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**Testimony before the Appropriations Committee
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Good afternoon Senator Harp, Representative Geragosian and Committee Members:

I am here to support the funding that the Governor included in her budget to expand the Home and Community-Based Waiver for Adults with Mental Illnesses to decrease the number of persons with mental illness in expensive nursing homes. It is not clear how many additional slots this funding would support, but I am here to support an increase of persons to be served by the waiver from 216 to at least 420.

The Dollar Costs of Nursing Home “Treatment”

In spite of the Medicaid Waiver proposed for persons with mental illness, and in spite of its being the subject of a federal lawsuit, one private, for-profit nursing home is planning to expand its rogue detention unit from 25 to 35 persons at the cost of some \$3,000,000 per year per unit alone (35 persons @ Medicaid rate of \$233.79 per day per year = \$2,986,667). This facility and a sister facility, as well as similar units operated in four more nursing homes managed by the chain, are attempting to “fly below the radar screen” in these recessionary times by imposing Medicaid-funded “treatment” on a 24 hour basis when these persons are not acutely ill and could be served in the community. Nursing homes are not appropriate for the persons with mental illness because they actually offer no treatment

My data puts dollar signs on the “treatment” costs of a number of persons who were put in nursing homes years before their physical conditions would justify such placement.

My brother’s “treatment” cost the state of Connecticut \$1,022,000 over 14 years when he was dumped in a nursing home at the age of 44. Another person, dumped in a nursing home in 1996 at age 51, has cost the state some \$803,000 for 11 years of Medicaid reimbursement. A third person, placed in a nursing home at age 42, has cost the Medicaid system some \$102,200,000 for his “treatment” over 14 years. The cost of dumping 1329 persons in nursing homes in State Fiscal Year 2004 cost the Medicaid system some \$97,000,000 (1329 persons X \$73,000) in that year alone, not to mention the cost to be

expected till the end of their lives.

Even allowing for the federal Medicaid “contribution” of 50 percent, surely someone at DMHAS can find ways to ‘treat” those persons wishing to return to the community without resorting to 24/7 hour Medicaid “treatment”. The proposed Medicaid Home and Community-Based Waiver offers DMHAS an opportunity to serve its persons in the community where they belong.

Four Cases - Unlawful Detention in Nursing Homes When One is Not Acutely Ill

“Stone walls do not a prison make, nor iron bars a cage” was the Richard Lovelace quotation I found written in one of my brother’s books as I went through his personal effects after his death on July 9, 2007. My brother died on a rogue detention unit in a CT private, for-profit nursing home of heart failure due to renal failure. He was the victim of a psychiatrist, new to the state and new to my brother, obviously unfamiliar with his medical record, who prescribed a dosage of the powerful antipsychotic Risperdal when my brother, from the hours I spent with him as his sister and conservator, was not psychotic. My brother was a victim of sexual abuse by a mentor in the late 1960’s when the effects of a continuing trauma were not well known. Suffering a “breakdown” in 1970, my brother was thereafter labeled “mentally ill”. My brother was not psychotic but, to use the social psychologist Rosenhan’s phrase, “sane in an insane world”, the world of a rogue detention unit in a nursing home.

Lets call my brother’s case the \$1,022,000 “treatment” then death (14 years @ \$200/day = \$1,022,000).

Edward Rossow, born without a leg, spent the first 4 years of his life in a crib, according to his adoptive mother, Rachel Wheeler Rossow, a disability advocate. In spite of his being able to live in his own apartment with minimal support, Edward was dumped in a private, for-profit nursing home. Neither this facility, nor the one to which Edward was later transferred, incorporated the diagnosis which he was given at age 13 of “complex partial seizure disorder” in spite of its being re-confirmed during a stay at Hartford Hospital’s Institute of Living. Instead, staff at the first detention facility had him arrested when his leg prosthesis, losing its suction, grazed the hand of a staff member. In the second facility the staff punished him for alleged ‘behavior”, which behavior would have been explained by his seizure disorder. In spite of his working three days a week at the Manchester ARC, Edward was not allowed to leave the facility on his own nor walk around the grounds. Edward died in this facility on August 11, 2006.

Another person currently in the facility in which my brother died was removed from her apartment in the community with the cooperation of the Probate system in 1996. She was able to return to the community for a short time but was “unsuccessful” due to lack of community services. While not her mental health professional nor her attorney, I would say, from the time I have spent with her as pro bono successor conservator, I would call her a “compulsive hoarder”. Lets call her “treatment” in two nursing facilities the \$803,000 “treatment” (11 years @ \$200/day =).

Another person for whom I became pro bono successor conservator was placed in the facility in 1995 ostensibly for treatment of “psychogenic polydipsia”. The condition was never addressed until I raised the issue with the staff. Lets call this “case” the \$102,200,000 “treatment” (14 years @ 200/day =).

None of these persons would even qualify for civil commitment proceedings as, upon admission to a nursing facility, DMHAS officials or their contractor, Advanced Behavioral Health, must certify under Medicaid regulations that these persons do not need acute psychiatric care.

Persons “Unnamed and Uncounted”

That the Connecticut Department of Mental Health and Addiction Services has no handle on the number of persons it or acute psychiatric facilities “place” in nursing homes is shown by the following numbers from DMHAS documents: Year 2000: of some 2,300 persons in nursing homes with “serious mental illness”, DMHAS claims some 241 as “clients”; Year 2001: of some 2,500 persons with “serious psychiatric disability” DMHAS claims 134 as “clients”; Year 2006: DMHAS states there are about 3,000 persons with mental illness in CT nursing homes. Yet, in another DMHAS document, the department claimed to have “approved” the admission of some 1,329 persons with “SMI” (serious mental illness) in the State Fiscal Year alone. Let’s call SFY 2004 the year of the \$97,017,000 “treatments”.

For years, DMHAS has taken the position that most of these persons are not its “clients” and that it has no “jurisdiction”. This is a “legal” position on a moral issue. All of these persons were dumped into nursing homes, as I understand from talking to them, by DMHAS outpatient contractors who never followed up with them. This is a perfect example of the jurisdictional “silos” metaphor used by Department of Social Services Commissioner Starkowski in his presentation “Wave of the Future: Long Term Care in CT” (April 2008).

Detention on Rogue Nursing Home Units Masquerades as “Treatment”

In fact, in deflecting any investigation into what, if any, responsibility DMHAS officials may have had for “approving” the placement of a 23 year old persons with a “history of multiple sclerosis and substance abuse” (not, I would add, a “mental illness” diagnosis) into a nursing home, then allegedly setting a fire which killed 16 people, DMHAS officials embarked on a “witch hunt” of persons with mental illness in nursing homes. DMHAS held a conference in 2005 at which the keynote speaker was a “consultant” promising institutions using its services advice on opportunities to “grow census, and enhance revenues”. The consultant, David Lennox, Ph.D., offers “Quality Behavioral Solutions to Complex Behavioral Problems”. That is, he advocates a form of treatment called “behavioral” treatment which, according to the psychologist John Rosemond is a “psychological paradigm that has no proven effectiveness with human beings outside of closely controlled institutional settings (Hartford Courant, February 4, 2009). It certainly

is a “treatment” used despite scant proof that it works or for which there is any scientific evidence.

I understand by e-mail from a regional ombudsman that the outfit operating these detention facilities has used this consultant to advise on the setting up of these units.

Another example of a seriously pejorative reference to the mentally disabled was DMHAS Commissioner Kirk’s statement giving his “imprimatur” to the setting up of “separate” [a euphemism for “locked”] units: “...I would not encourage or believe or support a view that says there needs to be a separate unit within the nursing facility **solely** [my emphasis] for people with psychiatric disabilities ... persons with dementia ... some of the same behaviors that you would see with persons with dementia are also seen with persons with psychiatric disabilities. And so the differentiation between the two, I think, is not necessarily the most informed way to go. ... whether it’s a separate unit as part of the nursing home that is responsive to persons with these significant behaviors, whether they are due to dementia or psychiatric disabilities, that’s responsive to what their conditions are ...”

With all due respect to the Commissioner, “separate”, locked units are no longer accredited by the Joint Commission due to concerns with the Americans with Disabilities Act. References to “difficult” or “challenging” behavior are unacceptable in modern medical practice as they ‘blame the victim’ instead of attempting to see what the “behaviors” are symptoms of.

Facility Plans Expansion of Rogue Detention Unit

As the result of that “witch hunt” one of the two facilities has announced the expansion of its “dementia” (sic) and “behavior” (sic) units by letter dated September 15, 2008. Lets call the expansion of the locked “behavior” unit from 25 to 35 persons, in spite of the lawsuit and in spite of MFP efforts, the \$3,000,000 annual “treatment” operation. If the owners/managers of nine facilities are operating 6 rogue detention units, think of the taxpayer Medicaid reimbursement dollars going into their pockets.

Now that these two private, for-profit institutions are the subject of a lawsuit filed in federal court against DMHAS, DSS and DPH for alleged violations of the Americans with Disabilities Act, and now that the great “Medicaid Fountain in the Sky” is drying up, DMHAS staffers are in these facilities looking for persons to return to the community. There are, so far as I can tell, no plans to close down or stop the expansion of these rogue detention units.

I would argue that the operation of these rogue detention units by this for-profit chain of nursing homes is a marketing creation unheard of in Connecticut when the chain set up

operations in 2001 and proceeded to buy the bricks and mortar of existing nursing homes until now, in 2009, it owns some 9 facilities with 6 operating these units. It is a marketing strategy by facility operators to pocket Medicaid dollars at some of the highest rates in the country while filling otherwise empty beds as Connecticut's seniors with a choice look to other available options: assisted living, continuing-care retirement communities, and smaller, more home-like alternatives. CT nursing home facilities show an average vacancy rate of some 9 percent. At the same time, DSS figures show that CT's nursing home population from 1999 to 2006 showed decreases in the 65 and older population, while showing increases in the under 65 population (DSS: Wave of the Future, p. 6).

Conclusion: Medicaid Waiver Alone Will Not Stop Abuses of Rogue Detention Units

I would also argue that, as noted in The Kaiser Commission on Medicaid and the Uninsured (September 2005), so far, and this would include Connecticut's efforts on MFP, states have not been changing established practices of Medicaid programs that favor institutional care. To the extent that MFP does not challenge the existence of the rogue detention units currently in CT, even an increase in the number of persons returned to the community is an inadequate response.

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** That is, 35 persons @ \$233.79/day/"head in bed" ("facility specific rate") = \$2,986,667.20/year operation.