The discontinuation and closure of long-term state level psychiatric units

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This constructivist grounded paper is a long overdue proposal to close all 'extended-care' state level wards and discharge all remaining patients to a lower level of care. From long-term care and extended service units to admissions and adult, children, and adolescent services provided by inpatient treatment wards, this is a call for the complete discontinuation of long-term state level care units in state-level treatment centres in the US through the commission, implementation, and commission of Ward Closure Team (WCTs). Without question, society has arrived at a crossroad in determining the future of mental health treatment. Consumers and practitioners acknowledge that the current mental health system does not address gaps in mental health care and treatment. Instead, the system is still informed by the era of institutionalisation and does not facilitate access to services at the local level where the potential need for connectivity and person-centred care is greatest. This dispenses a new term in being: WCTs' and marshals' new recommendations to challenge the ongoing denial of full community access to mental health care in the US. Aiming to disrupt the increasingly insidious neo-institutionalisation, this paper intends to make visible the theory that access to mental health treatment should be the first priority in addressing the mental health crisis at stake for consumers who have historically fallen through the cracks of the system.

Keywords: extended care, institutionalisation, mental health treatment, psychiatric units, state hospitals

I will never forget the words of my psychiatrist in the community hospital in which I was receiving treatment for first-episode psychosis: 'You're not going to like where you are going' (Personal communication, 2008). My doctor was referring to the local state hospital in which I was pending immediate transfer for 'unresolved psychosis' for 'ongoing care'. I am a consumer of mental health services who has been hospitalised in a state psychiatric centre in New York. I am also a social worker, a disability rights advocate, and therapist for mental health treatment. This presentation will offer facts, data, and professional analysis based on years of clinical practice and research. In addition, I will incorporate the shared experiences of peers in the US. Utilising peer-informed literature written by consumers of treatment in New York State and from other state-run regulatory bodies in the US hiring peers, this paper presents a new perspective on uses of long-term hospitalisation at the state level. The argument builds on existing research suggesting the state hospital system needs to be expanded and reformed. Instead of supporting this claim, I turn this fallacy on its head by re-examining the data already presented by supposed independent researchers contracted by the state governments from which they receive funding, which provide data and analysis of trends in modern mental health within the same system in which they serve.

The research report written by Parks and Radke (2014) contends that, state psychiatric hospitals are a vital part of the continuum of care and should be recovery-oriented and integrated with a robust set of community services. The authors lay out a set of recommendations on how to reform and revamp the existing state-run mental health system. The central arguments proposed then were neither new nor radical departure from standard practice in psychiatric medicine during the 1980s. At that time, shortly after the beginning of deinstitutionalisation, clinicians were forced to accept that patient involvement in their own care should be central in the recovery progress. This notion, radical then, was driven by peer movement and disability rights advocates who were passionate about changing clinical practices at the ground level. On a more global level, the report hammers existing roadblocks in the culture and environment of state psychiatric hospital facilities. Those barriers obstructed the provision of effective care, particularly in light of new recover-oriented, trauma-informed, culturally and linguistically competent regulations for best practice. These include patients receiving treatment in the 'least restrictive environment possible' Parks and Radke (2014) and other peer-driven, recovery-oriented practices, such as the inclusion of recovery specialists as equal members of the treatment team.

Unfortunately, when considering praxis in the day-to-day operations of contemporary state-run facilities, theory is not congruent with practice on the units and wards where patients live out their lives when treatment fails them in the community hospital. The very language 'when treatment fails', is the point of departure for this argument. It questions the complicity and ethics of practitioners who consign their patients to the categories of 'failed' or 'untreatable' (Guttman, 2018) instead of immediately revising or urgently critiquing the praxis existent in available mental health treatment. The first step to providing the least restrictive measures in treatment is eliminating the use of restraints, including seclusion practices that isolate patients from their community members of the unit. In reality, from both professional and lived experience, state-operated units are smaller, more confined, overcrowded, and jail-like in architecture and layout of services in the wards. In addition to the aesthetics of institutionalisation and the confining environment of the hospital, the restrictions placed on the patient living away from the community-at-large in a locked hospital, usually hundreds of miles from family and friends, is antithetical and a sharp departure from the words and language used in the reports by Parks and Radke (2014). It is, instead, the very reason why this presentation seeks to re-evaluate so-called reform in today's mental health system, ad discussed by Spindel and Nugent (1999).

Research supporting the further expansion of the state hospital system acknowledges the lingering debate about whether patients can be better served in the community than in voluntary treatment in long-term state-run units. Given that this debate still persists, government stakeholders and decision-makers need to give more consideration to both sides of the argument and truly look at the facts.

Instead, revenue, insurance, and cost-based analyses of the situation continue to be firmly in the hands of the people who keep the system running. This presentation is independent of the Office of Mental Health (OMH), the Department of Health (DOH) and other federal commissions that hire researchers based on trends in funding and insurance reimbursement. At the crux of it, both sides of the community versus inpatient debate realise the risks and benefits. Patients must be continually evaluated to determine if treatment given in a state hospital can be safely provided in community settings.

A report written by NASMHPD states that in the year 2012 alone, over 40000 patients across the US were housed in state-level psychiatric centres. In the future, state psychiatric centres and mental health hospital networks will just be relics, anachronistic holdovers of the sins of psychiatry. Where the last great psychiatric cathedrals now stand is a carefully laid out and organised system of hospitals. These hospitals continue to symbolise the harm done to an entire population of mental health patients, who were then described as 'sick' or 'mad'. The institutions included treatment rooms in which 'medical intervensionists' forced medication, shock treatment and lobotomies upon patients. Even more insidious and covert forms of treatment were also administered, particularly by the most recent abuser, the pharmaceutical companies. This sets the stage for a new level of state psychiatric mistreatment as the 21st century unfolded. Today, the legacy of state psychiatric centres in the US is being challenged by former patients, psychiatric survivors and peers, whose goal is to liberate medicine from psychiatry.

Still, research funded and disseminated by organisations like the Treatment Advocacy Center (TAC) and other reports which inform the emerging trends in state funding continue to be off the mark. Indeed, forced treatment and assisted outpatient care needs to be continuously re-evaluated which could benefit from release from psychiatric hold and deferred recovery due to problems rooted in access and connectivity to care. However, the reports generated by TAC and other advocacy organisations which put 'treatment' ahead of the needs and voices of the consumers truly requires more careful consideration on the part of lawmakers and stakeholders making decisions on how day-to-day operations are carried out by practitioners in state-run units than simply blanket appraisal and adoption of their recommendations. These are recommendations which continue to ignore the reality of life on the unit, and condemnation to extended and 'ongoing' treatment without consent and, even worse, effectiveness in avoiding rehospitalisation and certainly not expedited discharge to the community.

The writing in this presentation, its contents and history began as chatter, 'shop talk' among peers in the community mental health centre. But talk disseminated quickly, moving among the ranks of the peer movement to the level of the czar. The czar, leader among the peer movement, must finally end and era of institutionalisation. The spectre haunting consumers of mental health treatment even today, disguised ad neo-institutionalisation and passed off as treatment to patients in the state hospital system must be stopped. In no uncertain terms, the czar must stand before the state government in New York State and the US federal government DOH and set the deadline for New York State and all state-run psychiatric centres to comply with WCTs, and sign off on the discharges of all patients in the state hospital system. Indeed, under 'Article Zero', a future Office of Mental Health Regulation, WCTs will be charged with the organisation, dismantlement, and discharge of patients in state-run long-term and extended care units across the US. A grand consortium of peers, social workers, and psychiatrists will be assembled. Once Article Zero is written into law, something Teague, Bond, & Drake (1998) set as the true limits of establishing any best practice, high fidelity model, reproducible and EBP-informed, studies and further manualising of WCT can truly begin and offer tested evidence to this constructivist presentation.

DEFINING THE PROBLEM

As with all things absolute, an exception to the rule always exists. For all that rule, including the czar, peers themselves must answer call from all victimised people who demand and deserve justice. This is a justice as visible and clear as day to patients as the same euphonious chatter from the community

centre we peers would commensurate years ago and long before the last discharge. Until everything changes and patients can see the spectre rise in the gaze of their abusers, power and privilege will be restored in the hands of the consumer. Without question, full integration and access to mental health services resides in the community. To fully integrate services and consumers in the network of already available mental health programmes, remaining patients in the long-term state psychiatric centres must be discharged and released from the eternal holding pattern to ultimately integrate and help consumers gain access to community resources, and most importantly, to allow them to live among other people outside the gates of the institution. Therefore, the Phase I of the WCT manual for community access will target the release, discharge and reintegration of patients into the community. Later phases and future research will target the establishment of reliable systems in which chronic and high-risk patients will have reliable access to services and programmes that will benefit this group in lieu of hospitalisation (Gagani, Gemao, Relojo, & Pilao, 2016).

Access to outpatient services

This plan begins theoretically at the level of local and state governments and municipalities that govern the regulation of mental health treatment: the state mental health authorities, the National Association of State Mental Health Program directors (NASMHPD), in collaboration with federal agencies, must approve funding for WCTs to infiltrate access state psychiatric hospital operations and systems at all levels that impact discharge planning and community re-integration. In theory, each freestanding unit in all state hospitals will work side-by-side with its assigned WCTs. Social workers, psychiatrists and all inpatient staff charged with the successful discharge of its patients must partner with the WCTs until the final discharge from the hospital in which the final patient re-enters the community.

The crux of Phase I is the funding needed to staff the WCTs across the states. Each team will serve as an interdisciplinary reflection of the treatment gaps identified at each hospital's locale. This meant that prior to each WCT beginning its work in a unit, the hospital will send a memorandum of requirements to the Office of Mental Health, which will inform the make-up of the teams assigned to each hospital and community. Thus, needs related to transportation and rural concerns will be managed by WCTs specialising in the needs of rural communities and their mental health systems. More urban-based communities with complex spatial access issues will be staffed with workers adept at handling the mental health concerns of patients in urban setting.

The ward closure team

The WCTs are a multidisciplinary, mobile field unit, and treatment team operated and regulated by state mental health authorities. Each team will be trained to target chronic diagnoses, relapse prevention, and offer treatment in a flexible, organic, person-centred approach. While the WCT and assertive community treatment (ACT) are similar in composition, in keeping with evidence-based practices (EBP), the potential for the WCT's positive impact on clients and, in turn, likelihood for good outcomes could not be more radically different. ACT team meets with clients for a minimum of 15 minutes of face-to-face contact to be able to bill and consider the home visit a session. While sessions usually run longer, as patients typically have errands or complex case management issues or need transportation to medical appointments to and from treatment, or any number of complex case management issues the WCT clinician or peer needs to address in session, 15 minutes alone is simply not enough for patients discharged from state hospital step down unites. In keeping with this premise, the completion of tasks patients typically request help with, or just requiring the attention of the worker to go on and one. There is a laundry list of needs patients have after discharge from the highest level of care. It is immense, overwhelming for clients still symptomatic and clinically determined to be safe, stable and ready for re-entry into the community.

Integrating into the community is a challenge without a mental health disorder which distorts, complicates, and makes the vast obstacles ahead seem almost insurmountable. At the root of it, these are not clinical issues, but complex case management issues i.e., connection to medical providers, food shopping, obtaining hygiene and other household products due to transportation issues. Many clients surrender their driver licences prior to admission to the hospital due to legal, or mishap and unfortunate circumstance. In many cases, due to high case loads, productivity requirements, and other extraneous non-clinical issues, session times are limited, cut short, or only begin to address these serious problems patients struggle with upon re-integrating into the community. So, upon initial integration to the community, WCT sessions will be longer the length to bill for session under Article Zero and count the contact as a required visit. Similarly, instead of a minimum of six contacts a week with each client on the census, required monthly contacts should also increase. Simply put, for WCTs to consider the patient enrolled under the care of WCT, sessions should be doubled in length for clinicians and peers to be effective for the upward mobility of a patient's recovery.

METHODOLOGY

The planning involved for both the ward closure teams and the existent treatment teams in the units surpasses the assessment of the composition of the community. Indeed, ward closure teams will be required to have a full understanding of local existing services in the community and will work side-by-side with treatment teams in the units to identify issues foreseen prior to each discharge. Hence, issues of adherence will be measured against connectivity issues in the communities' existing healthcare networks. Other issues, such as medical comorbidities, will necessitate ward closure teams to acquire full understanding of existing health networks that serve clients with complex medical and psychiatric issues and other complex case management services, which freestanding clinics do not traditionally provide. Simply put, WCTs can supply case management services to users dependent on the system of care after discharge from the hospital, and its vast and complicated services. Given the freedom to complete more case management services, while also providing clinical services, and be the primary point person in consumer care, time consuming and high impact complex care management tasks can be completed without incident, including certification and recertification of benefits to continue all of medical necessities are completed so services run without interruption. Under Article Zero, the incentives to learn, either through continuing education, but either way, certified in new treatment modalities which are proven through evidence-based studies to improve the prognosis of chronic patients being discharged from long-term care settings i.e., state hospitals are not just to experience better outcomes for clients, but also build a track record as a practitioner.

So, all new and existing treatment team on the state hospital grounds as well as treating patients discharged from a state level facility will be required to be versed and certified in peer-supported open dialogue (POD); and cognitive behavioural therapy (CBT) targeting psychosis, delusional disorders, and a range of diagnostic interventions commonly associated with patients with chronic disorders. Thus, diagnostic and public policy stakeholders of health and medicine all suggest ACT or PACT (Programs of Assertive Community Treatment) in some states should be repurposed and selected as the best available discharge plan after graduation from a step down unit in a state hospital. In addition to being a mobile unit, care managers, and discharge planners for high-risk patients will benefit by beginning treatment within the walls of the hospital, something ACT teams are limited to do, and according to state regulations and programme guides, in New York State, and can only perform tow 'hospital visits' per month to bill for, and maintain the client on the team's census. Thus, in addition to being more versed new EBP, WCTs benefit from operating the same physiological space as patients treatment team on the unit, a length of time which can be determined state to state, but always able to fully operate at two polarities, the highest level of care and conversely, the least restrictive environment possible, that is, within the community. Upon discharge, patients still under the care of extended care, will step down to transitional care units, sometimes called TCU, WCTs can begin their fieldwork inside the hospital

unit, and plan to one day complete home visits upon their patients' successful discharge from the step down units or TCU inside the facility of care of ACT or PACT, and, under the provision of services for an undetermined, if necessary, permanent team of patients determined by individual state mental health authorities to require its care which is already prescribed by ACT or PACT guidelines for practice across states (Stein & Santos, 1998) and in *A Manual for PACT Start-Up* (Allness & Knoedler, 1999).

Phase I

Prior to discharge from the hospital, and incongruence with regulations in several states (New York, New Jersey, Connecticut, etc.), discharge planners across all state facilities will have the responsibility of preparing all clinical treatment plans up for review for immediate step down to a lower-level of care. In doing so, the timetable will be set; while in some states, plans are reviewed every six months, others three, regardless of the lifespan of the plan, personnel in the hospital documenting the transition of patients to the community. Thus, discharge planners will begin to put paperwork into place which will follow clients' records to the treatment teams in the community which will continue care upon re-integration. This means, across longer-term care units, state hospitals will internally reconfigure their units, to prepare for the large volume of clients discharged from the facility.

Without question, this will in turn serve remaining patients well who are mandated by the court, and largely the criminally insane. This subgroup of the state hospital system, according to reports written by NASMHPD, are mostly forensic patients, not including sex offenders, which make up a fraction of the entire state mental health system census. I am suggesting by emptying out and closing down long-term units containing non-violent mentally ill patients, all remaining units will more likely to be less crowded, better staffed with additional funding now less spread across fewer units. This has proven to reduce the likelihood of conflict and reduce safety issues on the unit in which clients who are extremely agitated react, or act out against their peers and other patients. When this plan goes into effect, all patients will less likely be exposed to violence. With more money to go around, new spaces and units with a lower census, for more personalised, person-centred, and safer environment will blossom at the state level.

The last segment of Phase I is the expansion of state level step down units. In various states, including many of the Northeast, Midwest, and West Coast of the US, step down units are too frequently used to transition patients back to the community. In many state facilities, including GBHC (Greater Binghamton Hospital Center), RPC (Rockland State Psychiatric Center), and several other state hospitals, only one or two transitional units exist. In theory, all patients in extended care and long-term care units will be transferred to the transitional units available in the facility. Upon the patients' treatment plan, all new plans requiring an update, will in turn determine the potential date patients are transferred from long-term units to TCU. This is the spark that will light the fire that signals to the inpatient treatment team that new patients now require the attention of hospital staff to determine the long- and short-term planning necessary to begin to successfully discharging patients from long-term units to a lower level of care. This lower level of care, specifically the transitional units available in the facility, will then prepare themselves for new admissions internally transferred from all remaining long-term units. Should, give an analysis of the volume of patients being transferred internally, and ultimately discharged from the transitional unit to the community, it is recommended that the immediate allocation of funding to the creation and expansion of transitional step-down units.

Phase II

To achieve the desired goal, the next major step is implementing Phase II which begins just after the assignment of WCTs to respective communities and state psychiatric centres. At this point in the plan, WCTs of new hired personnel, and even those transferred internally, composed of staff from units

farmed out and closed down after the facilities reconfigure their census and disbursement of the hospitals' population, patients' needs prior to, and after discharge. These WCTs will target, and be staffed by people who are able to target and specialise in specific diagnoses, and be prepared for less than promising patient prognosis. Upon gaining access to inpatient services, hospital operations will begin working side-by-side with existing hospital staff. Teams will identify all remaining concerns for patients prior to discharge. This will be a process in which patients will work voluntarily with newly instated WCTs and contract to work with treatment teams in the community earmarked for their care at post-discharge.

Thus, all services will be matched with the needs identified by both the long-term and longstanding clinicians assigned to each unit and patient, as well as the newly commissioned closure teams to achieve the primary goal, which is complete access and the integration of all state hospital patients still in long-term care back into the community and the end of institutionalisation forever. To achieve this aim, the plan and each of its phases require not only community support, but also support from stakeholders regarding mental health and public policies, and also the shared goal of creating a society without walls or restrictive barriers for chronic and long-term mental health conditions who are typically assessed and slated for long-term, ongoing, round-the-clock care that a state institution provides. Thus, the vision and scope of this proposed plan and the prospective teams charged with implementing the final solution and ending the era of neo-institutionalisation is clear: full community access to and the integration of all community mental health programmes as well as the elimination of a level of care that is both dated and obsolete in the context of the full meaning of deinstitutionalisation.

Phase III

Studies continue to evidence the positive trend which suggest people, regardless of their precipitating reason for admission to the hospital, whom are supported in their discharge from long-term units, eventually transitioned to a lower level of care without incident, and provided access to community resources and mental health treatment are much more likely to succeed in the community than patients either clumsily discharged or without adequate planning. Thus, this three-phase plan lays out a comprehensive third phase. In keeping with the assumption, ACT teams continue to further more and more empirical evidence of treating the most chronic and at most imminent risk of self-harm or harm to others. WCTs will ultimately prepare their existing census for discharge to ACT teams, the highest level of outpatient care and most effective evidence-based modality across the US for treating this population. Therefore, since ACT teams are already existent everywhere a potential patient is awaiting discharge from a TCU in a corresponding state hospital, these ACT teams will absorb the majority of patients discharged from the WCT.

The transition of patients to their assigned WCTs will be synchronised, time and documented similarly to ACT treatment planning. Without recreating the wheel for documentation in the field, WCTs will follow the freewheeling, liberal documenting style and manner of capturing the patients' clinical picture in the most representative and appropriate outpatient service. Since all outpatient mental health services are ultimately tied to coding and congruent billing, WCTs will follow the coding of ACT services. Therefore, the creation of new medical billing questions does not interfere with the speed and necessity of discharge. Thus, ACT teams will be able to replicate the practices and treatment of WCTs, and the continuum of care will be intact through from the moment the patient is discharged from the state hospital and fully transitioned back to the community, without anyone falling through the cracks due to insurance, poor planning, or inadequate services after discharge from the hospital.

The end neo-institutionalisation

Mental health is a community of public health need and after implementing the proposed plan, the fallacies and misnomers of the old system will never again point towards institutionalising people and sending the 'problem' patients to the long-term care units far from the community and its resources. Access to services must be provided and new pathways must be engendered so that consumers can gain access to the many lines of care already provided by the systems of care in New York State and by all regulatory bodies with a vested interest in mental health treatment. Neo-institutionalisation is complex and insidious, and it must end. Therefore, the focus of the ward closure operations manual is threefold. The first phase of operations targets the state psychiatric centres based on a global assessment of outlying communities and on the express needs of the consumers being discharged. The second phase targets the overhaul of treatment silos and installations already in place in the community that need more integrated access for consumers. Without questions, the resources already exist in the community, and this document proposes how to reconfigure existing structures that provide mental health treatment to serve patients.

The success of Phase II depends on the elimination of freestanding treatment silos. This means that all treatment programmes that discriminate and choose to openly serve only subgroups or 'high-functioning' patients will be given a mandate by the Office of Mental Health to broaden their scope of services, or they will be subject to a loss of licencing and funding. An example of a programme that only serves a small niche of 'qualified' patients include outpatient settings that refuse to accept state-sponsored insurance for patients who are disabled and reliant on Medicaid and other service dollars. Conversely, treatment centres that offer services to all patients or that are cited for restructuring and successfully reconfigure their clinics, group practices and day treatment centres will be awarded funding to commit to on-site projects and community outreach projects to further extend services to the community.

The next and final phase of this plan after patients are assigned to ACT teams is an ongoing community mental health surveillance and hygiene study which will continue throughout reintegration and the patient discharge to the community. Upon the final discharge of patients from extended care units, and all existing treatment plans up for review have expired, the final discharge from the locale's state psychiatric centre will have walked out of the gates of the hospital. Under the assumption that the influx of thousands of newly discharged chronic patients will test the limits of the community's local emergency rooms and the community hospitals' abilities to provide services and will largely increase the census of mental health treatment at health centres, a surveillance and hygiene study will bridge the existing gaps in each community during the critical phase of mass-organised discharges from state psychiatric centres. The study will be monitored and fed into a state-wide planning commission for full community access to and integration of mental health care. Next, a broader approach, including at the global level, can be implemented and used as a model for other state regulatory bodies interested in eliminating the dated level of care and the deferred recovery of patients.

CONCLUSION

At the root of it, the planning and hygiene study will be ultimately analysed and measured against the restructuring efforts already underway in the community. The gaps in care identified based on the hygiene and surveillance study will be seriously considered, and once verified, local community mental health care planners, managers and stakeholders will be charged with identifying solutions to the problems. Given the latitude required to make changes at the local level, the recommendation is that county community mental health departments and Single Point of Access (SPOA) committees spearhead the final structural adjustments to the mental health care system. Ultimately, the Office of Mental Health will begin drafting new regulatory codes that promote and encourage the end of neo-institutionalisation. Thus, codes will be established that discourage extended hospitalisations and ongoing treatment plans without an end. While not forbidden, these treatment pathways will generate

red flags at community mental health offices and in the Office of Mental Health headquarters where programmes are monitored for compliance with these new integration and access practices.

Ultimately, this proposal is essentially a recommendation and call for regulators at the state and federal levels to revamp and to raise the bar to promote the best practices among practitioners and public health stakeholders of mental health care. Research suggests that the delivery of mental health treatment must go on without interruption from either hospitalisation or from falling into a gap in available treatment at the local level. Given that many community treatment setting are either inaccessible or do not target the provision of resources for patients to continue recovery on their own terms and in their own communities, it can be assumed that the next logical step in creating a culture equipped and prepared to address mental health care crises will require practitioners and law bodies to pay close attention to this recommendation with due diligence. The rollout and the implementation of ward closures in the US and anywhere that patients are in a psychiatric holding pattern without hope of accessing services in their communities is urgent.

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