Dorothea Dix Psychiatric Center Working Group Minutes (PL 2011, c.380, Part NN)
September 30, 2011

Present: Linda Abernethy, Carol Carothers, Charlie Clemons, Dan Coffey, Guy Cousins, Greg Disy, David Emery, Nichi Farnham, Lisa Hall, Dale Hamilton, Dennis King, Simonne Maline, Mary Mayhew, Mary Louise McEwen, Kim Moody, Jane Moore, Patrick Murphy, Sara Stevens

Absent: Vicki Rusbult

Facilitator: Helen Weizcorek
DDPC staff: Jenny Boyden, Bill Dunwoody, Michelle Gardner, Sharon Sprague, Melissa Hayward (recorder)

Commissioner Mayhew welcomed the group and introductions were made.
Minutes – approved with changes.
Helen reviewed the agenda.

Dr. Michelle Gardner, DDPC Acting Medical Director presented: What does DDPC Really Do?" Dr. Gardner profiled a typical patient of DDPC and presented information regarding the current 61 patients (on 9/23). This information included the referral source, involuntary vs. voluntary commitments, and diagnosis. Out of the 61 patients, 53 suffer from schizophrenia/schizoaffective disorder which affect 1% of the population here in Maine. DDPC treats those with persistent, unremitting psychotic symptoms through the course of their illness (approximately 10% of the 1%). Dr. Gardner explained that for those acutely symptomatic, it can take up to 6 weeks for medication to work.

Commissioner Mayhew asked the group to continue the discussion from the last meeting regarding "are the patients served by DDPC different than those served in the private hospital?" Dennis King indicated that we have a system that works the way it does because of funding. The private hospitals cannot sustain themselves with long lengths of stays (such as 6 or more months). Dan Coffey agreed that they are not able to treat people for that length of time; those patients are referred to the state hospitals.

Jane asked how many people are here longer (than needed) because of the lack of community services. Dr. Gardner stated that the lack of residential care is a huge factor. Currently, DDPC has close to 10 people waiting for residential placement. There also needs to be a philosophy change in the community as many of our patients have substance abuse issues. When a patient has legal issues and substance abuse issues, along with their mental illness, community placement is very difficult.

Dale commented that this was a very helpful presentation. He stated that the group must keep in mind the services that DDPC currently offers (who DDPC serves). This group cannot recommend closing DDPC without including ideas, proposals, etc., on how this population will be served. Dr. Gardner agreed that there would be a huge domino effect – patients will end up on the street or in the correctional system.

Sara asked for clarification on why people are transferred from other facilities? Are they inpatient here because there is a different program here? Dr. Gardner stated that people are here because their symptoms are such that they cannot be released safely. DDPC reviews for admissions are based on pure clinical need.

The Commissioner asked for discussion regarding the financial incentives that have created our system. If the two private IMDs had all of the money currently provided to the state hospitals, including DSH, would you care for the patients (for the length of time) served by the state hospitals. Do your budgets dictate who your serve? Dennis King stated that Spring Harbor is not defined as a long term psychiatric facility; our length of stay is approximately 10 to 11 days. The real question is what is the best way to manage the needs of this population – how can we create a better system of care. Acadia agreed that services and programs follow the money. If we could come up with a more flexible comprehensive financial model, we could develop a better system of care.

Kim asked if there is a fundamental difference in the way care is delivered at DDPC. Dr. Gardner responded that people work here because they have the time to treat patients. Patients and families leave more satisfied because the doctors have and take the time for treatment. Vicki spent time since the last meeting trying to find out why clients are happier with their treatment at DDPC. She was told that people at DDPC care more and focus on the holistic recovery.

Resource allocation has driven a different approach at the state hospitals than at the private hospitals. The Commissioner clarified that the resources allow DDPC/RPC to treat patients who need a longer time for treatment.

Lisa asked if the funding was moved to a private hospital, would the treatment still be at the same level? How would that impact the current patient population? Dennis stated that Spring Harbor would probably have a longer stay unit. The hospital believes that they (Spring Harbor) should be a minor part of a person's life and tries to keep to a shorter length of stay. Jane Moore indicated that the patient to patient

interactions are important. Seeing someone moving through the recovery process is important.

We should create a system where multiple agencies can work together – provide the flexible funding and hold providers accountable.

David revisited the topic of the facility itself – can the building be made more cost effective? If DDPC closed, should a new facility be developed in its place? Lisa Hall asked about moving other departments onto the campus – utilizing the vacant space. David indicated that this is an option but we still have to discuss making this a cost effective facility. The Commissioner added that there is probably no chance that a new facility would be built.

Carol stated that there is evidence that ACT Teams are more effective and more cost effective. Dr. Gardner agreed that ACT Teams are effective. She stated that this group needs to address how we meet the needs of the patients in the community so that people do not need hospitalization. Kim would like to discuss how we provide the services and close DDPC. Kim made the suggestion that this group break apart into two subcommittees, one looking at closing DDPC and the other at keeping DDPC open.

Dale suggested that we recommend additional funding to secure those services in the community with expectations and a group who would oversee them. Denis suggests a three year plan to address the needs of those with severe psychiatric/dual diagnosis needs.

Carol made the motion that we create two subcommittees – one to prepare a written report outlining the closure of DDPC and one to maintain services at DDPC. Dennis King seconded for discussion.

PUBLIC COMMENTS

Jeanne Mirisola gave a presentation about her son, Nick, who has had 21 hospitalizations in 6 years. She has no intention of blaming other hospitals, simply sharing information from a family member's perspective – how the system can make it difficult to navigate and to get help for her son. She's hoping her presentation will show where the system failed and hopes that this information will help folks develop a better system.

She shared information and pictures of Nick as a child, he was a happy and fun kid with a genius level IQ. He had a normal childhood and was active in school – both in sports and in the arts fields, having received awards for his art work. After high school, he went off to college, barely making it through the first year, and then things fell apart. He was in and out of hospitals between Maine and Vermont (where he went to college). Jean stated that the Vermont's version of a PTP program served him well until the meds stopped working. She explained her frustration with regards to the system and how it was difficult for her to get Nick the help he needed, having to prove that he was a danger to himself or others was not easy. Nick was admitted to DDPC back in February. It took many weeks for the medication to make a difference and she is very grateful DDPC was able to care for him during this time. Jean also stressed the importance, especially for patients like Nick, who need the therapeutic space DDPC provides – being able to go outside, the services that are provided here, and that he could go home on a two week pass. She said it was difficult for him to be inside all the time. Nick has been commissioned in the PTP program for one year and Jean is hopeful that this is the first time in 8 years he'll have a chance to make it. He is being discharged today. Nick is someone that the world does not want to lose.

Simon Alexander spoke next regarding his wife Sarah. He stated that last winter, his wife deteriorated and her hospitalization at Acadia did not go well. Sarah spent three weeks at DDPC and is a completely different person upon discharge. He is very grateful to DDPC that their life is back on track.

Sarah Alexander spoke of being admitted to Acadia a few times, only to have a medication change, be discharge, and then crashed, having to be re-admitted. Sarah feels that all the services provided at DDPC are very helpful, especially the sessions with the psychologist. The outpatient DBT program has been helpful. She feels the outpatient therapy is very key to her recovery. She believes that Acadia and DDPC do serve different populations – some react to a short term stay while others require longer periods for recovery. Sarah also read a letter signed by many supporting DDPC.

Lonnie Gould spoke about recovery. It's all about recovery. It can be at here, Acadia or anywhere. The focus has to be on each person's definition of recovery – their goals and dreams. He was successful at DDPC because he had the time. Acadia served him well in the past and they kept him safe but sometimes some people need more time. I do not want people to spend any more time in the hospital than they have to, but some people just need the time. I needed the time to find my path to recovery.

Helen read two additional comments/letters.

Helen returned the group back to the motion this morning regarding the formation of two subcommittees. The motion was passed 6-4-3. Carol passed around two sheets for sign up. Dennis suggested that we use next Friday's meeting time to prepare their reports.

- Keep DDPC open: Lisa Hall (lead); Sara Stevens, Linda Abernethy, Jane Moore
- Close DDPC: Carol Carothers (lead); Dennis King, Dan Coffey, Simonne Maline, Jane Moore
- David and Lonnie requested that they be allowed to observe the subcommittee meetings. Commissioner Mayhew approved.

Both reports will touch on A-I included the legislation regarding the forming of this work group – Part NN. Both reports are due to Melissa by Wednesday, October 12th.

Jenny provided follow-up information regarding per patient/per day cost: Spring Harbor $942; Acadia $1076; RPC $1005; DDPC $1373. Amount of vacant space here on campus is 92,000 sq feet; this includes the Pavilion.

Sharon Sprague, Director Therapeutic Services, presented DDPC Patient Placement report. She described the placement options and discharge barriers. The wait time for the placement options can be one day to months. Sharon also noted that many of our patients would like to live in their own homes, life independently. We have had the most success with supported apartments. Currently we have only one supported apartment available. Another hurdle with discharge is the guardianship process, which can take weeks and sometimes months. Currently there are 11 people in the guardianship process. Dale Hamilton reiterated that housing is the major issue we need to address. Charlie would like to see the CRS rate increased by decreasing the high cost of PNMI rates. Sharon suggested eliminating some of the higher priced PNMIs and creating some clubhouses. Some other barriers include: patients refusing to sign paperwork, medical complications, denial of illness, some sites unwilling to accept patients with certain medical issues, etc. Some area group homes expect our folks to grow/rehab and move on to independent living; this philosophy is different than the original purpose of group homes. We have folks in group homes that expect to live there for the reminder of their lives.

Linda provided a brief overview what the $2.5 million budget cut means to DDPC. There are some things that the hospital can do without legislation. We cannot wait until April to begin the changes. DDPC will be going to 3 units at the end of November. We currently have a census of 60-64 beds and we will be scaled back to 51 patients with 3 buffer beds (PTP or ER admits). We have 2 outpatient programs one which serves 38 patients that includes the DBT program; we are keeping this as it is not offered anywhere else in this area. We also have 135 patients in our outpatient clinic for medication management. Those patients are being transitioned to community providers. The majority of these people are here for a reason – they are profoundly ill and have been "fired" from other providers. DDPC will bridge people if there is a timing issue. This is the immediate plan. We have longer term plans that will go to Guy and the Commissioner; they will go to the Governor to be put in the supplemental budget and be addressed by the legislature.

Dale Hamilton provided a one-page handout outlining potential pilot project. He asked that each subcommittee review the information during their work session.