UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	**CIVIL ACTION NO.:**
	)	**1:09-CV-0119-CAP**
vs.	)	
	)	**OBJECTIONS OF**
THE STATE OF GEORGIA et al,	)	**CYNTHIA WAINSCOTT,**
	)	**CARTER CENTER, AND OTHERS**
Defendants.	)	
	)	

This document expresses the deep concerns of numerous stakeholders[1] with very strong, often personal, connections to Georgia's mental health system. We together—and unanimously—ask this Court to refrain from finally approving the Settlement Agreement between the Georgia and the United States ("Agreement"). The Agreement must be modified and improved if it is to succeed in protecting patients and ensuring their successful transition to life outside hospital walls.

The Agreement represents little more than a promise by Georgia to do better. We are pleased that Georgia has officially recognized, in the Settlement Agreement, its obligations to serve hospital patients consistent with professional standards and to comply with the Supreme

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1 The stakeholders joining Ms. Wainscott include the Carter Center, Mental Health America, Mental Health America of Georgia, the Georgia Mental Health Consumer Network, the Georgia Parent Support Network, the Depression and Bipolar Support Alliance, Dr. John J. Gates, the Georgia Council on Substance Abuse, and the Atlanta Legal Aid Society.

The Georgia Advocacy Office, the federally-funded Protection and Advocacy System for Georgia, is a part of our coalition. It is filing a separate but complementary document that reflects our views as well. We ask the Court to consider that document along with this Objection.

Court's decision in *Olmstead v. L.C.,* 527 U.S. 581 (1999) (addressing needless institutionalization in Georgia state hospitals). However, neither Georgia nor the United States has articulated—in the Agreement or otherwise—how and when Georgia intends to protect patients, provide professionally adequate services, and respect *Olmstead.* Georgia will file reports and the U.S. will make visits, but what corrective actions will Georgia implement and the U.S. monitor? There appears to be no actual plan for remedying the legal violations rampant in Georgia's state hospitals.

We hoped that the intervention of the federal government, including the Department of Justice (DOJ) and the Department of Health and Human Services' Office of Civil Rights (OCR), would secure urgently needed changes in Georgia's mental health system. We looked forward to rhetoric being replaced with concrete and effective plans for change. However, no such plans have emerged.

Because this case addresses life and death matters, as well as implicating fundamental rights under the U.S. Constitution and the Americans with Disabilities Act, we respectfully ask this Court to maintain close and active oversight of this case. We also ask that the Court condition its final approval of the Settlement Agreement on the parties, with stakeholder input, developing a meaningful and concrete corrective action plan that would become part of the Agreement. The plan should require that the number of hospital patients be reduced. In our view, improving hospital conditions in our state requires that needlessly high hospital admissions rates and needlessly high hospital census be corrected. Finally, we ask the Court to ensure that stakeholders are actively involved in monitoring Georgia's progress.

The Carter Center's Mental Health Program has graciously agreed to convene and support stakeholders to work with the parties to identify needed corrective actions, develop

plans, and monitor whether desired ends -- patient safety, competent treatment, and community reintegration – are being achieved.[2]

Background

On paper, Georgia's mental health system is committed to "enabl[ing] Georgians to live to their full potential and enjoy meaningful lives in accepting communities."[3] The reality is tragically different. An aptly titled investigative series, "A Hidden Shame," *Atlanta Journal Constitution,* Jan. 2007, depicts the disastrous and deteriorating status of public mental healthcare in Georgia, as well as the reality that government has kept hidden the essential facts. A lack of transparency and accountability, eroding resources, and limited public awareness has produced an environment ripe for unexplained deaths, poor treatment, abuse, and unwarranted institutional confinement of Georgians with serious mental illness.

The tragedies in Georgia forced the federal government to take heed. After an investigation, DOJ issued scathing reports. Last summer, years after complaints had been filed, OCR entered into a non-enforceable agreement with the state to improve its compliance with *Olmstead.*

The OCR agreement reflects far greater attention to people with developmental disabilities than to those with serious mental illness, and we do not think the agreement will bring the state into compliance with its obligations under *Olmstead.* The DOJ settlement now

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2 We believe we have substantial expertise to offer. Among us are national experts and leaders in the field of mental health. Our experience is described more fully at page 10.

3 1/31/2005, "Commissioner B.J. Walker leads reform of Georgia Mental Health Delivery System" http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/menuitem.5f0f430d0b5cf94b50c8798dd03036a0/?vgnextoid=6d8d2344e99c1010Vg

before the Court—executed, literally, in the final hours of the Bush administration—is little more than a recitation of basic principles that guide psychiatric hospitals.

Our coalition submitted a letter to the Court expressing concerns, including that we did not have an opportunity to provide input. In response, the Court issued an order allowing us to submit by March 1, 2009, a summary of our concerns and recommendations and instructing us to confer with DOJ and the state.

Meetings with DOJ and State Officials

On February 5, 2009, we had a teleconference with DOJ, during which DOJ showed little interest in responding to our concerns. DOJ indicated that we should endorse the Agreement as it stands—then and there—or else DOJ might approach the Court to move up the March 1 deadline for our comments. Our coalition declined to endorse the Agreement. It is our understanding that the following business day, DOJ asked the Court to shorten the time for comment, which would effectively have limited citizen input. We submitted a letter to the Court asking that the March 1 date be maintained.

On February 23, 2009, we met with the Commissioner of the Georgia Department of Human Resources (DHR), the Director of DHR's Division of Mental Health, other officials in Georgia's mental health system, and a representative of the Governor's office. The meeting focused on our concerns about discharge planning, including the needlessly high number of individuals in state hospitals. The unduly large patient population at the hospitals both impairs the state's ability to improve hospital conditions and also reflects a failure to attend to the critical

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relationship between hospital and community services. State officials were aware that we had additional concerns not addressed at the meeting.

The state officials acknowledged the inseparable relationship between the functioning of Georgia's hospitals and the deficiencies in the community mental health system. In Georgia, state hospitals house many individuals who could be successfully served in the community if additional community capacity were developed. A conservative estimate is that 30% of the current hospital population could be served outside of state institutions if needed community supports were available.

Furthermore, state officials acknowledged that community capacity has dwindled and that community programs that had been effective in averting hospital admissions, shortening hospital stays, and promoting successful community living have been reduced. The DHR Commissioner summed up the situation with frankness, stating "community resources have been barren."

The state's mental health director reported that the community mental health system has an "inability" to carry out a basic function. Community providers do not participate in the treatment and discharge planning of hospital patients. The state reported that, in part, this "inability" was the result of bureaucratic failure, the failure to establish a reporting code so that community providers could account for their time in what should be a routine activity. It was also agreed that the failure of community mental health to carry out this basic function is also a reflection of diminished resources.

The DHR Commissioner invited stakeholders to attend "G5" meetings that are convened by her department. These meetings review data reflecting aspects of system performance that

have been identified for review. Our understanding is that the G5 group will focus on discharge planning in its next meeting.

Our meeting with state officials was a good start and we are glad to have been invited to "G5" meetings. Time will tell whether this development heralds new openness and responsiveness by state officials.

In the end, however, the meeting did not, as far as we know, lead to a willingness on the state's part to make changes to the Settlement Agreement. Neither did a February 27, 2009, meeting with staff of the Georgia Attorney General's office, attended by one member of our group who described our concerns.

Lack of Transparency and Public Input

The serious abuses and rights violations within Georgia's hospitals have been perpetuated by denying information to stakeholders – including mental health consumers, their families, community providers, and advocates -- and excluding them from decision-making processes.

The longstanding patterns of mistreatment and system dysfunction identified by DOJ and the media should have been readily known to the public, but they were not. In 2000, the legislature authorized a Mental Health Ombudsman to avert just such an eventuality. Yet, no ombudsman has been appointed or funded (although there is some hope it may happen this year). If this office had existed during the past eight years, many deaths, injuries, and diminished lives might have been avoided.

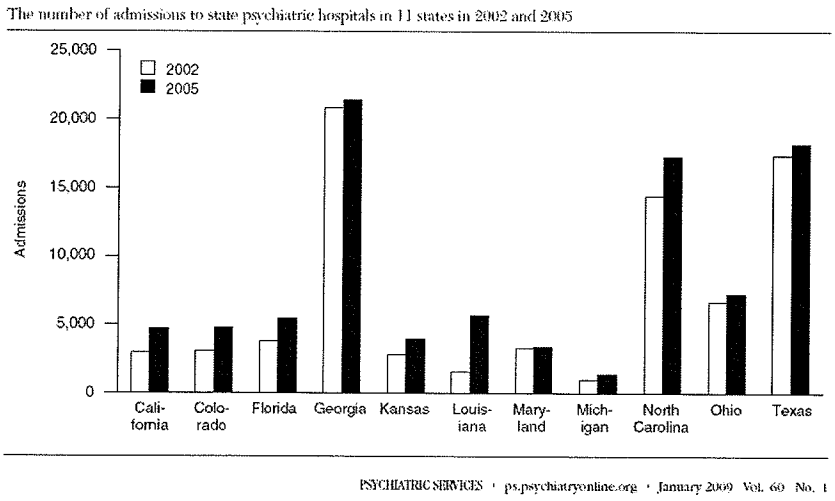
Moreover, stakeholders have not been valued partners in developing state mental health policy. Stakeholder participation in critical decision-making processes has been erratic and superficial. For example, DHR recently developed a "Behavioral Health Game Plan" without

any public input. This 2008 Plan calls for the privatization and consolidation of state hospitals, which we believe will set back efforts to improve hospital conditions and secure *Olmstead* compliance. Many regard the Plan as lacking a focus on community re-integration and instead committing the state for years to a needlessly large number of remote hospital beds.

High Rates of Institutionalization

Georgia sends people to state hospitals at alarmingly high rates. Recent studies of psychiatric hospital usage show that Georgia's admission rates are extraordinarily high. The chart below, appearing in a recent edition of *Psychiatric Services,* [4] presents gross numbers of admissions to state psychiatric hospitals in Georgia and of ten other states representative of national trends. Among these states, the raw number of admissions to Georgia's state hospitals are the highest—higher than Texas and even higher than California.

This circumstance is sadly ironic in the state that is home to the *Olmstead* decision. And it is especially alarming in a state where a state hospital admission can be a death sentence.



The high rate of admissions reflects both poor discharge planning at state hospitals and the inadequacy of community-based services that, if properly configured, could avert crises that trigger hospitalizations, enable many individuals who are needlessly stuck in hospitals to be discharged to appropriate community settings, and otherwise promote successful community living.

The state's over-reliance on hospitals is a practice that stands in conflict with *Olmstead*. The state must shift resources and patients from hospitals to the community for improved hospital conditions and successful community re-integration to be assured. Reducing hospital admissions and thereby reducing hospital census (the number of patients in a hospital on a given day) would make far more manageable the task of keeping patients safe and improving hospital conditions. In addition, because hospital care costs much more than community care, hospital census could be reduced while at the same time *increasing* the funding and resources available, per patient, in the hospitals. In our view, no plan to improve hospital conditions in this state is likely to work unless the issues of high admissions and needlessly high census are addressed.

In addition to remedying Georgia's over-investment in hospitals, the state must increase its overall spending on mental health. Georgia ranks 45th nationally in per capita mental health spending,[5] although it ranks 33rd nationally in per capita income.[6] It spends about 40% less on

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4 Manderscheid et al, Changing Trends in State Psychiatric Hospital Use From 2002 to 2005 *Psychiatric Services* 60 (1) 29-35. 2009

5 Unless otherwise noted, data presented here are drawn from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services "Unified Reporting System" for 2006.

6 U.S. Department of Commerce, Bureau of Economic Analysis, 2008. .

mental health services than the average of its neighboring states,[7] although it has a higher per capita income than all but one of its neighbors.[8]

One way to increase Georgia's investment in mental health services is to generate more federal reimbursements through the federal Medicaid program. The Medicaid program does not reimburse states for most care in state hospitals. (The program provides no coverage for state hospital care for patients aged 21-65, the great majority of patients.). However, the Medicaid program does provide federal funding for community mental health services. The federal government will pay approximately 65% of the cost of community care; hence, one state dollar spent on Medicaid-reimbursable community services results in an additional $1.86 federal match. (We are informed that the new Economic Stimulus legislation will increase the percentage the federal government will pay during the next two years to approximately 70%.)

Stated differently, Georgia must shoulder 100% of the financial burden of most of the state psychiatric hospital care it provides. However, the federal government will pay 65-70% of the cost of community treatment (excluding room and board). Better compliance with *Olmstead* could be a financial boon to Georgia's mental health system, especially when coupled with aggressive efforts to access other federal funding available to finance room and board. It would also reduce the number of individuals vulnerable to the abuses that occur in Georgia's hospitals.

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7 Florida, Alabama, South Carolina, Tennessee, and North Carolina spend on average about $75 per capita; Georgia spends $49 per capita.

8 According to the U.S. Department of Commerce, Bureau of Economic Analysis, 2008, the four adjacent states which have equivalent or lower per capita incomes each spend substantially more on mental health.

Our Capacity to Help

We have long years of direct experience with Georgia's mental health system. Some of our members are nationally-recognized experts and leaders. Among us are past and present chairs of Georgia's Mental Health Services Coalition, a former state director of Georgia's mental health system, three former chairs of Georgia's Mental Health Planning and Advisory Council (MHPAC), the current chair of MHPAC's Public Policy Committee, members of Georgia Governor's Advisory Council on MHDDAD, a past member of the president-appointed National Council on Disability, a member of the National Advisory Council of the federal Substance Abuse and Mental Health Services Administration, and leaders in the academic community.

The Carter Center's Mental Health Program has committed, at the direction of both former President Jimmy Carter and former First Lady Rosalynn Carter, to convene and support our efforts to aid the parties and this Court.

The Settlement Agreement Must be Improved.

As stated above, the proposed settlement agreement outlines basic processes required in any functioning psychiatric hospital. We have no doubt about the validity of DOJ's findings that these basic processes are inadequate in Georgia's state hospitals. However, we strongly believe that the severity of the issues warrants a corrective plan that lays out a clear set of expectations for how reform efforts will proceed and that includes an explicit process for public reporting on progress, as well as a commitment to meaningful participation by stakeholders.

In our February 23 meeting, the DHR Commissioner acknowledged that the Agreement is not specific. For the most part, its stipulations are generic and lack time frames or measurable objectives toward implementation. In the few areas where the Agreement does specify a time

frame, it is often inexplicably long. For example, Section IV.B allows the state six months to notify "officials, employees, agents and independent contractors" of the provisions of the Agreement.

Notwithstanding the urgent need for change, the state is required to report to DOJ only semi-annually (Sections IV.D and IV.K). This cannot be justified in light of DOJ's findings, including that rights violations are systemic throughout Georgia's hospital system.

There are special and additional reporting requirements for serious adverse events, but even these are problematic. The Agreement states: "The State shall notify the US promptly upon the death of any patient and other sentinel events[9]." (IV.H) On its face, this appears to be a reasonable requirement. Yet, its meaning is unclear in a setting in which "sentinel events" may be routine and go undocumented. When DOJ found acute problems at Georgia Regional Hospital that are "serious, recurring and that frequently result in grave harm," it also found substantial problems with tracking and documenting incidents. Absent from the Agreement is a plan for how the state will ensure accurate tracking and reporting of incidents, let alone reduce the overall number of incidents. The literally life-and-death issues documented by DOJ's require more.

We look forward to working with the Court and the parties to craft improvements to the Agreement. Below we outline changes we believe are needed. We wish to emphasize that we have not had the opportunity to work with Georgia or the U.S. to refine these proposals or to address any concerns the parties may have.

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9 A sentinel event, per the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), is "an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof...such events are called 'sentinel' because they signal the need for *immediate* investigation and response." (SE-1, emphasis added)

(1) Developing a Concrete and Specific Corrective Action Plan.

Georgia must develop a concrete corrective plan that identifies the specific actions it will take to achieve each element of the Settlement Agreement and the dates by which these actions will be taken and anticipated timeframes for achievement of compliance. The plan should also specify measurable indicators that will be used to identify whether the actions taken are having the desired result of improving patient safety, treatment outcomes, and community re-integration.

The plan should include specific targets for reducing the number of deaths and other sentinel events, as well as describe how deaths and other events will be tracked and reported. Additionally, the plan should include a process with specific time frames for reviewing deaths and other serious incidents with an eye to preventing reoccurrence. Selected stakeholders (they might be chosen by the Carter Center) should participate in this process.

The plan should also provide for at least quarterly public reports of deaths and serious incidents (with identifying information redacted) and of progress toward implementing the plan.

We believe such a plan can and should be developed by July 15, 2009. The plan, including the frequency of reporting, can be revised as needed over time.

(2) Reducing Hospital Census.

The corrective action plan should squarely address the community service needs of hospital patients. In particular, the plan should call for individual assessments conducted by teams comprising a representative of the hospital or DHR, a senior representative of the community mental health system, and a peer specialist. Assessments should be conducted for both repeat system users (see III.F.5) and for patients with a length of stay greater than 60 days. The assessments should identify the specific community services needed to allow the patient to live successfully in an integrated community setting.

We see it as essential that these assessments be conducted not as an internal process of the hospital system, but instead collaboratively with community mental health and peers who will ultimately be key in ensuring successful community integration. The assessments should include interviews with the patient, a review of the case record, and interviews with the clinical team. By a date established in the plan, this assessment process should become a routine element of discharge planning at state hospitals.[10]

Based on data from these assessments, the state should develop a specific plan to establish the community services these patients need and to avert the needless institutional confinement of individuals with similar profiles. The plan should include targets for reductions in hospital census as well as specify what proportion of the savings from census reduction will be invested in hospital improvements and what proportion in the community service system. The plan should identify specific strategies for financing an expansion of community services through federal disbursements under Medicaid. Finally, the plan should consider whether "bridge money"--money used to offset expenses until savings associated with the closure of hospital units and impact of federal reimbursements are realized-- is required.

Such a plan is needed, among other things, to address the disconnect between DOJ's findings of severe deficiencies in discharge planning and transition services and the relative inattention to these matters in the Agreement. Repeatedly, DOJ found tragic and egregious problems in these areas, but the Agreement fails to adequately address these issues.

For instance, DOJ's investigative reports state: "The State's own audits . . . identified egregious, systemic deficits in the coordination of care between [the hospital] and the community.

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10 Discharge planning should begin upon admission to the hospital. Also upon admission, the hospital should assess whether appropriate community services could have prevented the admission and if so, report its finding.

Based on our review of recent discharges from [the hospital investigated], these same deficits persist." (Atlanta Report at p. 45; Rome Report at p. 49). Georgia's bare promise in the Agreement to "[p]rovide hospital transition services to patients consistent with generally accepted professional standards" (p. 17) holds little hope of solving this problem. The Agreement does not articulate these standards and our assumption is that the state considers itself to be now operating under such standards.

DOJ also found that that, "Contrary to generally accepted professional standards, ... professionals reported that the State lacks sufficient Assertive Community Treatment teams, which serve as a vital link between the hospital and the community for participants. Assertive Community Treatment programs offer an array of services customized to individual needs, delivered by a community-based team of mental health practitioners, and available 24 hours per day. The State's own findings in the 2005 Georgia Mental Health Gap.Analysis also discussed the dearth in this essential service." (Atlanta Report at p. 48). The Agreement reflects no plan or intention to increase this service.

DOJ found that"[a]lthough [the hospital's] policy identifies the major resources necessary for a successful return to the community, in the vast majority of cases, these resources were not considered or were not made available." (Atlanta Report at p. 46). DOJ also found a "glaring gap" between the services needed by individuals upon discharge and the services actually provided. (Rome Report at p. 52). "In most cases, neither formal or informal supports have been developed and prepared for patients transitioning from [the hospital]." (Id.) Again, the Agreement reflects no plan or intention to correct the situation.

Finally, DOJ found that in 2006 and 2007 hundreds of patients were discharged to homeless shelters (Atlanta Report at p. 46; see also Rome Report at 51), a practice that often

guarantees a quick and unnecessary return to the hospital. Yet, the Agreement fails to prohibit or place any restrictions on this practice.

The statement of Susan C. Jamieson, filed along with these comments, provides additional information on systemic deficiencies in discharge planning and community resources, including the stories of two representative patients denied appropriate discharge planning and community services. Unfortunately, these patients' experiences are all too familiar to those knowledgeable about Georgia's mental health system.

(3) Rethinking Privatization of State Hospitals.

The state is considering a plan for privatization and consolidation of its state psychiatric hospitals, developed without public input. We believe that this course will impair the state's ability to improve hospital conditions and ensure secure appropriate discharges. Accordingly, we believe that decisions about privatization and consolidation should be deferred until after the development of the corrective action plan discussed in (1) above.

(4) Formation of an Advisory Panel.

We urge the Court to invite the Carter Center to form an advisory panel whose charge would be to aid the Court, as desired, in its active supervision of this case and to assist the parties in developing a corrective action that gives meaning to the promises made in the Settlement Agreement. The panel would include adult consumers (clients of Georgia's mental health system), family members, representatives of the community mental health system and of private providers, national experts, and others.

(5) Addressing Incomplete Standards.

The Agreement attempts to articulate the basic standards for operation of state hospitals. However, in some areas, the identification of core standards is incomplete. Where there are important omissions, the Agreement should be revised.

We have not attempted here to catalogue each area where more complete standards are needed. One area that warrants mention here, however, is seclusion and restraint. These highly invasive interventions are high risk procedures. Many deaths and injuries in state hospital settings occur in the course of their implementation. Nationwide there is movement to reduce – and in some settings to eliminate– the use of these practices. To bring the Agreement in line with professional standards, and to better protect hospital patients, we believe the seclusion and restraint provisions of the Agreement, at page 12, should include additional provisions requiring that:

-- Orders for seclusion or restraint include instructions for staff on assisting the patient in meeting release criteria,

-- Before a patient is secluded or restrained, an assessment must be done of factors such as trauma history or physical problems that contraindicate use of seclusion or restraint,

-- Within 8 hours following the episode of seclusion or restraint, professional staff must conduct a debriefing with the patient to ensure the patient has an appropriate understanding of the event and to consider strategies for avoiding recurrence, and

-- Unless contraindicated in writing, the patient should participate in the post-episode review.

Conclusion

We thank the Court for the opportunity to comment on the Settlement Agreement. We are happy to provide additional information and to answer any questions the Court may have. We would welcome the opportunity to have a spokesperson, who is an attorney, participate in

hearings concerning the proposed Settlement Agreement.

For the reasons described above, we respectfully urge the Court to withhold final approval of the Settlement Agreement and instead:

1. Maintain close and active oversight of this case.
2. Condition its final approval of the Settlement Agreement on the parties, with stakeholder input, developing a meaningful and concrete corrective action plan that, once developed, would become part of the Agreement. The plan should include mechanisms for evaluating whether implementation is achieving the desired ends of patient safety, competent treatment, and community reintegration
3. Ensure that stakeholders are actively involved in monitoring Georgia's progress.

Respectfully submitted,

/s/

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JOINED BY:

THE CARTER CENTER
MENTAL HEALTH PROGRAM
Contact: Thom Bornemann, Ed.D.
tbornem@emory.edu 404-420-5165
The Carter Center was founded in 1982 by former U.S. President Jimmy Carter and his wife, Rosalynn, in partnership with Emory University, to advance peace and health worldwide. The Carter Center Mental Health Program, founded in 1991, works to promote polices and practices locally, nationally, and internationally that advance the prevention of mental illnesses and lead to improved mental health and social functioning.

MENTAL HEALTH AMERICA
Contact: President and CEO, David Shern, Ph.D.
dshern@mentalhealthamerica.net 703-684-7722
Mental Health America is the nation's oldest and largest organization concerned with all aspects of mental health. Headquartered in Alexandria, Virginia, it has more than 330 affiliates throughout the nation

MENTAL HEALTH AMERICA OF GEORGIA
Contact: Director of Public Policy and Advocacy, Ellyn Jeager
ellyn@mhageorgia.org 404-527-7275
A statewide organization with over 70 years of service in Georgia, Mental Health America is recognized as a leading voice of advocacy for people with mental illnesses, and education about mental wellness.

GEORGIA MENTAL HEALTH CONSUMER NETWORK
contact: Executive Director, Sherry Jenkins Tucker
sjtucker@gmhcn.org 404-687-9487
The Network was founded in 1991 by consumers of state services for mental health, developmental disabilities and addictive diseases. Our membership is now over 3,000. We created a national model for peer support services. Our mission is to promote recovery through advocacy, education, employment, peer support and self help.

GEORGIA PARENT SUPPORT NETWORK
Contact: Director, Sue Smith, Ed.D.
sue.smith@gpsn.org 404-758-4500
A state chapter of the Federation of Families for Children's Mental Health, the Network represents families of Georgia youth who have serious emotional behavioral disorders or mental illnesses. Its director is a nationally recognized expert on systems of care for children.

DEPRESSION AND BIPOLAR SUPPORT ALLIANCE
Contact: CEO/President, Peter Ashenden
PAshenden@DBSAlliance.org 800-826-3662
The Alliance has over 450 chapters and 1,000 support groups throughout the nation and is the largest consumer-operated national organization in the country. It provides hope, help and support to improve the lives of people living with depression or bipolar disorder.

JOHN J. GATES, Ph.D
jjgates@bellsouth.net 404-872-1685
Fomrer Director, Georgia's Division of MHDDAD
Former Director, Carter Center Mental Health Program

GEORGIA COUNCIL ON SUBSTANCE ABUSE
Contact: Executive Director, Neil Kaltenecker
neil@gasubstanceabuse.org 404-523-3440
The mission of the Council to reduce the impact of substance abuse on Georgia communities through education, training and advocacy. The Council provides information and resources for

individuals, families and communities that seek to reduce the stigma of addiction and that call attention to the economic and social costs of substance abuse.

ATLANTA LEGAL AID SOCIETY
MENTAL HEALTH AND DISABILITY RIGHTS UNIT
Contact: Director, Susan Jamieson
scjamieson@atlantalegalaid.com 404 377-0705 x225

Date: March 2, 2009

STATEMENT OF SUSAN C. JAMIESON

1. I have been involved in advocacy for persons in Georgia's state hospitals for more than 20 years. I am Director of the Mental Health and Disability Rights Unit at the Atlanta Legal Aid Society.

2. In my experience, among the most serious problems facing hospitalized individuals and their families is: (a) lack of meaningful discharge planning; b) discharge plans that fail to take account of the individual's past experience in community settings, and (c) lack of appropriate community supports including residential services.

3. Over the past several years, there has been a much-needed focus on the serious problems in Georgia's state hospitals, including media attention, state commissions, and federal investigations. Each of these examinations has noted that the United States Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), declaring needless institutionalization a form of discrimination outlawed by the Americans with Disabilities Act, was filed on behalf of two women at the Georgia Regional Hospital at Atlanta, the same facility that is a focus of DOJ's investigative reports. I was one of the lawyers who represented the plaintiffs in Olmstead. Ten years after the Supreme Court decision, DOJ found the discharge planning and the provision of community services continue to be highly inadequate at the hospital.

4. Georgia state hospitals have long failed to engage in adequate discharge planning. Georgia has also failed to develop the services needed in the community mental health system that would avert unnecessary admissions and re-admissions and would prevent unnecessarily prolonged institutional confinement.

5. I have extensive experience with the discharge planning process at the state hospitals. It is rarely individualized and is more like a "find a bed" service than a professional planning process. Unfortunately, many of the placements that are found and to which hospital patients lack appropriate services and supports. The result is a needless re-admission to the hospital. Additionally, in many cases, no bed, even an inappropriate one, can be found and the individual languishes at the hospital.

6. Social workers and discharge planners are simply expected to "locate placements" and the hospitalized individual is discharged to any home willing to take him or her. Frequent discharges are made to " personal care" homes whose staff lack training and have limited understanding of or tolerance for persons with in need of behavioral supports. These homes were originally established to serve elderly and/or physically disabled persons, but they have become dumping grounds for individuals with mental illness due to a lack of alternatives.

7. When a hospitalized individual is placed on a "planning list" for community services, this does not appear to result in any specific effort to secure or develop the needed community services. Instead, the person remains in the institution.

8. Similarly, even if a planning or transition meeting is conducted at the hospital, this does not appear to result in any specific effort to secure or develop the needed community services. Instead, the person remains in the institution.

9. Below I summarize two recent individual cases. In my experience, these cases are typical of what occurs in Georgia's system.

AB.

10. AB is a woman in her 30's who has been hospitalized many times in Georgia's state hospitals. Most recently, she was from September through December 2008. In response to a call, there may have been an effort to look for a structured, funded placement for AB. The hospital chart indicates that the social worker was told there is a 2-year waiting list for residential services in the central Georgia MHDDAD Region, which includes the Atlanta area.

11. What followed was a series of calls to personal care homes. At one point, the social worker asked AB's mother to find a home but the mother, after making several efforts, was unable to locate one. Finally, AB said she would consider a placement in Thomaston, Ga., far from her family. She was discharged to a home that could not provide the behavioral supports she needed. The same problems that had occurred in the community in the past recurred and she was at the home for less than a month. She was re-admitted to the same state hospital three weeks after she was discharged and she is still hospitalized.

12. I visited AB in late February 2009, about 6 weeks later. By this time, hospital staff had contacted one personal care home whose rate was more than twice the amount of AB's disability check and two that served only elderly and frail individuals with physical disabilities. Eventually, a personal care home agreed to interview AB in early March.

13. In discussing my client's situation with staff, it did not appear that any consideration had been given to AB's past experiences in similar personal care homes or to the behavioral supports she would require to be successful in the community. It was also clear that AB's placement would be funded entirely with her own disability check. Despite the high cost of her predictable but unnecessary readmissions to the hospital, the state seems to have no process for ensuring she receives the services she needs in the community.

CD

14. CD has also been re-admitted to state hospitals many times, including some protracted stays. During a hospitalization in 2007-2008, CD's social worker advised me that she was ready for discharge and had been referred for community

services. The staff agreed she needed community services and was unlikely to improve in a hospital setting. After her referral, CD remained in the hospital for many months.

15. During that hospitalization, and despite the fact that she was in continual need of a community alternative, CD was placed "on" and then "taken off" the mental health "planning list." I did not see any notices regarding these decisions in her chart, despite specific requirements in the OCR "Voluntary Compliance Agreement" to provide such notices. In April 2008, I brought CD's situation to the attention of her treatment team leader and asked that a new program called "Money Follow the Person" be utilized to assist in funding her community placement. In May and June 2008, we contacted the MHDDAD Region 4 office about CD's need for community services. In July and in September 2008, we wrote to hospital and state officials regarding the failure to provide notices under the OCR agreement and to marshal community alternatives for individuals with mental illness. Shortly after my September 2008 letter, CD was discharged to a personal care home that could not meet her needs. Like AB, it did not appear that the problems CD had experienced during previous community placements were considered or addressed. She remained in the personal care home for 4 days before being re-hospitalized and remains hospitalized, although she could easily live in the community with appropriate supports.

16. She appears to be overmedicated at the hospital and on two of my recent visits, she fell asleep. There have been transition meetings for her but her social worker explains that he is told that there are no community resources available to meet her needs. There is now talk of placement in a personal care home in Thomaston, Ga., far from family, similar to the failed placement for AB.

17. These two cases are typical of those that I regularly encounter. The hospital discharge planning and community placement process fails to identify and connect the hospitalized individual to the resources she or he needs to successfully live in the community. Regularly, the hospitalized individual is kept in the hospital unnecessarily and/or discharged to a personal care home without necessary services and supports.

18. I have not seen any significant changes in the discharge planning and community placement practices in Georgia's state hospitals, when an individual needs individualized supports to address challenging behaviors, in recent years, including since August of 2008 when the state entered into its agreement with OCR.