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United States Senate
Committee on Homeland Security and Governmental Affairs
Ad Hoc Subcommittee on Disaster Recovery
"Post-Catastrophe Crisis: Addressing the Dramatic Need and Scant Availability of Mental Health Care in the Gulf Coast"
Wednesday, October 31, 2007

To Chairwoman Mary Landrieu and Ranking Member Ted Stevens, distinguished members and guests of the Senate Ad Hoc Subcommittee on Disaster Recovery:

I am Dr. Kevin U. Stephens, Director of the Health Department for the City of New Orleans, a city that contributes greatly to the culture and commerce of this country, and a city that is still facing a crisis in the availability of mental health care after the worst natural and man-made catastrophic disaster to occur in the United States of America.

Thank you for providing this opportunity for us to share with the Subcommittee the urgent mental health care needs of our community. We appreciate your continued concern about our progress in rebuilding the mental health care delivery system for our citizens while we work diligently towards resolving our long term mental health policy issues.

Hurricane Katrina devastated our health infrastructure, flooding seven of the nine acute care hospitals in New Orleans and many other medical facilities. Some of that infrastructure has been replaced or is coming on line with financial assistance from federal and state sources. However, critical gaps remain in the medical safety net for our citizens. These gaps have contributed to a significant increase in mortality rates which I reported in the American Medical Association's Public Health Disaster Journal in May of 2007, and which have been corroborated by the State of Louisiana. They are also causing a particularly acute problem in mental health care.

This testimony focuses on three critical problems: the lack of an adequate number of available psychiatric hospital beds for citizens in our region; the ongoing challenge of recruiting and retaining mental health professionals; and the criminalization of mental health patients that system gaps are causing. I will outline what existed before Katrina, what is currently available, and what we must have to adequately serve our citizens with crisis mental health needs.

Prior to Hurricane Katrina, approximately 350 public and private psychiatric beds were available in New Orleans. These included capacity for 152 patients at the Medical Center of Louisiana – Charity campus (formerly Charity Hospital), 30 at New Orleans Adolescent Hospital (NOAH), and others at such places as the Veterans Affairs Hospital, Methodist Psychiatric Pavilion, DePaul Hospital, Touro Hospital, Bywater Hospital, Lakeland Hospital, and Community Care Hospital.

The beds at Charity were critical because they served our large population of uninsured and underinsured citizens. The facility included 92 inpatient beds, 20 dual diagnosis beds for those with psychiatric and substance abuse problems, and a critically important 40-person capacity Crisis Intervention Unit (CIU). This specialized unit allowed for individuals in psychiatric crisis to be observed for evaluation in a locked, safe environment. The Charity CIU served as the Single Point of Entry (SPOE) or central regional triage station. First responders were able to transfer care of mental health patients to a designated area for medical clearance and psychiatric evaluation. Its proximity to the Emergency Department (ED) provided the seamless and critical medical clearance needed for patients to be moved to the CIU for evaluation, treatment and release or admission for their mental illness as the case warranted. The CIU also accepted referrals from other facilities which depended on Charity to appropriately triage patients.

Currently, less than half the number of public and private mental health beds available in New Orleans before Katrina are open. This is a particularly acute problem regarding public hospital beds available to the uninsured. Of the original two Medical Center of Louisiana campuses - University and Charity - only University Hospital has reopened. It provides Emergency Department (ED) services and has 10 beds in a temporary mental health emergency room extension (MHERE) unit. University Hospital also has a 20-bed detox unit. The state has opened 52 beds at the New Orleans Adolescent Hospital (NOAH) and the DePaul sites, with plans to increase the number of beds at DePaul. It is also contracting for 100 additional detox beds. With 60 beds, the Orleans Parish Prison has the single largest facility for mentally ill patients in our region.

Thanks to the perseverance of Congress on Katrina-related health issues, the recent hearing of the House Energy and Commerce Committee, and the action of Secretary Leavitt, the New Orleans area received $100 million DRA dollars for primary and mental health services. Since these funds were just distributed to community providers several weeks ago, it is too early for us to determine their impact on mental health, but we are confident that these resources along with others will have a tremendous positive impact on the availability of out patient mental health services in New Orleans. However, this funding will not increase the number of inpatient psychiatric beds.

We are grateful for all of the efforts of the Medical Center of Louisiana, the regional and private hospitals, and the individual medical professionals who are working diligently to rebuild the mental health infrastructure and provide increased services. The need is tremendous and growing, not just because of a steady stream of people returning home and new people coming to be a part of this community, but because of the increasing prevalence of mental illness since the storm.

Recent reports have shown that there is an increase in the prevalence of serious mental illness among New Orleans residents since Hurricane Katrina. Witnesses from the next panel, Dr. Ronald Kessler, Harvard Professor of Health Care Policy and Chairman of the Hurricane Katrina Community Advisory Group, as well as Dr. Howard Osofsky,

Chairman of the LSU Health Sciences Center Psychiatry Department, can attest to this growing problem. Experiences of our police and Emergency Medical Services (EMS) staff also support these findings. We average 190 police calls per month from our 911 call log for serious mental illness or threat of suicide. Our EMS Department averages one call per day of suicide attempt, bizarre behavior or actual suicide.

The City of New Orleans has three immediate mental health needs: a centrally located Crisis Intervention Unit (CIU) in downtown New Orleans with a 40-person capacity; further assistance in retaining and recruiting health care professionals; and a Criminal Justice Diversion Program for citizens with psychiatric and substance abuse issues.

The lack of a CIU in the area is causing a crisis in the first responder and hospital systems. The 10-bed MHERE at University does not accept referrals from other hospitals; it does not serve as a single point of entry for mental health patients in the region; and does not provide law enforcement with expedited crisis system access. Ambulances now sometimes travel long distances to follow the regional hospital Emergency Department (ED) rotation set up after the disaster and frequently are backed up for hundreds of hours per month waiting to offload patients. That wait is often exacerbated because ED beds are filled with uninsured mental health patients who cannot get triaged into appropriate mental health care units. The City of New Orleans EMS director estimates this back up has cost the city $1 million in personnel costs and unbilled revenue over the last six months. It also threatens overall emergency response capacity. Police officers also are severely impacted by this problem. They must respond in pairs to mental health emergencies and must also follow the rotation. They log between 400 and 500 hours per month in “start to finish” time transporting patients in crisis and waiting with them at area hospitals to be evaluated.

Since no hospital is equipped with a CIU for appropriate stabilization, observation, and diagnosis of psychiatric emergencies, nor with adequate in-patient beds, there is a revolving door for those who cannot afford private care. Though some patients are held in EDs for long periods of time waiting for available psychiatric beds in the region or elsewhere in the state, others, some unstable and potentially violent, are examined for urgent “medical needs” and then released. The cycle has worsened in the past six months. Police officers had to spend a record 534 hours in July transporting and waiting with mentally ill persons instead of handling traditional law enforcement activities. They experienced the longest “start to finish” time to date with one case in July: 4½ hours for the team of two - the equivalent of one full nine hour officer day. Many of these calls were to handle “disturbances” caused by people with untreated mental illness or drug addiction who perpetuate the cycle of quick ED release, and are frequently jailed on municipal charges.

A centrally located CIU in downtown New Orleans with a 40-person capacity will ensure that patients receive more appropriate care for their mental illnesses; it will relieve the back-up at area hospital EDs, and cut travel and wait time for NOPD and EMS staff.

Additional support to recruit and retain mental health professionals is a second critical need. We are grateful for the financial resources which have been made available to our

state and region for this purpose, but there is still an ongoing crisis. For example, the Executive Director of the Metropolitan Human Service District, which provides publicly-funded community programs and services related to out-patient mental health, developmental disabilities and addictive disorders, has said that agency has a shortage of mental health professionals that is hampering their ability to bring funded out-patient mental health programs on line. We thank the Acting Surgeon General who is currently working with us to send temporary mental health professional assistance while we work on long term human resource infrastructure needs.

Lastly, we must create a system that does not criminalize mentally ill citizens who go in and out of a revolving jail door due to lack of services. A Criminal Justice Diversion Program for citizens with psychiatric and substance abuse issues will provide a wrap-around network of forensic psychiatric, social service and housing assistance to the mentally ill. These services will reduce crime and recidivism among citizens with mental illness and substance abuse. Components of this program include: a Forensic Assertive Community Treatment (FACT) Team to stabilize and assist released prisoners with follow up services and monitoring; a forensic supervised housing program; and expanded treatment resources at both Orleans Parish Prison and Mental Health/Drug Court. Together these proven program elements will provide appropriate care for mentally ill citizens, save police time spent on minor offenses, reduce the overcrowding in EDs, and improve the quality of life for all citizens of New Orleans.

In addition to these key funding needs, we also have recommendations for legislative changes to improve access to mental health services in the case of future catastrophic disasters.

The Stafford Act provides significant resources for crisis counseling after major disasters. The act, however, does not provide for psychiatric services or funding for prescription drugs. Many of our uninsured citizens could not afford the medications or the services they needed after the storm. The systems that might have been able to assist them before Katrina were damaged and inadequate. This situation added to the suffering of many citizens and to increased pressure on first responders handling mental health cases.

The lack of portability of Medicaid from state to state also must be addressed to improve access to health and mental health care following a disaster. States should be required to give full faith and credit to the evacuating state's Medicaid program for the time of the declared emergency. This is critical for mental health patients, as well as those with other physical illnesses.

Thank you for allowing me to speak with you today on the status of our mental health recovery and the challenges we face. We thank you, Senators Landrieu and Stevens, your Subcommittee, as well as the Louisiana delegation and other members of Congress, for your continued support as we rebuild our city and region. Though we still face a historic crisis, we are hopeful that with your assistance, we can solve the remaining problems and build a better and stronger community for everyone.

Attachment A

Police Response to Mental Health Calls[*]
January – August 2007

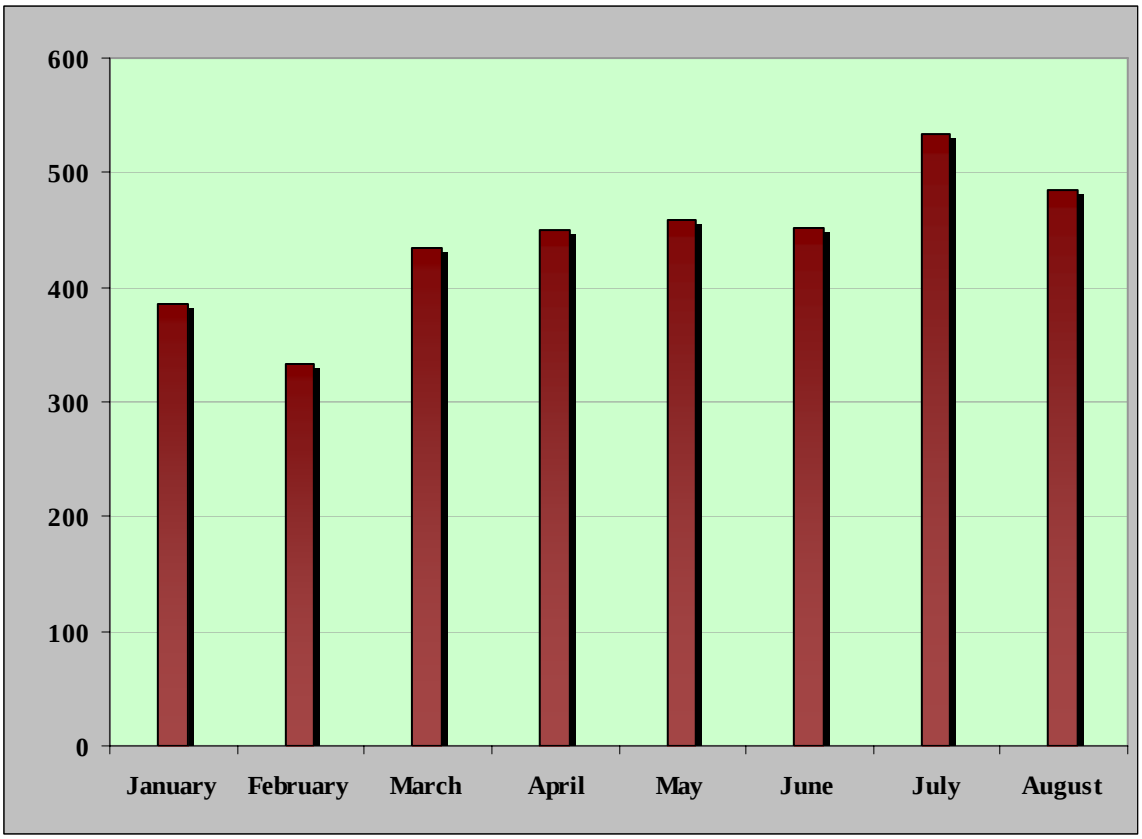
Month 2007	Mental Health Calls to NOPD (2 NOPD officers respond per call)	Average Time for NOPD mental health call from start to finish	Longest wait time	Estimated hours per month of police time taken away from other traditional law enforcement activities
Jan	196	59.1	n/a	385 hours
Feb	167	60	n/a	334 hours
Mar	207	63	n/a	435 hours
April	200	67.5 minutes	2.5 hours	450 hours
May	194	71 minutes	2.25 hours	459 hours
June	191	71 minutes	2.5 hours	452 hours
July	208	77 minutes	4.5 hours	534 hours
August	211	69 minutes	35 hours	485 hours

[*] Source: James Arey, Commander, NOPD Crisis Negotiation Team, City of New Orleans

Attachment B

Estimated hours of police hours spent from "start to finish" on mental health calls*

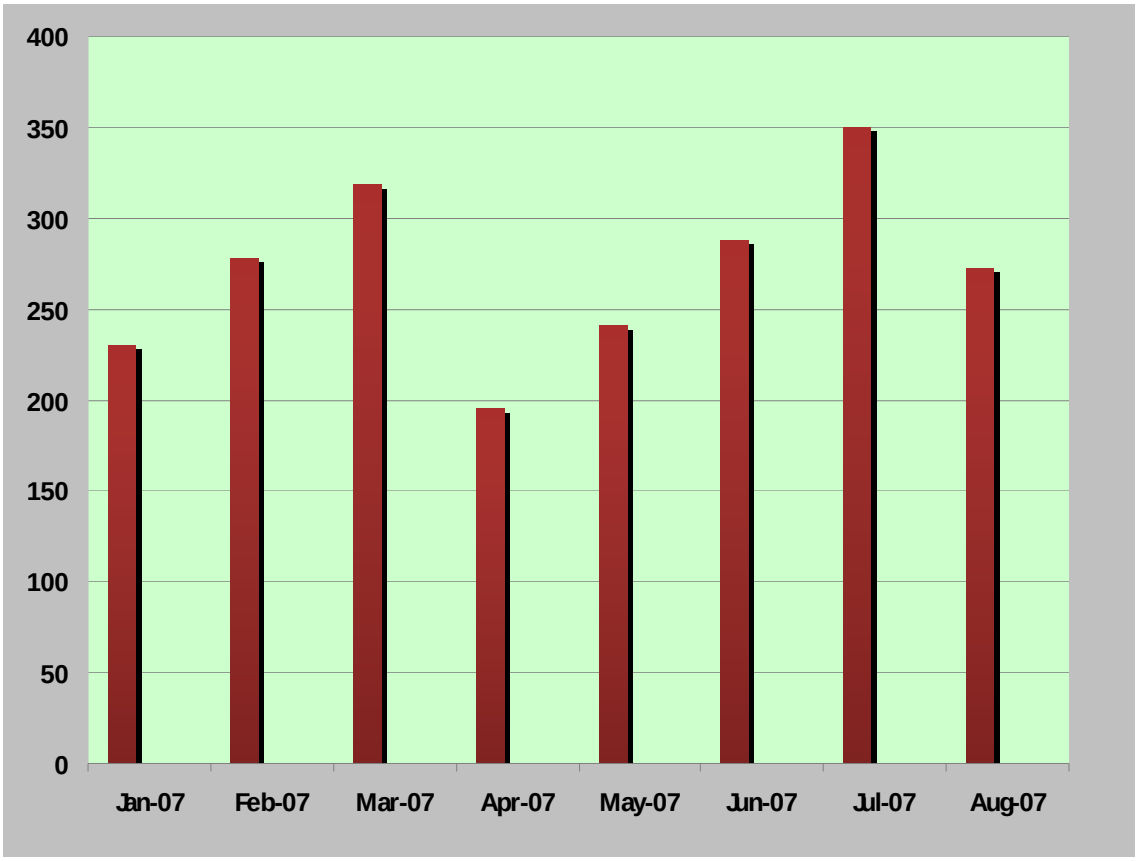
January – August 2007



* Source: James Arey, Commander, NOPD Crisis Negotiation Team, City of New Orleans

Attachment C

Real Wall Time EMS: Total hours of EMS wait time at all hospitals[*]
January – August 2007



[*] Source: Dr. Jullette M. Saussy, Director of EMS, City of New Orleans