories (Boyer et al. in Barriers to discharge, optimal housing and supportive mental health services for residents with conditional extension pending placement legal status, 2006). The first occurs when hospitalized individuals are resistant to discharge, the second occurs when individuals have persistent non-dangerous psychiatric symptoms and or behavior problems that make discharge difficult. The third and fourth barriers, respectively, involve individuals with major medical co-morbidities and/or co-occurring intellectual disability. This paper describes a program designed to discharge individuals who present with one or more of these unique needs in one state psychiatric hospital in the north eastern United States. "The Special Treatment Cottage" (STC) program was initiated for hospitalized individuals who had been determined ready to be discharged but who remained in the hospital until they were willing or able to tolerate discharge and until appropriate residential services could be found. The STC program involved the development of a specialized therapeutic setting in which clinical discharge barriers would be targeted and the focus of treatment would be on discharge. In the first year of operation the STC program admitted a total of 22 residents with an average length of hospitalization of over 5 years. Fifty percent of the hospitalized individuals (11) were discharge within an average of 7 months of entering the program. The clinical strategies utilized are discussed along with a description of the critical ingredients thought to be responsible for the success of the program. Suggestions for future work in this area are also addressed.

Keywords Inpatient · Discharge · Institutionalized

Introduction

State Psychiatric Hospitals have been experiencing decreasing census' as effective community based treatment and hospital diversionary programs becomes more wide spread [7, 14]. Despite this, a core group of hospitalized individuals remain hospitalized for extended periods of time even though they may no longer meet the criteria for involuntary commitment. Attempts to discharge these hospitalized

T. Bartholomew (✉)
Department of Psychiatric Rehabilitation and Counseling Professions, Rutgers University, Room 518, Scotch Plains, New Brunswick, NJ 07076, USA
e-mail: barthoth@rutgers.edu

individuals often encounter numerous barriers. The barriers can be related to a lack of community placements willing or able to accommodate the unique needs and sometimes difficult behaviors of these hospitalized individuals [7, 12]. The lack of residential options is best understood as following from the fact that long term hospitalization can involve complex clinical, medical and behavioral issues. Boyer and colleagues [1] examined this issue in New Jersey's State Psychiatric Hospitals and found that there were four distinct groups of difficult to discharge individuals. The first group involves hospitalized individuals who are unwilling to be discharged. This barrier may be a product of long hospitalizations and institutionalization [16, 17]. Many of these hospitalized individuals may be content with their life in the hospital and/or cannot imagine a better life in the community [13]. Other individuals may have seen their living skills atrophy and are no longer confident that they can be successful in the community [9]. Secondly, there is a group that have non-dangerous, persistent symptoms and difficult behaviors all of which may be exacerbated with the stress of discharge [13]. Additionally, and possibly concurrently, are hospitalized individuals that have a medical co-morbidity and or co-occurring intellectual disability which can seriously compound the difficulties of discharge. A final group have immigration, legal or Megan's Law issues that can result in extended hospital stays. These hospitalized individuals represent barriers to discharge that are outside the scope of this project and this paper.

Long term hospitalization in a psychiatric hospital, sometimes for years, can have serious effects beyond the impact on the person that is hospitalized. It can affect the attitudes of staff working with these individuals. When staff believe that the appropriate community resources do not exist and that the hospitalized individuals will not or cannot partner in the discharge process, a lack of urgency regarding discharge can result. Over time, interactions with these hospitalized individuals may appear to confirm staff's latent beliefs that these people are not dischargeable and are best served by remaining in the hospital [10]. A major concern is that when this occurs these individuals may remain hospitalized indefinitely.

The Program

The Special Treatment Cottage (STC) was started in one of twelve cottages (buildings that resemble group homes) located on the grounds of a state psychiatric hospital in an area that is open and unlocked. The STC cottage housed nine people in a setting like the housing found in community discharge sites.

The STC leadership and configuration of the clinical team paralleled other treatment teams in the hospital and consisted of an Assistant Complex Administer, a Program Coordinator, a Psychiatrist, a Psychologist, a clinical nurse specialist, three social workers, an art therapist and a Dr. of Occupational Therapy from the rehabilitation department, a behavioral technician, one chaplain and numerous nurse's assistants. Of these team members, a clinical champion and administrative champion for the program were identified. A faculty from a local university also participated as a consultant. The development of the program began with a charter from the hospital's Deputy CEO to design a project which would focus on discharging individuals with long-term hospitalizations. The project plan included the rationale for the project, and the delineation of the roles and responsibilities of the STC team as well as the proposed clinical ingredients of the program. A fidelity scale for the STC was later developed (See Appendix). The fidelity scale was developed to identify whether the program ingredients from the original project design were being utilized. The primary vehicle for attaining and maintaining fidelity to the design was the weekly clinical supervision meetings chaired by the program's psychologist (clinical champion). A second administrative meeting was held weekly to address administrative issues and was chaired by a hospital administrator of the project (administrative champion). The STC project was characterized by a high degree of hospital leadership support and considerable staff autonomy to develop the program.

The Programming

The program's clinical approach consisted of an eclectic mix of group and individual interventions ranging from the evidence based practice of Illness Management and Recovery [11] to Art, Psychology and Spirituality groups. Unstructured, individual, face to face interactions with staff and were also utilized.

As the program evolved it became clear that an enriched rehabilitation environment had been established and appeared to be having a positive effect. Many aggressive and bizarre behaviors of the residents of the STC were quickly reduced in frequency. The catalyzing feature of the program appeared to be more attitudinal than programmatic. The increasingly positive, hopeful attitude of the staff toward these hospitalized individuals was tangible and seemed to lead to improved relationships. This in turn appeared to allow for greater staff influence on the behaviors of these residents. While no formal relational or attitudinal aspects of the clinicians were measured in the STC, one indication of a changing team consciousness occurred when new staff members from other areas of the hospital joined the team, bringing with them attitudes that were based on a more custodial model of care. When one of these new staff suggested that the team knows that Judy (not her real name) will be going to a nursing home so why should we bother with STC programming, the STC team reacted with stern disapproval. Judy had been hospitalized for over two decades and required daily insulin injections. Her former treatment did not focus on teaching Judy how to self-manage her diabetes, which in 3 months, she had begun doing in the STC with verbal assistance and visual clues from an STC nurse. Judy was eventually discharged. This theme was repeated in less dramatic ways when a staff insisted that that this is the best Nancy (not her real name) will ever do and repeating that this is the best she will ever do, etc. Another STC staff challenged her asking how she can know that. Nancy ended up "doing better". The presence of treatment interfering beliefs and attitudes of staff was overcome largely by having a critical mass of believers to pull the STC culture in the desired direction. This attitudinal ingredient of hopefulness [3–6], and a belief in the possibilities of recovery, appeared to be a necessary but not a sufficient ingredient for the program's success. The STC program was designed to maintain fidelity to a set of seven more objective "critical program ingredients". After 1 year the program was scored by the project consultant based on the STC fidelity scale and achieved a total score across all items of 3.65 out of a possible 5 suggesting moderate fidelity to an ideal STC program. The real value of the fidelity scale was that it provided "aspirational" goals for the program and served as a guide for the development and operation of the program. The program's critical ingredients are delineated below and the program's behaviorally weighted fidelity scale is attached (See Appendix 1).

STC Clinical Components

1. *Advocate* Each STC resident was assigned a member of the team as an advocate. The role of the advocate was to focus on the development of a therapeutic relationship with the person they were working with. They were also asked to inform the team on what the team could do to help the person move toward discharge by identifying and documenting the person's recovery goals, strengths and barriers to discharge. This information was then used to develop specific interventions by the team.
2. *Assertive Discharge* It became apparent that many of the individuals in the program had such long hospitalizations that their desires to leave the hospital were tempered by ambivalence and fears of discharge. These fears, in turn appeared to produce significant amounts of stress as discharge approached. The term "assertive discharge" was coined to refer to the need for the team to identify a discharge site soon after admission to the STC. This simplified the process by allowing the team to target just those skills that would be needed in that environment. The team and the advocate then developed an actionable plan to support the hospitalized individuals as they moved closer to discharge. The discharge plan was going to continue despite a hospitalized person's recurrent fears and ambivalence. The failure to proceed in this way resulted in STC residents opting out of discharge options only to declare later, after the option was no longer available, that they really wanted to proceed. Assertive discharge came to be understood as the process of anticipating that discharge stress often exacerbated psychotic symptoms and would frequently lead to discharge interfering behaviors such as refusing to sign necessary releases, attend court hearings, meet with housing agencies etc. Assertive discharge was an effort by the team and the person being discharged to confront discharge stress using coping strategies and support so that long term

success was not sacrificed to a transient exacerbation of symptoms, increased ambivalence or stress. In the final analysis, all hospitalized individuals made the final decision about when and where to be discharged.

3. *Individualized rehab plan* Each hospitalized individual was asked about their recovery goal and had specific targeted discharge barriers identified with a plan to address them. Efforts were made to align the recovery goal with the need to address a discharge barrier. Ex: "If you want to live in your own apartment can you think of some other ways you could deal with your anger so that you don't lose the chance to meet your goal?". Plans were focused on what the hospitalized individual was trying to learn. Each person also had a "safety plan" as part of a larger hospital initiative. This plan focused on self-soothing and activities that a person can use when they are feeling upset or overwhelmed.
4. *Stage Based Acceptance and Interventions* It was clear that the STC team needed additional support to address the more difficult behaviors occurring in the STC compared to other similar cottages within the hospital. If hospitalized individuals engaged in the same difficult behaviors elsewhere in the cottage program they would have been sent back to locked wards early in their stay. Avoiding this was key to these STC residents having time to change. Along with this, was seeing problematic behaviors as "teaching moments" where the person could begin to learn another way to respond versus seeing the behavior as evidence of a failed treatment.
5. *Team Based Interventions* The team identified and documented barriers to discharge and strengths with each person in the program. These "clinical formulations" became the clinical focus of the entire team's work with the person and was discussed in weekly supervision. This was done regardless of the specific discipline of the clinician or the modality they were using. Examples included encouraging one resident to use deep breathing to deal with anxiety instead of aggression and staff saying "you are safe here" when another resident began discussing delusional beliefs. Each team member was encouraged to learn the specific plans for each person in the program.
6. *Team Supervision Meeting* This weekly staff meeting served as the heartbeat of the clinical team and was characterized by humor, laughter and hope. The mission of the program and issues of fidelity to the program's design were debated as were clinical formulations and action steps. In retrospect, many staff believed that the staff meeting served a team building function which included staff holding one another accountable, sharing success and struggles, pointing out when staff were being pessimistic and angry at one of the program residents. Each week of the month a different meeting agenda was used, two of the meetings were updates by the social workers on identifying discharge plans, another was a round where the advocates facilitated a discussion about the clinical formulations for the folks that they worked with and the last was a discussion about the staff's group process. Considerable efforts were made to go beyond just identifying the problems by deciding on specific action steps to use in collaboration with the clients. All team members were expected to be present. Minutes were taken and reviewed at the beginning of each meeting.
7. *Community Exposure Trips* Weekly trips were coordinated by different disciplines with the focus on exposing clients to alternative environments that involve living, working or socializing in the community. It appeared that one by-product of long term hospitalization was the formation of cognitive distortions or ignorance about life in the community. Community trips appeared to be the best way to address, and begin to remediate, these cognitive distortions and knowledge deficits. Potential residential sites in the community for STC residents were frequent destinations that also served to build relationships with community staff. A second goal was to practice social and living skills addressed in the clinical groups "in vivo" while having fun in the process. Many of the program residents had not spent much time out of the hospital in years.

Three additional aspects of the program also deserve mention:

1. *Housing* An increase in community funding resulted in funds being directed to making available specialized housing tailored to the needs of

some of these residents (three of the eleven STC residents had housing identified for them that was unique to their needs). This specialized housing had an additional advantage because the residential staff from these sites began engaging the STC residents long before discharge. This appeared to have the effect of reducing the transitional stress associated with discharge.

2. *The Cottage and Cottage Staff* A house with a 9 bed capacity was made available to the STC staff as well as two very experienced Residential Living Specialists (RLS) from the nursing department without whom it is unlikely that the program would have had such success. An RLS is a nurse's aide that has been promoted to an advanced and more autonomous position. Implementing fidelity item number four (Staged Based Acceptance and Interventions) required an impressive array of clinical skills on the part of the RLS working in the house. The normative "family like" atmosphere of the house created by the RLS was one of humor, care and affection. This provided a necessary platform for the rest of the program to be effective.
3. *Consultation* A University Consultant participated in the STC. He was on loan from another implementation effort and participated in the development and roll-out of the project. His role was primarily supportive with an additional focus on documenting the project. At the request of the hospital's Deputy CEO, the consultant completed the initial project plan and fidelity scale. He was also in charge of the evaluation of the program and helped in the development of a mission statement for the STC program, which was done by Staff and Residents. It read:

"Building relationships to overcome obstacles, enhance skills* and foster independence and community living". The asterisk by "skills" referred to the growing recognition that, while skills were an important part of the STC program, the STC is a program based primarily on relationships and support between staff and residents.

Method

Participants

The first STC residents in the program were individuals who had the longest hospital stays and who were "no longer meeting commitment criteria but still hospitalized" as determined by the hospital's clinical records. This was done regardless of the person's diagnosis. These hospitalized individuals also had to meet the inclusionary criteria listed below:

1. Not meeting commitment status for 6 months or more, And /Or
2. They have a history of unsuccessful attempts at community placements and or prior unsuccessful stays in the unlocked hospital Cottage Program.
3. They do not present as an imminent threat to self, persons, or property,
4. They have limited life skills including the ability to perform laundering, self-care cooking.
5. They have demonstrated that they have difficulty navigating treatment in an open setting.
6. They are on level III supervision (can move about the hospital un-chaperoned) even if they may require additional staff support beyond which the other cottages could provide.

Hospitalized individuals that met the above criteria were referred to the program from across the hospital. The staff of the STC then approached each person and encouraged them to try the program. If they accepted they were then added to the program as openings occurred, Hospitalized individuals with the longest hospital stays having priority. These potential residents also needed to be ambulatory enough to manage a flight of stairs. Individuals were often reluctant to join the program and the STC staff engaged in all manner of engagement efforts from nagging, nudging and encouragement as well as enticements in the form of food and trips. This effort paralleled future efforts to promote movement toward discharge even in the face of discomfort and resistance.

Results

The first 22 individuals in the program (1 year's admissions) were assessed by the treatment staff based on the categories proposed by Boyer et al. [1]. Some fit

more than one of the categories. The results are listed below:

Resistant to get out	Have persistent symptoms coupled with major behavioral problems	Major medical co-morbidity	Co morbid diagnosis of mental retardation
21	22	7	4

There were no differences, though the statistical power is quite low, in discharges relative to the number of categories someone was in $F(2, 21) = .913$ $p = .418$. Of all the STC residents, 10 were diagnosed with schizophrenia, 9 with schizoaffective disorder, 1 with psychosis, NOS and 2 were diagnosed with bipolar disorder. The average age of the residents was 56.6 years old with a range of 35–63 years old. There were 15 females and 7 males. Of the 22 residents in the first year 5 were sent back to locked wards, all within an average of 3 weeks of arriving. This was done for their safety of for the safety of others in the program. Two later returned to the STC and were discharged and one was discharged from the locked unit. The remaining 2 were still on locked units in the hospital at the time of the writing of this paper.

In the first year of its operation the STC program admitted 22 residents. When their hospital stays are added together they have spent a combined total of almost 121 years hospitalized. The mean number of days spent hospitalized was 2003.86 or almost 5.5 years. The range was from a person hospitalized for over 20 years to a person hospitalized for less than 2 years. In the program's first year, fifty percent of the residents (11) were discharged within an average of 7 months of their entering the STC program.

Discussion

It appears, based on this project, that some individuals who have long hospitalizations in state psychiatric hospitals can be discharged without expensive and large scale implementation efforts. Effective interventions appear to require that the staff working with these individuals possess certain attitudes that include a hopefulness about recovery and the ability to see beyond the person's current difficulties. It is also apparent that specialized community housing designed to meet the unique needs of individuals who are difficult to discharge is important, but not always necessary. This is made evident because only three of the 11 individuals that were discharged in the first year of the STC went to this type of specialized housing. A better explanation is that a sense of urgency coupled with a clinically focused, relationally oriented program was the proximate cause of the rapid and successful discharge of these hospitalized individuals.

Conclusion

The results of the STC program suggest that discharge for many individuals who are hospitalized for long periods can be facilitated provided certain conditions are met. Efforts to replicate the success of the STC would do well to begin by providing strong leadership support, and by selecting a group of clinicians that already have beliefs and attitudes consistent with recovery principles of hopefulness and a belief in the possibility that everyone can improve. Future programs of this sort may need certain key ingredients that include the assignment of a staff advocate to each program resident, planning for the effects of increased stress and symptoms as discharge nears, the development of an individualized rehabilitation plan and a unified clinical formulation that the treatment team implements as a group. The treatment team will need weekly supervision to build team cohesion and address the natural tendency to drift away from the program's philosophy and design. The team will need to work closely and over an extended period with community residential programs including going on community trips and visiting potential residential sites. Programs should also seek to replicate the "enriched environment" involving the provisions of interventions from a broad array of clinical approaches even if the specific STC groups are not replicated. There is reason to believe that discharge, even after many years, comes with important quality of life improvements for the individuals involved [2, 8, 14, 15].

An area for future research includes determining the relative effect of different program components on the discharge-ability of individuals with long term hospitalizations. It is important to assess the

longitudinal outcomes of the STC's rapid discharge. The limitations of this study are numerous and begin with a lack of randomization of clients into the STC program, the lack of a control group and the difficulty of identifying if any of the identified critical ingredients were necessary and or sufficient to explain the success of the program. Despite the limitations of this study, effective strategies that support the discharge of individuals with long term psychiatric hospitals needs the attention of future research.

Acknowledgements Special thanks to Chris Morrison, Robyn Caporoso and Faith Johnson for their invaluable leadership in this project.

Appendix

Fidelity scale for the STC project	1	2	3	4	5
1. Advocate					
a. STC residents have an assigned advocate	< 20% of residents have an identified advocate	20–39% of residents have an advocate	40–69% of residents have an advocate	70–89% of residents have an advocate	= or > 90% of s have an advocate
b. Identification of intrinsic motivators/ recovery goal	< 20% of residents have documentation of their recovery goals	20–39% of residents have documentation of their recovery goals	40–69% of residents have documentation of their recovery goals	70–89% of residents have documentation of their recovery goals	= or > 90% of have documentation of their recovery goals
c. Identification of discharge (D/C) barriers	< 20% of residents have documentation of their D/C barrier	20–39% of residents have documentation of their D/C barrier	40–69% of residents have documentation of their D/C barrier	70–89% of residents have documentation of their D/C barrier	= or > 90% of have documentation of their D/C barrier
Rational Treatment teams in state hospitals often share caseloads resulting in a potential diffusion of responsibility across the team to develop a therapeutic relationship with the patient and become thoroughly familiar with the person's background. Though not "score-able" development of the therapeutic relationship is understood to be of central importance					
Scoring Sub-items a-c are scored independently and the scores are averaged together					
2. Assertive discharge					
a. After 1 month discharge sites are identified for all residents	< 20% of residents have a discharge site identified after 1 month	20–39% of residents have a discharge site identified after 1 month	40–69% of residents have a discharge site identified after 1 month	70–89% of residents have a discharge site identified after 1 month	= or > 90% of residents have a discharge site identified after 1 month
b. Relationships and planned strategies are used during exposure to discharge anxiety	Plans to address potential discharge anxiety are documented for < 20% of s	Plans to address potential discharge anxiety are documented for 20–39% of s	Plans to address potential discharge anxiety are documented for 40–69% of s	Plans to address potential discharge anxiety are documented for 70–89% of s	Plans to address potential discharge anxiety are documented for = or > 90%
Rational Often the skills necessary for a successful discharge are defined by the discharge site. Knowing the expectations of the discharge site early in the program can allow the treatment team to tailor its efforts to prepare for the specific discharge requirement. The stress of discharge after many years of hospitalization can exacerbate latent fears and ambivalence. It can also exacerbate symptoms of mental illness. Anticipating this and proceeding despite this stress was coined "assertive discharge". Despite this, residents always exercised the right to make the final decision about when and where they would be discharged					
Scoring **"**Identified site" does not necessarily mean accepted. Sub-items a-b are scored independently and the scores are averaged together					

Fidelity scale for the STC project	1	2	3	4	5
3. Individualized rehab plan	Less than 20% of residents have individualized interventions in their charts or house log	20–39% of residents have individualized interventions in their charts or house log	40–69% of residents have individualized interventions in their charts or house log	70–89% of residents have individualized interventions in their charts or house log	90% or more of residents have individualized interventions in their charts or house log
a. Individualized intervention is in the residents chart					
b. Each resident has documented "replacement behaviors" or skills to learn	< 20% of residents have at least one individualized replacement behavior documented	20–39% of residents have at least one individualized replacement behavior documented	40–69% of residents have at least one individualized replacement behavior documented	70–89% of residents have at least one individualized replacement behavior documented	= or > 90% of residents have at least one individualized replacement behavior documented
c. Safety plan is completed	Less than 20% of residents have a safety plan completed and in the chart	20–39% of residents have a safety plan completed and in the chart	40–69% of residents have a safety plan completed and in the chart	70–89% of residents have a safety plan completed and in the chart	90% or more of residents have a safety plan completed and in the chart
Rational Individuals in the hospital for long periods of time often engage in learned behaviors which are adaptive in hospitals but that may not be useful in community settings. Reinforcement of replacement behaviors is, ideally, suggested as opposed to trying to extinguish mal-adaptive behaviors alone					
Scoring Sub-items a-c are scored independently and the scores are averaged together					
4. Stage based acceptance and interventions	Less than 20% of the residents in the STC have a plan that details the shaping of behavior over time	20–39% of the residents in the STC have a plan that details the shaping of behavior over time	40–69% of the residents in the STC have a plan that details the shaping of behavior over time	70–89% of the residents in the STC have a plan that details the shaping of behavior over time	90% of the residents in the STC have a plan that details the shaping of behavior over time
a. Target behaviors are identified with time to achieve them					
b. Every effort is made to keep residents in the program	Less than 20% of the residents in the STC are successful in staying in the program	20%-39% of the residents in the STC are successful in staying in the program	40%-69% of the residents in the STC are successful in staying in the program	70%-89% of the residents in the STC are successful in staying in the program	90% of the residents in the STC are successful in staying in the program
Rational Psychiatric rehabilitation and behavioral theory identity that individuals generally change slowly over time and may require the reinforcement of successive approximations of target behaviors before behavior change occurs					
Scoring Sub-items a, b are scored independently and the scores are averaged together					
5. Team based interventions	Less than 20% of staff know the individualized interventions of the residents	20–39% of staff know the individualized interventions of the residents	40–69% of staff know the individualized interventions of the residents	70–89% of staff know the individualized interventions of the residents	90% of staff know the individualized interventions of the residents
a. Team know these plans					
b. Team works on same skills	Less than 20% of resident charts have documentation of teams reinforcement of team based intervention	20–39% of resident charts have documentation of teams reinforcement of team based intervention	40–69% of resident charts have documentation of teams reinforcement of team based intervention	70–89% of resident charts have documentation of teams reinforcement of team based intervention	90% of resident charts have documentation of teams reinforcement of team based intervention

Fidelity scale for the STC project	1	2	3	4	5
Rational Behavior change is thought to be most reliably accomplished when replacement behaviors are reinforced in numerous environments by numerous individuals					
Scoring Sub-items a, b care scored independently and the scores are averaged together					
6. Weekly supervision	< 20% of STC team meets weekly	20–39% of STC team meets weekly	40–69% of STC team meets weekly	70–89% of STC team meets weekly	= or > 90% of STC team meets weekly
a. Team is present b. Reviews minutes c.. Social workers report d. All advocates report e. Interventions are delineated	None of the sub-steps (b–e) are documented in the STC minutes in 1 month	One of the sub-steps (b–e) are documented in the STC minutes in 1 month	Two of the sub-steps (b–e) are documented in the STC minutes in 1 month	Three of the sub-steps (b–e) are documented in the STC minutes in 1 month	Four of the sub-steps (b–e) are documented in the STC minutes in 1 month
Rational The weekly supervision of psych rehab practitioners is essential to the rigorous application of a program model					
Scoring The 1st component is scored by looking at the attendance at the supervisory and comparing to the identified STC team Sub-items a–e are scored independently and the scores are averaged together					
7. Community exposure trips	< 20% of weekly trips happen each quarter	20–39% of weekly trips happen each quarter	40–69% of weekly trips happen each quarter	70–89% of weekly trips happen each quarter	= or > 90% of weekly trips happen each quarter
a. Trips occur every week b. Skills are reinforced during trips	< 20% of weekly trips have documentation of skills being reinforced "in vivo"	20–39% of weekly trips have documentation of skills being reinforced "in vivo	40–69% of weekly trips have documentation of skills being reinforced "in vivo	70–89% of weekly trips have documentation of skills being reinforced "in vivo	= or > 90% of weekly trips have documentation of skills being reinforced "in vivo
c. Patients are exposed to alternative settings (live, work, socialize)	< 20% of weekly trips happen each quarter offer exposure to living, working or socializing locations	20–39% of weekly trips happen each quarter offer exposure to living, working or socializing locations	40–69% of weekly trips happen each quarter offer exposure to living, working or socializing locations	70–89% of weekly trips happen each quarter offer exposure to living, working or socializing locations	= or > 90% of weekly trips happen each quarter offer exposure to living, working or socializing locations
Rational Community trips serve to expose residents to "alternative environments" where they might live, work, and socialize					
Scoring Sub-items a–c are scored independently and the scores are averaged together					

References

1. Boyer CA, Kontorinakis M, Scotto-Rosato N, Lucas JA, Fuller R, Howell-White S (2006) Barriers to discharge, optimal housing and supportive mental health services for residents with conditional extension pending placement legal status. Final report to the New Jersey Department of Human Services, Division of Mental Health Services.
2. Davidson L, Hoge MA, Merrill ME, Rakefeldt J, Griffith EE. Hospital or community living? Examining consumer perspective on deinstitutionalization. Psychiatr Rehabil J. 1996;19(3):49–58.
3. Deegan PE. Recovery: the lived experience of rehabilitation. Psychosoc J. 1988;11(4):11–9.
4. Deegan PE (1996) Recovery and the conspiracy of hope. In: Transcript of a presentation given at: the sixth annual mental health services conference of Australia and New Zealand.
5. Deegan PE (2004) Rethinking rehabilitation: freedom. In: Transcript of a presentation given at: the 20th world

congress of rehabilitation international: rethinking rehabilitation, Olso, Norway.
6. Deegan PE (2005) Relationships can heal. Unpublished article, www.patdeegan.com. p. 317.
7. Fisher WH, Geller JL, Pandiani JA. The changing role of the State Psychiatric Hospital. Health Aff. 2009;28(3):676–84.
8. Leff J, Trieman N. Long-stay patients discharged from psychiatric hospitals. Br J Psychiatry. 2000;176:217–23.
9. Linn LS. State Hospital Environment and rates of discharge. Arch Gen Psychiatry. 1970;23(4):346–51.
10. Mechanic D. Mental health and social policy: the emergence of managed care. Boston: Allyn and Bacon; 1999.
11. Mueser KT, Meyer PS, Penn DL, Clancy R, Clancy D, Saylers M. The illness management and recovery program: rationale, development, and preliminary findings. Schizophr Bull. 2006;32:1:S32–43.
12. New Jersey Division of Mental Health (2008) Home to recovery CEPP plan; plan to facilitate the timely discharge of CEPP s in New Jersey's State Psychiatric Hospital. http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_FINAL.pdf. Accessed 5 Apr 2011.
13. Patrick V, Smith RC, Schleifer SJ, Morris ME, McLennon K. Facilitating discharge in state psychiatric institutions: a group intervention strategy. Psychiatr Rehabil J. 2006;29(3):183–8.
14. Singh Nirbhay N, Barber JW, VanSant S. Handbook of recovery in inpatient psychiatry. Basel: Springer; 2016. https://doi.org/10.1007/978-3-319-40537-7.
15. Trieman N, Leff J. Long-term outcome of long-stay psychiatric in-patients considered unsuitable to live in the community. Br J Psychiatry. 2002;181:428–32.
16. Wirt GL. Institutionalism revisited: prevalence of the institutionalized person. Psychiatr Rehabil J. 1999;22:302–4.
17. Wirt GL. Causes of institutionalism: and staff perspectives. Issues Ment Health Nurs. 1999;20:259–74.