

U.S. House of Representatives  
Committee on Energy and Commerce  
Oversight and Investigation Subcommittee  
"Where Have All the Patients Gone: Examining the Psychiatric Bed Shortage"  
March 26, 2014  
Written testimony of Jeffrey Geller, MD, MPH

**Credentials**

Jeffrey Geller, MD, MPH is a board certified psychiatrist who currently is a professor of Psychiatry at the University of Massachusetts, Medical Director of the Worcester Recovery Center and Hospital, and staff psychiatrist at the Carson Community Mental Health Center. I have consulted to public mental health systems and state hospitals in one-half the states, the District of Columbia and Puerto Rico. I am the author of about 250 publications in the professional literature and of the book, *Women of the Asylum*. I serve on boards of the American Psychiatric Association, the American Association of Community Psychiatrists, Clubhouse International, the Treatment Advocacy Center, and the World Federation for Mental Health. Despite these affiliations, I come before you today representing only my experience taking care of persons with serious mental illness for 40 years.

**Testimony**

**Background:** If we are today to understand why we have persons with serious mental illness stalled in hospital emergency departments with nowhere to go for hours to weeks, we need to start with the **Land-Grant Bill For Indigent Insane Persons**, passed by both houses of Congress at the urging of Dorothea Dix in 1854. On May third of that year, President Franklin Pierce vetoed this bill—the first veto of his presidency.

In his Veto Message, President Pierce opined, “It is clear that public charities within the States can be efficiently administered only by their authority.” In the matter of those persons with inadequate resources for psychiatric treatment, Pierce stated, “if the several States, many of which have **already laid the foundation of munificent establishments of local beneficence [i.e., state public psychiatric hospitals]**, and nearly all of which are proceeding to establish them, shall be led to suppose, as, should this bill become a law, they will be, that Congress is to make provision for such objects, the fountains of charity will be dried up at home, and the several States, instead of bestowing their own means on the social wants of their own people, may themselves, through the strong temptation which appeals to states as to individuals, **become humble supplicants for the bounty of the Federal Government, reversing their true relations to this Union.**

Thus by the mid nineteenth century, the President of the United States believed public psychiatric hospitals were

- meritorious institutions doing good
- fulfilling a historic role belonging to the states
- meeting the needs of a population outside the purview of the federal government
- susceptible to becoming the responsibility of the federal government if the federal government provided any opportunity to the states to shift the burden

If you remember nothing else about Franklin Pierce, remember that his prophetic statement of 1854 turned out to be exactly correct.

We can jump ahead about 110 years, as the federal government remained steadfast in its position and the states took on the ever expanding costs of caring for persons with serious mental illness and related conditions. By the mid 1950's every other hospital bed—that's 50% of all hospital beds of any kind in the USA—were occupied by persons who were in those beds due to their mental illness. In the USA, we had state hospitals with censuses at high as 16,000 – 18,000 patients.

In the mid 1950's, the modern era of psychopharmacology was born. First at Rockland County Psychiatric Hospital in New York State, then throughout New York State with the support of Governor Averill Harriman, and then across the USA, reserpine and then chlorpromazine were able to effectively treat the symptoms of schizophrenia sufficiently enough for people to be discharged in large numbers from state hospitals. These medications, along with shocking exposés that were fueling the exodus from state hospitals for a decade by then, and other forces such as advocacy, created, what in retrospect, was labelled “deinstitutionalization.” Deinstitutionalization was not initiated as a considered policy; it was an accident of history.

With people emerging from state hospitals, some of whom had not cared for themselves for years, decades, or more than half a century in some cases, there needed to be a system of care and a workforce to meet these individuals' needs.

On October 31, 1963, President John Kennedy signed the last piece of major legislation he was ever to sign, Public Law 88-164, the “**Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963**”. With this act, Kennedy did what Pierce had not done: He put the federal government in the role of being responsible for some part of the care

and treatment of persons with mental illness. The bill called for the construction of community mental health centers pursuant to state plans with later modifications of the bill specifying 2000 community mental health centers by 1980, and then one per 100,000 population holding steady at that rate.

But, as Senator Daniel Patrick Moynihan, who had worked with Kennedy on this project, said in his Senate Finance Committee hearing in 1994 (one I worked as a Robert Wood Johnson Health Policy Fellow in Senator Tom Daschle's office), "we built about 400 and then we forgot we set out to do this" (p.2). Moynihan went on to say, "To make great changes casually and not pay rigorous attention to what follows is to invite large disturbances." (p3)

The late Senator Paul Wellstone testified at that hearing. Senator Wellstone lamented, "Deinstitutionalization depended on the premise that the community and State systems would be well integrated and well-funded and it raised all sorts of expectations. It did not happen." (p. 9)

What did happen?

With the enactment of Medicaid under the 1965 Amendments to the Social Security Act, states, for the first time, could use the formula for federal financial participation (FFP) for a population in mental institutions—in this case those 65 years of age or older. The FFP is the part of the bill the federal government will pay and ranges from 50% to 87% based on the per capita income of the state's population.

Other populations were not included at that time because Congress again voiced its intention of leaving the care and treatment of those in psychiatric (mental) hospitals as the responsibility of the states. Congress did, however, expand use of the federal financial participation formula to include services to those with mental illness in general hospitals.

The 1965 changes to what became the **IMD exclusion** opened the first door for the states to begin to shift costs for the care and treatment of mentally ill persons to the federal government. In a state hospital, the state generally bears 100 percent of the cost of care and treatment. In any facility that is eligible for Medicaid reimbursement, each state pays much less than 100 percent, according to the federal financial participation formula.

Simply put, the Federal Government would pay its share if the individual was in a facility specializes in providing psychiatric-psychological care and treatment and had 16 or fewer beds, or if there were more than 16 beds than more than 50 percent of all the patients-residents in the facility had to primarily require care for reasons other than a mental disease.

And the race was on.

The states had two fiscal goals in competing in the race for Medicaid dollars. The first was to transfer as many people as the state could from places where the states paid dollar for dollar for care and treatment, i.e., state hospitals, to places where states paid only a fraction of the

cost for care, i.e., community residences and general hospitals. The second was to do so as fast as possible because, for example, if Pennsylvania could do it faster than New York, than New York tax payers would subsidize Pennsylvania's translocation of patients since Pennsylvania's mentally ill poor would be using more federal dollars than New York's.

The states could not publically acknowledge they were moving persons with serious mental illness from one location to another to garner more federal dollars. They risked a public uproar. So the states attached their fiscal policy to the progressive thinking of the day. The states proclaimed they were interested in patients' autonomy and self-determination; they sought to treat patients in the most integrated setting; and they were interested in patients' recovery. If all these interests had cost the state more, rather than less, I believe they would not have been interested in any of them. Ironically, we were dismantling the state hospitals with the same rationale we had built them: Do what's right and save money.

But no one actually *knew* we saved healthcare dollars with the wholesale movement of patients from hospital to community. The best study ever done, by Weisbrod, found there is no cost difference and perhaps you get a little more for your money in the community. But the myth eclipsed the reality.

In the 1990's, the federal government did a few things that provided even greater **thrust to the movement of persons with mental illness out of state hospitals. The Americans with Disabilities Act of 1990** was used by advocates and the US Justice Department to require states

to expand any form of existing community services they provided to accommodate all individuals in state hospitals who needed that service, arguing that Title II—"no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"—required this

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

The U.S. Supreme Court, for its part, had little justification for its assumptions. The court never defined "can handle" or "can benefit"; never indicated how it came to conclude that time in a

state hospital said anything about unworthiness”; and never informed us how simply moving a person with serious mental illness from the hospital to the community would accrue to them “family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” And in thousands upon thousands of cases, it has not.

There were other federal initiatives in the 1990’s that further incentivized states to empty out their state hospitals. The Balanced Budget Act of 1997 created a progressive deduction in disproportionate-share payments to facilities classified as IMDs between fiscal years 1998 and 2003. Disproportionate-share requires states to make payments, using federal dollars, to hospitals serving a disproportionate percentage of Medicaid and low-income patients. Since specialty hospitals can qualify as disproportionate-share facilities, and state hospitals serve populations that meet criteria for disproportionate-share payments, states applied for these payments—that is, federal dollars—even though patients do not qualify for federal dollars through Medicaid. States were thus able to increase their overall receipt of federal dollars by including state hospitals in their disproportionate-share hospitals. When Congress cut into this loop hole, maintaining patients in state hospitals became even less attractive to the states.

Further, the federal government was offering states various ways to obtain Medicaid waivers (sec 1115 and sec 1915(b)) that expanded the types of hospitals that could be used as alternatives to state hospitals. One such hospital type was the free-standing private psychiatric hospital. Thus states had more beds to use as Medicaid-funded alternatives to its state hospital.



The states, for all the reasons explained above, were moving patients out of state hospitals with Herculean gusto, outstripping the resources in the community. The states needed dollars to fund its part of Medicaid for the former state hospital patients. What better source than the money used to operate its state hospitals.

And while the states did do this, they did not do it in an effective manner. First, the funds from the closed state hospitals followed rather than preceded the patients into the community, so there were always inadequate community funds. And second, the states did not use all the money from closed state hospitals for community-based services, but rather transferred some to the states' general funds, so there were always inadequate community funds.

**We now have our formula for the current debacle: A progressively expanding array of fiscal incentives for states to move people out of state hospitals; inadequate resources to meet the needs of the states' residents with serious mental illness in the community; no beds in state hospitals to meet the needs of former hospital patients who did not find the community the panacea promised by Supreme Court and were dangerous or unable to care for themselves outside of hospitals; no beds to meet the needs of new cases of serious mental illness requiring hospital-level of care; and a public much more willing to build jails and prisons than hospitals at taxpayers' expense because they found no solace in a state system they saw as pushing ill-prepared folks with mental illness into their neighborhoods.**

**Problem:** Here's the debacle.

Pick any state. There are no available beds in the state's public psychiatric hospitals in large measure because the state closed so many beds. There are about 40,000 state hospital beds in the USA, a rate of 13-14 beds per 100,000 population. A consensus of experts polled for a Treatment Advocacy Center report suggests that 50 public psychiatric beds per 100,000 population is a minimum number. Thus, over 80% of the 50 states had less than half the minimum number of state hospital beds needed. The effects of the actual shortage are exacerbated by the fact that about 50% of the states have no systematic way to determine where a vacant bed might be, should one even exist in their public hospitals.

In the designated state, a patient on the psychiatric unit in a general hospital has been approved for transfer to the state hospital, but cannot be transferred because there are no available beds. Thus, the general hospital psychiatric unit is populated by some patients who are "stuck" there awaiting state hospital transfer. An individual is brought to the general hospital's Emergency Department by police, family, or ambulance, or came on her own. The individual is assessed and determined to need an inpatient hospitalization. This individual cannot be admitted to the psychiatric unit located in the same hospital as the emergency department because there are no beds there.

What happens next is a hospital ED staff or a member of the contracted crisis team starts a "bed search". A bed search means calling every hospital in the state that accepts the individual's insurance seeking a bed. Frequently, the bed search is fruitless; there's no bed

available anywhere because all the other hospitals are in the same situation as is the psychiatric unit in the hospital the worker is calling from.

So, the individual remains in the ED waiting for an available bed. How long can he be waiting? In the best case scenario, a few hours. In some of the least resourced areas, for a month.

Those days of waiting benefit no one. The ED becomes over-crowded. The patient is a “patient” in name only. He is not getting treatment. Except that he is receiving food, a bed or gurney, and maybe some medication, he might as well be waiting on a bench in a train station.

Individuals who might otherwise be hospitalized after an ED evaluation are simply released from the ED because there is no place else for them to go. The threshold for holding someone in the ED awaiting admission keeps creeping up.

Not everyone sits idly by. The police often respond to persons they believe are both mentally ill and violating the law with arrests rather than ED drop-offs since leaving the person they picked up at the ED often means he or she will quickly be back on the street. The arrested individual is arraigned and a question of his competency to stand trial is raised. He is sent to the state hospital for a forensic evaluation, taking a bed that might have been used for a patient transferred from the general hospital. Thus, the movement of psychiatric patients from general hospitals is further slowed, and consequently the movement from the ED to the general

hospital psychiatric bed is delayed. The ED staff, told yesterday that today was the day for the ED discharge, find out it's not. No expected vacancy materialized.

The Affordable Care Act (ACA) appears to have some unintended consequences that could very well exacerbate the conundrums of psychiatric patients stuck in ED's. **More Americans will be insured.** That means more individuals will have the financial means to get outpatient psychiatric care and treatment. This should mean less use of the ED. But, insurance does not necessarily translate into access. There are not enough providers of psychiatric services. This will mean the newly insured will not get the psychiatric treatment they now expect, driving them to seek that treatment in ED's. There will be more insured individuals needing psychiatric inpatient treatment, but no more psychiatric beds than before. More demand, no more beds, means longer waits, translates into more people with psychiatric illness boarding in general hospital ED's.

The ACA **integrates care for Medicare-Medicaid enrollees** (the "dually eligibles") in an effort to support improved quality and lower cost of care for individuals enrolled in both Medicaid and Medicare through both the elimination of the duplication of services and expanded access to needed care. Where before, these individuals could be admitted from an ED to a psychiatric bed, in some states the companies contracted to manage the care of the dually eligible are requiring prior approval for psychiatric admissions. This means further delays in the ED, and may mean no approval at all for some who would have previously been approved for admission. The ED will have a new group of psychiatric patients with nowhere to go.

The ACA is not the only source of ambiguities reigning terror in America's ED's.

Medicare will generally not pay for services rendered to a beneficiary who is in custody or incarcerated at the time the service was delivered (42 CFR 411). What does that mean in ED's when police bring in patients they wish to keep in custody? And some overzealous CMS staff has interpreted the regulations to empower Medicare to deny payment for services rendered to an individual who was *ever* in custody or incarcerated, not just those currently in custody or incarceration. This may well be yet another fact to be checked before an ED can make a disposition. More facts to check translates to more time.

**The remedies.** There are measures that Congress can enact to ameliorate the problem of borders in Emergency Departments.

- **Provide states with the opportunity to obtain IMD Exclusion waivers.**
  - Under such a waiver, states would get Medicaid reimbursement for treatment in public IMD's.
  - States for their part would have to have maintenance of funding levels for community services to prevent wholesale shifting of persons with serious mental illness into state hospitals.
  - The net effect would be an increase in state hospital beds without a decrease in community resources.
  - The American Psychiatric Association adopted a Position Statement in 2007.
    - States should be offered the opportunity to receive a Federal exemption from the IMD exclusion for state hospitals and all nonprofits over 16

beds....To participate in the exemption states must demonstrate a maintenance of effort (maintain its mental health and substance abuse expenditures (excluding medication costs) from all sources, e.g., states DMH, DPH, DMA, DMR, DOC, DSS, DYS, other) at a level no less than the state's average expenditure over the preceding five years.

- **Make SSI and SSDI payments to eligible individuals independent of where they reside, and require their contribution for room and board to be the same in all locations, including jails and prisons. Individuals keep their Medicaid and Medicare in all settings.**
  - This would eliminate the gyrations states and recipients go through to maximize their incoming dollars and minimize their expenditures, ignoring treatment needs and unnecessarily maintaining folks in the wrong locus of service. Why would a patient move to an apartment and pay rent when he can live rent free in the state hospital and use the “rent money” for all manner of other expenditures.
  - In nonhospital settings, e.g., jails, prisons, payments for psychiatric services would be paid through outpatient billings.
- **Improve the federal grant process for research into prevention and early intervention for mental illness and substance abuse.**
  - The most effective way to decrease overcrowding in ED's is to have fewer people in the community who need to use the ED for psychiatric services.

- Study the effectiveness of wellness programs for persons with serious mental illness.
- **Provide grants to states to create or expand Crisis Intervention Teams (CIT) programs so that such a program is available in every city and town.**
  - CIT is a local initiative designed to improve the cooperation among law enforcement; mental health providers; agencies; and individuals and families affected by mental illness when police are called upon to respond face-to-face in situations with complex issues relating to mental illness.
  - CIT is most commonly made up of volunteer officers from each Uniform Patrol Precinct.
  - The CIT Model is based on special trained officers to respond immediately to crisis calls, ongoing training of CIT officers, and the establishments of effective partnerships.
- **Set Medicaid payments for psychiatric services at CMHC's and FQHC's at rates that actually allow persons with serious mental illness to receive the treatment they need.**
  - Current rates require these outpatient settings to subsidize their psychiatrists with income generated by other practitioners, e.g., social workers, doing psychotherapy.
  - Psychiatrists are forced to see patients at 15 minute intervals which can mean scheduling six patients per hour to account for no-shows.

- **Incentivize states to actually use the Assisted Outpatient Treatment (AOT) statutes they have.**
  - AOT, also called outpatient commitment, is court-ordered treatment in the community (including medication) for individuals with severe mental illness who meet strict legal criteria as defined by the state. Violation of the court-ordered conditions can result in the individual being hospitalized for further treatment in some states.
  - Forty-five states permit the use of assisted outpatient treatment AOT.
  - AOT is often underutilized due to lack of funding.
  - AOT is often underutilized because those unfamiliar with AOT fail to understand the ways in which AOT can protect individual rights.
  
- **Define Medicaid and Medicare payments to Clubhouses in ways that do not destroy the mission of Clubhouses.**
  - Clubhouses are local community centers that provide members with opportunities to build long-term relationships that, in turn, support them in obtaining employment, education and housing.
  - Clubhouses members function within a work-ordered day during which members work to support the functioning of the Clubhouse; participation in consensus-based decision making regarding all important matters relating to the running of the Clubhouse; use opportunities to obtain paid employment in local jobs through Clubhouse-created Transitional Employment and then participate in Clubhouse-supported and independent jobs programs; avail themselves of



assistance in accessing community-based educational resources; receive assistance in securing and sustaining safe, decent and affordable housing; and enjoy evening/weekend social and recreational events sponsored by the Clubhouse.

- The nature of these activities does not fit the traditional Medicaid/Medicare reimbursement structure.

- **Incentivize states to establish Mental Health Courts.**

- Mental Health Courts have their origin in the concept of specialty courts and the idea of therapeutic jurisprudence.
- Mental Health Courts embrace a therapeutic rather than a punitive approach, but use the power of the court to enforce ordered treatment.
- Mental Health Courts include identification of defendants for treatment and referral shortly after arrest, judicial supervision of structured community-based treatment, regular hearings to monitor treatment progress and compliance, and graduated sanctions for noncompliance with the MHC's ordered treatment.
- Generally the defendant is given the choice: go to jail or participate in court-ordered treatment.

**Conclusion:** From the time the colony of Virginia opened America's first public psychiatric hospital in 1773 until now, responsibility for persons with serious mental illness has rested with the states. In more recent times, the federal government has become involved, but largely through the unintended consequences of federal policy. The federal government has issued

proclamations, such as President George W. Bush's New Freedom Commission Report on Mental Health, but these have been thought rather than action missives. It's time the federal government took explicit action--through bipartisan, bicameral efforts-- to remedy the calamitous state of the public care and treatment of persons with serious mental illness, one so well illustrated by individuals with serious mental illness languishing in hospital emergency departments, benefiting no one and interfering with emergency treatment of Americans in cities and towns coast to coast.