

**Statement of Jonathan Delman**  
Consumer Quality Initiatives, Inc.  
To the Massachusetts Department of Mental Health  
Inpatient Study Commission  
Boston, MA  
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Members of the Commission,

Thank you for this opportunity to speak to you during this time of positive programmatic change in mental health services in Massachusetts, which are unfortunately balanced to a degree by the Commonwealth's fiscal challenges.

I. Introduction

I am the director of Consumer Quality Initiatives, Inc. a mental health consumer run research and evaluation organization. Over the past 10 years, we have had contracts with DMH and the Mass. Behavioral Health Partnership to evaluate programs they fund, primarily from the consumer perspective but also from staff perspectives. As part of our work, we have evaluated State Hospitals, acute inpatient psychiatric hospitals, and psychiatric units of general hospitals, as well as outpatient programs (egs, clinics, day programs, Programs for Assertive Community Treatment, Structured Outpatient Addiction programs, Enhanced detox, and so on). In this testimony I will focus largely on the capacity needs for state hospitals beds, but I will also reference private hospital care.

As for me personally, I am a long time mental health consumer, with my academic degrees mostly indicators of my distress. I was finally hospitalized when I was 30, leading to a decade of 6 acute care hospitalizations, over 50 Electro-Convulsive (shock) Treatments, living in a halfway house, living on disability and MassHealth, many medication changes, and of most frustration, not being able to find a job. In my late 30's I began to volunteer with M-POWER (Massachusetts People/Patients Organized for Wellness Empowerment and Rights), a peer lead organization trying to improve the quality of mental health services. It was my involvement in that organization, which lead to my current job, which was initially funded by MBHP through M-POWER. Our organization, by involving consumers in research and evaluation, has had a major impact on many services, in particular those for youth aging out of adolescent services, family wraparound programming (eg, Rosie D), and day program services. It was for this work that I was awarded a Robert Wood Johnson Foundation Community Leadership award in 2008, one of ten nationally. The points here are that at my worst I was not seen as a candidate for employment, and that I got my chance at employment because I was free to engage in specific volunteer activities, not doable from a hospital

## II. The need for fewer state hospital beds and more community placements

Based on my knowledge and experience, I believe that if state government's mission is to help people with mental illness attain recovery and integrate into society, then the need for State Hospital beds is lower than what currently exists in Massachusetts. That is, there are many state hospital patients who are not dangerous and do not need to be behind lock and key; they would have a much greater chance at community integration by receiving outpatient services and peer supports, perhaps living in supported housing or in a respite. Below is some of my reasoning:

- Ø According to our data, **most mental health consumers want to work and have a social life**. Not only is work and socializing an outcome, but it is also can be therapeutic. It is very difficult to effectively plan to work or otherwise reintegrate into society from a state hospital. In fact, history demonstrates that people become **MORE** dependent hospitalized over a period of time.
- Ø A large majority of people end up in state hospitals because they **couldn't get the help they needed earlier** (ie were not DMH eligible). That is, they deteriorate and become homeless, then making them eligible for DMH services and a state hospital patient. These are people who are very much able to function outside of a state hospital, they just need housing and either regular help (eg, PACT teams whose capacity is growing) or occasional help (peer support, crisis intervention). An improved triage system would be helpful here.
- Ø DMH has been able to successfully discharge state hospital patients into the community (from **Medfield** recently and from Metropolitan and Danvers 15-20 years ago). And as note below, the delivery of community supports has improved greatly since that time.
- Ø As recently as 10 years ago, many providers and policy makers were of belief that mental illness is disabling for life. However, studies have demonstrated that people living with mental illness, including those in state hospitals, can and often do **recover** with the right outpatient supports. For state hospital patients, recovery only takes place after they are discharged because they are able to establish a valued role for themselves in society. Of note, it is of particular importance to have in place consistent supports for those who struggle with substance abuse.
- Ø In addition to recognition of the findings or recovery, **outpatient care and supports have improved greatly in the last decade**, a quantum leap from the 1980s, and even from the 1990s. MassHealth and MBHP recently procured an emergency services system with a focus of keeping people OUT of hospitals and on maintaining people in the community. In addition, there are far more peer support services that provide consumers an immediate connection to the community; this includes certified peer specialists, who have been trained and certified by the Transformation Center (a consumer-run consulting and technical assistance organization) (with DMH funding) to work with consumers to integrate into the community. Of course DMH's new flexible supports contracts is person-

based, not program based, with far greater opportunity for program integration. Vocational supports will be available to all DMH clients. Housing supports are now more sophisticated, geared towards the needs of individual consumers. Also strengthened are clubhouses and day programs, many of which now have peer specialists. In addition, the state has developed state of the art transition age youth services promoting independence and consumer involvement, and ultimately will even more significantly. DMH and many MassHealth clients are now developing Wellness Recovery Action plans, which help consumers to identify the early warning signs of distress in order to avoid hospitalizations. In essence, DMH, MassHealth and MBHP have over the last year made significant changes to service system geared towards community and independent living.

Thus, any analysis of bed needs that references the good old days of mental health services earlier this century is misguided. First, it assumes that the outpatient service system has remained static. And second, I have not met any people who were in state hospitals in the 1980's and before who did not suffer from various levels of humiliation and abuse. Ø Of note, even our 2002 report on **satisfaction with state hospital services** (attached) demonstrates concerns raises above. The general satisfaction rate of 67% is relatively low. In addition, while many patients believed they were treated with respect by staff, they did not believe that their strengths and skills were being developed. A major reason for this dissatisfaction is the very nature of the state hospital, which limits patients' freedom and choices over an extended period of time.

III. Acute Care Hospitals: Their role and improvements to be made For various reasons, acute care hospitals, as currently operating, are ineffective for many patients, particularly those who would do not want to be locked up. A notable outcome is the 30-40% 30 day readmission rate for DMH clients. Systemic problems are the short lengths of stay and that the most common treatment is a change in medications, which often has been done without consultation of the outpatient psychiatrist (who presumably knows the patient better).

Based on thousands of interviews with many patients, a major concern for them is that they don't feel that a staff member is available to them when they need some attention. This is more true at acute inpatient psychiatric facilities, where staffing and activities tend to drop around the weekends, as opposed to psychiatric units at general hospitals, which seem to have stronger staff presence overall. In addition, only about half of those who needed housing felt they were receiving that help.

I've attached a quality improvement report we completed in 2005, but it really does reflect findings from before and after that. Some of the questions we raised in 2005 are:

*While CQI's data is very useful in understanding the strengths and weaknesses of hospitals, questions remain with regard to **patients' continuity of care while in the hospital**. Such a methodology would involve answering the following questions:*

- *What happens upon admission? Is an individualized treatment plan being developed in collaboration with the patient? Does staff have information about*

*how best the patient wants to be dealt with in acute distress? Does staff know why the person is in the hospital? Is the hospital already beginning to plan for the person's discharge?*

*• Does every day count? Are treatment and activities taking place on the weekend? If the patient is admitted on a Thursday through Sunday, is s/he getting a thorough work-up and a thoughtful medication regimen from a prescribing psychiatrist?*

*• Is the patient being kept up to date on the medications being prescribed, and the potential benefits and side effects?*

*• Is the patient being effectively connected to housing and other aftercare? Answering these questions for a particular hospital would involve a combination of unannounced visits to the unit, a review of patient records, and interviews with patients whose records are being reviewed.*

So we need to support acute hospitals to improve the quality of care if they are committed to change. My sense is that basic staff training, orientation and monitoring is a big part of this. Changes here would result in lower readmission rates and less need for inpatient continuing care (eg, state hospital beds).. Finally, I am concerned that psychiatric units of general hospitals are losing financial ground. I believe they provide the most staff intensive care of any inpatient facility, and are important for patients with multiple medical conditions. I encourage the committee to explore ways keep general hospital beds open, though we may lose others.

Respectfully,

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**Attached** State Hospital report  
Acute care hospital report