DMH Inpatient Study Commission – Hearing in Worcester, MA June 4, 2009

Testimony of David Bunker, Trustee, Worcester State Hospital and President of the Central Massachusetts Area Board for DMH

There is concern that the inpatient beds contemplated by the Department of Mental Health upon the completion of the State Hospital at Worcester may be insufficient to address the need. While Community First is an excellent policy, the fragile members of our community and their families who rely upon the Department for services must have some assurance that the resources necessary to accomplish Community First are in fact in place.

Massachusetts is currently facing extreme cuts in all State budgets which will necessarily impact the ability of the State to accommodate additional community services. The capacity of the community service delivery system must be sufficiently enhanced before patients can be discharged from inpatient facilities. The alternative to proper treatment is in many cases incarceration in our jails and prisons, self medication through illicit drugs and/or alcohol and/or harm to the patient or by the patient towards others.

Reliance upon short term hospitalizations in private facilities, while sufficient for some, is not sufficient for all of the Department's patients. A single visit to UMass Emergency mental Health Center, where patients wait hours and even days to be placed suggests that the capacity of the private system is not adequate for the current need. There must be some alternatives built in to our plans.

06/04/2009

Alan P. Brown, M.D.

Alan P Brown

Thank you for the opportunity to address this commission regarding the future of continuing care beds in the Commonwealth. I would like to make two points today: In my opinion, 1) there has been a large ripple effect from previous continuing care bed reductions that has dramatically lowered the standard of care for persons hospitalized on acute inpatient services and this should be understood and addressed before further reductions occur--there is not an adequate public health assessment process in place to monitor the impact of these changes--looking at waiting lists and patients within state hospitals does not describe this broader impact, and 2) acute inpatient care has been relegated to a fragmented, under financed and poorly regulated non-system of acute care units that are systematically disincentivized to refer patients for ongoing care in DMH continuing care facilities--instead consumers suffer from "revolving door" care, inadequate access to long term facilities or supports and a "triage by morbidity" where services are often doled out to persons with severe illnesses and high risks only *after* they have suffered injury or losses.

I have had the privilege of working in Massachusetts psychiatric hospitals since I came to the area for training at the Massachusetts Mental Health Center in 1983. I have served as the Medical Director of Medfield State Hospital in 1986, led a DMH team to assist in the transfer of civilly committed patients from the prison hospital at Bridgewater in 1989, joined the faculty at UMass Medical School in 1991 as the director of the medical center's adult services in the department of psychiatry and have continued to administer services, treat patients and teach since then. I have seen many positive and negative changes and have had the opportunity to work with many dedicated consumers and staff here in Worcester and in the DMH. However, in my view there has been a gradual decline in the overall services we offer to patients with severe mental disorders in the last two decades with a negative impact on their well being.

We have all seen the statistics. Dramatic reductions in the average length of stay for patients on acute services--from one month in 1990 to one week in 2009. A reduction of transfers to continuing care--in 1992 10% of patients admitted to the old acute service at Worcester State Hospital were transferred to long term continuing care units. In 1993, we opened a second acute service, a DMH

funded "replacement unit", the Psychiatric Treatment Center, and the number of transfers to continuing care dropped to 5% in the first year and over the last 15 years that number has dropped to about 1% of all discharges from our two acute inpatient services. The promise had been that reductions in hospital use would fund a host of innovative, recovery based, non-hospital alternatives to inpatient care. This has been a broken promise. While we can point to a successful innovative program here and there, the options facing a person hospitalized for acute psychiatric care are incredibly limited. In 1993, a discharge to a shelter was expressly forbidden by the Department of Mental Health. Patients admitted to acute inpatient services had access to residential services, group homes, DMH case management and step down services at discharge. Indeed, our treatment planning for many patients was directed at working with them and families to establish a safe and meaningful disposition at discharge. Today, on our PTC unit about one quarter of patients are discharged to a shelter or temporary crisis bed and an eighth of patients find temporary housing; unless a patient already comes from a group home or has independent means, there is virtually no access to residential facilities at discharge; case management is inconsistent in its ability to connect with patients while in the hospital; and young adults with new onset psychotic disorders have almost no access to residential aftercare unless they pass first through a continuing care unit.

Why has the waiting list to DMH continuing care units actually declined in this period? I do not think that it is due to new miraculous cures, a robust growth in access to alternative treatment settings or an ample network of outpatient providers. To the contrary, providers under fiscal pressure from managed care organizations have adjusted their treatment models to this dismal situation. The few acute units that step up and try to mitigate this situation suffer financial penalties; the pursuit of desperately needed guardianships incurs legal costs that are born by the institution; pursue transfer to a state hospital and the MCO arbitrarily places the patient on lower paid administrative days; keep an occasional patient who is at risk of death with improper discharge and the unit will accrue a handful of so-called "outliers" who will skew average length of stay and incur financial penalties for the institution. The games begin at admission, as hospitals struggle to avoid patients who may require

additional costly services, such as, special observation, legal consultation, or lengthy stays. Another game of musical chairs awaits patients who cannot settle into a stable community based situation--they shuttle between scattered inpatient services receiving brief "stabilization" admissions, until the music stops, either by admission to one of the few units left willing to do the right thing or by injury, incarceration, or death. The waiting list has shrunk, not because acute inpatient care has improved or that private or public payers have expanded options for consumers at the point of discharge--rather, there has been a gradual adjustment to a diminished standard of care and at a cost born primarily by our most vulnerable citizens.

Are there better ways to spend our citizens' dollars than maintaining the current number of continuing care beds? Perhaps, if we can find them. Unfortunately, there is little to suggest that we can and much to suggest we cannot. If we do reduce the beds, then I would urge accountability for monitoring the impact and an investment in consumer centered services oriented toward patients being discharged from acute inpatient services--proactive case management, the identification of services for high risk young adults, respite and residential sites that are plentiful and accessible, enhanced state oversight of managed care organizations, and a public health assessment tracking the fate of patients discharged from our acute services.

Testimony of Jeffrey Geller, MD, MPH
Department of Mental Health Inpatient Study Commission
Worcester State College, Worcester, Massachusetts
June 4, 2009

In 1842-43, in preparation for her Memorial to the Massachusetts legislators in 1843, Dorothea Dix travelled the Commonwealth to ascertain how many individuals not currently in asylums would benefit from being there. She emphasized that it was inhumane that they were not. As a result of her efforts, the asylum in Worcester was enlarged.

In his efforts on behalf of the Governor of Massachusetts in 1854, Edward Jarvis surveyed the Commonwealth to determine how many insane persons there were who needed to be in public hospitals. His recommendation, followed by the legislature, was to build another public mental hospital, adding to the beds available in one private hospital, two state hospitals, and one municipal hospital for the inane. The result was Northampton State Hospital.

Over the next 100 years, Massachusetts continued to build and fill up state hospital after state hospital. These institutions began to shrink in size after the mid-1950's due to a complex set of reasons including exposure of horrible conditions, the introduction of chlorpromazine (thorazine) and other antipsychotic medications, changes in state laws, and advocacy movements.

In 1978, Massachusetts entered into a federal court consent decree that affected all of western Massachusetts and was based on the concept that every patient and prospective patient had a right to treatment in the least restrictive alternative appropriate to her or his need. The efforts in western Massachusetts had wide-ranging positive effects on the persons with serious mental illness who reside in the western one-third of the state, but there were also some fundamental miscalculations. One was planning only for those *in* Northampton State Hospital ignoring those who needed the state hospital, but were not an inpatient on December 8, 1978 for a myriad of reasons; and a second was failing to consider the incidence of serious mental illness, i.e., new cases who would need state hospital services.

Moving forward from the 1970's to the current time, Massachusetts has closed many state hospitals, such as Boston State Hospital, Danvers State Hospital, Foxboro State Hospital, Gardner State Hospital, Grafton State Hospital, Medfield State Hospital, Metropolitan State Hospital, and Northampton State Hospital. In each instance, the Commonwealth examined the needs of the patients in the hospital at the time. The Commonwealth did not consider the factors that Dorothea Dix and Edward Jarvis had—what are the psychiatric needs of the population of Massachusetts and how are those needs failing to be met now.

In considering the bed capacity of a new inpatient facility in Central Massachusetts (See Report of the Special Commission to Study the Feasibility of Constructing a New Department of Mental Health Inpatient Facility: The Future of DMH's Inpatient Psychiatric Care in Massachusetts), the Commonwealth did a superb job of considering many factors, but again failed to look at who, beyond the current inpatients censuses of Massachusetts state hospitals, needed to be in Massachusetts' public psychiatric hospitals.

I urge this Commission to return to the methodology of our wise nineteenth century forbearers, and not repeat the errors of the last half century. I urge you to consider who in this Commonwealth needs inpatient psychiatric care and treatment in our public system of inpatient care. I urge you to look at persons with serious mental illness who need inpatient psychiatric treatment (beyond acute treatment) in public hospitals but who are now

- Homeless
- In shelters
- In nursing homes
- In large state hospital substitutes, such as Farren Care Center in Turners Falls
- In proprietary state hospital replacements, such as Kindred Hospital-Parkview
- In jails
- In prisons
- In general hospitals on waiting lists for transfer to a state hospital or discharged because such transfer is seen as not forthcoming
- In rooming houses/board and care homes/residential hotels
- In public health hospitals
- In private hospitals with payment made by Medicare or Medicaid (under a waiver)
- In families who struggle beyond reasonable forbearance to maintain a family, and
- Anywhere else people would suggest those with serious mental illness may be found

In these remarks, I have focused on the adult population. The same analysis should be conducted for children and adolescents.

If we don't know how many individuals with serious mental illness in the Commonwealth of Massachusetts *need* inpatient care and treatment in our state hospitals, how can we possibly determine how many beds, or evening buildings, there need to be to meet the Commonwealth's *obligation* to serve these citizens?

Thank you.