



# Northeast Region HealthChoices Program

*Annual Report  
2006 - 2007*



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## NBHCC Vision Statement

The Counties of Luzerne, Wyoming, Lackawanna and Susquehanna have partnered to create the Northeast Behavioral Health Care Consortium.

NBHCC is a regionally focused, non-profit, Behavioral Health Organization serving the medical assistance population.

Our mission is to provide enhanced access to high quality, fiscally responsible, recovery oriented Behavioral Health Services.

These positive outcomes will be accomplished through an intense, ongoing dialogue including consumers, families, providers and all other stakeholders.



# HealthChoices

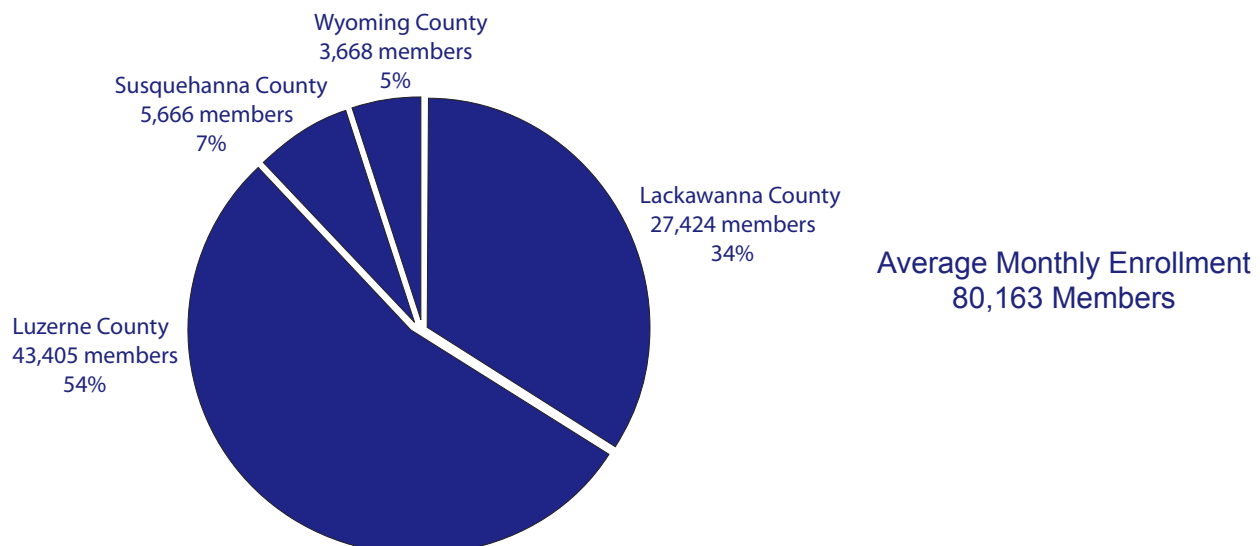
The Commonwealth of Pennsylvania's mandatory Medicaid managed care program, called HealthChoices, is the largest Medicaid program administered by the Department of Public Welfare (DPW) and consists of three components. The Office of Medical Assistance Programs (OMAP) administers two components: the Physical Health Program and the HealthChoices Enrollment Assistance Program. The Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the third component, the Behavioral Health Program that provides mental health and substance abuse treatment services.



On February 1, 1997, the Commonwealth introduced a new integrated and coordinated health care delivery system (HealthChoices). The purpose of the program is to provide medical, psychiatric, and substance abuse services to Medical Assistance recipients throughout Pennsylvania. HealthChoices is a capitated managed care program. The needs of the high risk populations included in the HealthChoices managed care program require broad-based coordination to assure appropriate access, service utilization, and continuity of care for persons with serious mental illness / addictive diseases. Because of the cross-cutting coordination needs of Medical Assistance recipients, the unique structure of the behavioral health and human service delivery systems administered by the counties, and their over 30 years experience in administering behavioral health services programs, it was determined that county government would be offered the right-of-first-opportunity to enter into a capitated contract with the Commonwealth.

NBHCC is a 501-C-3 non profit organization which has primary responsibility for managing the HealthChoices contract with the Department of Public Welfare on behalf of four counties in northeastern Pennsylvania (Lackawanna, Luzerne, Susquehanna and Wyoming). NBHCC subcontracts with Community Care Behavioral Health (CCBH) to provide network management, claims processing, member services, care utilization and complaint and grievance services.

NBHCC is confident that HealthChoices provides opportunities for enhanced and extended services through re-investment, as well as new opportunities to improve access to services, improve the quality of services and create opportunities for system development based on member and family input.



# Enrollment

## Membership by Category of Aid

### Categories of Assistance:

#### Temporary Assistance to Needy Families (TANF)

Assistance to families with dependent children who are deprived of the care or support of one or both parents.

#### Healthy Beginnings (HB)

Assistance for women during pregnancy and the postpartum period.

#### State Only General Assistance

State funded program for individuals and families whose income and resources are below established standards and who do not qualify for the TANF program. This includes the Categorically Needy (CATN) and Medically Need Only (MEDN) groups.

#### Federally Assisted Medical Assistance for General Assistance Recipients (FGA)

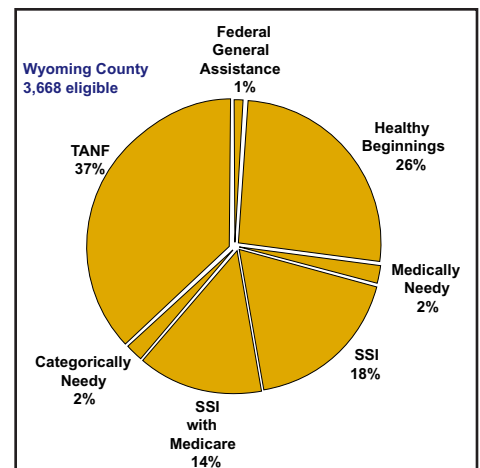
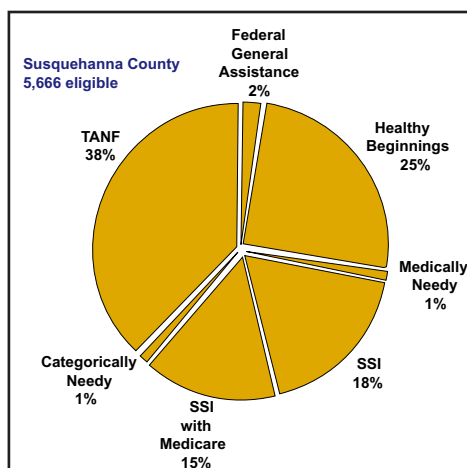
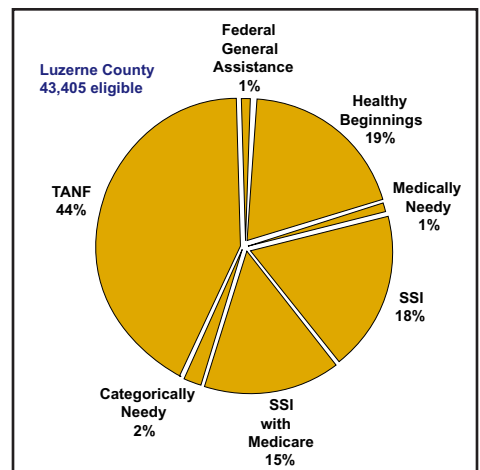
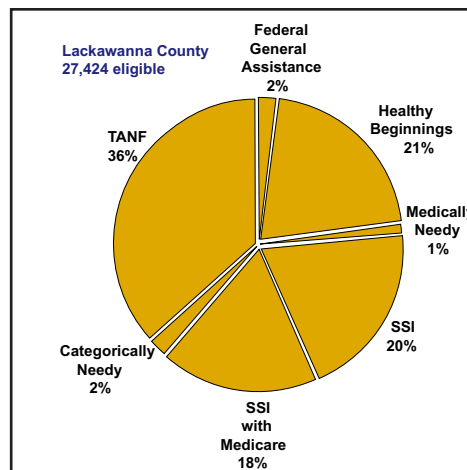
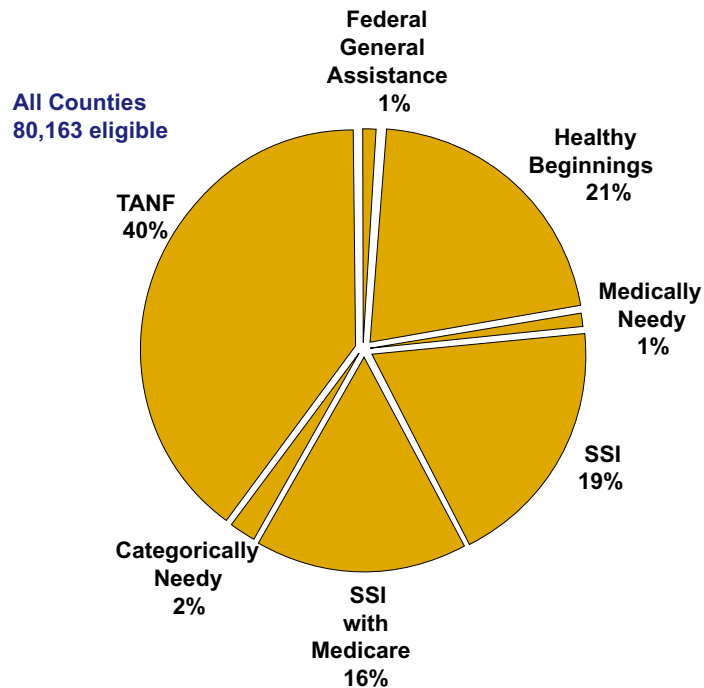
Federal and state funded program for individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

#### Supplemental Security Income without Medicare (SSI)

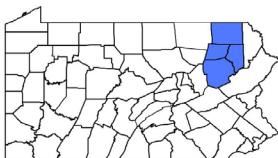
Assistance for people who are aged, blind, or determined disabled for less than two years.

#### Supplemental Security Income with Medicare (SSIM)

Assistance for people who are aged, blind or determined disabled for over two years.

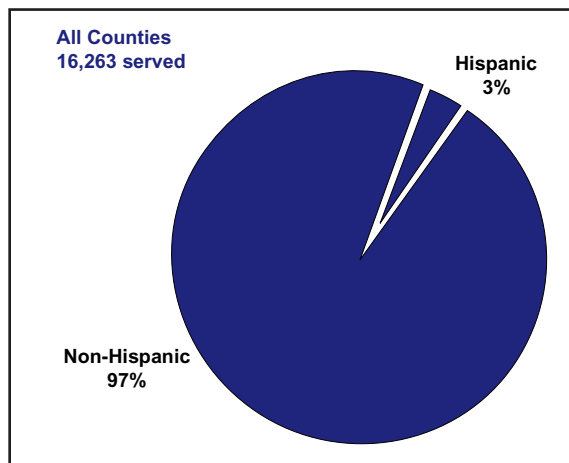
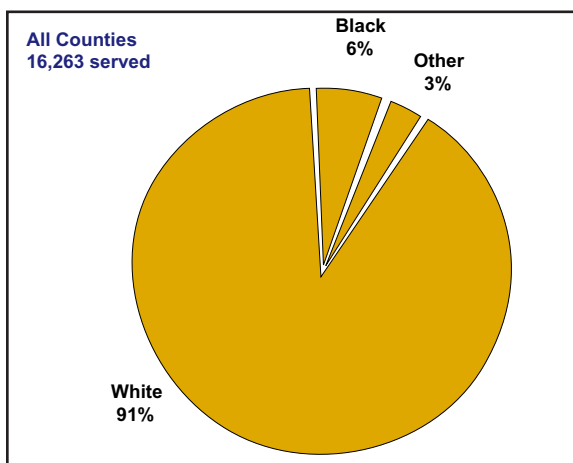






County Census Facts:	Lackawanna	Luzerne	Susquehanna	Wyoming
2006 County Population:	209,728	313,020	42,889	28,093
2004 Percent Below Federal Poverty Level:	11.2%	11.5%	11.5%	10.3%
2004 Median Household Income:	\$37,545	\$36,968	\$36,104	\$39,883
2006 Percent 18 and Under:	20.7%	20.0%	22.3%	22.7%
2006 Percent 65 Years and Older:	18.1%	18.2%	15.8%	14.2%
2006 Percent SSI Recipients:	2.9%	2.8%	2.2%	2.4%
April 2008 Percent Enrolled in Medicaid:	16.5%	17.5%	16.1%	16.3%
2006 Percent Children Enrolled in Medicaid:	35.8%	40.3%	36.5%	34.3%
2006 Percent Elderly Enrolled in Medicaid:	8.9%	8.5%	8.9%	8.9%
2005 Number Children and Families Enrolled in Medicaid:	16,757	28,317	4,113	2,596
2006 Number Disabled Enrolled in Medicaid:	9,719	14,043	1,785	1,110
2006 Number Chronically Ill Enrolled in Medicaid:	1,517	2,226	277	207

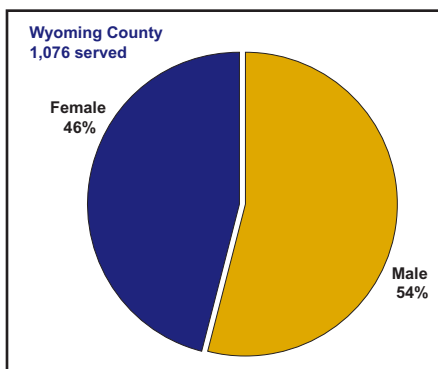
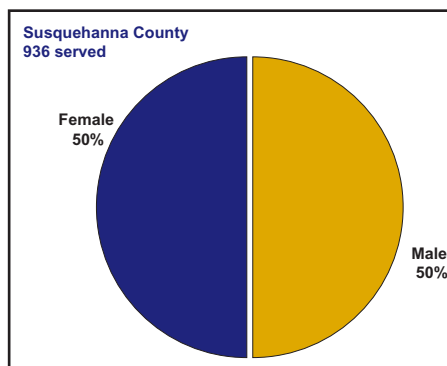
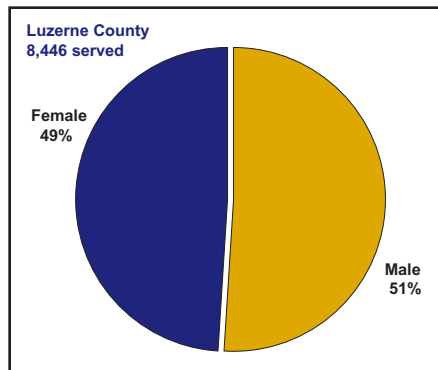
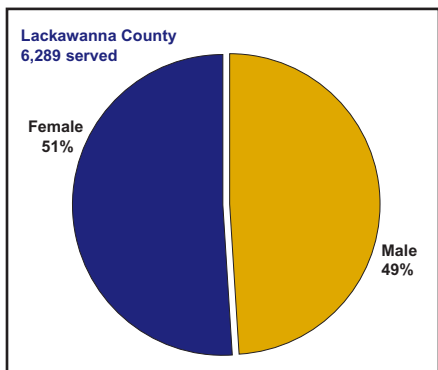
## Members Served Race and Ethnicity



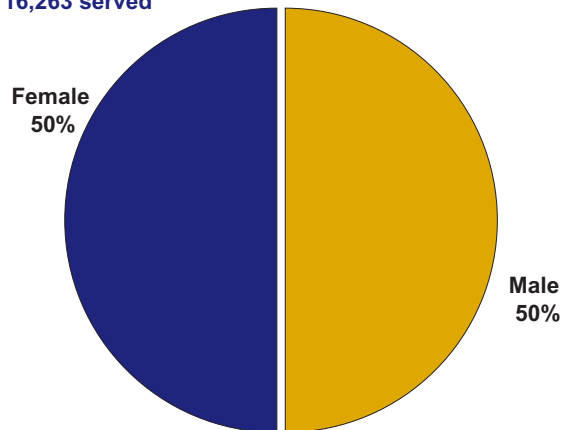
The charts in this report represent demographic information for utilization during the operating year 2006—2007. Utilization is defined as claims that were paid for services rendered between July 1, 2006 and June 30, 2007.

# Members Served

## Gender



**All Counties**  
16,263 served

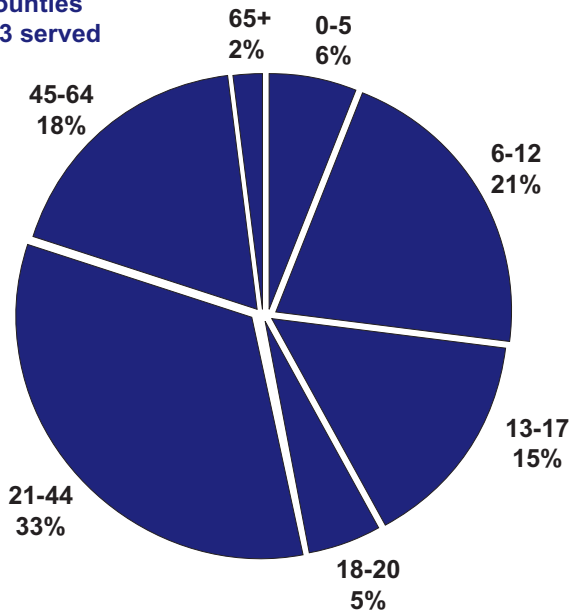


Over 16,000 individuals in Lackawanna, Luzerne, Susquehanna, and Wyoming Counties received behavioral healthcare services during the 2006—2007 operating year.

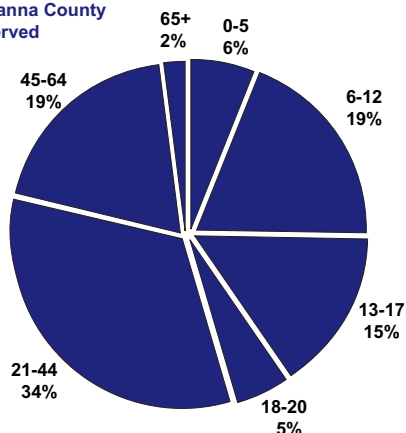
# Members Served

## Age Groups

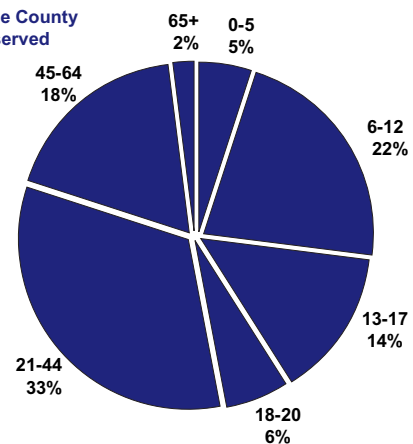
All Counties  
16,263 served



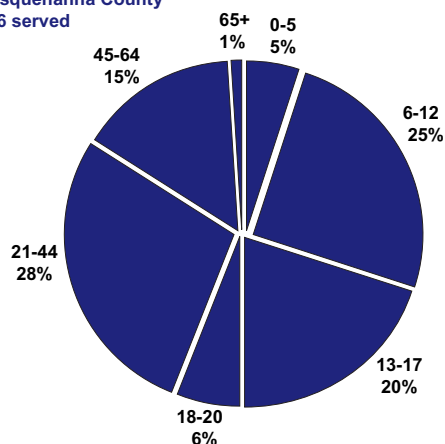
Lackawanna County  
6,289 served



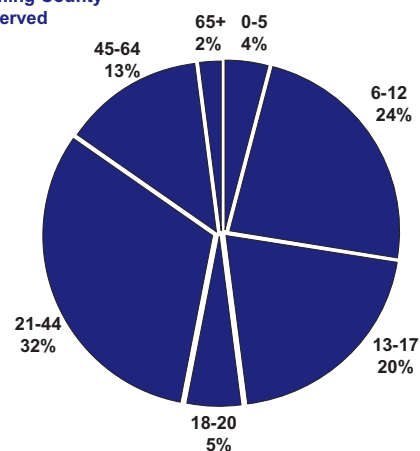
Luzerne County  
8,446 served



Susquehanna County  
936 served

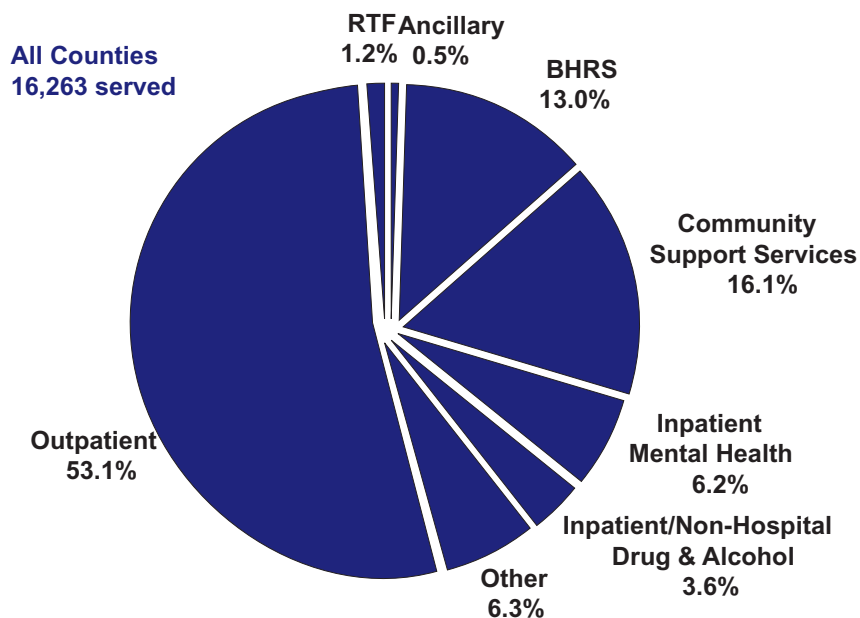
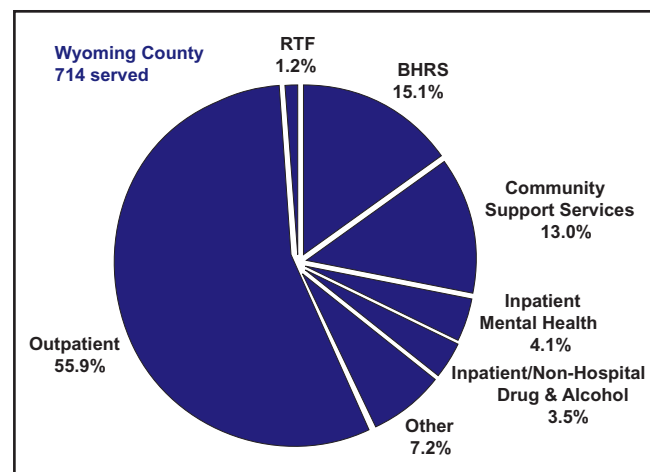
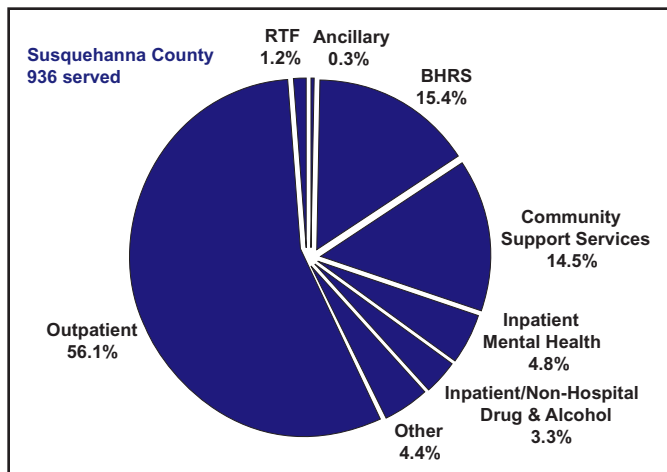
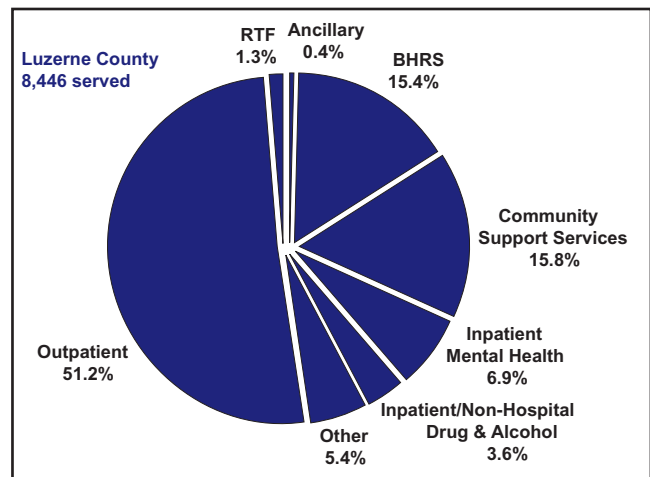
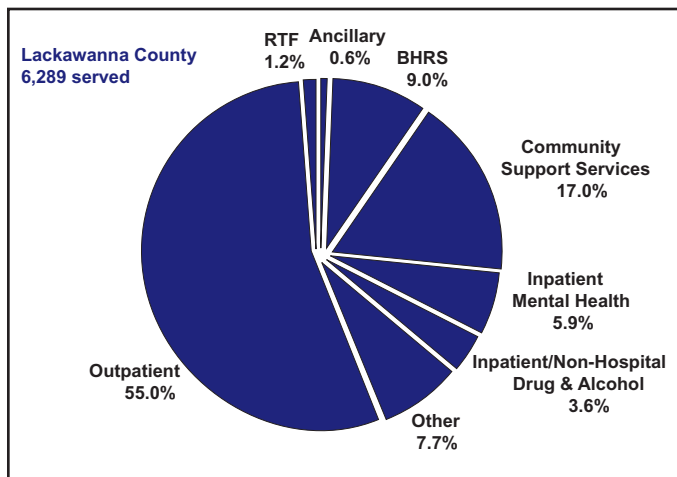


Wyoming County  
714 served



# Members Served

## Level of Care

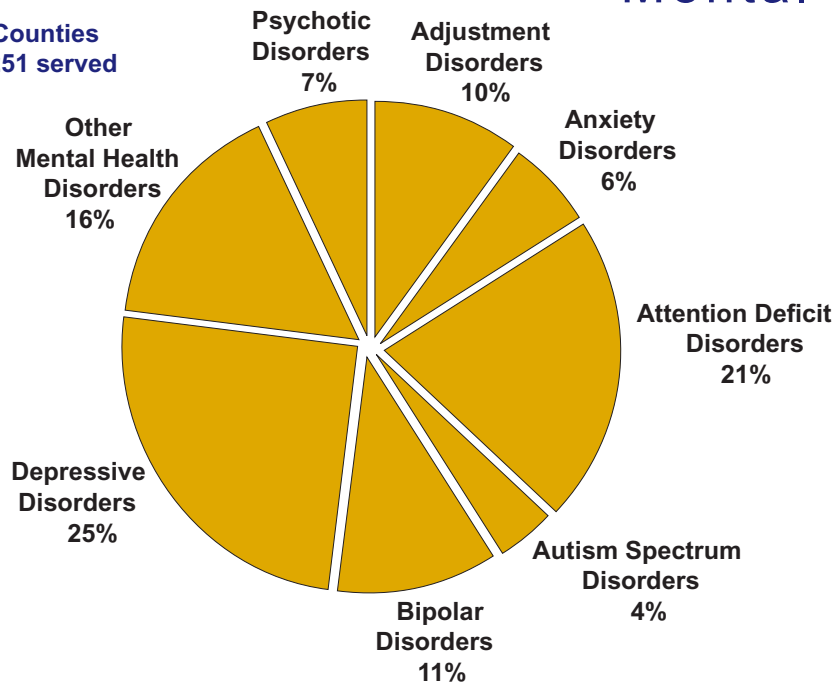




# Members Served

## Mental Health Diagnoses

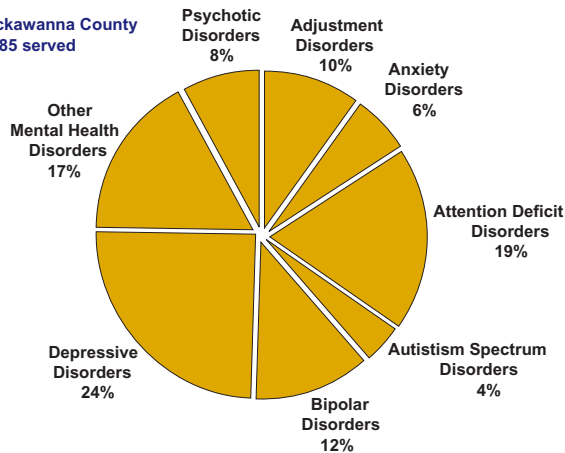
All Counties  
16,251 served



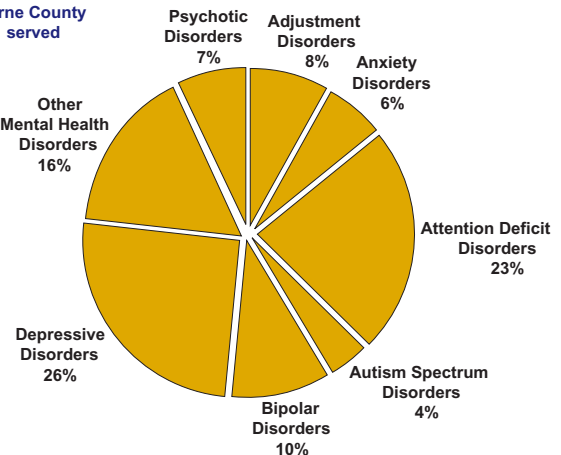
Mental illnesses can affect persons of any age, race, religion, or income

Other Mental Health Disorders include Tic Disorders, Learning Disorders, Communications Disorders, and Motor Skills Disorders.

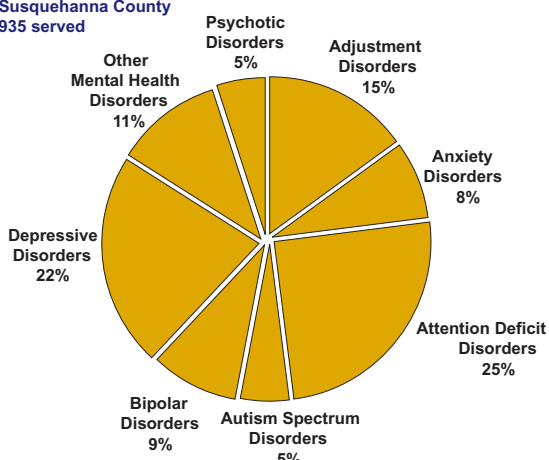
Lackawanna County  
6,285 served



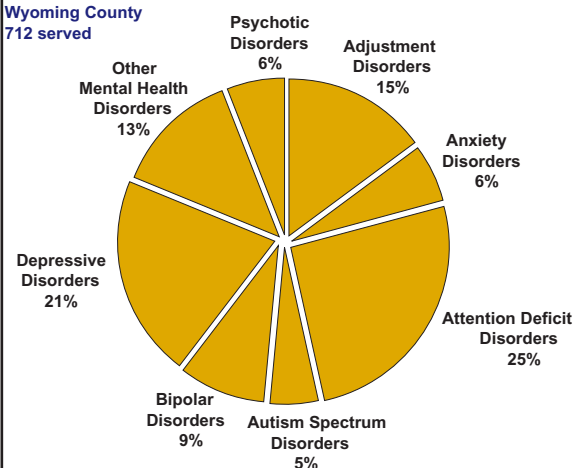
Luzerne County  
8,441 served



Susquehanna County  
935 served

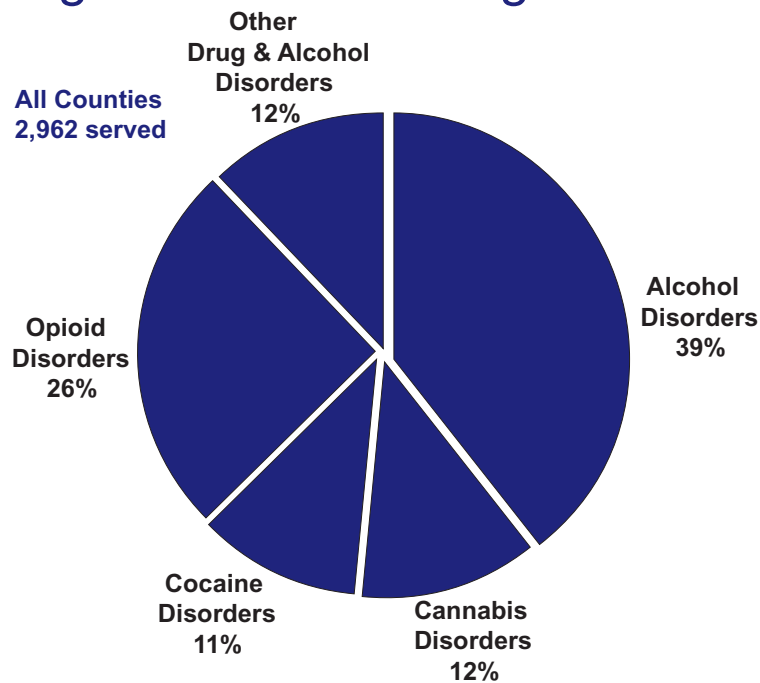


Wyoming County  
712 served

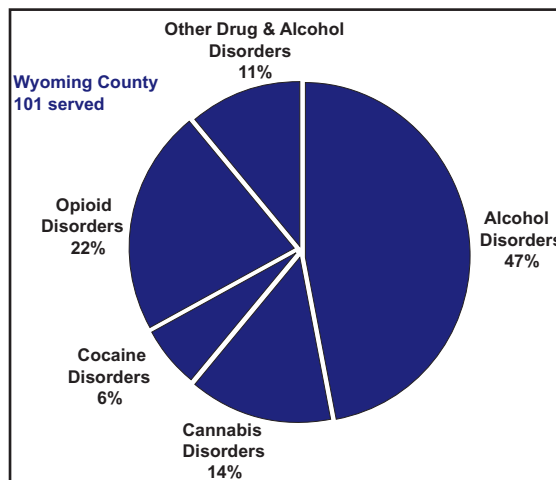
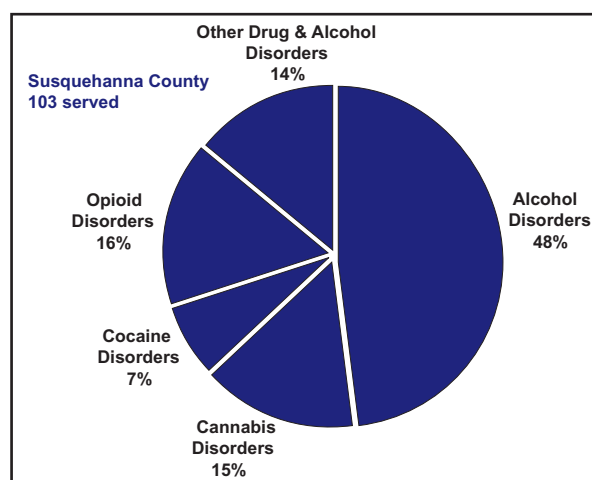
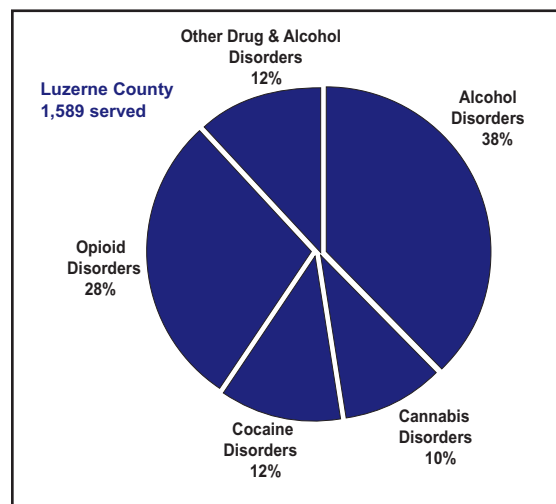
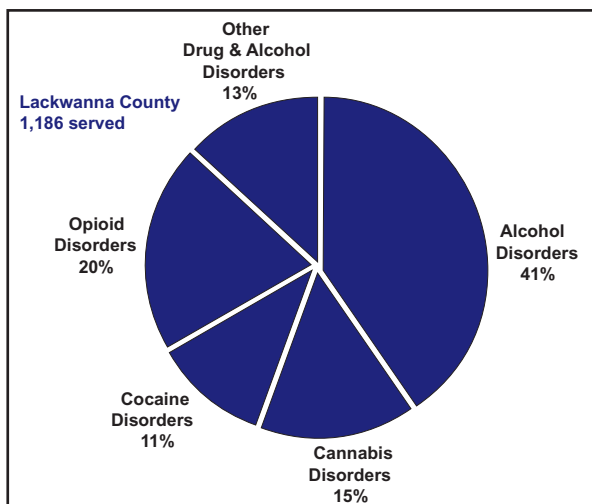


# Members Served

## Drug & Alcohol Diagnoses

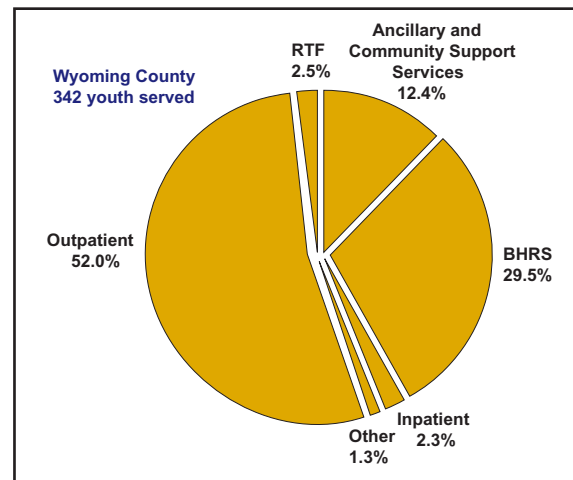
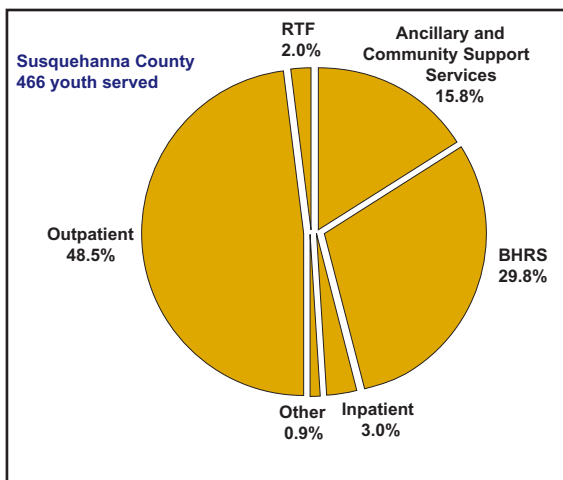
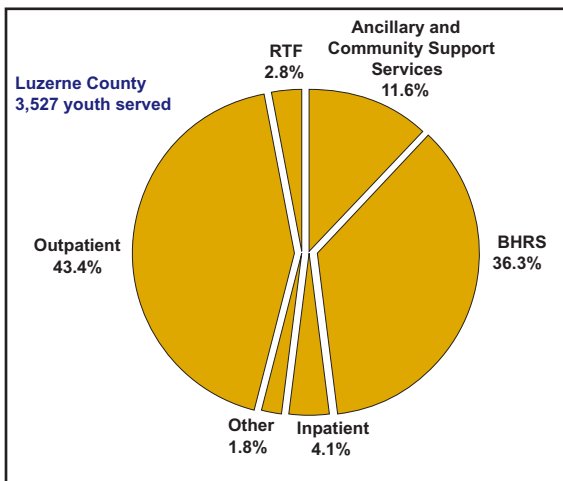
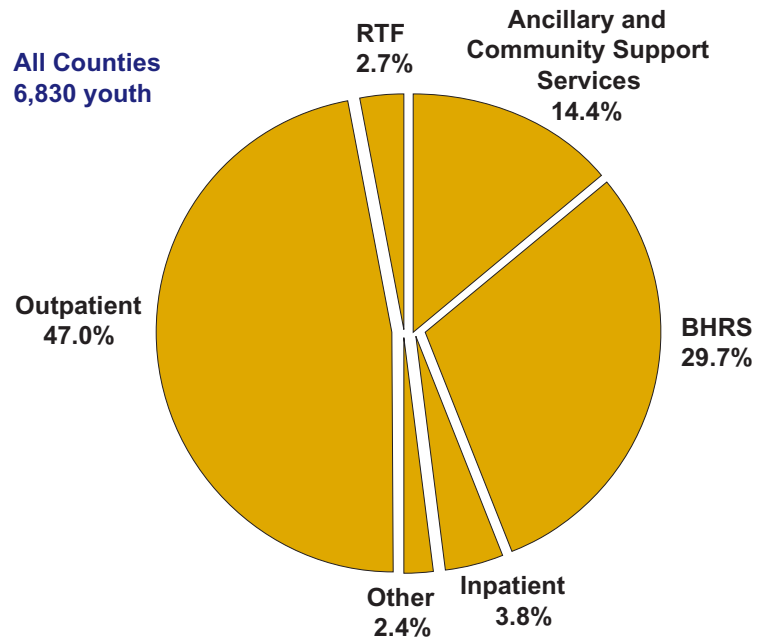
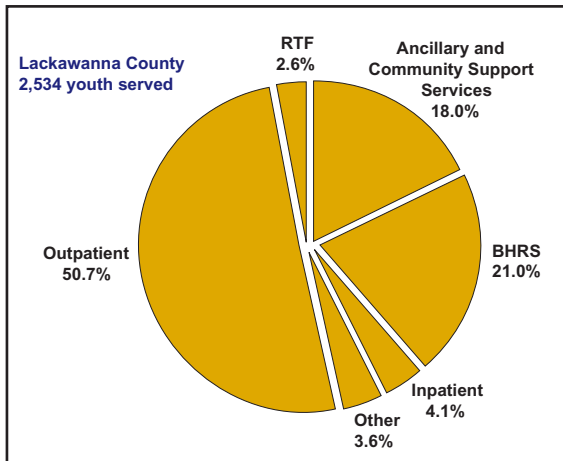


Early identification and treatment is of vital importance; by getting people the treatment they need early, recovery is accelerated and the brain is protected from further harm related to the course of illness.



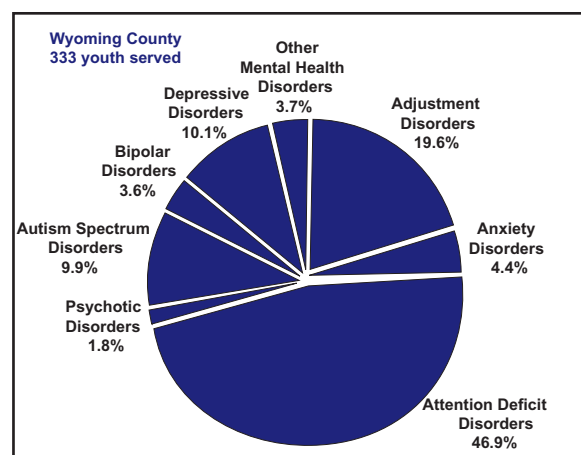
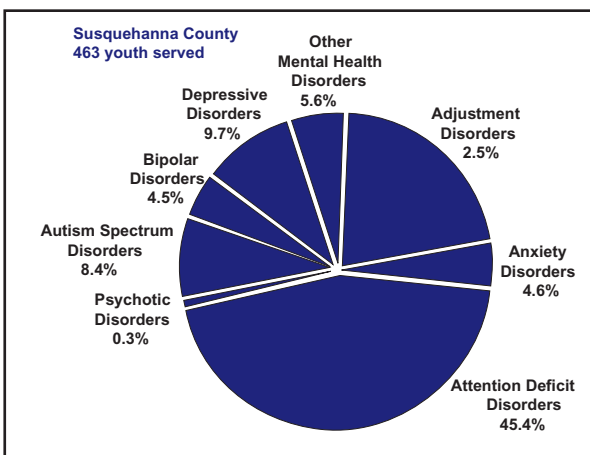
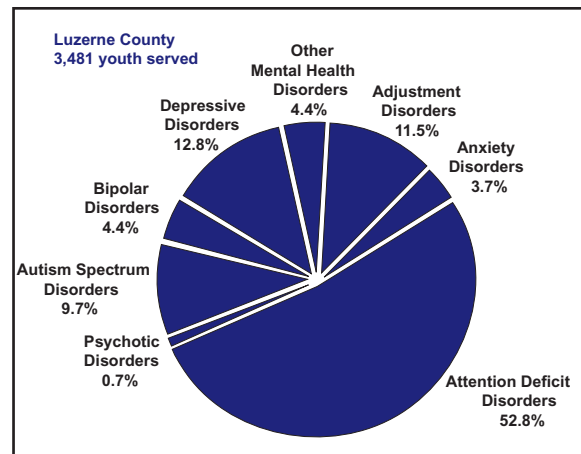
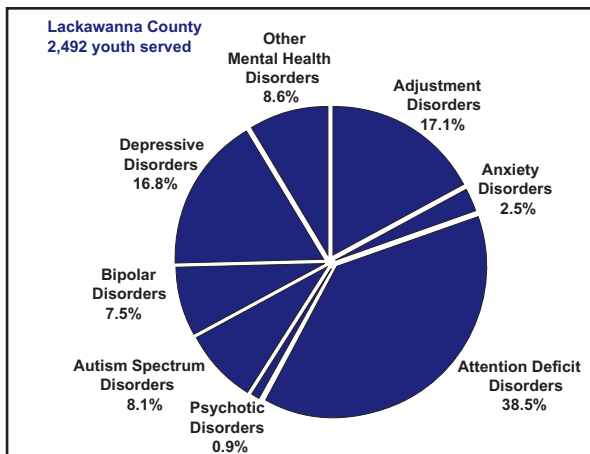
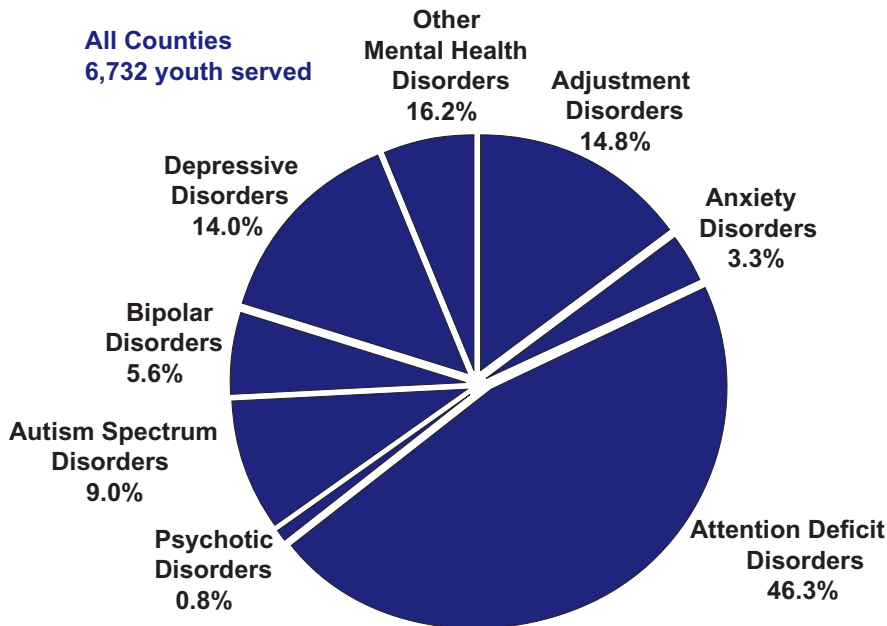
# Youth Served

## Level of Care



# Youth Served

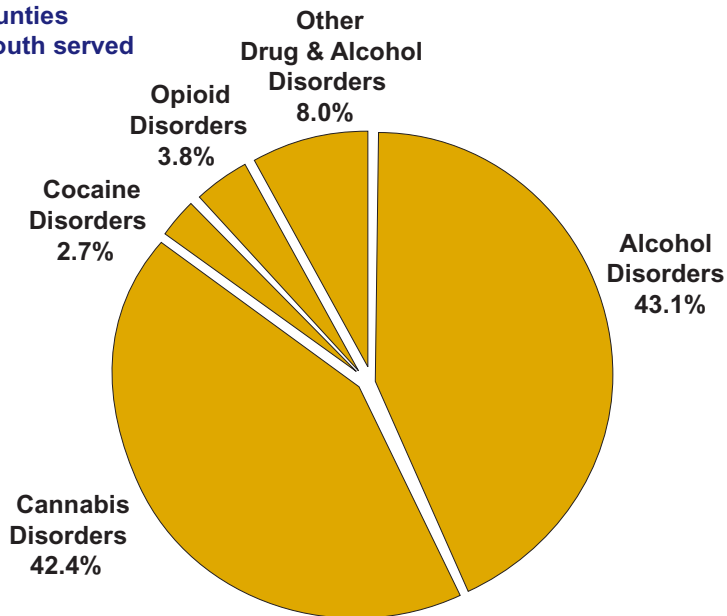
## Mental Health Diagnoses



# Youth Served

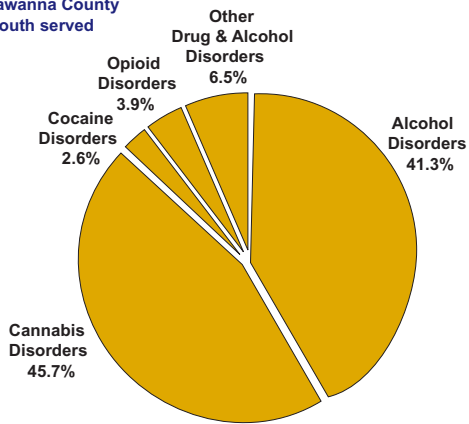
## Drug & Alcohol Diagnoses

All Counties  
242 youth served

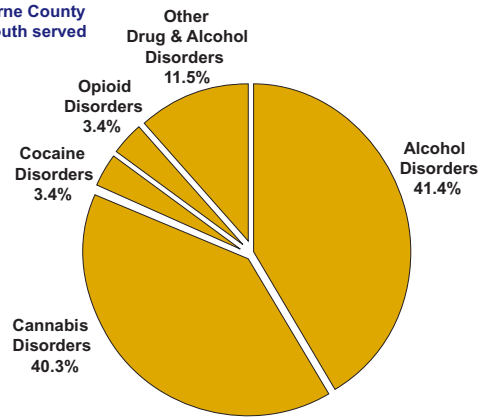


Over 50 percent of students with mental/substance use disorders age 14 and older drop out of high school - the highest drop-out rate of any disability group

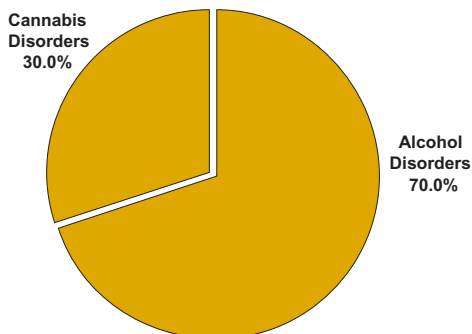
Lackawanna County  
144 youth served



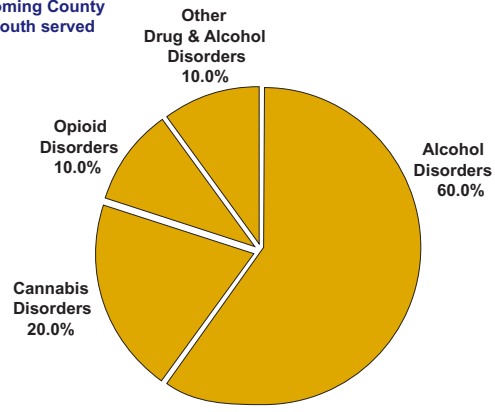
Luzerne County  
80 youth served



Susquehanna County  
8 youth served



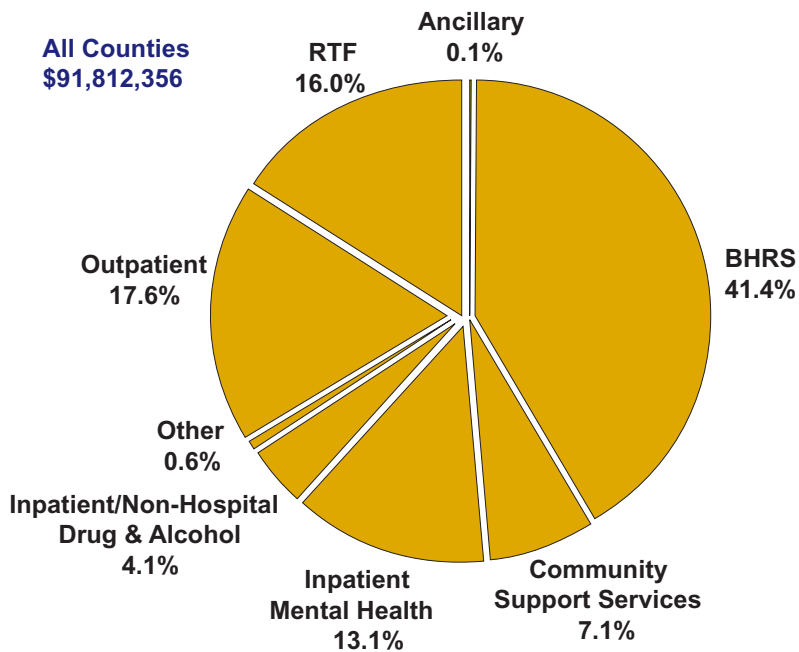
Wyoming County  
10 youth served



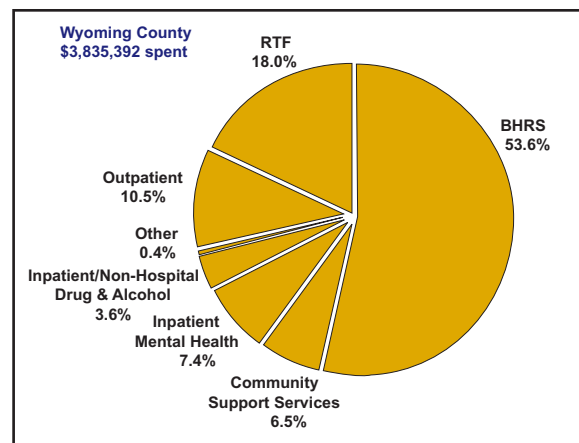
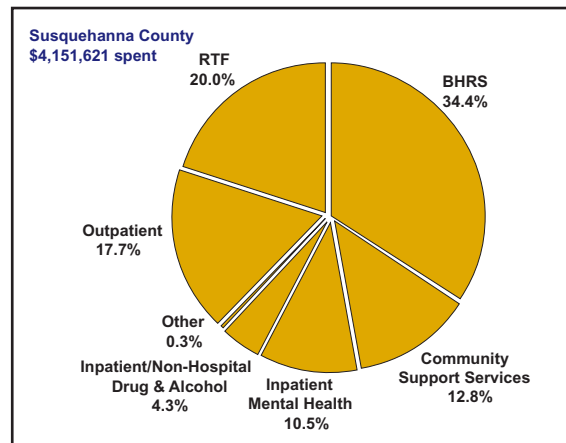
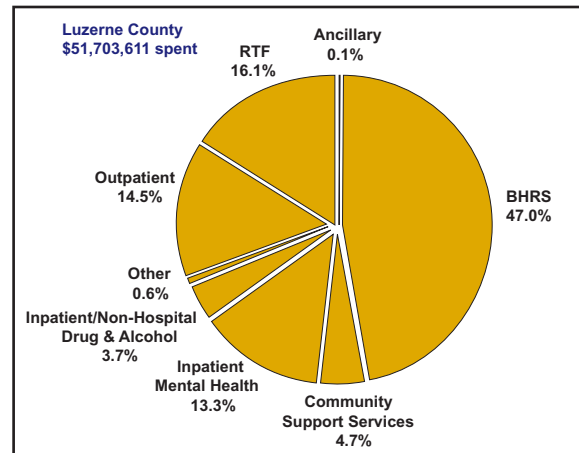
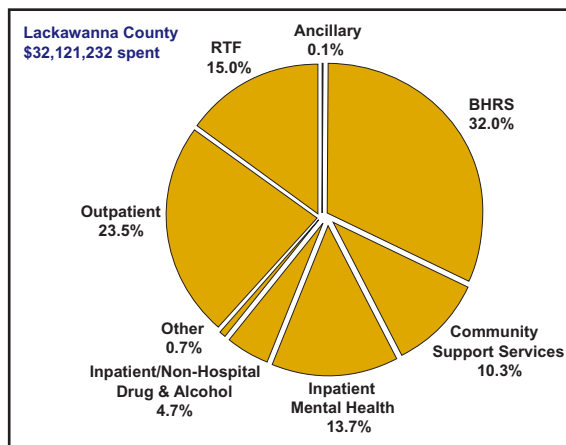


# Expenditures

## All Members

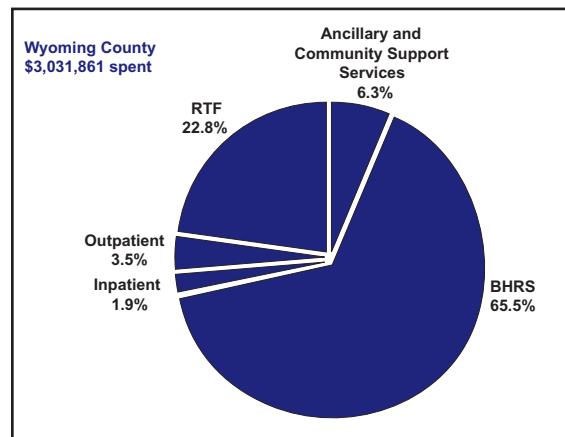
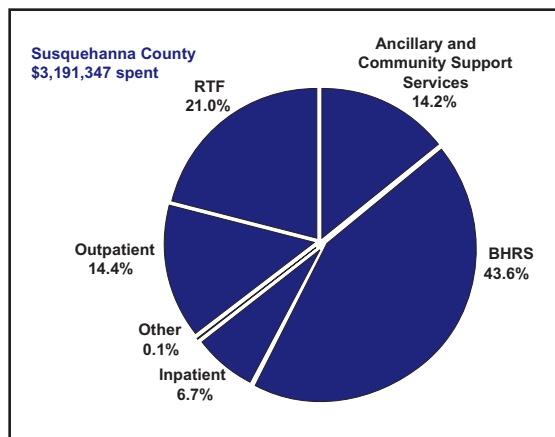
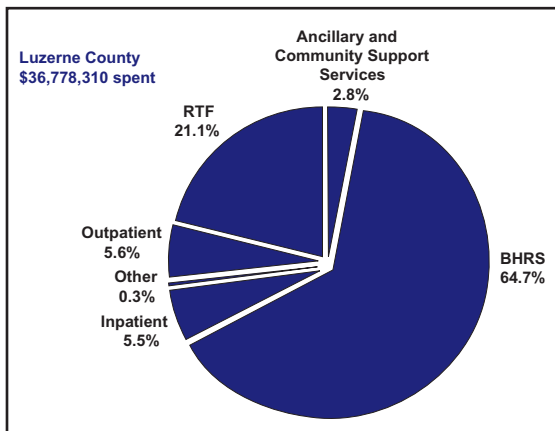
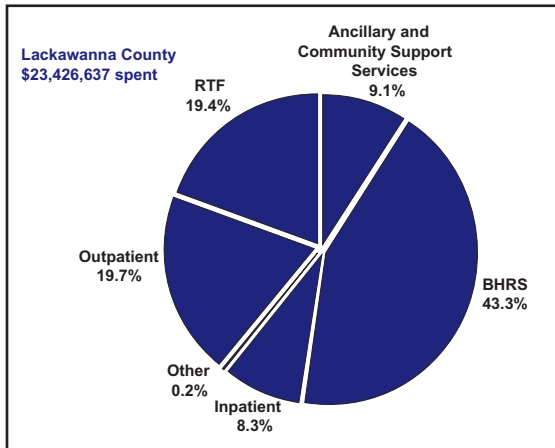


During Operating Year 2006—2007, over \$91,000,000 was spent on behavioral healthcare services for HealthChoices members in Lackawanna, Luzerne, Susquehanna, and Wyoming Counties

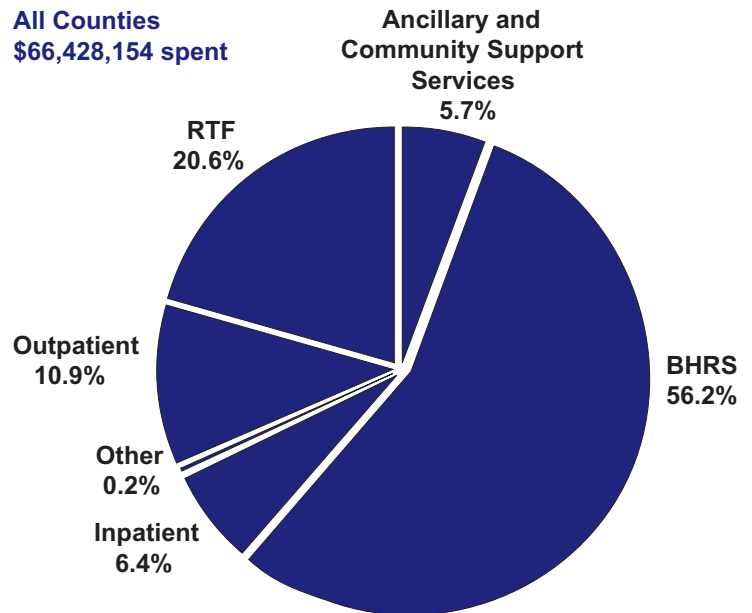


# Expenditures

## Youth



**All Counties**  
\$66,428,154 spent



# Services for Members

- Inpatient Psychiatric Hospitalization
- Inpatient Drug & Alcohol Detoxification and Rehabilitation
- Outpatient Mental Health and Drug & Alcohol Counseling
- Medication Management and Clozapine Support
- Psychiatric Evaluation and Psychological Testing
- Residential Treatment Facilities for Adolescents (RTF)
- Blended Case Management
- Methadone Maintenance
- Intensive Case Management
- Resource Coordination
- Crisis Intervention
- Behavioral Health Rehabilitative Services for Children and Adolescents (BHRS)
- Family Based Treatment
- Mental Health and Drug & Alcohol Partial Hospitalization
- Psychosocial Rehabilitation
- Drug & Alcohol Halfway House

## Youth-Focused Services

**Behavioral Health Rehabilitative Services (BHRS)**, the behavioral health component for Early Periodic, Screening, Diagnosis and Treatment (EPSDT), is a service to children through the age of 21 years old, to develop individual specific plans to care for social and emotional disturbances.

**Family Based Mental Health Services** are 24-hour, 7-days-a-week services that are designed to assist families in caring for their children or adolescents with emotional disturbance at home. A licensed program, Family Based Mental Health Services offers mental health treatment, case work services, and family support for up to 32 weeks, and no longer if medically necessary. Family Based services are delivered by a team of mental health professionals and mental health workers, primarily in the family home.

**Residential Treatment Facilities (RTF)** are medical assistance approved, mental health treatment facilities for medical assistance eligible children and adolescents (up to age 21) who cannot be maintained in the home.

## Comparison of Family Based and BHRS Services

	Family Based	BHRS
<b>Therapy Component</b>	• Co-Therapy Team	• One Therapist
<b>Other Services</b>	<ul style="list-style-type: none"> <li>• Family Based usually includes Mobile Therapy &amp; Behavioral Support Consultant functions</li> <li>• Use of Therapeutic Staff Support on occasion</li> <li>• Team an ongoing unit</li> <li>• No separate case management</li> </ul>	<ul style="list-style-type: none"> <li>• Possible use of Behavioral Health Consultant</li> <li>• Possible use of Therapeutic Staff Support</li> <li>• Team usually ad hoc</li> <li>• Separate case management</li> </ul>
<b>Indications</b>	• Out-of-home diversion	• Out-of-home diversion
<b>Guiding Philosophy</b>	• CASSP Principles	• CASSP Principles
<b>Primary Focus</b>	• The family unit, including child, siblings, and parents	• The child, and parents in relation to child
<b>Primary Technique</b>	• Systems therapy	• Varies by therapist
<b>Site of Services</b>	• Home and community	• Home, community and school
<b>Coverage</b>	• 24/7," by Family Based program	• Case management and crisis intervention covers after-hours
<b>Special Uses</b>	<ul style="list-style-type: none"> <li>• More than 1 child in need</li> <li>• Parents identify own problems</li> <li>• Parents request Family Based</li> <li>• Multi-system involvement of BHRS ineffective</li> </ul>	<ul style="list-style-type: none"> <li>• Child at risk with moderate need</li> <li>• Child needs Therapeutic Staff Support</li> <li>• Specific psychiatric diagnoses</li> </ul>
<b>Potential Pitfalls</b>	• Under-focusing on child and his/her specific symptoms	<ul style="list-style-type: none"> <li>• Limited therapy with family</li> <li>• Service over-utilization</li> </ul>

# Understanding Mental Illness

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.

Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder. The good news about mental illness is that recovery is possible.

Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weakness, lack of character, or poor upbringing. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.

In addition to medication treatment, psychosocial treatment such as cognitive behavioral therapy, interpersonal therapy, peer support groups, and other community services can also be components of a treatment plan and assist with recovery. The availability of transportation, diet, exercise, sleep, friends, and meaningful paid or volunteer activities contribute to overall health and wellness, including mental illness recovery.

Here are some important facts about mental illness and recovery:

- Mental illnesses are biologically based brain disorders. They cannot be overcome through "will power" and are not related to a person's "character" or intelligence.
- Mental disorders fall along a continuum of severity. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 percent, or 1 in 17



Americans — who suffer from a serious mental illness. It is estimated that mental illness affects 1 in 5 families in America.

- The World Health Organization has reported that four of the 10 leading causes of disability in the US and other developed countries are mental disorders. By 2020, Major Depressive illness will be the leading cause of disability in the world for women and children.
- Mental illnesses usually strike individuals in the prime of their lives, often during adolescence and young adulthood. All ages are susceptible, but the young and the old are especially vulnerable.
- Without treatment the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives; The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States.
- The best treatments for serious mental illnesses today are highly effective; between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports.
- With appropriate effective medication and a wide range of services tailored to their needs, most people who live with serious mental illnesses can significantly reduce the impact of their illness and find a satisfying measure of achievement and independence. A key concept is to develop expertise in developing strategies to manage the illness process.
- Early identification and treatment is of vital importance; by ensuring access to the treatment and recovery supports that are proven effective, recovery is accelerated and the further harm related to the course of illness is minimized.
- Stigma erodes confidence that mental disorders are real, treatable health conditions. We have allowed stigma and a now-unwarranted sense of hopelessness to erect attitudinal, structural, and financial barriers to effective treatment and recovery. It is time to take these barriers down.

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Article courtesy of the National Alliance on Mental Illness (NAMI), 2008



# Understanding Substance Use Disorders

Substance abuse can simply be defined as a pattern of harmful use of any substance for mood-altering purposes. Medline's medical encyclopedia defines drug abuse as "the use of illicit drugs or the abuse of prescription or over-the-counter drugs for purposes other than those for which they are indicated or in a manner or in quantities other than directed." But the broad range of substance abuse in today's society is not that simple.

There are substances that can be abused for their mood-altering effects that are not drugs at all – inhalants and solvents – and there are drugs that can be abused that have no mood-altering or intoxication properties, such as anabolic steroids. Generally, when most people talk about substance abuse, they are referring to the use of illegal drugs. Substance abuse is a pattern of use that displays many adverse results from continual use of a substance. The characteristics of abuse are a failure to carry out obligations at home or work, continual use under circumstances that present a hazard (such as driving a car) and legal problems such as arrests become evident. Use of the drug is persistent despite personal problems caused by the effects of the substance on one's self or others.

In a number of cases, abuse may lead to dependence. Substance dependence has been defined medically as a group of behavioral and physiological symptoms that indicate the continual, compulsive use of a substance in self-administered doses despite the problems related to the use of this substance. Increased amounts are needed to achieve the desired effect or level of intoxication so the patient's tolerance for the drug increases.

Substance dependence is a phenomenon whereby a person becomes physically addicted to a substance. A substance-dependent person must have a particular dose or concentration of the substance in their bloodstream at any given moment in order to avoid the unpleasant symptoms associated with withdrawal from that substance. The common substances of abuse tend to exert either a depressive (slowing) or a stimulating (speeding up) effect on such basic bodily functions as respiratory rate, heart rate, blood pressure. When a drug is stopped abruptly,

the person's body will respond by over-reacting to the substance's absence. Functions slowed by the abused substance will be suddenly speeded up, while previously stimulated functions will be suddenly slowed. This results in very unpleasant symptoms, known as withdrawal symptoms.

The term "addiction" refers to the mind-state of a person who reaches a point where he/she must have a specific substance, even though the social consequences of substance use are clearly negative (loss of relationships, employment, housing). Craving refers to an intense hunger for a specific substance, to the point where this need essentially directs the individual's behavior. Craving is usually seen in both dependence and addiction. Such craving can be so strong that it overwhelms a person's ability to make any decisions which will possibly deprive him/her of the substance.



Most persons with substance abuse disorders believe they can stop using drugs on their own, but the most abusers who try this do not succeed. Research shows that long-term drug use alters brain function and strengthens compulsions to use drugs. This craving continues even after drug use stops. Because of these ongoing cravings, the most important component of treatment is preventing relapse. Treating substance abuse depends on both the person and the

substance being used. Behavioral treatment provides the abuser with strategies to cope with drug cravings and ways to avoid relapse.

In many instances, a drug user has an underlying mental disorder, one that increases risk for substance abuse. Such disorders must be treated medically and through counseling along with the drug abuse.

Treatment has several goals, which include helping a person deal with the uncomfortable and possibly life-threatening symptoms associated with withdrawal from an addictive substance (called detoxification), helping a person deal with the social effects which substance abuse has had on his or her life, and efforts to prevent relapse (resumed use of the substance). Individual or group therapy plays an important role in the treatment of substance use disorders.



# Understanding Autism

According to the Autism Society of America (ASA), autism is defined as a severely incapacitating lifelong developmental disability that typically appears during the first three years of life. It occurs in approximately fifteen out of every 10,000 births and is four times more common in boys than girls. It has been found throughout the world in families of all racial, ethnic and social backgrounds. No known factors in the psychological environment of a child have been shown to cause autism.

The symptoms are caused by physical disorders of the brain. They include:

- Disturbances in the rate of appearance of physical, social and language skills.
- Abnormal responses to sensations. Any one, or a combination of, senses or responses are affected: sight, hearing, touch, pain, balance, smell, taste, and the way a child holds his body.
- Speech and language are absent or delayed while specific thinking capabilities might be present.
- Abnormal ways of relating to people, objects and events.

Autism occurs by itself or in association with other disorders which affect the function of the brain such as viral infections, metabolic disturbances, and epilepsy. It is important to distinguish autism from retardation or mental disorders since diagnostic confusion may result in referral to inappropriate and ineffective treatment techniques. The severe form of the syndrome may include extreme self-injurious, repetitive, highly unusual and aggressive behavior. Special educational programs using behavioral methods have proven to be the most helpful treatment. Autism is the most common of the Pervasive Developmental Disorders, affecting an estimated 1 in 250 births (Centers for Disease Control and Prevention, 2003). This means that as many as 1.5 million Americans today are believed to have some form of autism.

And that number is on the rise. Based on statistics from the U.S. Department of Education and other governmental agencies, autism is growing at a rate of 10-17 percent per year. At these rates, the ASA estimates that the prevalence of autism could reach 4 million Americans in the next decade.

The overall incidence of autism is consistent around the globe, but is four times more prevalent in boys than girls. Autism knows no racial, ethnic, or social boundaries, and family income, lifestyle, and educational levels do not affect the chance of autism's occurrence. **AUTISM IS TREATABLE** – early diagnosis and intervention are vital to the future development of the child.

There is no cure for autism. However evidence shows that early intervention results in positive outcomes for children with autism; and the earlier treatment begins, the better. Studies show that those with autism respond well to a highly-structured, specialized education program tailored to their needs. Some may need one-on-one or small group support, while others may be successful in a fully inclusive general education environment with supports. Because autism is a spectrum disorder, no one method alone is effective in treating autism. Other treatments that may help include: medicine, diet, vitamins, and occupational and sensory therapies.



# Recovery Model

The Recovery Model refers to the process of recovery from a mental health disorder or substance dependence, and/or from being labeled in those terms. Recovery has been defined as “an individual’s journey of healing and transformation to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential” (U.S. Department of Health and Human Services, 2005). It incorporates a philosophy of support, respect, empowerment, choice, hope, and social inclusion. Originating in programs to overcome substance dependency, the concept of recovery in mental health emerged from the realization that there was inadequate support and assistance for deinstitutionalized individuals in their efforts to integrate into the community in a meaningful manner. The recovery model is a form of social model of disability by contrast to a medical model of disability and may involve “consumers” and “survivors” of mental health service as well as mental health professionals.

In general medicine or psychiatry, recovery has long been used to refer to the end of a particular experience of illness. In the context of long-term conditions, it might refer to a period of remission and therefore potentially relapse.

The concept of “full recovery” as a general philosophy first became popular in relation to substance use programs, including 12-step approaches. Application of full recovery concepts to psychiatric disorders is comparatively recent and stems largely from two interrelated sources: the consumer/survivor movement, a grassroots self-help and advocacy initiative, and psychiatric rehabilitation, a professional approach to mental health services provision.

The concept of full recovery has emerged as a significant paradigm shift in the field of mental health and became increasingly implemented in the policies and practices of mental health systems. The recovery model has been said to be based on the premise that all consumers have the capacity to improve and develop a life distinct from illness. Scientific and consumer models of recovery have differences and commonalities; the consumer model of recovery involves a nonlinear process in which an individual gradually adapts to and moves beyond what may be termed an illness, while scientific and clinical models typically view recovery as an outcome, primarily involving reduced symptoms and improved functional capacity (sustained for a particular duration, for example two years). Scientific-professional views also place considerable emphasis on the role of treatment, especially including maintenance pharmacotherapy, while the consumer model places greater emphasis

on peer support and personal experience.

Hope is a feature proposed to be important, including a realistic openness to failure, disappointment and possible relapse along the way. Recovery can be seen as an individual experience; a fundamental change in the concept of self. For many, recovery has a political as well as personal implication, where to recover is to find meaning, to challenge prejudice, to reclaim a chosen life and place within society, to validate the self. Recovery can thus be viewed as one manifestation of empowerment. An empowerment model of recovery may emphasize that conditions are not necessarily permanent, that other people have recovered who can be role models and share experiences, and symptoms can be understood as expressions of

distress related to lack of a connection on

a deep emotional level to the people around them, involving loss and trauma and interruption in social development.

One such model from the US National Empowerment Center advances 10 such principles of recovery framed within a cognitive-behavioral approach.

In psychiatric rehabilitation, the concept of recovery has often been used in a more limited way to refer to functional criteria and reduction of psychosocial disability. To recover is to improve and

maintain personal capacity in one or more of the major domains of life, whether it be work, housing, relationships, or recreation. Psychiatric rehabilitation also focuses on individuals’ role performance.

The recovery model has been supported by evidence from both quantitative and qualitative research. Long term (longitudinal) studies have shown that a psychiatric disorder does not necessarily take a course of inevitable deterioration and that, for a significant number of people, a return to full potential is possible. Other research, including studies of reports by consumers/survivors of mental health services, has identified resilience and resourcefulness, diverse and individual pathways of healing, and factors which can enhance or detract from recovery. Increasingly, recovery has become both a subject of mental health services research and a term that is emblematic of many of the goals of the consumer/survivor movement. Specific policy and clinical strategies are currently being used to implement recovery principles although key questions remain.



# Myths & Facts About Mental Health

Often people are afraid to talk about mental health because there are many misconceptions about mental illnesses. It's important to learn the facts to stop discrimination and to begin treating people with mental illnesses with respect and dignity. Here are some common myths and facts about mental health.

**Myth: There's no hope for people with mental illnesses.**

**Fact:** There are more treatments, strategies, and community supports than ever before, and even more are on the horizon. People with mental illnesses lead active, productive lives

**Myth: I can't do anything for someone with mental health needs.**

**Fact:** You can do a lot, starting with the way you act and how you speak. You can nurture an environment that builds on people's strengths and promotes good mental health. For example: Avoid labeling people with words like "crazy," "wacko," "loony," or by their diagnosis. Instead of saying someone is a "schizophrenic" say "a person with schizophrenia."

Learn the facts about mental health and share them with others, especially if you hear something that is untrue. Treat people with mental illnesses with respect and dignity, as you would anybody else.

Respect the rights of people with mental illnesses and don't discriminate against them when it comes to housing, employment, or education. Like other people with disabilities, people with mental health needs are protected under Federal and State laws.

**Myth: People with mental illnesses are violent and unpredictable.**

**Fact:** In reality, the vast majority of people who have mental health needs are no more violent than anyone else. You probably know someone with a mental illness and don't even realize it.

**Myth: Mental illnesses cannot affect me.**

**Fact:** Mental illnesses are surprisingly common; they affect almost every family in America. Mental illnesses do not discriminate—they can affect anyone.

**Myth: Mental illness is the same as mental retardation.**

**Fact:** The two are distinct disorders. A mental retardation diagnosis is characterized by limitations in intellectual functioning and difficulties with certain daily living skills. In contrast, people with mental illnesses—health conditions that cause changes in a person's thinking, mood, and behavior—have varied intellectual functioning, just like the general population.

**Myth: Mental illnesses are brought on by a weakness of character.**

**Fact:** Mental illnesses are a product of the interaction of biological, psychological, and social factors. Research has shown genetic and biological factors are associated with schizophrenia, depression, and alcoholism. Social influences, such as loss of a loved one or a job, can also contribute to the development of various disorders.

**Myth: People with mental illnesses cannot tolerate the stress of holding down a job.**

**Fact:** In essence, all jobs are stressful to some extent. Productivity is maximized when there is a good match between the employee's needs and working conditions, whether or not the individual has mental health needs.

**Myth: People with mental health needs, even those who have received effective treatment and have recovered, tend to be second-rate workers on the job.**

**Fact:** Employers who have hired people with mental illnesses report good attendance and punctuality, as well as motivation, quality of work, and job tenure on par with or greater than other employees. Studies by the National Institute of Mental Health (NIMH) and the National Alliance for the Mentally Ill (NAMI) show that there are no differences in productivity when people with mental illnesses are compared to other employees.

**Myth: Once people develop mental illnesses, they will never recover.**

**Fact:** Studies show that most people with mental illnesses get better, and many recover completely. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

**Myth: Therapy and self-help are wastes of time. Why bother when you can just take one of those pills you hear about on TV?**

**Fact:** Treatment varies depending on the individual. A lot of people work with therapists, counselors, their peers, psychologists, psychiatrists, nurses, and social workers in their recovery process. They also use self-help strategies and community supports. Often these methods are combined with some of the most advanced medications available.

**Myth: Children do not experience mental illnesses. Their actions are just products of bad parenting.**

**Fact:** A report from the President's New Freedom Commission on Mental Health showed that in any given year 5-9 percent of children experience serious emotional disturbances. Just like adult mental illnesses, these are clinically diagnosable health conditions that are a product of the interaction of biological, psychological, social, and sometimes even genetic factors.

**Myth: Children misbehave or fail in school just to get attention.**

**Fact:** Behavior problems can be symptoms of emotional, behavioral, or mental disorders, rather than merely attention-seeking devices. These children can succeed in school with appropriate understanding, attention, and mental health services.



Department of Health and  
Human Services, 2006

# Terminology

## **ADMISSION RATE**

The number of admissions into services per 1000 HealthChoices enrollees.

## **AUTHORIZATION**

A process that is related to the payment of claims by which a provider receives approval from CCBH to provide a particular service. Authorizations typically limit the number of units and the time in which the service can be provided. If a service requires authorization for payment, the lack of authorization will result in an unpaid claim.

## **CAPITATION**

A set amount of money received or paid out; it is based on membership rather than on services delivered and is usually expressed in units of PMPM (per member per month) or PMPD (per member per day). Under the HealthChoices program, capitation rates vary by categories of assistance.

## **CLAIMS**

A request for reimbursement for a behavioral health service.

## **COMMUNITY RESIDENTIAL REHABILITATION (CRR)**

CRRs are residential programs designed and operated to assist persons with chronic psychiatric disability to live as independently as possible in the least restrictive setting.

## **COMPLAINT**

A process by which a consumer or provider can address a problem experienced in the HealthChoices program.

## **CONSUMER**

HealthChoices enrollees on whose behalf a claim has been adjudicated for behavioral healthcare services during the reporting period.

## **DENIAL**

A denial is defined as “a determination made by a BHMCO in response to a provider’s request for approval to provide in-plan services of a specific duration and scope.

## **DIAGNOSIS**

A behavioral health disorder based on DSM-IV or ICD-9 diagnostic criteria.

## **DIAGNOSTIC CATEGORIES**

Subgroups of behavioral health disorders. This report contains the following groupings:

**Bipolar Disorders** – a group of mood disorders that characteristically involve mood swings. This group includes: Bipolar I Disorder, Bipolar II Disorder, Bipolar Disorder Not Otherwise Specified, Mood Disorder, and Mood Disorder Not Otherwise Specified.

**Depressive Disorders** – a group of mood disorders that includes Major Depressive Disorder, Dysthymia, and Depressive Disorder Not Otherwise Specified.

**Schizophrenia and Psychotic Disorders** – a collection of thought disorders such as Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, and Psychotic Disorder Not Otherwise Specified.

**Anxiety Disorders** – a group of disorders that includes: Panic Disorder, Social Phobia, Posttraumatic Stress Disorder, Obsessive Compulsive Disorder, Generalized Anxiety Disorder, and Anxiety Disorder Not Otherwise Specified.

**Adjustment Disorder** – the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors.

**Impulse Control Disorders** – include Intermittent Explosive Disorder, Trichotillomania, and Impulse Control Disorder Not Otherwise Specified.

**ADHD and Disorders in Children** – Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, and Disruptive Behavior Disorder Not Otherwise Specified.

**Other Mental Health Disorders** – includes Tic Disorders, Learning Disorders, Communications Disorders, and Motor Skills Disorders.





Substance Abuse/Dependence Disorders – a group of disorders related to taking a drug of abuse. The DSM-IV refers to 11 classes of substances: alcohol, amphetamines, caffeine, cannabis (marijuana or hashish), cocaine, hallucinogens, inhalants, nicotine, opioids (heroin or other narcotics), PCP, and sedatives/ hypnotic/anxiolytics.

Mental Retardation – includes Mild, Moderate, Severe and Profound Mental Retardation.

#### **DSM-IV**

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association. This manual provides a diagnostic coding system for mental and substance abuse disorders (also see ICD-9-CM).

#### **ENROLLMENT**

The number if Medicaid recipients who are active in the Medical Assistance program at any given point in time.

#### **FAIR HEARING APPEAL**

A grievance process through which a HealthChoices member can file a written appeal, to the Department of Public Welfare, regarding a behavioral healthcare service decision.

#### **GRIEVANCE**

The process by which a consumer addresses a problem with a decision made about his/her behavioral healthcare service. This may include denial of a service, approving less service than what was requested, or approving a level of care different from that requested.

#### **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

This is a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives the Health and Human Services Department of the federal government the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, K2, or Public Law 104-191.

#### **MEMBER**

Eligible Medical Assistance recipients enrolled in the HealthChoices program during the reporting period.

#### **MENTAL HEALTH COMMITMENT**

An involuntary admission into a psychiatric hospital as per the Pennsylvania Mental Health Procedures act. Also referred to as a '302 commitment'.

#### **OUTPATIENT REGISTRATION (OPR)**

The process by which HealthChoices members are registered with CCHB to receive specific outpatient services. This process eliminates the need for pre-authorization of services and allows the member to access mental health or drug and alcohol services with the provider for up to one year.

#### **RESIDENTIAL TREATMENT FACILITY (RTF)**

A self-contained, secure, 24-hour psychiatric residence for children and adolescents who require intensive clinical, recreational, educational services, and supervision.

#### **UTILIZATION**

The amount of behavioral healthcare services used by Medicaid recipients. Utilization is based on encounter (paid claims) information.





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