A State Mental Health System With No State Hospital: The Vermont Plan Ten Years Later

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The feasibility and desirability of closing Vermont's only state hospital have been debated for ten years. The author examines the current status of the state department of mental health's plan to close the state hospital and concludes that although closure would be feasible, it would not be desirable. It would reduce the tertiary capacity of the mental health care system and would limit care for severely and persistently mentally ill persons who resist treatment and who have few social resources. (*Psychiatric Services* 48:1078–1080, 1997)

A study of both the feasibility and the desirability of operating a state mental health system without a state hospital was carried out in Vermont in 1985, and the results were published in 1987 (1). The study concluded that comprehensive regional community support and rehabilitation services could replace the state's only public mental hospital, Vermont State Hospital, for all public mental health clients, except forensic patients, and that developing such services was both feasible and desirable because it would result in higher-quality services at a roughly equivalent cost to the state.

At that time, alternate opinions, including my own and my colleagues', questioned the advisability, not the feasibility, of eliminating Vermont State Hospital (2). We pointed out that proper use of a small state hospital could enhance the ability of some persons to use community-based services and could also enhance the ability of community mental health centers to provide such services. Another point was that involuntary treatment could increase in a completely decentralized, non-state-operated system. We also objected to the suggestion that "community" means "anywhere except the Vermont State Hospital."

Ten years after the Vermont feasibility study, the debate about the fate of the state hospital continues. This paper summarizes the proposed steps in closing Vermont State Hospital and discusses why common reasons for closing a state hospital do not apply to Vermont State Hospital.

The plan for closing the hospital

In 1987 Vermont State Hospital had 160 beds and 450 admissions annually. These figures reflected the results of more than 30 years of deinstitutionalization, beginning in the 1950s, when the census was 1,250-plus (3). At the beginning of 1997 the state hospital had an average daily census of 55 to 60; it served 300 admissions in 1996. The length of stay was shorter—less than a year for 78 percent of admissions—than in 1987. Vermont State Hospital is currently a tertiary care center for persons with acute mental illness, some of whom have forensic issues. The hospital has three treatment units—Dale Three, with 25 beds; Brooks Two, with 23 beds; and Brooks One, with 20 beds.

Tertiary care is involuntary care when an individual is mentally ill and in need of treatment and a less restrictive setting cannot secure the safety of the individual or the community. Patients with forensic issues include persons who are sent to Vermont State Hospital by court order in a criminal case for a competency evaluation, those who are found incompetent and committed to the custody of the commissioner of mental health, and inmates of the state department of corrections who are committed to the custody of the commissioner of mental health.

Governor Howard Dean; the secretary of the state human services agency, Cornelius Hogan; and commissioner of mental health Rod Copeland have strongly supported a plan to close Vermont State Hospital in three phases (4).

Phase 1 of the plan, begun in 1995 and currently in progress, involves enhancing home intervention teams, a form of assertive case management; increasing the program capacity of long-term residential beds; and increasing the use of outpatient commitment. In Vermont civil commitment is currently used primarily to provide care at the state hospital for people who are severely in need of treatment and who have refused treatment elsewhere or for people who need services that are not available elsewhere.

The assumption is that phase 1 will produce a sustainable drop in census to allow the closing of a ward—Dale Three—by 1998. Phase 1 consists of an intensification of the services that have worked to deinstitutionalize mental health care over the last 30 years. To date, phase 1 efforts have had little effect in reducing Dale Three's census below its ideal capacity. By June 1997 the average Dale Three census was 30 patients, and the hospital census was above 70 patients.

Phase 2—which would begin ideally

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in 1997 but actually when the hospital census averaged 40 patients—has been projected to last two to four years. The goal is to increase the capacity of psychiatric units in two to four general hospitals around the state to receive and treat people who are an active danger to themselves or others as a result of mental illness and who are refusing treatment. Presumably this increased capacity would expand the scope of services for those patients beyond the services currently available through a 72-hour hold. The increased general hospital services would also allow people who are severely self-harming, suicidal, or behaviorally unstable and those who are in acute psychotic crisis to be treated closer to home. Supporters of the department of mental health's plan assume that these efforts would produce another drop in the state hospital census, allowing closing of another ward—Brooks Two—in two to four years.

Between 1950 and 1990, the number of beds in American state mental health systems decreased from 569,455 to 98,304, and the number of state hospitals decreased from 322 to 272 (5). General hospitals now provide more episodes of psychiatric care than any other inpatient location (6), and the number of psychiatric hospitalizations is increasing (7). Persons who are hospitalized tend to have poor self-care and community-living skills, high levels of aggression and demoralization, and many physical health needs; they are more likely to be substance abusers and to be unemployed and homeless (8). The private-sector system typically refers the most difficult patients to state hospitals and serves patients whose families are involved in their care, patients with private or Medicaid insurance, those with presenting problems of depression or suicidality, and those with a supportive discharge site (9).

General hospitals in Vermont follow this pattern. No patient comes to the state hospital without having been screened by a community mental health center and without community-based staff having attempted to meet the patient's care needs through creative nonhospital interventions or non-state-hospital inpatient settings. The state hospital serves as the psychiatric intensive care unit for community mental health centers and local general hospitals and provides specialized, concentrated, active short-term care until a long-term noninstitutional solution can be found.

This system meets the need for increased care of individuals in severe crisis and does not deplete the resources needed to serve other people whose care needs are serious but who are not immediately dangerous to themselves or others.

Phase 3 of the plan to close Vermont State Hospital is scheduled to begin when the hospital census reaches 20 and to last two to four years. During this phase, forensic patients and a few unique other cases will be treated on the remaining 20-bed unit, Brooks One, which is the most secure of the three units currently in operation. Several administrative arrangements for operation of the remaining unit are being considered. They include making an agreement with the state department of corrections or contracting with a managed care company to operate the unit. Another option is to contract for private administration of the unit by a medical center such as Fletcher Allen Health Care, which is associated with the University of Vermont.

Reasons to keep Vermont State Hospital

Like all systems changes, particularly those in mental health, the plan to close Vermont State Hospital has generated considerable controversy. However, there is general agreement that the plan is feasible. Even the plan's detractors acknowledge that other states have used a similar process to close state hospitals, that Vermont has the advantage of being a small state with strong care delivery systems, and that anything that can be built by humans can also be changed by them.

The disagreement is over whether closing the hospital is a good thing to do. Many clinicians, families, consumers, state legislators, judges, police, town government leaders, and other citizens fear that closing Vermont State Hospital will be a step backward and will have a deleterious effect on the rest of the community mental health care system (10).

The two usual reasons for wanting to close a state hospital are not the main issues in Vermont. In other states, closure of a state hospital has been recommended because state hospital care is poor and the hospital environment diminishes patients' potential to be fully functional in a normal environment. This is not the case at Vermont State Hospital, a small, well-staffed facility that provides active, individualized treatment. With few exceptions, patients' stays range from a week to a few months. The hospital consistently meets and exceeds standards for psychiatric hospitals set by the Health Care Financing Administration and the Joint Commission on Accreditation of Healthcare Organizations.

A second reason state hospitals are closed is that they are expensive to operate and community care is less expensive. In Vermont, however, keeping the current group of state hospital patients out of the hospital is believed to be equally as or more expensive than keeping them in the hospital (4,10). In the past, increasing community mental health services did reduce expensive inpatient days, but the point of diminishing returns has been reached. Further reductions in inpatient days are possible only through increasing expensive wrap-around services or transferring state hospital inpatient days to more expensive psychiatric units in general hospitals.

Currently, Vermont State Hospital has the lowest per-day rate in the state—$402 a day—compared with $664 for Fletcher Allen Health Care, $666 for Brattleboro Retreat, and $634 for Central Vermont Hospital (10). The daily rates for other hospitals do not reflect the actual cost because costs for physicians' services are not included, whereas the rate for Vermont State Hospital includes all services.

So, why close a hospital that offers necessary expert specialized care to a needy clientele, and does it better and less expensively than any existing facility or system? Four reasons have been presented.

First, mentally ill persons have been thought to experience less stigma if they are treated at a local general hospital than if they are treated at the state hospital. However, stigma, prejudice, and misunderstanding are associated with mental illness itself, not with

where it is treated. Discrimination exists in housing, jobs, social settings, and medical care regardless of whether a mentally ill person has been treated at the state hospital, a community mental health center, or a general hospital psychiatric unit.

A second reason is that state hospitals force people to leave their community and social support network. However, "community" consists of interconnections with other people, which are often completely exhausted by the time people come to Vermont State Hospital. People who are screaming at voices, living in a terrified paranoid state, using razor blades and paper clips to cut every body part, and wrestling with Dante's demons have already lost "community." Vermont State Hospital gives it back, by providing a community of its own that allows people to renew and practice interactional abilities needed to rebuild the connections that make life worth living.

A third reason for closing a state hospital is that surveys find that former state hospital patients and consumer advocates prefer life outside the hospital. This preference could apply to any hospital and does not mean that the hospital should be closed and unavailable just because people prefer to spend most of their lives outside of it.

The fourth reason has to do with the state's role. Those in favor of closing a state hospital often claim that the state should not be in the business of directly operating a specialty health care service. In Vermont they point out that the state does not operate maternity hospitals, cancer care units, or orthopedic hospitals, so why operate a mental hospital? Historically, severely mentally ill persons with no money went to jails or almshouses. The state hospital was invented to provide appropriate care that was not provided by the private sector. Also, mental illness sometimes produces a need for involuntary care. It is risky business to privatize the power to intrude on personal liberty.

States should be directly involved in involuntary care as a gatekeeper for civil rights and to prevent abuses of restraints and involuntary medication. The citizenry controls the state much more than it can control a private facility. Even the advocacy groups in Vermont that have wanted to close the state hospital in the past have balked at the idea of transferring the capacity for involuntary treatment to local general hospitals and have preferred to keep the state hospital as the focus of involuntary care. What consumers of mental heath services want are programs and services that prevent all involuntary care.

Involuntary treatment is a problem for managed care. Patients who are not compliant with treatment do not show the outcomes that justify payment for continued treatment. This group may be denied access to treatment under managed care systems. The fact that patients often do not want treatment that others have deemed necessary does not relieve the state of the responsibility of providing care for a life-threatening illness. Vermont State Hospital specializes in helping people who are not participating in recommended treatment, most of whom are grateful for treatment after the crisis has passed.

The four arguments discussed above refer to closing all of Vermont State Hospital. There is also an argument to be made against reducing its size by closing one treatment unit. Program flexibility and efficiency associated with the interdependence of the hospital's three units would be reduced by more than a third if one-third of the treatment capacity is closed.

Conclusions

A small, acute care tertiary state hospital in a comprehensive service system increases the capability of other parts of the mental health system and is a necessary part of the total community service delivery system in Vermont. Vermont State Hospital currently serves Vermont very well by providing direct services that are not provided elsewhere and by serving as a teaching site for future caregivers who will work in all parts of the system.

I have presented arguments to support continuing this service. Closing Vermont State Hospital could constitute a form of discrimination against persons with severe mental illness. Vermont's mental health system is nationally recognized as one of the best, and the state hospital is part of that rating. It has not been demonstrated that other parts of the system can provide equally good or better care, even for more money, for those who use the services of the state hospital.

Fortunately, Vermont's clinical, governmental, and consumer communities are committed to trying to build community services first, before actually closing units at Vermont State Hospital. If the community services truly provide for the needs of everyone, not just the compliant and cooperative, then the hospital would close for lack of admissions. This approach is better than one in which the hospital is closed by a certain date and the hospital budget is transferred to the private sector with the hope that all care needs will be accommodated over the long run. Over the next ten years in Vermont, as the plan to close the state hospital evolves, it will be very important to evaluate what happens to people with serious mental illness who resist or do not respond to treatment and who have a high potential for destructive behavior. ♦

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