June 9, 2009

Comments to DMH Inpatient Study Commission for Taunton State Hospital

John A. Brennan
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The Board of Trustees of TSH recognizes the important work of this Commission. We support effective and efficient use of Commonwealth resources and will support the efforts of this Commission to achieve their goals. We recognize the work to be done as no easy task and offer our comments for your consideration:

- TSH has made significant gains in changing the culture of the hospital to a treatment approach that is patient centered and is effectively infused with the Principles of Recovery and Hope. This culture shift not only recognizes the importance of using less restrictive alternatives but also more importantly focuses on recovery and safety while at the same time respecting rights of patients.
- TSH was "commended" by the Joint Commission during the unannounced survey in November 2008 for integrating recovery into treatment, for the effective management of the dignity of risk and for reducing restraint and seclusion events by 90%.
- TSH provides many specialized clinical services such as the forensic evaluation service, the individual and group DBT (Dialectical Behavioral Therapy) treatment program, The Recovery Center and a coordinated program with the community to treat patients with a major mental illness and problematic sexualized behaviors.
- TSH also provides evidence-based practice for treatment of patients with challenging clinical problems including self-injurious and aggressive behaviors and schizophrenic disorders.

- **TSH has effectively integrated both salaried and volunteer "Peers", individuals who have lived through their own experience with major mental illness, into the overall treatment program. The hospital-based Recovery Resource Center is one of the first in the country to bring this volunteer run service as a real adjunct to inpatient treatment.**
- **TSH's specialty units meet the needs of many individuals with unique treatment concerns while at the same time respects the rights of those patients. For example, through hospital leadership and culture change, forensic patients are afforded many of the same opportunities the general hospital population realizes, at the same time TSH recognizes the importance of safety to patients, staff and the community.**
- **There are many examples of the hospital using the Dignity of Risk rather than relying solely "sticking to the norm". In many ways, TSH has become a "trend setter" in the way that the hospital has successfully balanced safety with individual patient choice.**
- **Over 90% of both the forensic evaluation and continuing care patients are from the Southeast Area; an area that includes Taunton, Brockton, New Bedford, Fall River, Attleboro, Plymouth, Bridgewater, Easton, Mansfield and Cape Cod. Travel to a hospital located further away would create a hardship for many families – some of whom do not have autos and must rely on others or public means for transport.**
- **TSH achieved a deficiency –free unannounced CMS Survey in May 2008 – another indicator of high quality care.**
- **TSH has a closely woven relationship with the community and the City of Taunton as evidenced by the number of residents that use the campus roads and trails for daily walks, the community groups that use the Ricky Silvia Gym on off hours, the consumers who shop at the Gift shop and Green House and the participants in the Run for Ricky Road Race.**
- **TSH is a crucial link in the continuity of care. Continuing Care beds for South East Area patients with a pervasive, serious mental illness that has not responded to intensive outpatient or acute inpatient psychiatric treatment should be available in the South East Area.**

Massachusetts Nurses Association
Testimony Before DMH Inpatient Study Commission

Delivered by Karen Coughlin, RN
Vice-President, MNA Unit 7 of RNs and Health Professionals

Thank you members of the Inpatient Study Commission for the opportunity to speak to you this afternoon. My name is Karen Coughlin and I am the Vice- President of the Massachusetts Nurses Association Unit 7 of RNs and Health Professionals, which represents more than 1,800 health professionals who work in state agencies and state-operated facilities. Our members include all state-employed registered nurses, physicians, psychiatrists, pharmacists, psychologists and occupational therapists, who work in the Department of Mental Health inpatient facilities under review by this Commission. I am a psychiatric nurse who has worked at Taunton State Hospital for the last 25years.

We bring a unique and important perspective to this process, as we are the clinical professionals on the frontlines of the DMH system; we are the professionals who are personally accountable for the health and well being of the clients served by the Commonwealth. Because we are on the frontlines, we see more and understand more of what works and doesn't work in the current system. In addition, because of this perspective, we have a greater sense of the potential impact of the decisions of this commission as we plot the future of inpatient psychiatric services in the Commonwealth.

We come here today with a sense of great urgency and with a deep concern about these proceedings and the work of the department. Our concern and our urgency has been fueled by statements made by officials at various facilities last week about a current plan to close up to 100 inpatient beds within the system by July 1st, as well as other unofficial reports of plans to close an entire facility within the coming months.

Given the prospect that either of these drastic measures is being seriously considered, we are here to tell you that we believe that such a decision will have a dramatically negative impact on the care of individuals with mental illness and greatly increase stress to their families and to the communities in which they live. The loss of these beds, or of an entire facility, combined with the recent dramatic cuts to community services and supports for the most vulnerable mentally ill, will adversely affect thousands of individuals and family members. Mental health consumers who have relied on these facilities and these services for years will surely suffer. We cannot change how things were done in the past. We learned then that closures without the appropriate planning and supports profoundly affected the clients we served. Many became homeless, others ended up in the correctional system, and many more found themselvesat greater risk to themselves and others. Then, as now, we faced difficult economic times. It is because of that, we urge you, please, do not let what happened in the past dictate our future.

First and foremost, the MNA is committed to the position that wherever, and whenever possible, people suffering from mental illness or other chronic conditions should be cared

for in community settings, with the greatest independence possible, and with access to the services and supports needed to ensure their independence and well being. In fact, we have played a major role in helping those that should be in the community, move to the community where they are best served. Further, through the efforts of our members who serve in transitional programs, we have worked for years to provide the supports needed to keep people in the community for as long as possible.

However, there are members of this population that require a level of clinical care that is best provided in state-run facilities designed to provide a higher level of care. Just as some frail elderly reach a point where they cannot sustain themselves in the home and must be cared for in a nursing home environment, so too do some of our severely mentally ill clients require more intensive services in a more protective environment. To understand the role and value of our inpatient facilities, one needs to have a clear picture of the clients we serve. At our inpatient facilities, particularly at my facility, Taunton State Hospital, we take care of a significant number of forensic patients, which means they come to us from corrections facilities or the court system, with varying levels of criminal involvement and some with violent behaviors and histories. At all of our facilities, we have many frail elderly mentally ill patients who can't be cared for in nursing homes. A large percentage of our patients have a dual diagnosis of mental illness and substance abuse which complicates their placements in community settings. We have a number of women suffering from serious trauma who are self abusive and suicidal and need intensive mental health monitoring and care. These are patients that often have nowhere else to go in the system.

In fact, there is a shortage of psychiatric beds throughout the entire health care system in our state, including the public and private sector. I would point to the recent DMH decision to allow Cambridge Health Alliance to close 35 of its acute psychiatric beds, as well as their substance abuse treatment unit. Other facilities have closed beds in the last decade, and we know that St. Vincent Hospital in Worcester was prepared to close its psychiatric unit, and may do so within the next two years.

Right now, we have psychiatric patients clogging our emergency rooms across the state, some waiting for 72 hours or longer for a psychiatric bed placement. We also know that in tough economic times and times of recession, the incidence of mental illness, depression, suicide and substance abuse increase, necessitating a greater need for all levels of psychiatric care.

I would also point to the Commission's own documentation on its web page which shows that the census at the facilities under study by this commission was running at an average census of 97 percent as of May 13, 2009.

The same DMH document, concerning the scope and purpose of the Commission, points to, and I quote, "an already significant reduction to DMH community services with the elimination of day and employment services and a reduced case management work force." It further states that, and again I quote "more than 200 of the 788 adult patients in

DMH continuing care facilities are ready for discharge but appropriate community services are not available."

Right now we know it can take up to two months to transition a client from one of our facilities to a community residence.

So if you admit that the community system cannot accept clients promptly now, how can it be done without the risk of harm to our clients? Because that is exactly what you will be doing. And in so doing, you are only going to increase the rate of homelessness, further clog up and destabilize our hospital emergency rooms, allow patients who are currently stabilized and safe to be placed in jeopardy, and in the end, drive up the cost of health care throughout the system, as we are forced to deliver care in more expensive settings, including our overcrowded jails.

We urge you to make different choices. Specifically we offer the following principals for our position on the future of inpatient services in the commonwealth:

- **Put Careful Planning for the Clients Before Any Other Consideration** -- No closing of beds or facilities should be contemplated unless and until a comprehensive process of evaluation and planning takes place as to what is best for those served by these facilities. We hope that this process will include a truly objective analysis of the current and future needs of the population being served by the facilities, an evaluation of how, where and at what costs alternative services will be provided, with specific funding allocations to allow those services to be delivered.
- **Guarantee Equal or Better Care** -- No closing should take place unless and until every client or patient impacted by the decision is guaranteed equal or better services as defined by the clients themselves, their families and guardians, as well as by the clinical team overseeing their care.
- **Provide Transitional Care** -- Any client displaced by a bed or facility closing, should receive appropriate transitional services and care to ensure the process of transition is conducted in a manner that will not cause undue harm or distress to the client.
- **Make True Cost Assessments** – No closing should take place until a realistic, comprehensive and independent analysis of the total societal cost of the closing is completed. Cost benefit analysis driving these decisions should factor in all costs, not just the cost of maintaining the particular asset in question. This should include the costs to state government for the impact closings will have on unnecessary emergency room visits, increases to the Medicaid budget due to poor management of conditions in an inappropriate community placement, and the cost of creating multiple community residences to replace the facility in question.
- **However Services are Provided, State-Operated Services are Preferable to Privatized Services** – The record of privatizing state services is spotty at best and in many cases, highly detrimental to the care of those placed in these systems. Studies have clearly shown that state-run facilities, with services provided by unionized health care professionals provide better care, with dramatically less

turnover of staff, which reduces costs and prevents increased cost associated with poor care.

- **An increase in state revenue to fund the system** – The MNA has been quite clear that we cannot maintain our health care safety net through cost cutting alone. Protecting the mental health of our communities will require an investment of new revenue. We support an array of revenue generating measures proposed by the legislature and urge passage of those measures.
- **If closures occur, they should be focused on removal of beds, as opposed to the closure of an entire facility.** As stated above, the demographics of our society, as well as recent trends in utilization of inpatient services, shows that the need for inpatient care will continue to increase and that we need to protect our sources of bed capacity to meet future demand. It is less costly to close and then open units or wards within a facility, then to build a new facility at a later date. This is particularly critical if privatization of services is being considered. Once the state eliminates the infrastructure needed to provide the services at all, private vendors will dramatically increase their costs. So it is far more fiscally prudent to close beds or wards than it is to close facilities.

We all want and strive for a system of care that is determined by the client, that is community based, and which fosters optimum independence. My entire career, and those of my colleagues, is based on that premise, but creating that system calls for an investment in resources that does not yet exist. As frontline caregivers, we can't abandon our clients to a system based on false promises. Our professional licenses demand that we be honest with our clients and the public about the consequences of our actions and yours. We hope you will use this commission to make a thorough and objective analysis, one that provides a plan based on the needs of the residents of the Commonwealth, and that you fight for the resources to meet those needs.

CPR

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TESTIMONY OF SUSAN STEFAN
CENTER FOR PUBLIC REPRESENTATION
BEFORE THE MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH
INPATIENT COMMISSION
Brockton, Massachusetts
June 9, 2009

Members of the Commission, thank you for taking my testimony and for addressing this important topic. My name is Susan Stefan and I am a staff attorney at the Center for Public Representation. I spent three years representing patients at Westborough State Hospital, and have spent decades working on bringing people with psychiatric disabilities home to live integrated lives in community settings.

The Center for Public Representation does not believe that any solution can be devised regarding the number of long-term inpatient beds needed by the Commonwealth without addressing a growing problem here in Massachusetts and across the country: the increasing capture of scarce mental health resources by the criminal justice system. Nationally, judges are ordering so many people into state facilities for competence evaluations and other similar evaluations that the actual availability of long term beds for civil patients is cut in half. In Maryland, forensic patients account for over half of all state hospital beds; in Oregon, forensic patients take up virtually all of the state beds, leaving nothing for civil patients. An article regarding this situation is attached to my testimony. Because the criminal justice system doesn't have to pay a penny for these beds, and no one is accountable for the costs, judges who think they are doing defendants a favor are flooding the mental health system with people from the criminal courts, the civil system becomes clogged and backed up, and the private psychiatric hospitals tell you there aren't enough long-term civil beds. There are plenty of long-term civil beds—but too many of them are occupied by people from the criminal justice system.

One reason that this is a problem here is that DMH cannot control the use of these beds. Massachusetts law provides that a person whose competence or criminal responsibility is in doubt can be initially examined, and that "whenever practicable, examinations shall be conducted at the courthouse or place of detention where the person is being held," M.G.L. 123, 15(a). However, if the judge "has reason to believe that further observation and examination are necessary," he can order a person be sent to a state hospital for twenty days, regardless of whether the person needs inpatient care, and

regardless of whether the facility can complete the competence evaluation in less time. M.G.L. 123, 15(b). The statute orders that the evaluation be sent back to the court at the conclusion of the evaluation period of twenty days, which can be extended. M.G.L. 123, 15(c). If the individual is being evaluated for delinquency or sentencing purposes, the statutory period is forty days.

Even if DMH clinicians believe that the person can be evaluated safely in the community, and even if they are finished with their evaluation within a few days, the defendant is likely to stay in that bed for twenty days, forty days, or longer. If the judge sends the person to a DMH inpatient unit, regardless of whether he or she actually meets inpatient critieria, that person stays there until the sheriff comes to take the person back to court. Because the law prescribes a period of 20 days for these evaluations, even if DMH officials finish the competence evaluations the day after the individual arrives, or that week, the individual cannot be discharged unless the sheriff arrives to take him or her back to court.

This situation is unfair to the civil patients who need long term care, and it seriously distorts attempts to evaluate long-term inpatient bed capacity. Worse still, the experience of other states indicates that the problem will escalate exponentially unless it is addressed.

The Center for Public Representation has several solutions to suggest to the Commission. First, we believe that the most appropriate and likely most successful way to solve this problem is legislatively, with a combination of legislative caps, more specific instructions to judges regarding the current legislative mandate to conduct competence evaluations in the community, fiscal accountability, and increasing bed turnover in evaluations. We believe if the Commission and the Department, along with private hospitals, NAMI, advocates and consumers, should urge the Legislature to adopt at least some of the following four suggestions, you can free up sufficient beds to both increase civil bed capacity and permit facility bed reduction and/or closure. We suggest that legislation be drafted that would:

1. Limit competence evaluations for individuals to court clinics and other community settings, as prescribed by Sec. 15(a), unless the individuals were specifically found by the court to meet inpatient commitment standards.

2. Reduce statutory competence evaluation time from twenty and forty days to ten days, with a provision permitting an extension of ten days for good cause if requested by the facility. In addition, the statute could be revised to require the sheriff to pick up the evaluee within two business days after the evaluation is completed.

3. Cap the use of long-term state hospital civil beds by the criminal court system for evaluation purposes at fifteen to twenty percent. If a hospital's population of forensic clients exceeded the fifteen or twenty percent limit, it would go on "diversion" status, and be able to refuse to accept evaluees from the criminal court system.

4. Reimburse DMH dollar for dollar for every individual sent by the criminal court system to be evaluated, and direct that those dollars be spent on providing community services to enable the Department to close long term civil inpatient beds.

Thank you for your attention, and I urge you to include the issue of forensic use of civil long term beds in your report to the Commissioner. As the experience of Maryland, Oregon, Texas, and other states show, you will never be able to build enough long term beds to satisfy the appetite of the criminal justice system, and the Department of Mental Health should not spend its own resources doing so. Rather, it should make an estimate of the real need for civil beds, limit forensic use, reduce civil beds, and devote the savings to providing the care that people need in the community.

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EDITORIAL

The Majority of Inpatient Psychiatric Beds Should Not Be Appropriated by the Forensic System

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In 2006, the National Association of State Mental Health Program Directors (NASMHPD) published a report entitled "The Crisis in Acute Psychiatric Care."[1] The report noted reduced inpatient bed capacity in state, private, and general hospital psychiatric units. Citing estimates from the National Association of Psychiatric Health Systems, NASMHPD reported a long-term shift in the locus of hospitalization from state hospitals to community hospitals and to nonhospital residential units. NASMHPD also noted the collateral effects of reduced hospital level psychiatric beds on hospital emergency departments and on the increased number of mentally ill individuals in the nation's jails and prisons.

The May 2007 meeting of the American Medical Association's House of Delegates passed Resolution 714, which stated:

> ...that our American Medical Association work with relevant stakeholders, such as the American College of Emergency Physicians, the American Psychiatric Association, the National Association of EMS Physicians, and the American Ambulance Association, to study and develop recommendations regarding the national scope of the problem of psychiatric bed availability and its impact on the nation's emergency and general medicine resources including emergency department overcrowding [Ref. 2, p 63].

This resolution, originated by the American College of Emergency Physicians, focuses on the problem

in the nation's emergency departments, which were described as being near collapse.

In October 2007, the *American Journal of Psychiatry* published a commentary entitled the "The Future of Psychiatric Services in General Hospitals."[3] The authors documented a significant increase in these beds from 1960 to 1998 and then a decline from 1998 to 2002 and presumably to the present time. They attributed this decline to several factors, including poor reimbursement from all payment sources and conversion to medical-surgical beds, which were needed and contribute much more to hospital margins. The authors concluded with a plea for policy makers to address these problems, emphasizing the importance of general hospital psychiatric beds as a significant component of the health care delivered by the nation's general hospitals.

We present a brief review of the substantial evidence demonstrating that the number of psychiatric inpatient beds nationally has declined dramatically in both state and community hospitals. Next, we review the psychiatric inpatient bed situation in Oregon where the dramatic decline in beds mirrors the national trend. Finally, we examine the legal status of patients hospitalized in these facilities. We make the assumption that a patient's legal status partially determines his or her hospital course, including the treatment received.

The Nationwide Decline in Psychiatric Hospital Beds

State Hospital Beds

The substantial decline in the number of state hospital psychiatric beds has been well documented. Lamb and Weinberger[4] reported that between 1955 and 2000, the number of state hospital beds declined from 339/100,000 to 22/100,000. Salzer *et al.*[5] examined national public hospital census data during five-year time periods from 1984 to 2003 with special attention to the effects of the 1999 U.S. Supreme Court decision in *Olmstead v. L. C. by Zimring*.[6] During the study period, the number of state hospital beds decreased by 55 percent. From 1984 through 1987, the average state hospital census was 110,000 while in 2000–2003 the average census was 49,437. The authors also found that the rate of decline in state hospital populations following the 1999 *Olmstead* decision slowed rather than accelerated, as they had expected.

In a recent non-peer-reviewed article published on its website, the Treatment Advocacy Center (TAC) reviewed the loss of psychiatric beds in each state, comparing data from 1955 and 2005.[7] This comparison revealed a 95 percent decrease in the number of available beds in the nation's public mental hospitals. In addition, the TAC used an expert panel to determine the number of public hospital beds needed for a "minimum level of care" for each state. The panel recommended that 50 public hospital beds per 100,000 population was needed for a minimum level of care. (Specifically regarding Oregon, the TAC noted that in 2005, Oregon had 19.2 beds/100,000 population, placing the state in the TAC category of currently having a "severe bed shortage.")

Community Hospital Psychiatric Beds

In 2004, the Subcommittee on Acute Care of the New Freedom Commission[8] appointed by President Bush went beyond state hospitals and examined summary data regarding total inpatient bed capacity nationwide. They reported that from 1990 through 2000 the number of inpatient beds per capita declined 44 percent in state and county mental hospitals, 43 percent in private psychiatric hospitals, and 32 percent in nonfederal general hospitals.

Within the overall picture of loss of inpatient beds, Mechanic *et al.*[9] in 1998 noted that the locus of hospitalization for persons with serious mental disorder shifted from state hospitals to community hospitals, with the largest increase in these patients found in private nonprofit hospitals.

Watanabe-Galloway and Zhang[10] examined trends in discharges from general hospitals in 1995 to 2002 for individuals with serious mental disorders (primarily schizophrenia, bipolar disorder, and major depression). They found a substantial increase in hospital discharges of patients with these disorders (from 29/10,000 in the U.S. population in 1995 to 39/10,000 in 2002). This increase occurred in the latter three years of the study period (2000–2002). In addition, they found that most of the discharges occurred in nonprofit hospitals but that the proportion of such discharges dropped from 78 to 64 percent, while the proportion in for-profit hospitals rose from 13 to 28 percent. Partially explaining this trend, the authors noted that the number of nonfederal general hospitals with separate psychiatric units increased from 1,674 in 1990, to 1,700 in 1998, but dropped to 1,373 in 2000.

Psychiatric Beds in Oregon

In 1988, Bloom *et al.*[11] reported on the legal status and place of hospitalization of 621 individuals with schizophrenia or bipolar disorder during two time periods, 1981 to 1984 and 1991 to 1994. Until the middle 1990s, there had been a division of labor between the state hospitals and the general hospitals in Oregon that was determined by the patient's legal status. During the first period, the general hospitals were used primarily for voluntary patients and for those on civil emergency holds,[12] while the state hospitals served voluntary and civilly committed patients and those with criminal court commitments. In the second period, the state hospitals were used primarily for those who were civilly committed and those entering the hospital from criminal courts, while the general hospitals continued to serve patients hospitalized on emergency civil holds and were also treating some civilly committed patients. Voluntary patients had declined in both settings and were primarily seen in nonhospital facilities. It is important to note that 76 percent of all of the voluntary admissions in this particular sample were seen in the 1981 to 1984 time period. As time went on, voluntary patients were less likely to be admitted to the state hospital. If they were admitted, it was to the general hospitals or to several types of nonhospital facilities.

Oregon's Psychiatric Bed Situation on July 13, 2007

Oregon's Alcohol and Mental Health Division (AMH) publishes data twice weekly on the population of patients in its remaining two state hospitals,[13] and the published data also track the number of beds that it is using in Oregon's community hospitals. On July 13, 2007, there were approximately 1,032 psychiatric beds in the state of Oregon. As depicted in Table 1, on this day 940 (91%) of the total

psychiatric beds in the state were used by the Oregon public mental health system: 752 patients in the state's two hospitals and 188 in the community hospitals. (State and county mental health programs in Oregon receive mental health service data for those patients who are enrolled in the Oregon Health Plan, who are Medicaid eligible, or who are indigent, including all patients who are entered into the civil commitment system, including those who may have private health insurance.) So, when we speak of public patients or say that the public system is using 188 beds, these are for patients who fit one of these categories, most admitted as emergency holds in the civil commitment process. On this particular day, only approximately 90 beds were available for all Oregonians who were covered by private insurance and may have needed voluntary admission.

View this table: **Table 1** Oregon's Public Psychiatric Bed Use on July 13, 2007
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Oregon's State Hospitals

Referring to Table 1, on July 13, 2007, of the 752 patients in Oregon's two state hospitals, 466 were hospitalized on criminal court commitments, 177 were civilly committed, and 109 were on a specialized geriatric inpatient service and were either civil or criminal court commitments. Subtracting the geriatric group of long-term patients who were very difficult to place, it means that approximately 28 percent of the state hospital patients were civilly committed, and 72 percent were committed by Oregon's criminal courts. Of the 466 patients committed by the criminal courts, 111 (24%) were committed for competency to stand trial evaluation or for competency restoration. The remaining 355 (76%) were insanity acquittees committed to the Oregon State Hospital's forensic units following their commitment to the jurisdiction of Oregon's Psychiatric Security Review Board (PSRB).[14] If there were voluntary patients in the hospital on July 13, 2007, the number of such patients was negligible.

Oregon's Community Hospitals

In 2007, there were approximately 280 community psychiatric beds in the state. (In January 2008, the state lost another 20+ beds when another general hospital closed its psychiatric unit.) The 280 beds were divided among 11 different inpatient units. On July 13, 2007, Oregon's public mental health program was using 188 (67%) of the 280 beds.

How does the state program use these beds? In 2005 (the most recent year when complete data were available), there were 7,453 public admissions to community inpatient units. Seventy percent of these admissions were patients involved in the civil commitment system (67% on civil emergency holds and 3% civilly committed) and 30 percent were voluntary. The average length of stay was 10.7 days for emergency holds, 7.3 days for voluntary patients, and 35.5 days for civilly committed patients.

Discussion

There is little dispute that the number of psychiatric inpatient beds has declined significantly in the nation's state-run mental hospitals. In addition, both the national data and the Oregon data demonstrate that general hospital psychiatric units may be very vulnerable at this time. The NASMHPD report and the APA commentary[3] mentioned earlier, speculated that general hospitals were increasingly converting psychiatric beds into more lucrative medical-surgical beds, mainly because psychiatric bed reimbursements have either remained static or have decreased. The NASMHPD report also noted that the Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency departments and hospitals to accept, evaluate, and hospitalize (should a bed be available) all psychiatric patients who present to their hospital in an emergency situation. Because of this law, hospitals may have limited their potential losses by reducing the number of available inpatient psychiatric beds. A decision of this nature would in turn cause a back-up of psychiatric patients in emergency departments as they wait for a bed to become available somewhere in the state. In Oregon, waiting for long periods in emergency rooms for a psychiatric bed is a common situation, and if an inpatient bed is finally located, it may be in a hospital many miles away. This situation represents a complete antithesis of a rational community mental health system.[15]

In addition to the loss of psychiatric beds in state and community hospitals, another important trend to note is the increasing use of the available beds for involuntary patients. As mentioned, Salzer *et al.*[5] found that the decline in state mental hospital beds slowed, rather than increased, in the period following the *Olmstead* decision. In this case, the Supreme Court determined that mental health authorities must provide necessary community-based care when an individual can safely be placed in the community. It is possible that, before *Olmstead*, state hospital populations were reduced to a group of very difficult to place civil patients and an overrepresentation of patients committed by criminal courts. In this latter situation, *Olmstead* might not apply in the same manner as it does to civil patients. A similar situation was described in 1991 in two Massachusetts[16] state hospitals, as civil patients were released into the community with a concomitant increase in the forensic population of the hospitals.

The Oregon data allow for examination of the legal status of patients in the system. On July 13, 2007, virtually all patients in the remaining two state hospitals were forensic. As noted, of the 643 nongeriatric patients in the state hospitals, 28 percent came from civil commitment court, and 72 percent came from criminal court. Although unorthodox in concept, we view those patients who come from either civil commitment court or from criminal court as forensic admissions. Both groups are committed to the hospital by a judge, following a court hearing in which physicians have less say about the wisdom of the commitment than do statutory definitions of mental illness. With this approach, at the present time Oregon's state hospitals are, in essence, forensic hospitals governed by the rules of three statutes: civil commitment, competency to stand trial, and the post-insanity defense commitments to the jurisdiction of the Oregon Psychiatric Security Review Board. After more than a century of struggling to achieve a balanced mental health inpatient system that is integrated with community care, the voluntary admissions have virtually disappeared from Oregon's state hospitals.[17]

Community psychiatric inpatient units in Oregon show the same trend. As presented earlier, in 2005, 70 percent of the public admissions were related to the civil commitment process (67% were on civil

emergency holds and 3% were committed) while only 30 percent were voluntary patients. We know from prior studies and from anecdotal experience that most of the emergency hold patients leave the hospital without having received any significant hospital-level care.[18] Further, we also know anecdotally that many individuals who are discharged from an emergency hold do not receive an effective referral to community treatment.

The conclusion is that the Oregon public inpatient psychiatric system is moving ever closer to a total forensic system governed by the rules of the civil commitment statute on the one hand and the criminal courts on the other. It is important to emphasize the role of the criminal courts in assigning patients to Oregon's state hospitals. Of the statewide total of 1,032 psychiatric beds, 466 (45%) were used by the state's criminal courts for competency evaluation and restoration or for the management and treatment of insanity acquittees, leaving only 55 percent of the beds in the state for other public purposes, such as voluntary and civil commitment, and for the use of the whole of the private sector.

Are there any solutions on the horizon? In regard to the portion of inpatient beds dedicated to civil commitment and voluntary patients, the *American Journal of Psychiatry* commentary[3] referenced earlier advocated for a renewed focus on general hospital psychiatric units with the goal of rebuilding the lost capacity and solving the problems that led to a decline in the number of these units in the first place.

The NASMHPD report[1] lists several strategies to "respond to the acute care problem," including "aggressive management of care" and improved collaboration between hospital service providers, to manage most effectively those beds that remain in the system. The report also summarizes steps taken by some states to increase inpatient capacity, including modestly increasing state hospital bed capacity, expanding contracts with private and community hospitals, and developing residential and nonhospital crisis services for pre- and post-hospital services.

In addition to advocating for an increase in state hospital beds to meet the experts' estimate of 50 beds per 100,000 in the population, TAC advocated[7] for the widespread use of assertive community treatment programs that can help offset the negative consequences resulting from the drastic reduction of state hospital beds.

Oregon will soon build two new state hospitals with a modest increase in capacity. The state has also focused on a recovery-oriented treatment philosophy in minimizing hospitalization and on post-hospital services, such as the development of secure residential treatment beds that serve as step-down units from acute hospitalization. However, Oregon has yet to develop a statewide strategy for acute inpatient care, even as the state hospitals are over census and facing difficult legal challenges, most recently from the U.S. Department of Justice.

There now seems to be national resignation to the fact that there will continue to be a large number of mentally ill persons in the criminal justice system and that state hospitals will have to designate a significant number of beds for the use of the criminal courts. In addition, the criminal justice system has come to rely more on itself and on building its own capacity[19] to care for mentally ill offenders. This self-reliance is demonstrated by the increased number of inpatient mental health facilities within prisons

and by mental health courts[20] for offenders who are kept in the community. The drift toward criminalization will continue without a well-reasoned and determined national mental health plan that attempts to re-establish a viable and well-funded mental health system that includes, but is not limited to, adequate state and community inpatient care facilities.

Acknowledgments

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References

1. The Crisis in Acute Psychiatric Care: Report of a Focus Group Meeting (mimeographed). Washington, DC: National Association of State Mental Health Program Directors, 2006
2. American Medical Association: Proceedings of the 2007 Annual Meeting of the House of Delegates. Resolutions 714 and 716. Chicago: American Medical Association, 2007
3. Liptzin B, Gottlieb GL, Summergrad P: The future of psychiatric services in general hospitals. Am J Psychiatry 164:1468–72, 2007[Free Full Text]
4. Lamb HR, Weinberger LE: The shift of psychiatric inpatient care from hospitals to jails and prisons. J Am Acad Psychiatry Law 33:529–34, 2005[Abstract/Free Full Text]
5. Salzer MS, Kaplan K, Atay J: State psychiatric hospital census after the 1999 Olmstead decision: evidence of decelerating deinstitutionalization. Psychiatr Serv 57:1501–03, 2006 [Abstract/Free Full Text]
6. Olmstead v. L. C. by Zimring, 527 U.S. 581 (1999)
7. Torrey EF, Entsminger K, Geller J, *et al*: The shortage of public hospital beds for mentally ill persons: a report of the Treatment Advocacy Center. Available at http://www.treatmentadvocacycenter.org. Accessed March 27, 2008
8. Subcommittee on Acute Care: Background paper. New Freedom Commission on Mental Health, DHHS Publication No. SMA-04-3876, 2004
9. Mechanic D, McAlpine DD, Olfson M: Changing patterns of psychiatric inpatient care in the United States, 1988–1994. Arch Gen Psychiatry 55:785–91, 1998[Abstract/Free Full Text]
10. Watanabe-Galloway S, Zhang W: Analysis of U.S. trends in discharges from general hospitals for episodes of serious mental illness, 1995–2002. Psychiatr Serv 58:496–502, 2007 [Abstract/Free Full Text]
11. Bloom JD, Williams MH, Land C, *et al*: Changes in public psychiatric hospitalization in Oregon over the past two decades. Psychiatr Serv 49:366–9, 1998[Abstract/Free Full Text]
12. Bloom JD: Thirty-five years of working with civil commitment statutes. J Am Acad Psychiatry Law 32:430–9, 2004[Abstract]
13. http://www.oregon.gov/DHS/mentalhealth/data/main.shtml, Accessed July 13, 2007
14. Bloom JD, Williams MH: Management and Treatment of Insanity Acquittees: A Model for the 1990s. Washington, DC: American Psychiatric Press, 1993
15. Caplan G: Principles of Preventive Psychiatry. New York: Basic Books, 1964
16. Geller JL, Fisher WH, Kaye NS: Effect of evaluations of competency to stand trial on the state hospital in an era of increased community services. Hosp Community Psychiatry 42:818–23, 1991 [Abstract/Free Full Text]
17. Bloom JD, Williams MH: Oregon's civil commitment law: 140 years of change. Hosp Community Psychiatry 45:466–70, 1994[Abstract/Free Full Text]
18. Bloom JD, Williams MH, Godard SL, *et al*: The influence of the right to refuse treatment on precomittment patients. Bull Am Acad Psychiatry Law 16:5–15, 1988[Medline]

19. http://gainscenter.samhsa.gov/html/about. Accessed March 29, 2008
20. McNiel DE, Binder RL: Effectiveness of a mental health court in reducing criminal recidivism and violence. Am J Psychiatry 164:1395–403, 2007[Abstract/Free Full Text]

PSYCHIATRIC SERVICES

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Effect of Evaluations of Competency to Stand Trial on the State Hospital in an Era of Increased Community Services

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The authors studied court-ordered inpatient evaluations of competency to stand trial at two Massachusetts state hospitals for the period from 1972 to 1987, with particular attention to the effects of a 1978 federal court consent decree that created an extensive system of community-based services in the catchment area of one of the hospitals. The authors found that the broad array of community services developed under the consent decree did not reduce commitments to the state hospital for evaluation of competency to stand trial at the same rate as it reduced civil commitments, with the result that the composition of the patient population changed to include a significantly larger proportion of patients referred by the criminal justice system. This proportion was as high as 17.8 percent in 1985. These patients used a disproportionate share of the hospital's resources, staying in the hospital for a median of 28 days, compared with 12 days for all other patients.

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M-POWER
Nothing about us without us

Massachusetts People/Patients Organized for Wellness, Empowerment and Rights

TESTIMONY FOR DMH INPATIENT STUDY COMMISSSION JUNE 2009

M-POWER, founded in 1987, is a statewide member-run organization of people with lived experience of mental health diagnosis &/or extreme states. We advocate for political and social change within the mental health system, the community and statewide.

We appreciate the opportunity to submit testimony to the Department of Mental Health Inpatient Study Commission. We truly embrace the Disability Rights Community's axiom, **"Nothing About Us Without Us"!** It is our belief that as people with mental health conditions, we know what is best for us. We are concerned that there are only two members of the commission who openly identify as people with mental conditions. We feel strongly that decision-making bodies such as this should be at least 51% people with lived experience. For this reason it is our hope that **from this point forward, those of us who hold the greatest stake in decisions on how best to spend the limited resources that are available for mental health services will make up the majority of the decision-makers.**

Several M-POWER members noted how ironic it was that Commissioner Leadholm held a meeting with the mental health advocacy and provider community to explain the purpose and scope of the DMH Inpatient Study Commission on the same day the groundbreaking ceremony was held in Worcester for the new state hospital. In a time of shrinking revenues, the state is spending $302 million to build a new institution (not including the $30-50 million already spent in design and preparing the site). It seems this commission whose charge is to determine the appropriate inpatient capacity of the Department should have been convened before committing so many millions to build a new state hospital. Just think of the number of peer-run respites or other healing communities which with some creativity could have been developed if that $350 million was spent in other ways.

We were please to read Commissioner Leadholm's confirmation of DMH's vision of transforming the system by creating flexible, recovery-based and person-centered services supporting consumer choice. The state's fiscal realities are making it clear that DMH can no longer spend $167 million each year to keep people in inpatient facilities. State hospitals must be closed.

There is a right way and a wrong way to close state hospitals. Even the word "deinstitutionalization" conjures up the image of homeless persons with obvious symptoms of mental illness and substance abuse living in the streets or in jail as a result of closing state hospitals without adequate community supports. It doesn't have to be that way. Massachusetts successfully transitioned people who had been hospitalized in Medfield State Hospital for many years to living in the community. Folks were given the supports they needed and were successful.

The money saved from closing state hospitals must be invested in flexible person-centered recovery-oriented supports. The money cannot go into the state's general fund

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as currently community programs are underfunded and have just experienced drastic cuts.

One type of support for individuals transitioning out of the hospital used very successfully in New York State is a Peer Bridger Project in which a trained peer specialist provides one-to-one support to a person ready to be discharged. This relationship begins several months before the discharge date and continues for several months after discharge. This is an excellent way to address the concerns and fears a person who has been in the hospital for months or years may have about being able to make it on the outside. The Genesis Club in Worcester and the Lighthouse Clubhouse in Springfield run Peer Bridger projects under a DMH contract entitled "Peer Support in After Care". Such programs need to be expanded throughout the state.

As a result of the 1999 Supreme Court's Olmstead decision the state is compelled to ensure that people with disabilities receive services in the least restrictive setting. In no way can state hospitals be considered the least restrictive setting. One objective listed in Massachusetts' *Community First Olmstead Plan* is "to increase the availability and diversity of residential support options". It is our understanding that over 200 people are currently stuck in DMH facilities. They are ready for discharge but have nowhere to go. Essentially, these folks are being warehoused at several hundred dollars a day.

Currently there is tremendous shortage of safe, decent affordable housing in Massachusetts. This remains a huge barrier to success in living in the community. DMH clients and other low-income people wait many years for subsidized housing. **Money saved by closing hospital beds must be diverted to greatly increasing the number of rental vouchers available to people with mental health conditions.** Also we need to think creatively—the old way of thinking about "independence" is moving from living in a state hospital to a highly structured group home with other adults not of one's choosing. Then the view is that people should move to their own apartment with residential supports. One size fits all just doesn't work. Why does the definition of "independence" always seem to include living alone in an apartment? For many people this can lead to isolation and worsening of one's mental health condition. Also, who would chose to live in a group setting with people you don't know and maybe don't like? The current idea of group homes needs to be revisited. **People must have choices as to where they live and with whom. They must be able to choose what type of supports they will receive.**

A form of community support that does not exist but would prevent hospitalization is personal care assistance (PCA) for people with mental health conditions. Currently Medicaid regulations stipulate that to be eligible for PCA services, a person must need "hands on care". This excludes most people with psychiatric disabilities. The few of our members who have PCA services have them because they have a physical disability as well as a mental health condition. One person uses her PCA mainly to support her through difficult periods of anxiety and depression. For her the companionship and support is more important than the help she receives getting in and out of the bathtub or mopping the kitchen floor. The peer support she gets from her PCA has kept her from using emergency services and kept her out of the hospital. Many

people with mental health conditions could greatly benefit from having a PCA. **Massachusetts needs to act now to obtain a waiver from the federal government so that MassHealth regulations can change to cover people with mental health issues.**

A second Medicaid waiver is needed to allow Certified Peer Specialist (CPS) services to be billable to Medicaid. Other states such as Georgia and Arizona have such waivers, and they have been able to greatly expand the number of peer specialists working in the community. We are excited that the new Emergency Service Program (ESP) contracts require ESPs to hire peer specialists, and the new Community Based Flexible Support (CBFS) contracts also require providers to hire peer specialists; however a Medicaid waiver would encourage providers to hire many more peer specialists. The role of a peer in supporting a person cannot be underestimated. Many of us have found peer support to be a central factor in our recovery.

Some people have expressed concerns that the system is blocked—that there are people in acute hospitals that are not ready for discharge and not getting better. Their insurance has run out and the private facilities are footing the bill. These same people argue that this has lead to longer waits in emergency rooms. They say these folks need to be sent to a state hospital. Why can't we be more creative? What about developing peer-run respites and other healing communities which allow for fresh air and various methods for healing? Why is hospitalization in a state institution have to be the answer?

This Commission has an important responsibility. **It is our hope that the Commission recommends the closure of state hospitals and ensures that the money saved goes to expanding community mental health services and support.**

It is M-POWER's belief that the key to recovery and wellness is COMMUNITIES NOT LOCKED WARDS!!