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

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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.

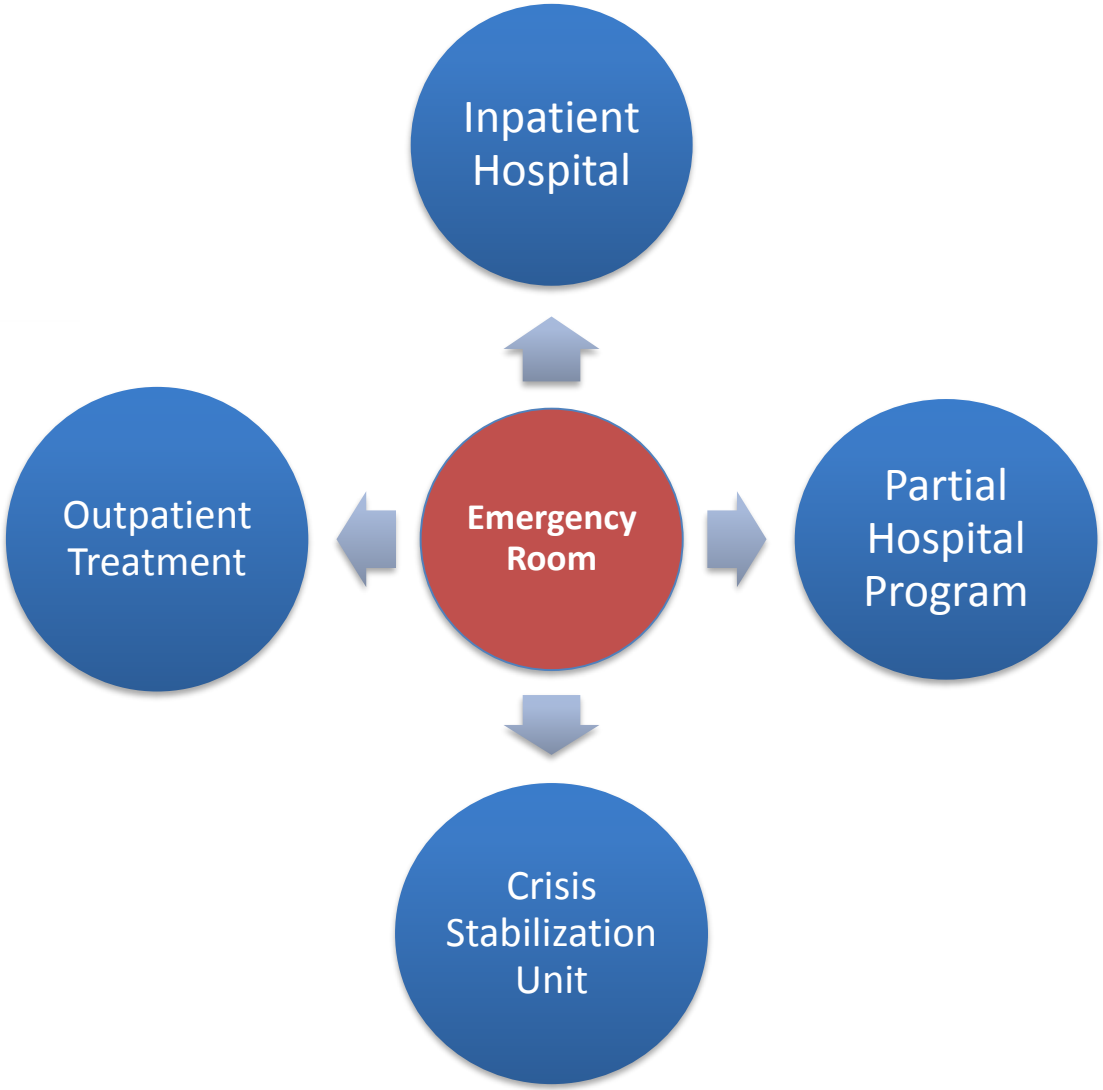
Chip's Story

- 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)

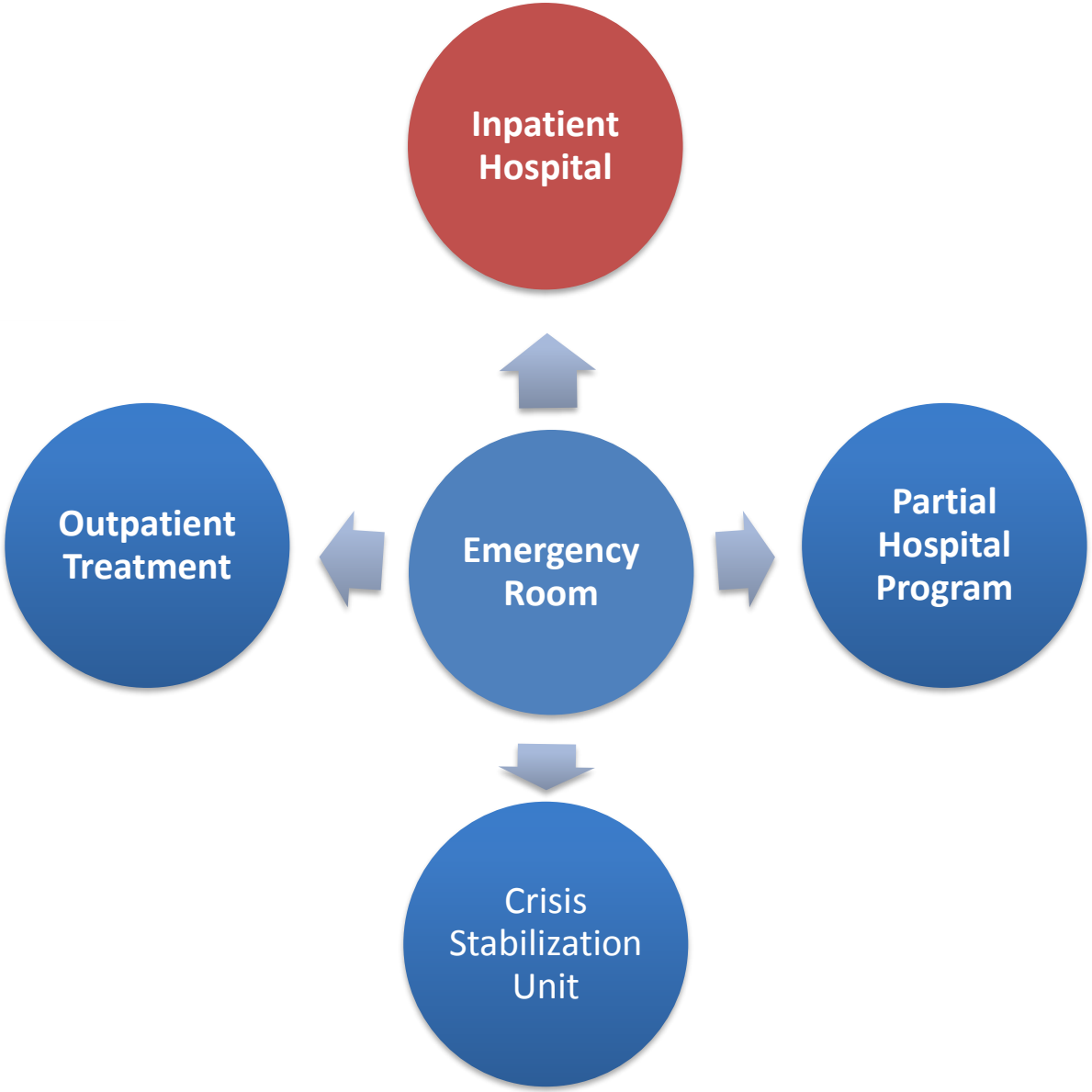
Chip's Story

- Chip waited for several hours in the emergency room to be seen.
- He had a medical workup, which 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
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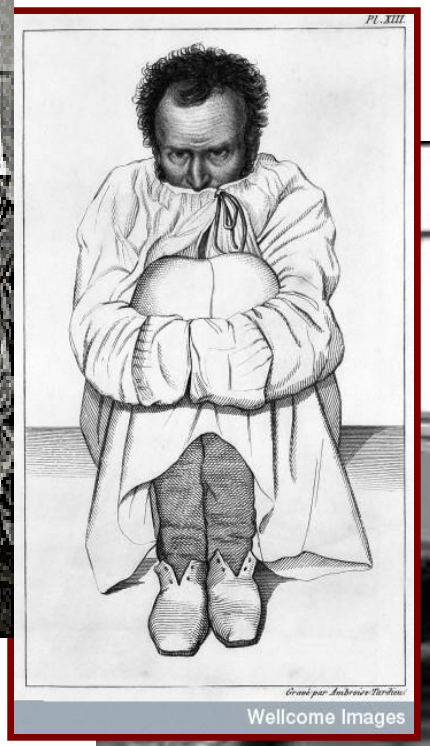

Wellcome Images

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.

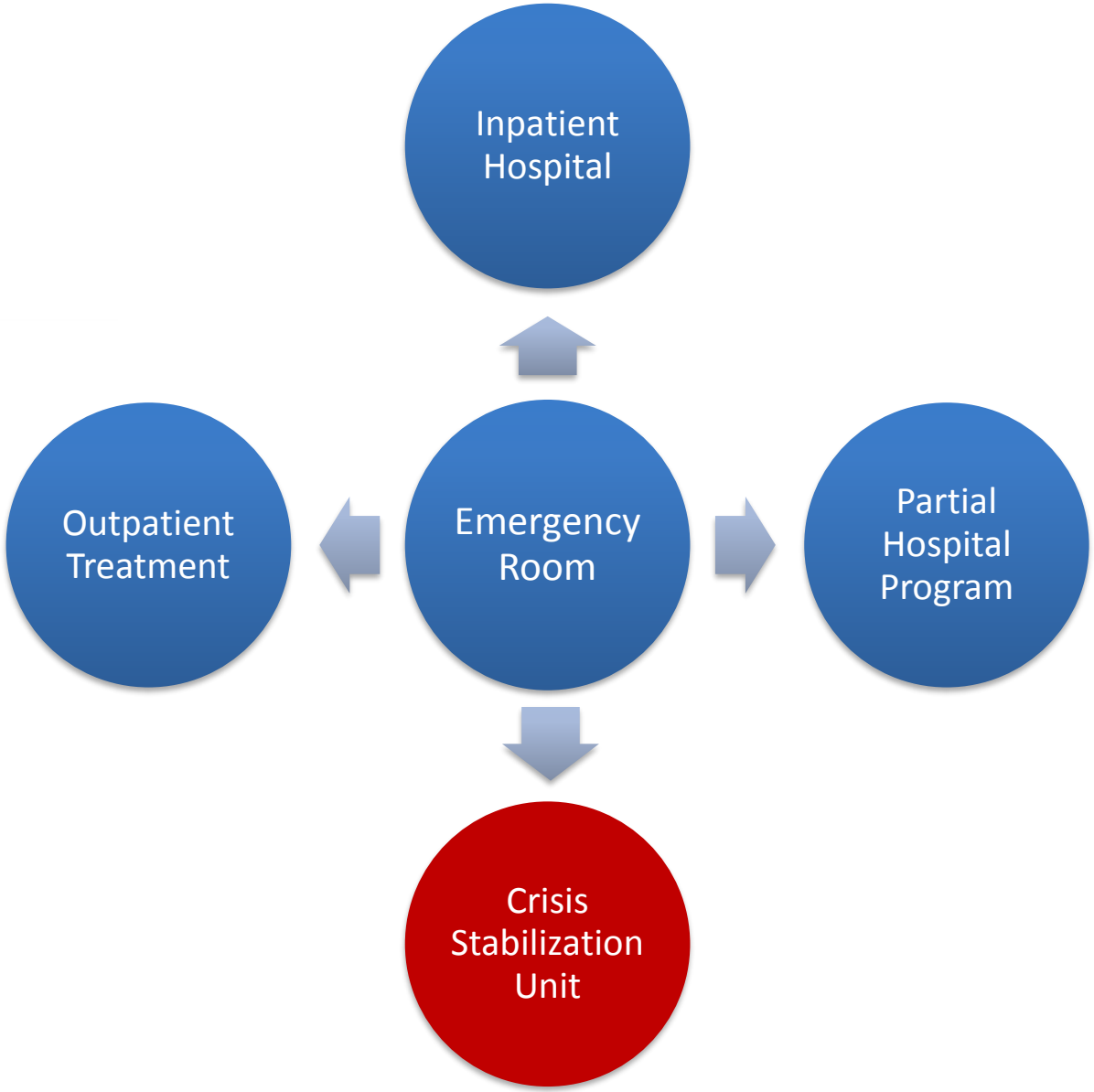
Inpatient Hospital

- 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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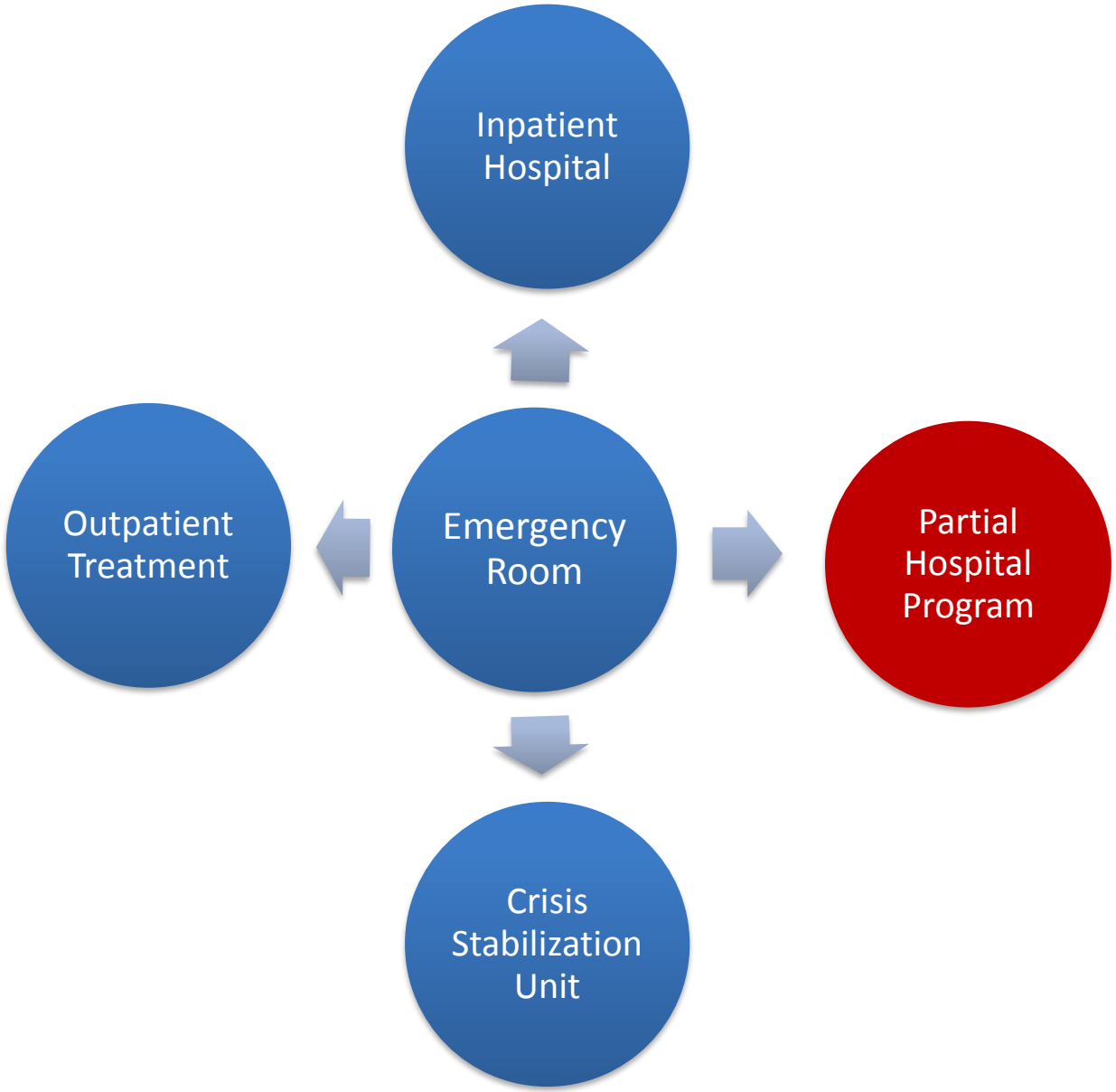
Crisis Stabilization Unit (CSU)

- 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

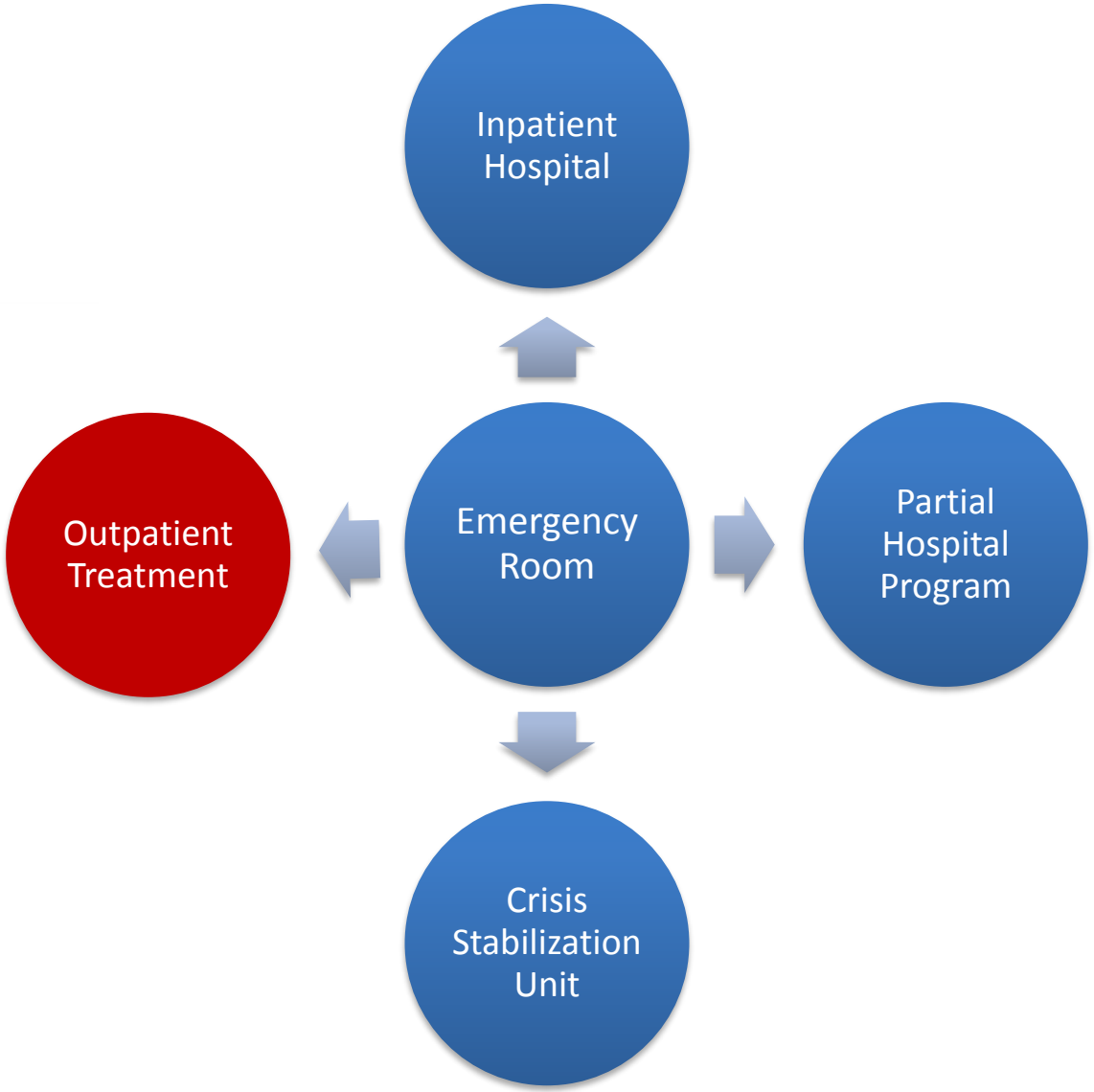
Partial Hospital Program

- 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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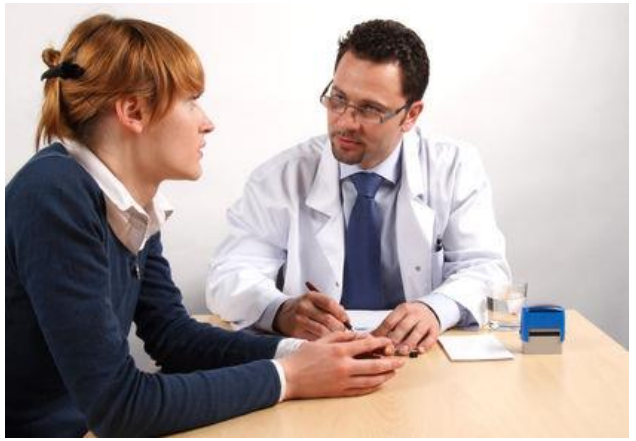
Outpatient Treatment

- 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.

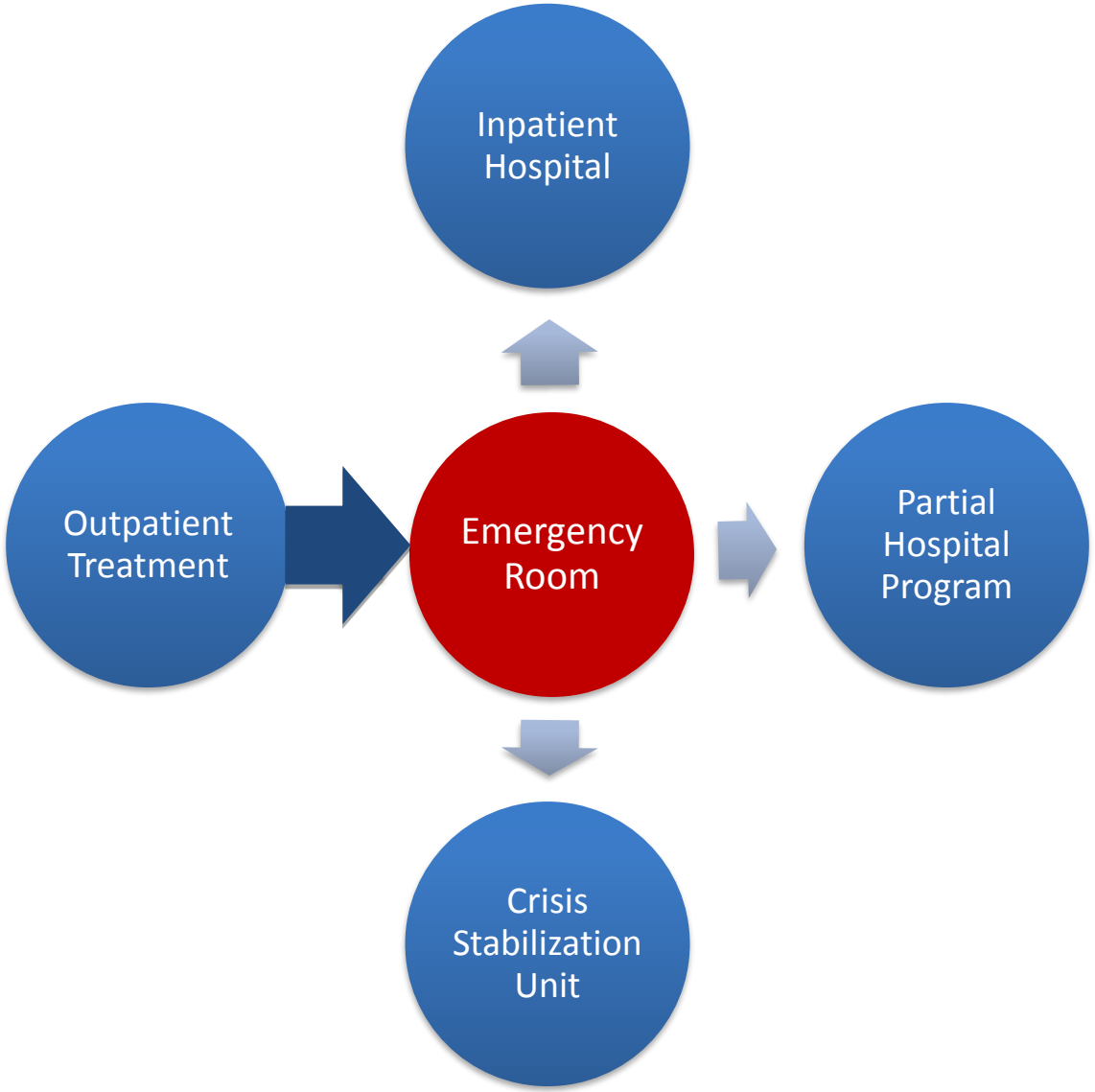
Chip's Story

- 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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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

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