A Patient's Journey: Exploring Levels of Care Within the Massachusetts Mental Health System

Christopher M. Celano, M.D.
Associate Director, Cardiac Psychiatry Research Program
Attending Physician, Inpatient Psychiatry and Consultation Services
Massachusetts General Hospital
Assistant Professor of Psychiatry
Harvard Medical School

Collaborators

Jeff C. Huffman, M.D.
Associate Chief of Psychiatry for Clinical Services
Director, Cardiac Psychiatry Research Program
Massachusetts General Hospital
Associate Professor of Psychiatry, Harvard Medical School

Abigail Donovan, MD
Director, First-Episode and Early Psychosis Program
Associate Director, Acute Psychiatry Service
Massachusetts General Hospital
Assistant Professor of Psychiatry, Harvard Medical School

The Journey

- Case presentation
- Levels of care:
  - Emergency Department
  - Inpatient Hospital
  - Crisis Stabilization Unit
  - Partial Hospital Program
  - Outpatient Treatment
- Department of Mental Health
- Areas for Improvement

Chip's Story

- Chip is a 24 year old man in his first year of graduate school.
- He felt enormous pressure to maintain good grades to keep his scholarship.
- He developed difficulty with concentration and memory, and his grades began to fall.
- He started to hear his upstairs neighbors talking about him while he was studying.

Chip's Story

- Over the next 6 months, he started to believe that they were monitoring his computer.
- When he went outside, he noticed people staring at him, and whispering.
- He began to believe that he was being followed by people who wished to harm him.

Chip's Story

- He started to make "evasive maneuvers":
  - Switching trains multiple times, jumping off at the last minute
  - Using multiple different pre-paid cell phones
- He left notes for the people following him taped to his windows.
- Eventually he began to call the police repeatedly, and he was brought to the ER

The ER is the Hub

The ER is the Hub

- The “easiest” way to access services
- Finding an outpatient psychiatrist takes many phone calls and months of waiting.
- Inpatient and crisis units often require an emergency evaluation and insurance approval.
- Partial hospital programs are difficult to access without systems knowledge.

The ER is the Hub

- The mental health system is difficult to navigate for most people, but virtually impossible to navigate with major mental illness, functional or cognitive impairment.

The “E” isn’t for easy

- ERs are difficult places to be.
  - Overcrowded
  - Over stimulating
  - Long waits to be seen
- Psychiatric ERs can be even worse
  - All of the above, plus exposure to other patients in crisis
  - Inpatient beds often not available in the same location (waits can be hours to several or more days in the ER)

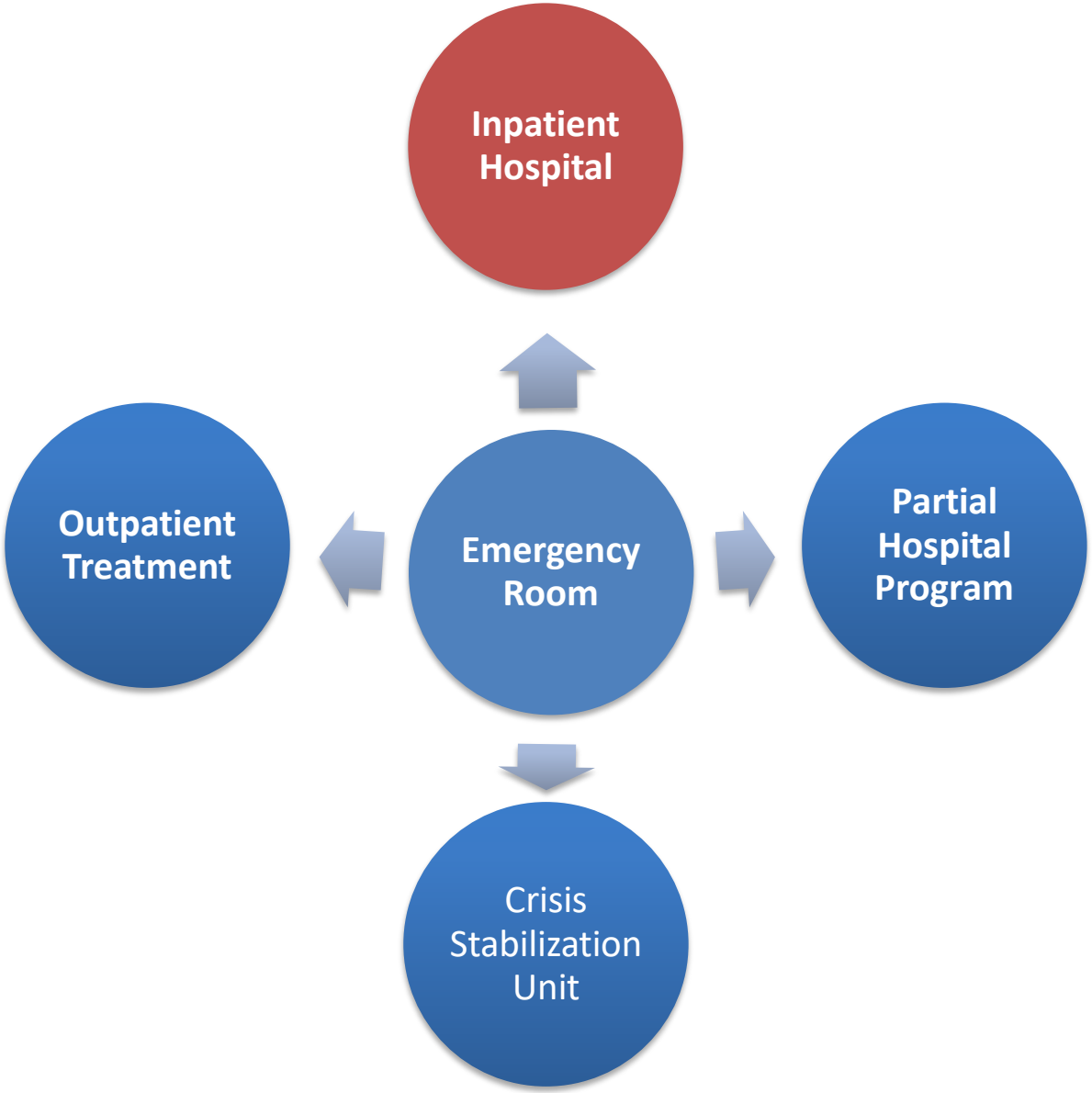
Chip's Story

- Chip waited for several hours in the emergency room to be seen.
- He had a medical workup with ruled out organic causes for his symptoms, including:
  - Drug abuse
  - Metabolic derangements
  - Brain tumor
  - CNS infection

Chip's Story

- He was evaluated by the ER psychiatrist, and found to have evidence of psychotic symptoms.
- He didn't understand that his mind was "playing tricks on him" and didn't believe that he needed treatment.
- Given his disorganized thoughts and lack of insight, he was subsequently admitted involuntarily to an inpatient hospital.
- Because of bed unavailability, he waited 2 days before transfer by ambulance to a receiving inpatient facility.

Chip's Story


Inpatient Hospital
Outpatient Treatment
Emergency Room
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Wellcome Images

Inpatient Hospital

- Locked unit
- Average length of stay (LOS): 1-2 weeks
- Typical patient: very ill
  - Basis for hospitalization: safety (#1), need for diagnostic clarification or complex medication management
  - Suicidal or homicidal thoughts
  - Grossly disorganized behavior
  - Involuntary or voluntary

Inpatient Hospital

- Types of evaluation and treatment:
  - Medication management: antipsychotics, mood stabilizers
  - Neurotherapeutics (electroconvulsive therapy)
  - Group therapy (basic)
    - Psycho-education
    - Coping skills
    - Substance abuse
  - Individual therapy
  - Family meetings
  - Case management (discharge planning, coordination of aftercare)
  - Neuropsychological testing
  - Specialty consultation as needed, particularly in general medical center (Neurology, Endocrinology, Infectious Disease)

Inpatient Hospital

- Goals of Treatment:
  - Resolve acute safety concerns (suicidality and homicidality)
  - Reach minimal levels of functioning
  - Reinforce coping skills, adherence
  - Arrange aftercare
- External and internal pressure to keep lengths of stay short – cost (insurers), need to open up beds (hospital)

Chip's Story

- Chip was diagnosed with schizophrenia.
- He started antipsychotic medication, which improved his paranoia.
- He participated in psychoeducation groups.
- After ~2 weeks, his symptoms improved, and he understood the need for ongoing treatment.
- He was stable enough to transition out of the hospital.

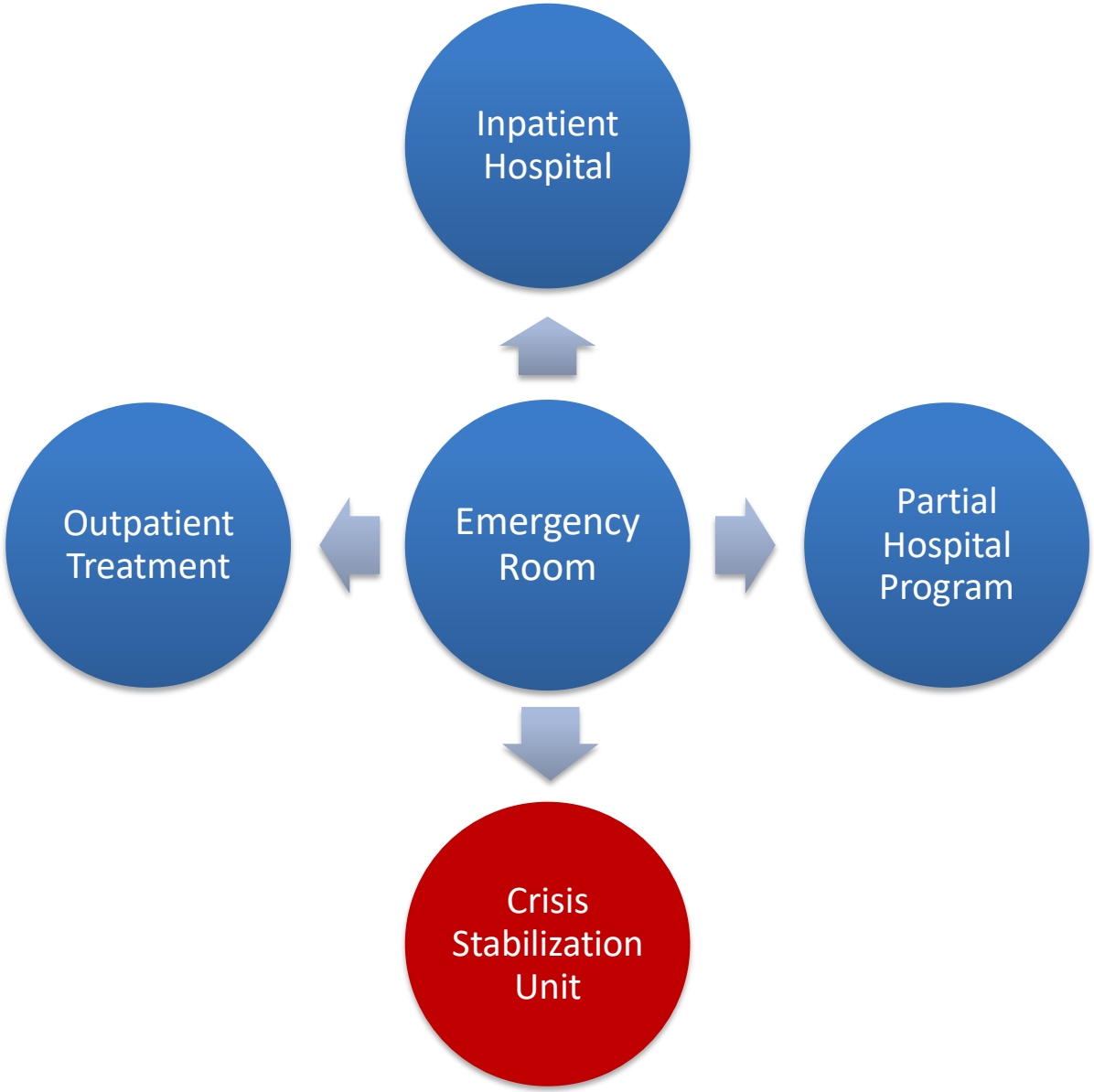
Inpatient Hospital

- After the hospital?
  - Step down to a partial hospital program (day treatment)
  - Jump down to outpatient treatment
  - Post-discharge is a high-risk period for decompensation, suicide.

Inpatient Hospital

- Level of care is determined by
  - Clinical need
  - Ability to use treatment
    - Motivation
    - Engagement
    - Cognition
    - Feasibility (e.g., transportation)
  - Insurance

Chip's Story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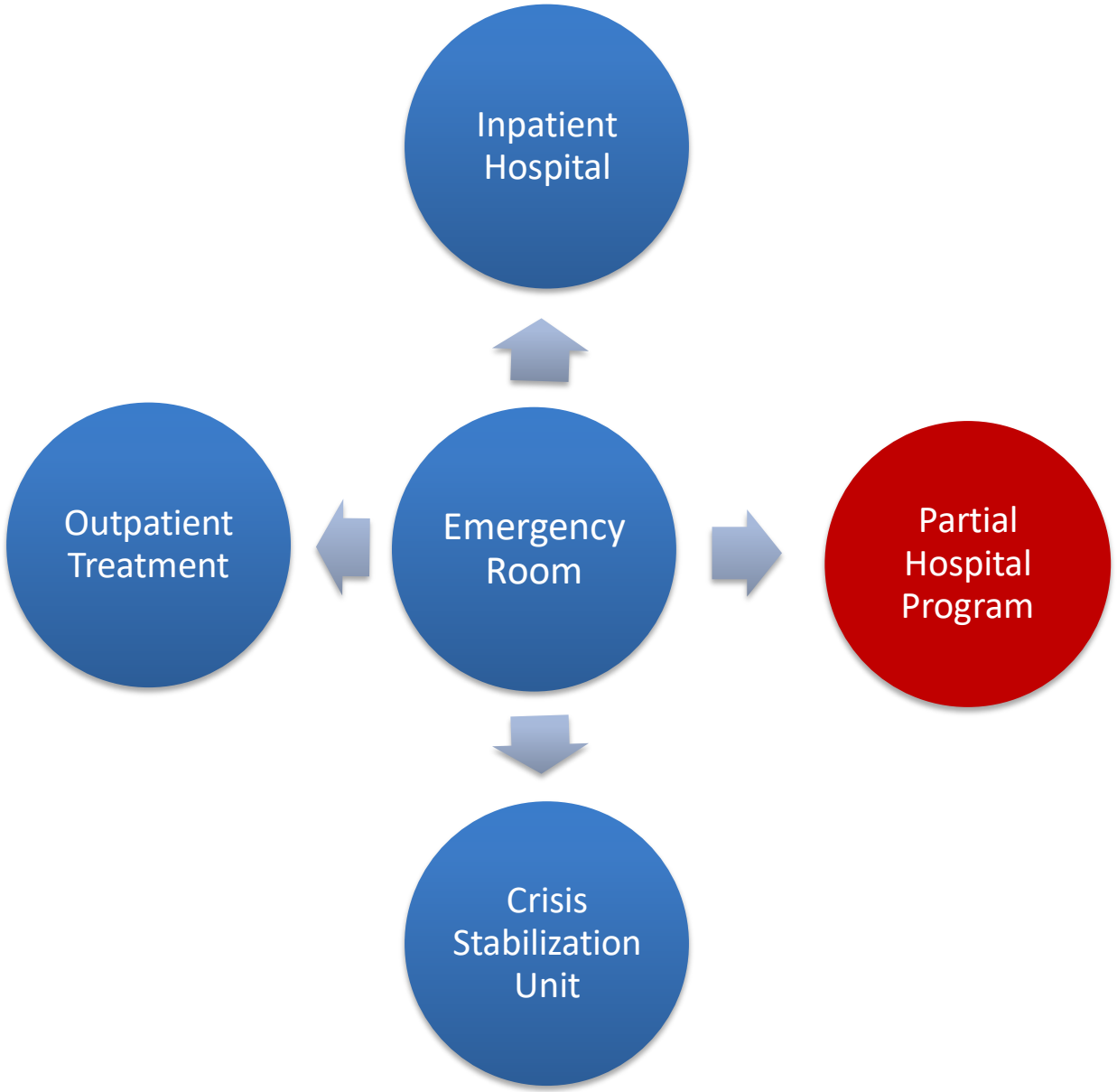
Crisis Stabilization Unit (CSU)

- Similar to an inpatient hospital except:
  - Unlocked - patients may leave
    - Must be voluntary
    - No acute safety issues (suicidality, homicidality)
  - Average LOS 3-5 days
  - Less intensive treatment:
    - Group therapy offered 2-4 hours daily
    - Meet with prescriber and case manager 2 times per week
    - Little or no access to additional treatment (e.g. neurotherapeutics, specialty consultation)

Crisis Stabilization Unit (CSU)

- After the crisis unit?
  - Step down to a partial program
  - Jump down to outpatient treatment
- Based on insurance, clinical need and ability to use treatment

Chip's Story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Partial Hospital Program

- Day Treatment
- Monday – Friday, ~ 9am-3pm
- Lives at home
- Average LOS: 2 weeks
- Treatment consists of
  - Group therapy
  - Rarely individual therapy
  - Medication management 2x/week
  - Aftercare planning

Partial Hospital Program

- Typical Groups
  - Communication skills group
  - Coping skills group
  - Cooking skills group
  - Relapse prevention group
  - Family relationships group
- Groups focus on higher level functioning

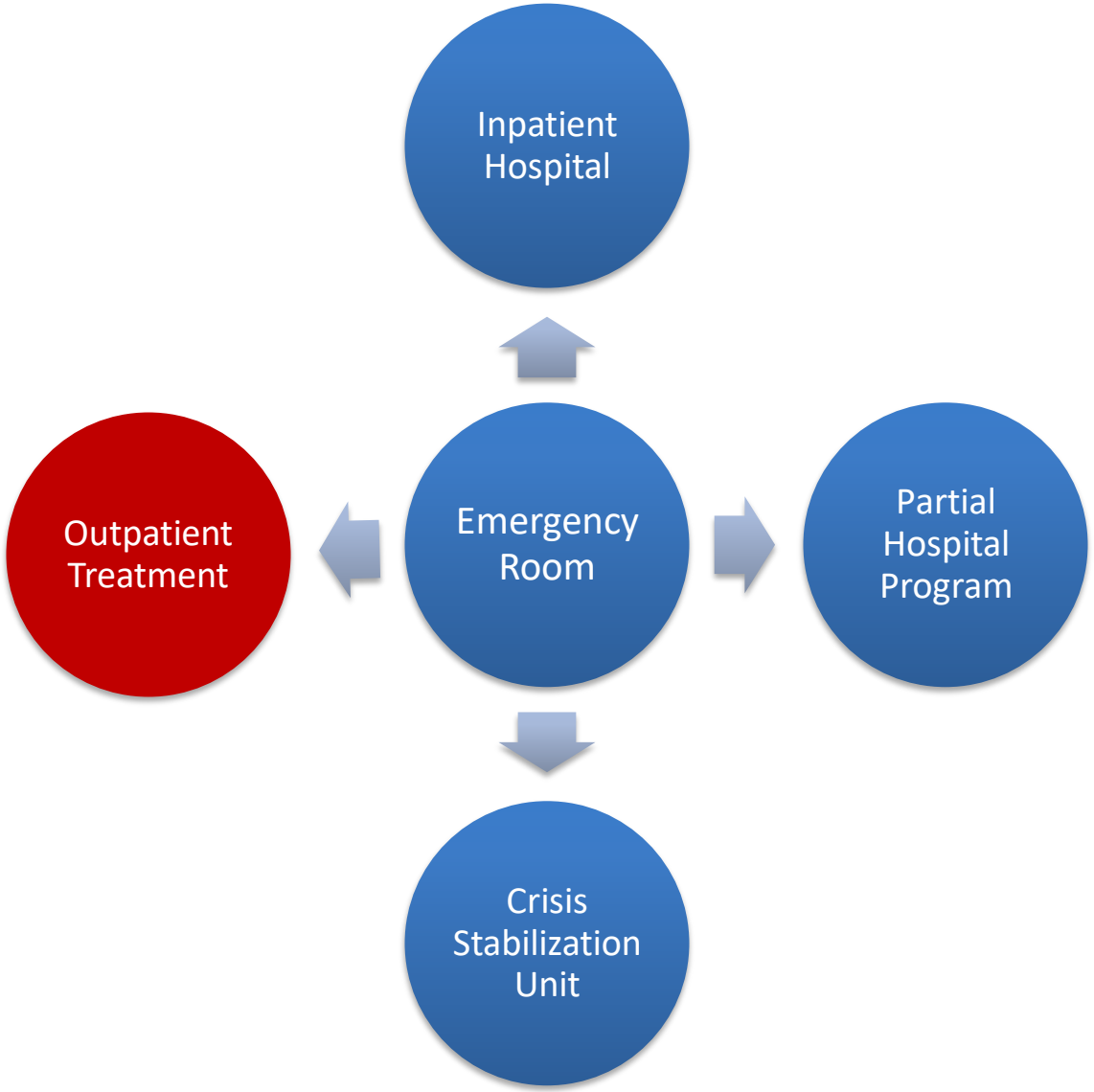
Partial Hospital Program

- Treatment Goals
  - Rapid symptom stabilization
  - Moderate improvement in functioning
  - Return to outpatient care
  - Not geared toward total functional recovery
- Intensive Outpatient Programs (IOP) – similar, less comprehensive (~ 3h/day 2-4 days/week)

Chip's Story

- Chip was engaged in treatment, motivated to improve, and had comprehensive insurance.
- He was referred to a partial program.
- In group therapy, he learned even more about his illness, including how to keep himself healthy.
- He worked with a case manager to set up long term outpatient care.

Chip's Story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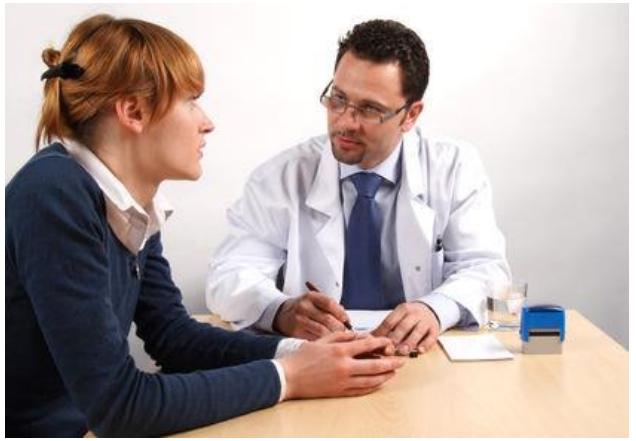
Outpatient Treatment

- Psychiatrist for medication management
  - Appointments every 4-12 weeks
- Psychologist or LICSW for psychotherapy
  - Appointments weekly or biweekly
  - Often involve elements of different approaches (e.g., cognitive behavior therapy, mindfulness, interpersonal skills, insight)



Outpatient Treatment

- Goals of Treatment
  - Symptom reduction or remission
  - Improvement in functioning
    - Work, school, with family and friends
  - Relapse prevention
- Medication can be effective treatment for many, but not all, symptoms.
  - Current medications do not target function specifically.
- How do we improve functioning?

Outpatient Treatment

Available Types of Therapy (at MGH)

- Cognitive Behavioral Therapy (CBT)
  - Improve coping with residual symptoms
  - Behavioral activation & scaffolding plans
- Family Therapy
  - Communication skills
  - Crisis management
  - Problem solving skills
- What if that isn't enough?

Outpatient Treatment

- PORT Treatment Recommendations (2009)
  - Supported Education and Employment
    - Patient centered school and work preparation and support
  - Skills Training
    - Improving interpersonal skills
  - Weight management
- Peer Specialists – recovery coaches
- Integration with Primary Care – Mental Health Centered Homes

Chip's Story

- Chip was referred to the First Episode Psychosis Program.
- He had medication management (antipsychotic) & therapy.
- CBT:
  - Coping with residual symptoms
  - Facilitating a return to school

Chip's Story

- Although high functioning, Chip continued to have challenges with concentration and motivation.
  - It took him much longer to learn new material and complete homework.
- School allowed him to take fewer courses.
- With accommodations, he was able to graduate.

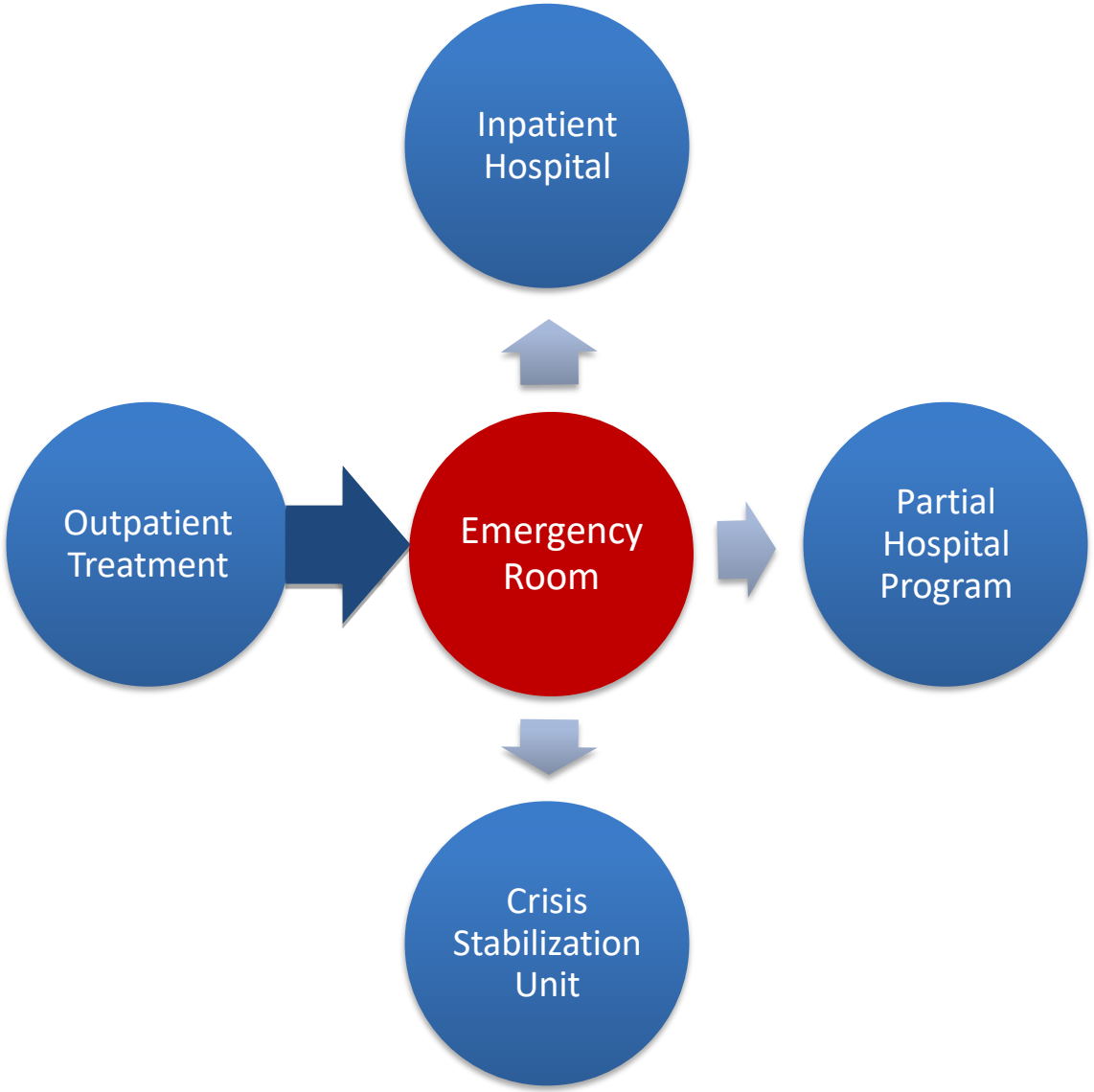
Chip's Story

- He has been stable for the past several years.
  - He has gotten married.
  - He has been able to hold lower level jobs, although higher level jobs have been challenging.
- His treatment outcome was outstanding.
  - Low level of residual symptoms with treatment
  - Retained cognitive and overall functioning

Relapse

- Most patients will have relapses.
  - Stress, substance abuse, medication non-adherence, course of illness
- Some relapses can be managed in outpatient care.
- Others will require partial hospital, crisis unit or inpatient admission, all through the ER.

Relapse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Department of Mental Health (DMH)

- Patients with multiple relapses and severely impaired function will become eligible for special services:
  - Case management
  - Community Based Flexible Support (CBFS)
  - Clubhouses

Case Management

- Case manager
  - Develops comprehensive individual care plan
  - Assists patient in accessing community services
  - Coordinates care
- Case managers have enormous caseloads (several hundred patients) and limited training.

CBFS

- Community Based Flexible Support Team
  - Prescriber, Masters level clinician, Bachelors level outreach worker
- Promote functioning in the community
  - Coping with symptoms
  - Work toward independent living
  - Work toward employment
- CBFS providers have limited training, limited resources, and large caseloads.

Clubhouses

- Community center that patients can attend daily for the long term
- Opportunity to socialize, provide a network of peers
- Provide daily structure
- Clubhouse “jobs” offer an opportunity to be productive and to contribute.
- Creation of a community

DMH Services

- These services have the potential to be enormously beneficial for patients' functional outcomes.
- Services are severely underfunded, and funding has been further cut in recent years.
  - Limited availability, limited staff training, limited efficacy

The Journey: Where Do We Go From Here ?

- Currently a winding road with uncertain outcomes
- Multiple levels of care, with little emphasis on functional recovery
- Opportunities for improvement
  - Availability and access to services
  - True parity in funding for mental health treatment
  - Better communication and coordination among treaters
  - Greater integration with Primary Care Medicine – health maintenance and prevention
  - Greater emphasis on functional recovery – patient outcomes that are meaningful to patients and families