Statement

Of

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At a Hearing
"Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage"

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Mr. Chairman, Dr. Murphy, Ranking Member Representative DeGette, and members of the committee, thank you for inviting me to participate in this hearing. I am Dr. Arthur C. Evans, Jr. Commissioner of the Philadelphia, PA Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and a faculty member of the University of Pennsylvania School of Medicine. I also appear on behalf of the American Psychological Association (APA) and the American Psychological Association Practice Organization. APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprised of researchers, educators, clinicians, consultants, and students, APA works to advance psychology as a science, a profession, and as a means of promoting health, education, and human welfare.

As the Commissioner of a Department of Behavioral Health Services my job is to ensure that resources are deployed to address the needs of the 1.5 million people in the city of Philadelphia. This involves assessing the needs of individuals living in our communities and developing a comprehensive strategy to prevent, treat, and rehabilitate individuals with varied and diverse problems including serious mental illness and substance use.

The title of this hearing is posed as a question; my response to this question includes key points drawn from my experience as a Commissioner of a public behavioral health delivery system, a scientist, and as a clinician:

First, people can and do recover from mental health and substance use disorders. As the commissioner of one of the country's largest behavioral health systems, Philadelphia's, I know we can effectively help most of those who seek treatment, even for the most serious forms of mental illness, including schizophrenia and bipolar disorder. We have countless examples of people

recovering and living fulfilling and productive lives in their communities. Recovery is facilitated when individuals live in an environment with the treatment and support services they need. With these appropriate community-based resources, more intensive interventions (such as inpatient hospitalization or outpatient commitment) are less necessary. It is counterintuitive that the solution to a perceived inpatient bed shortage is to build a strong community-based service system. But, experience consistently shows this to be the case. An over emphasis on inpatient beds can drain needed resources away from the very services that prevent people from needing crisis services. Service systems that have good inpatient service capacity and inadequate community resources create a climate of unnecessary hospital admissions and repeated crises that reduce the likelihood that both adults and children can achieve stability and health.

We know that the onset of serious mental illness typically occurs in the late teens and early twenties. Symptoms of serious mental illness often emerge slowly over this period and can be difficult to detect, and, what is most challenging, those who are experiencing behavioral health issues may not recognize their need for treatment. It is not that we do not know how to treat these individuals, but that too often, we are not given the chance. Usually the lack of treatment this causes distress that individuals and families experience in isolation; and can, in some cases, lead to public tragedies.

However, when we focus on those individuals in acute distress who need inpatient care we are taking a snapshot of their illness at only one point in time – we are not seeing the history of the development of their illness, and, we are not focusing on the multiple missed opportunities to intervene and heal. As we seek answers to improving our mental health system, we need to reframe our questions to: "What are the needs of people in psychiatric crises?" and, even more importantly, "How can we prevent these acute crises?"

Second, we need a comprehensive strategy for people in crisis across their lifespan and within their communities. We cannot wait for the illness to emerge or move from crisis to crisis, so this strategy must include as a first step comprehensive programs for prevention and early intervention. Prevention and early intervention are more efficient than a singular focus on treatment. Further, instead of just an individual focus, we need to focus on community level interventions – increasing understanding of mental health issues, reducing environmental stressors such as violence and trauma, increasing safe and healthy housing, developing employment opportunities, and decreasing misperceptions of mental illness that prevent people from seeking out help when needed.

As an example, Philadelphia is undertaking a public health approach that utilizes several low-cost and potentially high-impact initiatives that focus on early intervention. One of the most promising—Mental Health First Aid—is a program that teaches the public the basics of identifying behavioral health issues, supporting individuals experiencing symptoms and connecting them to needed services. The goal is to increase the community's ability to recognize these issues and to give them the confidence to assist relatives, friends, coworkers, and others who may be experiencing psychological distress. Philadelphia's program is perhaps the most ambitious in the country, with a target of training ten thousand citizens in the next two years, including teachers, first responders, parents, law enforcement, faith communities and others. So far, the enthusiastic public response has shown a thirst for this kind of information. We have collaborated with the Philadelphia Police Department and since 2006 we have trained 1600 law enforcement personnel in crisis intervention. This program is designed to reduce conflict and escalation between law enforcement and individuals with serious mental illness. In addition, my department has expanded its early intervention capacity by launching an online screening resource that can help detect mental health issues early and recommend ways to get help. If we focused our resources on early intervention and outreach programs, we would reduce the need for inpatient settings.

Third, it is crucial that our behavioral health systems rethink their current means of assessing the number of needed inpatient beds. From my experience developing and managing a comprehensive mental health delivery system, it is clear to me that the need for inpatient beds is driven by the scope of outpatient and community-based resources that exist in the community. This is very different from most existing modes of assessment that focus primarily on the size of the population and thus, may leave some areas with inadequate services.

Community-based outpatient treatment and support services can prevent the need for inpatient services; communities differ dramatically in these resources. Outpatient resources and support services are part of any equation to understand the drivers of the utilization of inpatient psychiatric treatment. These community-based resources include intensive outpatient therapy, partial hospital services, intensive case management, assertive community treatment, and other community support systems, such as safe housing, employment opportunities, family education and support such as respite care. A system with comprehensive community services will have less need for inpatient beds as compared to a community without such services. By increasing these resources and improving their linkages to one another, we can decrease the need for inpatient hospitalization and improve long-terms outcomes for people experiencing a mental health crisis.

Fourth, we need to develop post-inpatient treatment approaches and strategies that help to stabilize people and permit them to develop the skills they need to function in the community. These types of community resources reduce the need for crisis-driven services and inpatient psychiatric settings. For instance, one research finding is that employment is a stabilizing force in an individual's lives. By focusing on providing education, training, and other services that support employment those with serious mental illness and substance use problems can successfully reintegrate into the community and build a better life for themselves and their families.

In Pennsylvania we are investing in programs that build optimism, confidence, and skills in individuals with serious mental illness. In 2006, the Commonwealth started a statewide Certified Peer Specialist (CPS) Initiative. As a result of this initiative, people who were once relegated to the status of passive, long-term behavioral health care recipients are now being trained and then hired to support and motivate their peers. These positions are competitively paid, full or part-time jobs that enable Peer Specialists to serve as models of recovery for behavioral health program staff and participants and to serve as uniquely effective advocates. Philadelphia has succeeded in recruiting and training over 580 Certified Peer Specialists since the inception of this initiative. Out of the 580 trained, the Mental Health Association reports approximately 60% have gained employment in a variety of employment settings. Our own community-based treatment programs hire the majority of Certified Peer Specialists in practically every clinical setting in our service system including residential settings, outpatient programs, free standing support programs and inpatient psychiatric hospitals. Of particular note is that peer specialist are now being deployed in the city's network of crisis response centers which are designed to assess individuals who are in psychiatric crisis and connect them to the appropriate treatment service. Peer specialist in these settings play an important stabilizing role for individuals and provide a critical factor for people in crisis - hope that things will get better.

The introduction of peer specialists into our service system has been one of the most important factors in improving service delivery and outcomes for people with serious mental illness and substance use problems. For example, incorporation of peer specialist into our network of specialized services for people with serious mental illness has resulted in a decrease in crisis response center utilization, and an increase in community activity. We also have self-reports of an increase in positive connections with family members, friends, and community partners, increased confidence and hopefulness and an increase in education and employment. In order to fund this initiative, the

Commonwealth was successful in rewriting the State Medicaid plan that allowed Pennsylvania to pay for peer support services for individuals with serious mental illness using Medicaid dollars. Access to Medicaid funding allowed Philadelphia and other counties to implement and progressively expand this important resource.

New initiatives we are investing in are Recovery Wellness Community Centers (RWCCs). These centers will provide holistic wellness services to individuals (their families and significant others as well) in recovery from, or seeking to recover from, substance use disorders and/or serious mental illness. The RWCC is to be community driven, designed, implemented and then run by the community in which it is located. It is expected to offer the services which people of the community want and need to strengthen both their personal recovery and that of their community. Our experience has shown that these kinds of resources are critical for helping improve people's integration into the community and decreasing the need for acute hospitalizations.

Fifth, initiatives to address psychiatric inpatient bed capacity should include efforts to improve the efficiency of existing resources, while using data-driven approaches to inform practice and policy. Fortunately, we are at a point where our scientific advances have demonstrated effectiveness with the most serious behavioral health conditions, including serious mental illness. For example, in Philadelphia, we have utilized evidence-based treatment approaches to shorten lengths of stay for individuals who have historically had very long hospitalizations. Additionally, working with our inpatient providers, my department has implemented a pay-for-performance system for the past six years which has resulted in practice improvement and system efficiencies. This data-driven approach has reduced readmissions, as well as improved continuity of care. These improvements have resulted in more capacity, financial savings in excess of $4 million over 2 years, and most importantly, better clinical outcomes for people receiving these services.

Sixth, finally, we must address the perverse financial incentives in our mental health systems. Currently, our systems are diagnostically driven and crisis oriented. Typically, in most systems it is nearly impossible to get help if one does not have a diagnosis or is not in psychiatric crisis. Because of this, systems are almost entirely reactive, as almost all of their resources are devoted to treatment after the fact, with minimal resources available for engaging people prior to a crisis. This means funding agencies like mine typically devote less than 3% of their budgets to prevention and early intervention. That leaves families and communities to fend for themselves when it comes to identifying those who need help and then navigating the system to get it.

Flexibility of our payment system for behavioral health is essential. Our behavioral health system needs more resources focused on broad-based outreach, prevention, early intervention and engagement for individuals and their families. We know that early intervention can dramatically improve the trajectory of mental illness and recovery. Behavioral health systems across the country need more flexibility to fund these "upstream" activities. I believe we should be spending at least a third of our budgets on prevention and early-intervention services.

In conclusion, no discussion of the needs of those in with serious mental illness and substance use problems should focus solely on increasing inpatient beds or lowering the threshold for commitment without addressing the need for a comprehensive, culturally appropriate strategy to promote mental health and prevent behavioral health disorders across the lifespan. We must use the latest scientific evidence and management strategies such as pay-for-performance to get the most efficient use of resources. We must also broaden our range of services beyond the health care system to build on strategic local partnerships to build community resources necessary to respond and heal - for instance, training our first responders, partnering with community organizations and faith-based groups, and investing in our children and youth to support healthy starts to their lives.

Most importantly we must become effective allies of families - giving them the tools they need to raise healthy children and then providing them with comprehensive services and supports when they turn to us for help when in need.