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Inpatient Study Group 2009.

In order to determine the beds needed in DMH going forward, it would seem that the first question that needs to be asked is: To what purpose(s) do we wish to put DMH inpatient beds? Currently the inpatient beds at DMH are used for two main purposes: **Forensic and Intermediate care**

1. **Forensic**: Patients sent by the court for evaluation of competency and/or criminal responsibility on section 15B. Patients sent by the court on 15E's: Aid in sentencing. Patients sent by Framingham Prison on 18A for an evaluation of their need for psychiatric care. Pre-Arraignment 18A's, people sent over the weekend or in preparation for a court date, who are felt to be at risk in a police lock-up. Patient's who have had an initial hearing on their 15B and are sent back on a 16A for evaluation for their need for psychiatric hospitalization. 16B is a commitment for up to 6 months for a person who is not competent and/or not criminally responsible and meets commitment criteria (danger to self, danger to others, unable to care for self due to a mental illness or defect. 16 C is a one year commitment for someone who completes a 16B and is still not competent and or not criminally responsible and meets criteria commitment. Men who are transferred into DMH from Bridgewater State Hospital. If someone comes to us from the court, and has no observable mental illness, we must hold and evaluate them for the entire tenancy of their commitment and then return them to court.

Many, though not most, of the patients we see from the court, are DMH eligible patients. A DMH patient who is under the care of DMH cannot be discharged to the street. We are often backed up with patients who are discharge ready, but we have no community residential programs for. If a patient is sent back and committed

on a 16B, we cannot discharge them without giving the court 30 days notice. Patients often stay hospitalized longer than they need to given this legal requirement. Anything related to chapter 123 is law, and we most follow all of these rules and procedures despite the fact that they often keep people hospitalized for longer than they need to be.

DMH has no control over these admissions. (front door Issues)

2. **Intermediate Care:** Patients are transferred into DMH beds from acute care settings after their they no longer meet a Hospital Level Of Care (HLOC) criteria as defined by Medicare, and the acute care hospital can no longer bill for their stay, though they do continue to get a minimal reimbursement.

DMH controls these admissions. Clinicians from acute care hospitals must submit referrals for intermediate care. These referrals are reviewed by the area office and, if accepted for intermediate care there is often a lengthy wait, meaning that the patient continues to occupy an acute care bed, which leads to back up in emergency rooms as patients wait there to go in to acute care beds.

The admission piece is relatively clear and straight forward. The problems are more related to who we discharge and what are the obstacles to discharge. The main obstacles to discharge are: **Risk, lack of resources, administrative obstabcles**

1. **RISK,** or more accurately, perceived risk
   Given the nature of the patients that we admit into the hospital; forensically involved, unable to stabilize during an acute admission, and men transferring from Bridgewater we are receiving patients who are at risk for not only rapid decompensation in the community, but substance abuse,

violence, and criminal behavior (including sexual offending). What is the degree of risk that the DMH should be taking with regard to these very difficult patients? What are the repercussions when a patient is discharged from DMH and then goes out into the community becomes violent or commits a crime? DMH often determines discharge criteria on the basis of how something might look on the front page of the Boston Globe. The other group of concerning patients, are those who refuse services, live in generic shelters, or even on the streets. These patients often lack the skills and abilities to care for themselves. Sometimes they are people who have lived on the street for many years without major harm coming to them, so they are often discharged to DMH settings only to return back to live on the street. What should be DMH's obligations and responsibilities vis-a vis these kind of patients, who are fairly significant in terms of number, though they likely represent a tiny fraction of the patients followed by DMH.

There should not only be criteria for admission, but also a comprehensive criteria for discharge developed for each patient.

2. RESOURCES

The current community system/inpatient system is often an adversarial one in that community providers often resist taking patients into the community that are at high risk for problematic behaviors or for patients they have seen time and time again be unable to live successfully in the community. The tension between the two systems leads to delays in discharge, often lengthy, as community providers and inpatient treatment teams struggle to do what they perceive to be the "best thing" for the patient. Often when a patient has had multiple failures at community placement, outpatient providers become understandably reluctant to have that person back in the community. This is especially true when the

patient has posed behavioral issues when they have been in the The conflicts around discharge relate to the risk issues that a patient poses.

The risks we most focus on are:

Risk for sexual offending
Risk for violence
Risk for criminal behavior
Risk for noncompliance with treatment
Risk for substance abuse
Inability or limited ability to care for one's self

3. Administrative Obstacles

To what degree is it the responsibility of DMH to protect the community when the criminal justice system has not felt the need to contain these people?

Why is the DMH detaining people who are not n need of hospitalization because they may commit a crime or engage in some socially unacceptable behavior in the community?

The DMH has put a consultative service together where independent forensic psychologists come to inpatient units to determine if patients are too great a risk for privileges passes, and ultimately discharge. The cost involved in this, the time involved, and the obstacles to discharge this often poses flies in the face of DMH's stated desire to serve people in the community.

In the last few years, DMH has developed a specialized service called MI/PSB: Mentally Ill/Problematic Behavior. This consultative service provides assessments and individual and group treatment for persons with sexual behavioral issues, including convicted sex offenders. The costs involved with this program are

impossible to determine given the mix of vendor and state personnel. In July we are opening a specialized residence for men with sexual behavioral issues. This residence cost over $1,000,000 and will be for 12 men. Discharging people who are convicted sex offenders from the inpatient service requires "an act of congress." It must be signed off by the area office and the Central Office.

Risk management plays far too great a role in the discharge of patients from the Department of mental health.

DMH offers "transitional housing," which are shelters developed and run by the Department. They allow people to establish their homelessness for subsidies and provide shelter when sites do not have readily available housing or people can't be housed given immigration issues, CORI issues, have not been stable in housing after multiple tries. There is almost always a waitlist for transitional housing. The transitional housing is made up of 2 programs at the ELMHC and one of long Island. The one on Long Island will be moving to SCFMHC on July 1st. These facilities are NOT something to be proud of, and I am embarrassed to show them to prospective patient s and/or families.

Often what is needed to get someone out of a hospital setting is a 24/7 monitored and staffed group home. As the Department moves toward its view of normalization, there are far fewer of these. There is a glut of supported housing options, but a shortage of 24/7 group homes. The other issue is that as DMH has gotten out of the housing business, most beds are reliant upon subsidies. Many of our patients are not eligible because of CORI, SORI, immigration issues, or previous evictions. There is one program in the Metro area that offers good 24/7 supervision and monitoring. I have a patient who has been waiting for a bed in that program since November 2008, and I have been told that 5 people are on the waitlist ahead of him.

To close beds at this time is very risky. We are just beginning a new system of community support ,CBFS; Community Based Flexible Support. It does not go into operation until July 1 and is a vendor run system with poorly defined oversight by the Department. This contract will provide all of the services that a patient/client might need, increasing, decreasing depending upon the client's need.

As part of the cutbacks in the early spring, many community programs were closed. Clubhouses and consumer run RLC's are the only forms of day structure we currently have.

Moving very high risk difficult patients into the community is a wonderful philosophy, but how to we even begin to develop a community support system that can handle these clients safely.

Given the fiscal situation, beds will be closed, but the beds should not be closed blindly to the consequences, including those that are unintended. Currently we do not have the beds or necessary supports in the community to discharge patients. If closing beds goes forward at this time without adequate planning and resources, we will have a repeat of the failure of deinstitutionalization of the 1960's , from which we have yet to fully recover.

Ideas for change given that the need to close beds as a given.

Redefine the population of DMH eligible clients to only include those persons suffering from a mental illness that has psychosis as one of its symptoms.

Develop statutes that allow the Department to not accept individuals from the court who do not meet admission Hospital level of care criteria and to provide funding for 15B evaluations to be done in jail or in the community for those individuals who are not in need of psychiatric hospitalization.

Limit the 30 day notice rule to the court to apply to felony charges only.

DMH cannot be responsible to provide itself or via contract, housing to every person who has been identified as in need of DMH services with decreasing funding.

Homeless advocates should be on notice that DMH cannot even try to provide for the housing needs of the homeless mentally ill, whose numbers will most certainly increase if DMH inpatient beds are closed without the needed community support. The homeless mentally ill, should be viewed as homeless and in need of shelter like any other homeless person.

DMH should be about preserving housing that patients have before coming in to the hospital regardless of the problems with that housing. (substandard, family conficts...)

Mandatory Forensic reviews should be done with discharge as a given and then the reports should focus on how to manage the patient safely in the community rather than on whether the patient is safe to be discharged.

Registered sex offenders should only be held in the hospital for mental health reasons and not as preventative detention. Discharge of sex offenders should not be delayed for assessment by MI/PSB clinicians. The model for MI/PSB discharges should be with a quick eye toward discharge to the community and minimizing risk as we are best able.

Blair Mergel's Testimony
June 3rd, 2009

My name is Blair Mergel. I have lived almost in Dorchester 33 years. And been married for 35 years. Off and on I have gone for Hospital care at various private hospitals including the ~~Harbor~~ Arbour in Jamaica Plain and the Bayridge in Lynn Massachusetts. At Bayridge I was told my heath insurance ran out and I had to pay close to $80,000 for the rest of my stay at Bayridge. I was told if I went to a state mental hospital (the Shattuck in Jamaica Plain) medicare would pay the $80,000.

I was very scared. But I waited three weeks for a bed at the Shattuck and in November, 12 years ago (approximately) I was a patient at that hospital for two months. In that time I transfered home to my house (home) in Dorchester with my husband and last child (the other two in college getting masters degrees). The hospital was competent, compassionate and flexible about 4 day passes, a very good day program (Gil Rehab) and as it was around the Christmas holidays — kind about everyone's celebrations of the season.

I went home two days before Christmas. And visited and brought presents to people on Christmas day. The hospital

was so quiet. Most people were sleeping the day away.

After being at the Shattuck I went to the Alpha Day Rehab program where I was able to work ~~on~~ in the Education program there geared toward people getting their high school equivalency tests requirements.

At the program I heard about Consumer Providers Program in Cambridge run by Cascap. I applied and was welcomed into the program which involved study of the Humanities, a internship (in my case) to a sheltered workshop called Work Inc. in Quincy.

As I had considerable experience working for many, many years in the human services especially in sheltered workshops this was an excellent fit for me.

I am testifying today because I feel the loss of day programs, a program like C.C.P. would be a horrible loss.

Already day programs are disappearing. And the funding for excellent peer run programs and adequate hospitalization or something concrete enough to help people who suffer so much from mental illness is getting harder and harder to come by.

Social services are so important and necessary. Peers (people who have training

and the growth that comes from helping others with theis mental ~~ill~~ illnesses can't be applauded and found useful enough.

I have been blessed to have come from a family where bipolar disorder abounded. My family helped me financially, emotionally and with love. They still do. And I help them. I also have had a psychyatrist for 25 years who still sees me and has helped me considerably. Also training, work (when I could) in the human service field made me see people from the other side of my own illness.

Also friends, church, and Godparents (and Godfamily) have been there for me during very dark times in my life.

What will happen in these ~~terrible~~ economic times to people just let out of the hospital to survive for themselves?

I want to testify that if I were let go without all the help and knowledge I was given by places like the Alpha Day Rehab Center, Gil Rehab, CASCAP and now M-Power and the Transformation center — I don't believe I could have been there to see my kids grow up with me in the picture. And now I am a capable and loving grandmother.

I believe in ~~re~~ rerun services for those who desparately need them.

Gail Shamon
June 3, 2009
Inpatient Commission Hearings

Hello,

My name is Gail Shamon and I work at the Transformation Center as an admin assistant. I am also a C.P.S, I would like to talk a little about my inpatient experiences, which were probably 20 or so while I was using dually diagnosed and 15 or so after I was clean.

I've also been in the Shattuck, where I ended up for two weeks at the tail end of a two month stay in BID. My inpatient times never helped me; I left worse every time. I left full of shame, feeling like a defective human being. I remember when we went for walks at McLean's, coming back into the unit with the blue door locking behind me, and my heart just sinking. Locked in again. Barely human. Not having the right to leave. And I had to say I was suicidal in order to get admitted, so the moment I was in the ER door, I was trapped by my own need for help. How backwards is that? Trapped behind closed doors, when I needed help the most. Penalized, punished for having a "mental illness." And if I didn't say I was suicidal, thereby locking myself in, Mass health would not allow me to be admitted and treated, whatever that means.

As it was, I had two serious suicide attempts, one of which almost killed me, because inpatient visit after "visit" left me getting worse and worse. If I had been able to go to a respite, somewhere among friends instead of emotionless doctors, I probably would not have despaired to the point of suicide.

What's interesting is that I had all my power stripped away as a child, which resulted in PTSD and a dissociative disorder. And as an adult in psychiatric units, I was re-traumatized by having all my power stripped away again...even over my own body and my own freedom of movement. People do not get better behind locked doors. People like me feel punished and shamed. The inpatient experience is one of powerlessness and hopelessness. I believe I will never ever repeat that experience again. The day the insurance companies decided unlocked doors and levels of privileges were not okay "If they're well enough to walk to a coffee shop, they're well enough to go home" was the day inpatient units lost all their humanity and all their compassion.

I will tell you one thing that always helped me, though, and that was the other patients. I would feel so safe and relaxed with them...until the doctors came to find us. With the other patients, I could compare notes, sympathize, empathize and feel like one of them. As soon as the Doctors came, I became a patient. With my patient friends, I felt better. With the staff, I felt worse and like a freak, or a subhuman. Dehumanizing is the best word to describe the inpatient experience.

The alternative to locked psychiatric units is unlocked peer- run respites. I know that if I had had that option, I would NOT have attempted suicide twice. I would have felt human, instead of less than human. Locking a human being up is not the answer for most of us who have lived experience. People who know animals never lock them up in cages for

any length of time, unless they don't care that those animals will lose their sanity. People lose their sanity, instead of finding it, when they are locked up an in and become totally helpless and dependent on the mental health system. Providing safe, NON-THREATENING respite care is what we need for ourselves and those coming into recovery with us.

Thank you,

Gail Shamon

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Testimony for the DMH Inpatient Study Commission

Boston, MA
June 3, 2009

Commissioner Sudders, Representative Brett, and members of the Commission:

Thank you for the opportunity to testify today at this important hearing. As a consumer/survivor, I believe this is a critical opportunity to acknowledge the importance of recovery- and peer- based services, especially in acute care. These services are innovative, cost-effective, and proven to work.

It's good to see the terms 'recovery' and 'putting the consumer first' being talked about by the Administration and the Department of Mental Health. However, I don't see much "buy-in" from the State, and little resistance is given to the powerful, vested interests determined to maintain the "status quo."

Inpatient services may always be needed. But when hospital beds and medication become more important than dignity and community, it's time to transform services and create alternatives. How can recovery-based care keep to the spirit of the Olmstead Act and Community First while delivered behind locked doors? Instead of managing risks, why not discover possibilities?

All too often, inpatient settings are dehumanizing and disempowering. A typical stay involves quick medication adjustments and little else. We're not seen for our strength and resilience, but as collections of symptoms needing to be controlled. Childish 'privilege' systems rob us of our dignity. Of course, we mustn't demonize hospitals and the many caring staffers who are often overworked and underpaid. But inpatient units have, inevitably, become breeding grounds for ~~allow~~ serious rights violations.

There is one law protecting basic civil rights for psychiatric inpatients - the "Five Fundamental Rights" (Massachusetts General Laws, Chapter 123, Section 23). However, the law is violated with truly breathtaking frequency at private and public facilities. Attempts to stop these violations are steadily opposed by powerful hospital lobbyists. Meaningful systems change must demand an end to the wholesale violation of basic civil liberties.

One can argue that the use of force is necessary when serious risk exists. But the success of the State's restraint and seclusion reduction initiative has proved that alternatives to coercion and force exist, and are often very successful. For someone in a crisis state, being surrounded by clinicians and orderlies can lead to escalation, whereas talking with a peer who understands and respects their experiences is far more likely to result in a better outcome. Peers in ERs, Peer-run respites, and all sorts of peer-based interventions must be taken into consideration if Massachusetts is to make the necessary leap into the future.

Also, when massive budget cuts threaten the ~~very~~ existence of community-based programs which help people thrive and live healthy, independent lives, the State is spending over $300 million to build another hospital. The enlightened ideas inherent in its design may be "state of the art," but without "state of the art" ideas and resources, it's just another hospital.

It's been (rightfully) noted that the problem with de-institutionalization was that those released from institutions lacked supports in the community. However, it seems to me that instead of focusing on

creative, meaningful ways to live in the community, we are moving toward a type of 'reinstitutionalization,' driven in no small part by a broken, profit-based health care system.

Regarding the makeup of this Commission, I have no doubt that it consists of sincere people who are committed to serving our community, and again, I appreciate your hard work. But a prominent slogan of the recovery movement is "Nothing about us without us." WE are the people most intimately affected by the future of inpatient psychiatry – so why are we such a minority on the panel? There's an unfortunate history of 'token' consumer involvement on committees like this. The commission's findings are most certainly about us, but its makeup is mostly without us. If DMH's vision truly puts consumers first, then the makeup of future panels should reflect this commitment.

I believe that with a progressive inpatient plan, we all stand to win, even in these difficult and often-discouraging economic times. Thank you.

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My name is KS, **Corporate Director for PPMH** and I am also **a practicing psychologist.**

I represent the **Partners hospitals (MGH, BWH, MH, FH, NWH, NSMC)** which are all **dedicated to providing high-quality psychiatric and mental health services.**

- **Thank you** for allowing us the opportunity to provide our input around **the Commission's vision to provide a responsive mental health delivery systems that embraces the values of recovery choice and self-determination.**

- **We are all here today as we are committed to establishing and maintaining programs which are in the best interest of individuals with chronic and persistent mental health challenges.**

- **Our primary goal** is to ensure that all individuals receive **high quality psychiatric care in the least restrictive environment, preferably in their own communities.**

- **Recognizing the enormous challenges** these individuals face on a daily basis it is **critical to provide the mental health and social services necessary to support these individuals.**

- **The services received** allow each individual to reach their highest potential in all areas of their life.

- This past Sunday I had **the privilege of representing PPMH as the lead sponsor of the NAMI walk.**

- During the walk I had the **opportunity to talk with many consumers of mental health services.**

- It was **clear from my discussions that receiving compassionate mental health care in the right setting and at the right time were critical fac**tors in **their ongoing recovery.**

- In my **prior role as the Administrative Director of Psychiatry at NSMC**, I along with **other members of the NSMC psychiatric leadership team and the Lynn Health Task Force**, developed and designed programs working closely with community agencies to maintain clients in community based services.

- I recognize that the State is under eno**rmous pressures to manage the budget in a responsible and cost-efficient manner.**

- **However, as a representative of mental health system providing psychiatric care, I believe the following points are critical.**

FIRST

- **Access to community-based mental health and social services** such as **day treatment** and **residential programs, outpatient mental health services, social clubs** and **vocational training** are essential **in supporting consumers** in **maintaining their highest level of functioning.**

- **We are very concerned that the downsizing of DMH programs and supports will result in DMH consumers requiring more frequent crisis and inpatient services.**

SECOND

- **Access to inpatient level of care** when an individual destabilizes is essential in their recovery.

- **According to the DMH inpatient data dated May 2009, utilization of inpatient beds is at 97%.**

- This would **strongly suggest that if there was a decrease in the current DMH inpatient capacity that consumers of DMH services would likely utilize psychiatric emergency rooms to receive their care.**

- **In light of the fact that psychiatric units in acute care and free standing hospitals are running close to full capacity**, this would result in further **increasing the length of stay for all patients both on inpatient units and in already over crowded emergency rooms.**

- It is **common that by Monday morning hospital emergency rooms have been boarding psychiatric patients for the entire weekend** as they await an inpatient placement.

THIRD

- The **number of adult psychiatric patients who are "stuck" on inpatient units waiting for a DMH placement**, such as a residential program or an intermediate care bed, although improved, **still remains a challenge.**

- **Reducing the current DMH inpatient capacity will further exacerbate the "stuck patient" problem.**

- It is certainly **not in the best interest for DMH clients to remain on inpatient psychiatric units for extended periods of time while watching other patients discharged within 7 to 10 days.**

- **This practice often leads to destabilization for the "stuck" DMH patients.**

IN SUMMARY

- Due to the impending **reorganization of the adult DMH community based programs to be implemented in July 2009**

- And given that the **DMH hospitals, acute care psychiatric units and free standing psychiatric hospitals are running at full capacity**

- **This is not the time to reduce the existing DMH inpatient beds** as the **community and free standing psychiatric hospitals are not in the position to absorb additional capacity.**