What Comes Next? The Best Methods for Mental Health Organizations to Help Patients Transition.

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Abstract:

There is a gap between the end of mental health programs and community reintegration. What are the best methods to prepare participants of a program for the next step? How are organizations implementing these methods? How effective are transition programs truly? This paper analyzes statistically significant studies and uses interviews with organizations to find the answers to these questions.

Improvement during a program doesn't determine the program's effectiveness. Only if the participants continue to thrive in the long term is a program truly effective. Many mental health programs focus on immediate benefits, with little focus on the long term. With relapse rates of certain mental health problems reaching 80%, the need for programs providing lasting improvements is vital. Mental health organizations are reducing relapse rates in a cost-effective manner by providing transition programs back into the community. These transition programs bridge the gap between the end of a program and community life, as well as provide lasting benefits for participants.

Introduction:

For nearly 100 years Central State Hospital was the largest psychiatric treatment facility in Indiana. At its height, nearly 3,000 patients lived and were treated there. In 1994 this changed. Due to political changes and a lack of funding, Central State closed. Prior to closure, they transferred as many patients as possible to other treatment facilities, but they couldn't transfer everyone. Many of these people were unable to reintegrate back into the community, relapsed, and ended up hospitalized or homeless. Once more Indiana is facing a major transition phase. Indiana is in the process of

closing LaRue Carter psychiatric hospital, Indiana's largest psychiatric hospital, and opening a new facility. LaRue Carter has 148 beds and serves around 500 people annually (U.S. News & World Report, 2017), while the new psychiatric hospital will have 159 beds and aims to serve 1,500 people annually (Rudavsky, 2015). Though there are more beds not everyone from LaRue Carter will be transferred. They are currently assessing who would most benefit and who is ready to transition back into the community. This is where the risk of repeating the mistakes of the Central State Hospital lie. Those who aren't being transferred will need help reintegrating into the community otherwise they run a high risk of relapse, hospitalization, and homelessness. This issue is faced more often than when a psychiatric hospital closes. Whenever a patient leaves an inpatient program they must navigate a complicated change. They must transition from full supportive services, constant treatment, and a highly-structured environment to an independent lifestyle with various levels of support. Whether the inpatient program is a psychiatric hospital, recovery home, or prison the patient faces a similar struggle. To avoid this, the government needs to work with nonprofits and social workers to help transition those who aren't being transferred back into community life. This transition can take several different forms dependent on the level of need the patient needs. It could include supportive housing, case management, and support groups. It can also be indefinite support provided or limited time support. By helping patients navigate this transition we can reduce hospitalization and homelessness.

Background:

Inpatient programs are live-in programs which provide constant support, structure, and treatment. Typical inpatient programs include psychiatric hospitals,

recovery homes, and rehabilitation centers. Idealistically all inpatient programs have a rehabilitative focus, but this is not always the case. Due to the amount of people who need help and the lack of available beds many inpatient programs have become a place to stabilize or store someone who needs help without providing them long lasting rehabilitative benefits. Ten million people in the United States experience a severe mental health problem which largely impairs their life. Currently there are 35,000 inpatient bed in the United States, which is roughly 11 per 100,000 people. A study by the Treatment Advocacy Center, a national nonprofit focused on eliminating barriers to mental health treatment, shows to fully support those who need inpatient treatment we would need between 40 and 60 beds per 100,000 people (between 140,000 and 210,000 inpatient beds) (Fuller, 2016). To provide the most support these additional beds would have to be spread across the United States to underserved areas. There are 2,200 mental health professional shortage areas in the United States. This is an area where to patient to practitioner ratio is 30,000:1. To fill these gaps there is a need for 2,800 more mental health professionals (U.S. Department of Health and Human Services, n.d.). These gaps make it extremely difficult or impossible for people to get the mental health treatment they need. Statistically this leaves over 2.7 million people with severe mental health problems in areas where they can't get proper services.

This massive lack of inpatient beds has not always been the case in the United States' history. In the 1950's the United States had nearly 560,000 inpatient beds (Unite for Site, 2015). Though a sufficient amount of beds were available at this time, these programs were largely ineffective in the long-term. They were used as places to store those with mental health problems instead of truly treating them. In an effort to help

rehabilitate and reintegrate those with mental health problems, the United States started the process of deinstitutionalization. Deinstitutionalization is the simultaneous closure of large mental health hospitals and opening of small community based outpatient treatment centers. This approach has shown statistically significant results in reducing relapse when done correctly. The success of deinstitutionalization relies on a strong infrastructure of community based services being available. These community services expand the continuum of care.

The continuum of care is a community's ability to provide for those in need. A full continuum has five levels of services. The first level is early intervention. These programs focus on reducing the causes of mental health problems, homelessness, and substance abuse. The second level is regular outpatient services. Regular outpatient programs help people before they enter a psychosis or relapse. They are services a client can receive any time they need them and include therapy and help groups such as Alcoholics Anonymous and the National Alliance on Mental Illness' Peer to Peer program. The next level is intensive outpatient. Typical intensive outpatient programs can be found in hospitals. These services help those who don't need constant supervision or help to function, but may have intensive problems on occasion which require medical treatment. The fourth level is residential inpatient services. These services are for those who aren't able to fully function by themselves. They need help to recover and become stable, so they live with professional caretakers. Recovery homes are included in this category. The final stage is intensive medical inpatient services. These services are for those who need both strict supervision and recurring medical services. Psychiatric hospitals are a common example of intensive inpatient care. The

need for these services is based on where the individual patient is at in their life. One patient may go through all five levels of service throughout their life, which is why it is necessary for these services to be readily available.

(Tarzana Treatment Center, 2016)

A strong continuum of care reduces relapse and hospitalization by giving each individual the services they need in a nearby location. Unfortunately, the community treatment center infrastructure needed for deinstitutionalization to work was never properly funded. In 1963 President Kennedy signed the Community Mental Health Act, which began the process of deinstitutionalization, but due to the expense of the Vietnam War the program wasn't fully funded. As years progressed large state-run institutions were closed, but not enough outpatient centers opened to provide services for those who needed them. In 1980 President Carter signed the Mental Health Systems Act to provide increased funds for community outpatient centers. This Act focused on creating the mental health outpatient infrastructure so desperately needed to make deinstitutionalization work. But, in 1981 President Reagan signed the Omnibus Budget Reconciliation Act. This repealed President Carter's Mental Health Systems Act and replaced it with a grant funding system. Mental health funding was cut by 30%. There

wasn’t enough money for new outpatient centers to operate, large state run psychiatric hospitals continued to close, and the burden of mental health services shifted from a collaborative effort between government and nonprofits, to nonprofits managing the burden while government provided partial funding (Amadeo, 2017).

Inpatient Programs:

Deinstitutionalization in theory is a good program, but it had an extremely poor implementation. The main goal was to help those with mental health problems transition back into the community. When the large state run psychiatric hospitals shutdown the people had nowhere to go and the communities didn’t have the resources to support them. Due to the weak execution of this restructuring of services, people ended up homeless, in prisons, and lacking access to mental health treatment. The old state run hospitals didn’t give their clients the skills to thrive outside of the program nor did they help them transition back into the community. Without a focus on these two aspects, participants of an inpatient program are ill-equipped to leave that program. Mental health organizations must always be thinking, “What comes next?” Without a focus on the long-term, participants are more likely to relapse. Inpatient programs need to properly address the level of care their participants are ready for after the program ends. Some participants will need further intensive inpatient care. Others may be ready to move on to a less intensive residential inpatient service. Those who have made great progress may be able to move to independent living with various levels of outpatient services. It’s important to properly identify the individual’s need so they can receive the services which are best suited for them. After their needs are identified the participant will need help transitioning to the new level of services. By aiding development of social

cognitive skills, properly identifying the level of need the person needs, and helping them transition to a new level, mental health organizations can further reduce relapse and provide positive outcomes for their clientele in this underfunded mental health system.

There are four general stages to all inpatient treatment programs. The initial stage is beginning the treatment. The patient must find what program is best fit for them, and once they do they must commit to it. Most patients drop out of programs in the beginning before they've given it a chance. For this reason, it is vital the program employee bond with the patient and explain the goals and time frames to the patient. During the second stage, early recovery, the patient is subjected to a highly structured environment. The focus of this stage is to build the patient's skills, educate them, and help them form the basis of the lifestyle they want to live. The third stage, maintenance, is about building the skills they've been learning, being able to control oneself, and learning how to function independently. The final stage is community support. In this stage the patient switches their support system. They depend less on the program and become more self-reliant and reliant on their personal support network (Forman & Nagy, n.d.).

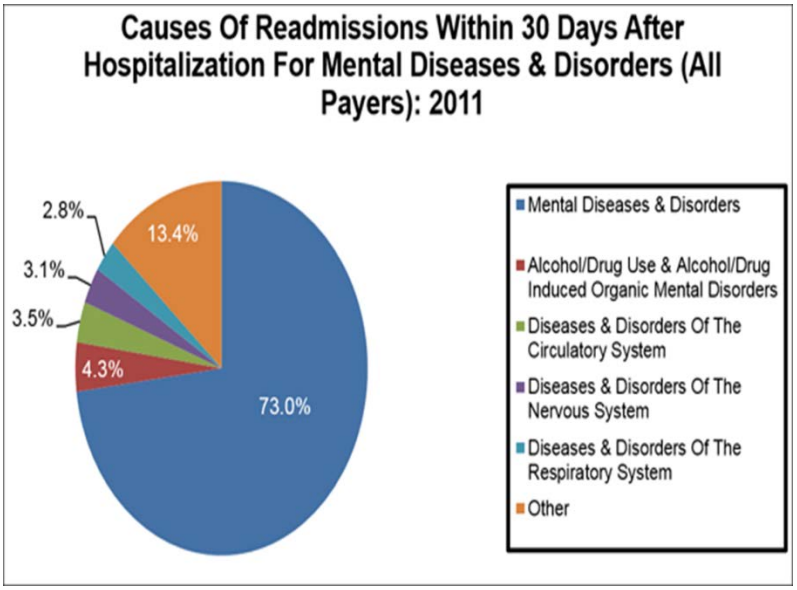
The final step can be challenging based on how habituated the participant has become during the inpatient program. Habituation is when a person becomes entirely reliant on a program instead of themselves and their social networks. When they leave the inpatient program they no longer have the services or structure they relied on. The longer the patient has spent in an inpatient program the weaker their past support network becomes. There can also be difficulties returning to one's previous social

support network. Support networks centered on criminal activity or substance abuse need to be cut out if the patient is to become truly rehabilitated. In these cases, the patient may have no support network to return to. Without help transitioning from one program to another or to independent life, people finished with inpatient programs can suffer from extreme stress of the unknown, weak social support, are more likely to abuse drugs or alcohol, and are overall more likely to relapse.

Relapse and Rehospitalization after Discharge from an Inpatient Program:

High rates of rehospitalization after an inpatient program leads to what is known as the “revolving door” of mental health. This is when a person enters a psychosis strong enough to require hospitalization or an inpatient program, they are released without being truly helped or without help transitioning back into the community, and the patient has a severe enough relapse to require further hospitalization or another inpatient program. A study in the United States found a year after release from a psychiatric hospital 30% of the patients had been rehospitalized. A study in Germany found 38% had required rehospitalization after only six months. Finally, a Brazilian study found 43% of patients released were rehospitalized within a year of release (Loch, 2014). These numbers dramatically increase when looking at the relapse rates for those with schizophrenia. Up to 80% of those diagnosed with schizophrenia relapse and are rehospitalized after their first episode (Tibbo, Malla, Manchanda, Williams, & Joober, 2014). Seventy-three percent of all people rehospitalized within 30 days of discharge

are rehospitalized due to mental health problems.



(Open Minds, 2014)

After a patient is released from psychiatric evaluation they are given a transition plan to follow. This plan is more of a list of suggestions of things the patient should do as well as what medication they should take. There are no requirements for what the transition plan must look like, it doesn't need to use accredited programs, and it is in no way mandatory for the patient to follow the program. This transition plan offers no actual support to the patient, it only offers suggestions. This type of plan is insubstantial. If a transition plan is not thoroughly thought through and focused on the specific patient's needs it won't work and may do harm in the long run.

After being stabilized a major hospital in Indiana transferred a patient with schizophrenia to a regular nursing home. This nursing home didn't have the knowledge or resources to treat him, so when he started becoming symptomatic they discharged him. With nowhere else to go and no one else to help him, he turned to his mother. His

mother was forced to manage him with no help from the hospital or nursing home. Due to stressors and inadequate care the patient relapsed and was sent back to the hospital. In this situation, the hospital didn't properly identify the patient's needs, so they sent him off to a program which didn't have the capability of helping him. This wasted resources for the nursing home, put a large pressure on the family, and ultimately increased the hospital's workload since they had to retreat him. Even when hospitals connect their patients with organizations with the resources to help them, there can be issues in the transition. There is often a disconnect between the hospitals and mental health centers. Due to a lack of funds, workers, and rooms mental health centers don't always have the necessary resources to take on a recently discharged patient. The hospital may be ready to discharge a patient, but the mental health center isn't ready to receive them. In this situation, the hospital is forced to hold on to the patient longer than necessary, the mental health center is forced to stretch its resources past capacity, or the patient is caught in a transition gap where they receive no services until something changes. Other times, the mental health center is ready to receive someone, but the hospital isn't quite ready to discharge them. Due to extremely limited resources and a vast need for mental health services, mental health centers reach capacity extraordinarily fast. The longer a hospital waits to discharge a patient the higher the probability the mental health center will have reached capacity before discharge (Sprunger, 2017). Increased collaboration between hospitals and mental health organizations, transition focused programs (not plans), and effective time sensitive programs are necessities if the revolving door is to ever be stopped.

Evidence Based Theories:

What are the best methods to prepare participants of a program for the next step? During the program, it is important to help every individual develop their social cognitive skills. Social cognition is one's interpersonal skills, how they interact with the community and others. A study using 125 people with schizophrenia showed social cognition and functionality have a statistically significant relation. The higher social cognition was the higher functionality was. The study reviewed all those it tested one year after the end of the program and found those who underwent social cognitive treatment retained a higher level of functionality (Brekke, Hoe, Long, & Green, n.d.). Increased social cognition makes it easier for one to gain and take advantage of social support. Social support is the support given from friends and family. A higher level of social cognition allows one to trust those who do support them, make stronger connections, and expand their social support by making more friends. Social support can be broken down into practical, family, and emotional supports. An analysis of 122 different studies found social support has a strong impact on the rate one takes their medication. Whether someone adheres to their prescribed medical regimen is the number one factor of relapse. Emotional support is given from those who nurture, empathize, and support a person consistently. The study found those who receive strong emotional support from friends and family are 1.35 times more likely to adhere to their prescribed medical regiment. Family support comes from one's family being accepting, warm, and close with each other. Those with higher family interaction and support have been shown to be 3.03 times more likely to adhere to their prescribed medical regimen. Practical support includes reminders, helping the afflicted person organize their medicine, and support in their struggles. Those who have strong practical

support are 3.6 times more likely to adhere to their prescribed medical regimen (DiMatteo, 2016).

The next big obstacle in a patient's ability to thrive in the long-term is at the end of the inpatient program. It is vital to get the participant connected with the appropriate level of support. If the transition is from inpatient services to outpatient services, the patient will need to be connected with a strong support network and taught how to take charge of their own treatment. Studies have shown transition programs focused on these aspects have been shown to reduce initial psychiatric relapse by up to 30% (Ouslander, Lamb, Tappen, Herndon, Diaz, Roos, Grabowski, & Bonner, 2015). Two of the most promising methods of transition programs are Assertive Community Treatment (ACT) and Critical Time Intervention (CTI).

Assertive community treatment is a program which uses community integration to provide maximum support for its clients. Assertive community treatment coordinates efforts between all the services offered in the community that the client needs. Services include medication, hospitalization, crisis intervention, substance abuse services, legal and advocacy services, and education. In addition to these services, a support specialist is available any hour of any day (National Alliance on Mental Illness, 2016). By forming this network between services, all the professionals helping the client will know how the client is doing in all aspects of their life. This allows each professional to make a more effective treatment program tailored to each of their clients' lives. This program also allows clients to stay in their community because the programs and services they connect with are local or within the client's reach. Staying in their community lets the client maintain and expand their social support network. An analysis

of 52 studies on assertive community treatment show just how effective it is. Compared to typical case management, clients of assertive community treatment had a statistically significant 37% reduction in homelessness and a statistically significant 26% who experienced reduced negative psychiatric symptoms (Coldwell & Bender, n.d.).

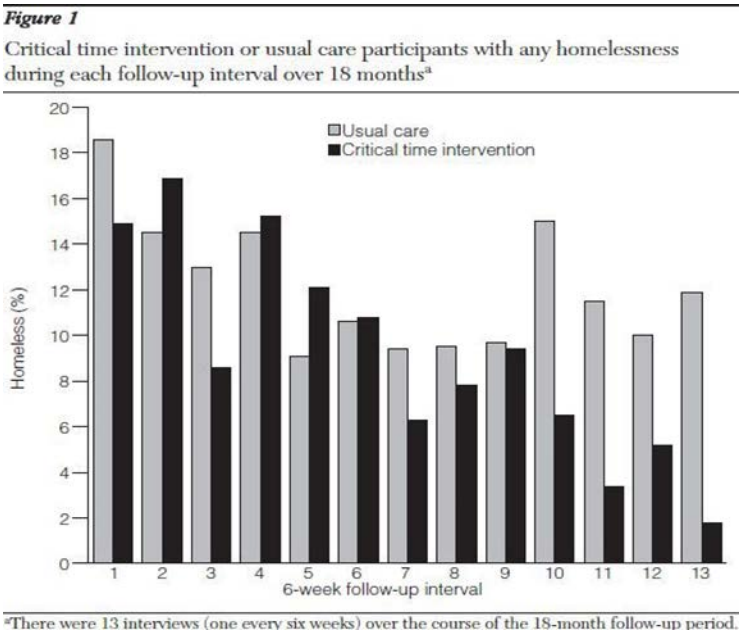
Assertive community treatment has many strong aspects, but it doesn't actively use the client's social support network, there are low caseloads, and there is no specific end to the program. Low caseloads and not having a specific end times greatly increase the cost of the program. Not actively using the client's social network and not having a set end to the program makes the client reliant on their management specialist instead of helping them become self-reliant. A similar program which takes these disadvantages into account is critical time intervention. Critical time intervention is a transitionary social support based program. The creators of the program found the first nine months after an inpatient program to be the most critical for community integration. In these nine months it is vital to rebuild the client's social network and support and connect them with services they need that are available in their area. Critical time intervention has dual objectives, to strengthen the client's ties to family, friends, and services in the long term, and to give emotional and practical support during the nine months. It reaches these goals through three phases. First, planning and implementation. Second, fine tuning. Third, self-reliance.

The first phase is the most intensive, it lasts the first three months. During these three months the CTI worker meets with the client and figures out their needs. They accompany the client to appointments, meet with the client's caregivers, negotiates ground rules between caregivers and the client, mediates any conflicts between the

client and their support network, and helps them expand their recovery and social support networks. This phase provides the client with the base of a permanent support network they will be able to rely on when the program is over. The second phase is less intensive and lasts from the beginning of the fourth month to the end of the seventh month. In this phase the CTI worker observes and modifies the rules and relationships between the client and caseworker where it is needed. This phase is to work out any problems or issues between the client and caregivers. By the end of this phase the client will have adjusted their social and recovery networks to what works best for them. The final phase is the least intensive section and lasts from the beginning of the eighth month to the end of the ninth month. During this phase the CTI worker helps the client cement all their relationships with their friends, family, and care providers. This phase is to create a smooth transition from reliance on the CTI worker to the client's personal permanent support network. Throughout this program, the CTI worker is gradually relied upon less, until at the end of the final month when the client no longer needs to rely on them. This smooths out transition gaps between the end of an inpatient program and life in a community. By actively using and building the client's support network and working towards a set program end time, critical time intervention increases the client's independence. Due to the varying levels of effort needed in each phase of the program each caseworker is able to manage up to 15 clients. This higher level of client caseload combined with the limited amount of time the program operates for each individual decreases the cost of the program (Susser, Valencia, Conover, Felix, Tsai, & Wyatt 2016).

How effective is critical time intervention? A study was done on how critical time intervention affects people diagnosed with schizophrenia. The study followed 96 men who had recently been released from a psychiatric program. It split them up into a control group who had usual services and the test group, which went through critical time intervention. The groups were followed for a total of 18 months. At the end of the 18 months it was found those in the critical time intervention program had spent one third as many nights homeless compared to those with usual services (30 days compared to 91 days). Studies consistently have shown CTI reduces homelessness by about one third. In addition, many studies show a statistically significant relation between critical time intervention and negative psychological symptoms. An average of 26% of participants in studies experience lessened negative psychological symptoms. Separate studies focusing on critical time intervention's effects on those released from prisons, homeless shelters, and psychiatric programs have all revealed similar statistically significant results. These studies have also revealed critical time intervention costs roughly the same as usual services. Though critical time intervention ends after nine months, its effects have shown to hold stable until the final check-up nine months after the program has ended. The benefits of the usual services, however, rapidly deteriorated once that program ended. This can be explained by the transfer of responsibility. In usual services the case worker is responsible for managing the client's recovery. When this type of program ends the client doesn't know how to continue their recovery, because the majority of their support has left. With critical time intervention, the CTI worker starts with the majority of the responsibility for their client's recovery, but by the end of the nine months they have smoothly and completely transferred that

responsibility to their client and the client's personal support network (Herman, Conover, Felix, Nakagawa, & Mills).



(Kasprow & Rosenheck, 2007

Transition Partnership:

Indiana University's Prevention and Recovery Center for Early psychosis, or PARC program, is focused on reducing rehospitalization and improving outcomes for those afflicted by schizophrenia. It focuses on providing immediate, comprehensive, and long-term outpatient treatment to those in the earliest stages of schizophrenia. The PARC program and Eskenazi Health have partnered to provide a more comprehensive continuum of services. Patients at Eskenazi who are going through early stages of schizophrenia are connected with the PARC program after discharge. The PARC program then provides several types of outpatient treatments including: psychotherapy, managing medicine, case management, and crisis intervention. They also educate the

participant, family members, and the community on psychotic disorders and how best to treat those affected by these disorders (Prevention and Recovery Center for Early Psychosis, n.d.). Their services have both reduced rehospitalization and suicide rates. There is a 10% suicide rate for those with schizophrenia, yet no patient in the PARC program has committed suicide.

Since it began in 2009, the PARC program has treated over 600 patients; the average patients used their services from two to three years. In this time, no one has been turned away. The PARC program was founded on the philosophy of no waiting lists, no patient being turned away, and patients being able to be seen whenever and however often they needed. They realized it is easier and cheaper to prevent further relapse if it is caught in an early stage. Similar to CTI, the PARC program understands the sooner a patient can receive services after discharge, the better their outcome will be. The PARC program goes further than this by targeting those in the earliest stages of schizophrenia. Intervening early in the disorder further improves the possible outcome. By providing comprehensive outpatient services to patients immediately after discharge they help prevent further treatment and rehospitalization. This reduces Eskenazi's costs and resource usage. In return the PARC program uses Eskenazi's administrative services and building, cutting down on PARC's overhead expenses (Alan Breier, 2017). This partnership allows the organizations to provide a more comprehensive impact by expanding the continuum of care, while doing it at a reduced cost by working together.

An Innovative Government:

Since Reagan's Omnibus Budget Reconciliation Act in 1981 the role of government has shifted from providing services to mainly providing funding. There has

been a 95% reduction state run hospitals leaving 200 in the United States (Corporation for Supportive Housing, 2017). Though the focus has shifted to funding, Ohio has implemented innovative new practices to help people transition back into the community. Their Community Transition Program (CTP) targets those in the prison system of Ohio. Though different than the typical inpatient program, the prison system has many similarities. They are live-in programs which provide constant support, structure, and some type of treatment. There are more people with mental health problems in jails and prisons than in anywhere else in the United States. A report by the Bureau of Justice Statistics revealed there are 479,900 people with mental health problems in jail and 784,400 people with mental health problems in prisons (National Institute of Corrections, 2016). The combined amount of people with mental health problems in the justice system (1,264,300) is over 36 times the amount of total psychiatric inpatient beds (35,000) in the United States. The National Alliance on Mental Illness did a survey of 1,400 families with members who have a mental illness. Of these 1,400 families, 40% of the mentally ill members had been arrested at least once (Honberg, n.d.). The Indiana Department of Correction reported the recidivism rate, or rearrest rate, of prisoners whom are mentally ill is also roughly 40% (Garner, n.d.). Most mental health treatment in the prison system is improperly given and lacks properly trained staff to make effective change. Ohio is an exception. It has the best prison mental health system in the United States.

In all 30 Ohio prisons, there is a trained staff of mental health professionals. Once the inmate gets to the prison they undergo a psychiatric assessment from the staff. During their sentence there are 15 self-development programs they are able to

enroll in. To be eligible for the transition program they must have been enrolled in at least one of these programs. If accepted into the CTP program they will use the assessment done by the mental health staff to form an individualized plan. Thirty days before the release of the inmate the staff will link them with nonprofits and services near the area they will be living afterwards. The program also finds and provides funding for housing, medical insurance, and transportation to get to their appointments. There are three types of housing available through this program: recovery, emergency, and long-term. Recovery housing serves those who need a lower level of inpatient services. Emergency housing is provided for those who need something immediately. Long-term housing is for those who may not be able to afford housing on their own or who may become homeless without housing assistance. Though the majority of participants live in urban areas where there are more resources available, many do return to more rural areas which lack treatment services. CTP pays the cost of transportation to take those who live in rural areas the nearest available service. There is a percentage of the CTP budget earmarked specifically for these areas. One particularly strong point of the program is how they react when participants relapse. If a participant relapses or is sent back to prison they are not kicked out or penalized in any way. “These are the people who most need help”, says Donald Christian, regional administrator of Ohio’s CTP. “This is the only type of health problem people get penalized for having. You wouldn’t kick someone out of chemo if their cancer came back”. By keeping those who relapse in the program they are helping those who are most vulnerable and in need. The program isn’t perfect. In the drug version of CTP, the participants and service providers meet before the inmate is released. This stabilizes the connection and allows the service

providers to best prepare for the participants needs once they are released. Due to insurance reasons, the mental health version of CTP does not allow this pre-release meeting between service providers and inmates. This program is extremely new. It began in 2016 and the effectiveness and results of the program are still being tested. It's based on an already existing community linkage program which has shown strong results, but it is not yet known if this new version is a cost-effective way to provide stronger results. The total expenses for these services is approximately $900 monthly per participant. Since the program began in 2016 there have been approximately 1,000 participants. For 2017 they anticipate an addition of 6,000 new participants. To fund this program Governor Kasich allocated $68,000,000 of the state budget (Christianson, 2017). Though the rehabilitative aspect during the participant's time in prison is weaker than the typical inpatient program, the assessment and transition back into the community is very strong. This innovation gets the government more involved in individual treatment than they have typically been since the signing of the Omnibus Budget Reconciliation Act in 1981. If proven a cost-effective method for reducing relapse, this may cause a shift in how government is involved with mental health care.

Conclusion:

The rate of rehospitalization and relapse is too high. Recidivism rates from prisons are 40%. The rehospitalization rates of psychiatric hospitals are 30% in the United States. Seventy-three percent of those rehospitalized after a short term stay in a hospital are rehospitalized for mental health reasons. The extreme rates of relapse combined with severely constrained resources make it impossible to treat all those who need it. By focusing on long-term outcomes after a program ends relapse rates can be

reduced to a more manageable level. Transition programs such as ACT and CTI have shown to reduce homelessness by over 30% as well as reduce negative psychological symptoms by 26%. Partnership programs, such as PARC have reduced suicide rates and rehospitalization rates by expanding the continuum of care and helping patients transition. Partnerships like this also reduce costs to both organizations allowing them to create a larger impact in a more cost-effective rate. Innovation like Ohio's CTP program provide structural and financial support to those most in need. CTP eliminates the transition gap and provides financial and structural support to those who are trying to make a meaningful change in their lives. Though this program is too new to have concrete scientific support, it is testing new methods which could change how government approaches mental health funding. All of these theories and programs focus on reducing the time gap between programs and services. By helping patients transition relapse, recidivism, homelessness, suicide, and rehospitalization have all been reduced. To gain the best long term results, mental health organizations must help participants transition into the next stage of their life. When a program ends, participants should not be afraid of the unknown. They should be hopeful, knowing they will still have support once the program is over.

Creating a better transition system and expanding the continuum of care have recently become large focuses in the mental health community. Due to how new many of these programs and innovations are, there is much research needed to be done on the effects they have. This is an area of research I have been following for over a year and plan to continue my research even further. The theories and their practical application have shown impressive results so far. If these results continue they could be

used to reshape the mental health system into a far more effective and cost efficient system.

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