TESTIMONY TO THE DMH INPATIENT STUDY COMMISSION

PUBLIC HEARING HOLYOKE, MA 6/10/09

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Thank you for the opportunity to testify before this distinguished Commission and thanks to Secretary Bigby for asking you to make recommendations to her on the inpatient services provided or paid for by the Commonwealth. I am Dr. Benjamin Liptzin, Professor and Deputy Chair of the Department of Psychiatry at Tufts Medical School and Chair of Psychiatry for Baystate Health, a health system which operates Baystate Medical Center in Springfield, Baystate Franklin Medical Center in Greenfield and Baystate Mary Lane Hospital in Ware along with the Baystate Medical Practices that provide primary care and specialty physician services in Western Massachusetts. Baystate is one of the largest providers of mental health services in Western Mass with a 28 bed inpatient unit in Springfield and a 24 bed inpatient unit in Greenfield. We also operate: a Partial Hospital Program for children and adolescents in Springfield and adult PHPs in both Springfield and Greenfield; outpatient mental health services for children, adolescents and adults in Springfield and in Greenfield; Substance abuse detox, Intensive Outpatient, outpatient, and residential services in Springfield and Intensive Outpatient and residential services in Greenfield. As the Western Campus of the Tufts University School of Medicine we also teach 3rd year medical students doing their clerkship in Psychiatry. We are starting a new residency in Psychiatry at Baystate Medical Center on 7/1/09. We provide educational opportunities for students in other disciplines including nursing, psychology, social work, and occupational therapy. We also provide Continuing Medical Education opportunities for professionals throughout the Northeast. As an academic institution we also have faculty doing research supported by NIH and other external funding.

I have seen many changes in inpatient Psychiatry since I began my Psychiatry residency in 1971. I have studied the organization and financing of psychiatric services (including under Canada's single payer system) since I served at the National Institute of Mental Health from 1974-1978. From 1986-1987 I Chaired the Inpatient Committee of the State Mental Health Coordinating Council appointed by Governor Dukakis. Attached to this testimony are a recent journal article and a book chapter I published on financing psychiatric services in hospitals. Based on my clinical and administrative experience over the last 38 years I would like to share with you the following observations:

1. There will always be a need for inpatient psychiatric care for both crisis stabilization and continuing care. Inpatient hospitalization is required for at risk patients who are unable to participate in outpatient treatment or have not responded to that treatment. Most patients can be stabilized fairly quickly (average stay is now 7-10 days) and transitioned to a less intensive level of care. However, some patients take considerably longer (6 months or more) to stabilize so that they can be safely transitioned out of the hospital.
2. The state has traditionally had the responsibility to provide or pay for continuing care since private or public health insurance only covers acute care.
3. Currently acute care in Massachusetts is provided on inpatient psychiatric units in general hospitals, at specialty psychiatric hospitals, and at a few community mental health centers.
4. The state operated or funded continuing care units currently run at 97% occupancy and with their long length of stay there is often a long wait for patients

who are on acute psychiatric units awaiting such a bed. If the number of such beds is reduced those waits will get longer and acute units will be less able to admit acute patients who will back up in Emergency Rooms or on med/surg floors in general hospitals. We already have the experience when there are no available psychiatric beds for children or adolescents that they wind up staying in Emergency Rooms for days or sometimes get admitted to pediatric medical floors that are ill equipped to manage them. Similarly, geriatric patients with behavioral problems can remain stuck in a medical bed because there are no appropriate geriatric acute care or continuing care beds.

5. When Northampton State Hospital closed as a result of the Brewster consent decree western Mass developed an excellent range of community-based services and an inpatient replacement unit now at Kindred/Parkview. That system is under enormous stress as a result of reprocurement and inadequate funding and it has become increasingly difficult to find appropriate services for patients. It would be regrettable for the system to collapse to the point of winding up back in Federal court.
6. Inpatient psychiatric units are under particular stress because of inadequate financing. The State-funded studies by an independent consulting group several years ago documented that hospitals were reimbursed substantially less (more than 20% less) than the cost of providing psychiatric care. The psychiatric hospital of the Sisters of Providence Health System has required millions of dollars in special funding from the State Legislature for the last several years because of large deficits in their operating budget from inadequate reimbursement rates. Baystate Health also has sustained losses in its behavioral health programs of $7-8 million/year. Cambridge Health Alliance has closed many of their psychiatric beds as a result of such pressures.
7. The acuity on inpatient psychiatric units is higher than ever and that presents challenges to provide a safe environment for patients and staff. Despite the acuity we have been able to reduce our use of seclusion and restraint to a minimum and BFMC was recognized for that effort several years ago by the Commissioner of DMH. The DMH system has historically been a critical resource for violent or assaultive patients including those involved with the Court system.

In conclusion, Massachusetts has built up a system of mental health care that has been recognized (even with some of its deficiencies) as among the best in the United States. It would be tragic and shortsighted to let that system deteriorate as a result of short-term budget challenges. We look forward to working with you to provide the care required by the citizens of this Commonwealth.

Thank you for your attention.

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STATEMENT OF ROBERT D. FLEISCHNER
CENTER FOR PUBLIC REPRESENTATION
TO THE MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH
INPATIENT STUDY COMMISSION
Holyoke, Massachusetts
June 10, 2009

Members of the Commission,

Thank you for the opportunity to speak with you at this difficult financial time about this very important issue.

I am Bob Fleischner and I am an attorney at the Center for Public Representation. I've had over 30 years of experience representing individuals in state hospitals, state schools and juvenile justice institutions here and in several other states. Some of my litigation here and elsewhere has resulted in a reduction in the reliance on state operated institutions and the expansion of community-based services for youth and adults with mental disabilities.

The Massachusetts Department of Mental Health knows how to responsibly close state mental hospitals. Today's hearing is appropriately convened in a region that set the standard and created the model for the entire country. Brewster v. Dukakis, in which our office represented the plaintiff class, led to the creation of a comprehensive community mental health system where none existed and greatly reduced the need for long term, continuing care hospital beds.

The Northampton State Hospital Consent Decree worked for many reasons – meticulous and careful planning, talented and committed DMH administrators and staff, a set of agreed values, willing and able providers, vigorous monitoring and meaningful participation by advocates, consumers and families, and, not the least important, oversight by the federal court. As a result, despite some hitches, nearly every hospital resident was discharged to an appropriate community program, most staff were provided for, and community concerns were addressed.

The lessons learned in the phase down and closing of Northampton State Hospital – and many of the factors contributing to its success (except, of course, oversight by a court) – were replicated at Metropolitan State Hospital (under the careful management of your co-chairperson, Ms. Sudders) and then, later at Medfield State Hospital. In each

case, most of the hospitals' residents were successfully moved to appropriate community programs. For example, the Medfield closing enabled DMH to reallocate a significant portion of the hospital's operating budget to create community programs not only for most of the residents of that facility (108 of 147 moved to the community) but for about 60 Westborough State Hospital residents as well.

Despite its relative remoteness in time – the consent decree was signed 30 years ago – the experience in Western Massachusetts still stands as a model worthy of your careful consideration. What makes the outcome here different from even the successful closings of Met State and Medfield is that continuing care inpatient services are provided in 30 beds at a private hospital. These beds serve a large geographic area – the four western counties – with an urban and rural population of about 800,000 people, a population greater, by the way, than that of any of the six smallest states. Therefore, with about 12% of the state's population, the western area manages with only about 4% of DMH's continuing care beds. (Admittedly, the percentage is a little misleading because Park View Hospital does not do forensic evaluations. Nevertheless, this is balanced by the fact that Park View has the highest percentage, nearly 40%, of its beds occupied by forensic continuing care treatment residents.)

Interestingly, Park View's length of stay statistics are impressive as compared to the rest of the state. Among all the hospitals, it discharges the highest percentage of its residents within 90 days. Only the Fuller CMHC discharges a higher percentage within 180 days. The correlation between length of stay and the number of beds needed is obvious.

As impressive as the Western Massachusetts model is, there are places in the United States that provide quality mental health care with fewer beds. Madison, Wisconsin is one. With a population of about 400,000 people (about half of the population of the western part of our state), Madison has 5 continuing care beds and about 55 acute care beds. Not surprisingly, the key in Madison is that it has a rich community system, with effective and innovative programs. For example, the system has excellent working relationships with law enforcement and an extensive emergency services program.

The common key here and in Wisconsin, therefore, is the existence of a functioning, comprehensive and accessible system of community mental health care.

We believe that the number of continuing care hospital beds can be reduced. However, that cannot be accomplished if, because of budget problems, the community system is being dismantled at the same time.

Thank you.

Testimony Submitted to the Department of Mental Health

Inpatient Study Commission

June 10, 2009

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Chairwoman Sudders, Chairman Brett and Distinguished Commission Members:

I am the director of the Adult Court Clinics for Western Massachusetts. My staff and I provide evaluations for the Superior and District Courts of Berkshire, Franklin, Hampshire and Hampden Counties. As court clinicians we provide competence to stand trial, criminal responsibility, aid-in-sentencing evaluations, and evaluations for civil commitments for inpatient psychiatric hospitalization and inpatient alcohol and substance abuse treatment. It is from this perspective as a Designated Forensic Psychologist that I would like to advocate for the Commission to maintain the current level of forensic inpatient beds in Western Massachusetts. Having the availability to locally hospitalize individuals for further evaluation of forensic questions increases the chance that the individual can be linked to local community resources. Additionally, in some cases, it allows for families to be able to be involved with the treatment team. The presence of the Kindred Park View long-term psychiatric unit in Springfield is also a crucial resource. I strongly encourage the Commission to maintain Western Massachusetts' current capacity for inpatient forensic services.

For many years now Courts in Western Massachusetts and Court Clinicians have had the option of sending individuals who are evaluated in the courts for competence to

stand trial or criminal responsibility for further evaluation to two local inpatient units. Providence Hospital and Berkshire Medical Center have been the units where these evaluations can be completed. This has been made possible by a specific allocation of financial resources by the Department of Mental Health for this purpose. These are crucial services to have available locally. Using these acute inpatient units for appropriate forensic evaluation admissions can facilitate the evaluation and aid in developing a discharge plan. At times theses acute units have prior experience with the forensic patient, which helps in evaluating the individual from a clinical perspective. Additionally, the social workers on these units are knowledgeable about the local providers and services, so they are better able to make referrals or reconnect an individual to a service. Keeping the forensic patient local also helps by facilitating treatment team meetings with case managers. The availability of these acute units for forensic evaluations also bolsters the Commonwealth's cadre of forensically trained psychologists. Both Berkshire Medical Center and Providence Hospital are locations that candidates, training to be certified as designated forensic professionals, receive opportunities to perform the in-depth forensic evaluations.

There is no state hospital in Western Massachusetts. The Kindred Hospital Park View unit is the only long-term psychiatric unit in Western Massachusetts. Along with caring for civilly committed individuals, the Park View unit takes individuals on forensic commitments. Some of these admissions are of individuals who were forensically evaluated at Berkshire Medical Center or Providence Hospital, and after a finding of incompetence to stand trial or lack of criminal responsibility they are committed for longer periods due to continued psychiatric instability and risk. The Park View unit also takes individuals who are "stepping down" from other forensic units, such as Worcester State Hospital or Bridgewater State Hospital. These step downs allow for the individual to be returned to Western Massachusetts. As a result, the individual is much closer to their area of tie and, for those who are

ready, active planning can take place closer to where they will eventually return to the community. Bringing these individuals closer to their communities is very much in keeping with DMH's Community First plan, as it facilitates much better access to local providers and services. For example, when an individual is on a forensic status and has privileges to go into the community, he or she might visit the Lighthouse, which is a club house for individuals with chronic mental illness. The staff at Park View are better able to support an individual in becoming engaged in services prior to discharge by having this level of access to the actual services an individual might use in the community

I know that resources are limited, and the Commission has the difficult task of advising the Secretary of EOHHS and DMH concerning the appropriate inpatient capacity for the Department. As the Commission surveys the resources across the Commonwealth I would urge the Commission to preserve the current capacity for forensic inpatient services in Western Massachusetts.

Thank you,

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Testimony Before the

DMH Inpatient Study Commission @

Holyoke Community College

June 10, 2009

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Associate Clinical Professor of Psychiatry
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Thank you members of the Commission for permitting me to testify today.

My name is Alex Sabo, and I am the Chairman of Psychiatry and Behavioral Sciences at Berkshire Medical Center and am an Associate Clinical Professor of Psychiatry at the University of Massachusetts Medical School. We teach medical students from UMASS and UNECOM, and we also started an adult psychiatry training program in July of 2008.

Before taking my current position in 1994 I served as a clinical director at McLean Hospital.

Since 1994 I have also served as the Director of Psychiatry for the Clinical Collaborative of BMC and the Brien Center for Mental Health and Substance Abuse Services, whose combined acute units and outpatient clinics served approximately 12,000 residents of the county last year.

In April of 2002, this mental health and substance abuse treatment system was given state-wide recognition through the Massachusetts Department of Medical Assistance Commissioner's Innovation Award for "demonstrating exceptional leadership and vision in developing innovative practices to serve Mass Health clients with chronic needs".

Our services include: a thirty bed chemical dependency unit, a 15 bed acute psychiatric unit and a 20 bed acute psychiatric unit, a partial hospital program, a psychiatry consultation service to a 300 bed acute care community hospital, residential consultation to 800 nursing home beds, a primary care ambulatory outreach team, an ECT inpatient and outpatient program, support services to the county jail and psychiatric and advance practice nurses to a full continuum of community services at the Brien Center.

I would like to make the following observations:

The citizens of the Commonwealth at this moment are in a particularly vulnerable moment with respect to their mental health. Unemployment doubles rates of depression, and suicides increased by 60-70% during the national economic depressions that preceded the world wars of the previous century. Our current economic crisis now puts our citizens at greater risk of unemployment, depression and suicide. The opioid poisoning deaths in the Commonwealth now substantially exceed even suicides, and the combined suicide and opioid poisoning rates are a measure of severe psychosocial stress among our citizens (cf. attached graphs). Data from our medical examiners show a high rate of mental illness and substance abuse disorders among the people dying in the opioid epidemic.

The severe and persistently mentally ill are particularly vulnerable at this time. The Commonwealth, subsequent to the Brewster Consent Decree, has been a leader nationally in providing good care for its mentally ill citizens in the least restrictive environment and in their local communities.

The current budget crisis means that EOHHS leadership will have to make precise decisions to produce the safest and best outcomes while dealing with our limited resources. With respect to the need to eliminate $25 million from the DMH acute services budget please let me raise the following concerns:

1. The intermediate system of DMH is already operating at nearly full capacity. With possibly the exception of the very expensive three acute 16 bed units, the cutting of DMH beds will not decrease the costs for the Commonwealth. It will only shift cost to emergency rooms, medical hospitals, law enforcement, judicial and corrections systems at the risk of turning illnesses into law enforcement problems and at increased expense to the Commonwealth.
2. Acute psychiatric units in both general hospitals and private psychiatric hospitals provide the acute mental health care to the citizens of the Commonwealth. State-funded independent consultations showed several years ago that general hospitals were reimbursed 20% less than their cost of providing mental health services.
3. Berkshire Medical Center for the past 15 years has been working in a clinical collaborative with the community mental health and substance abuse treatment services of the Berkshires, the Brien Center, to provide psychiatrists, emergency and crisis psychiatric coverage, advanced practice nurses and other supports to the severe and persistently mentally ill in the community. An independent consulting group hired by BMC to evaluate this arrangement determined that BMC lost $7.6 million dollars in 2007 providing those services. BMC will not be able to continue to provide that level of care to the citizens of the county. DMH will be the default resource to take on that care.
4. As DMH considers cutting $25 million from acute care, we urge to DMH to spare both the Continuing Care Units and the support for acute residential beds. These two services are essential for preventing the long stays of patients in emergency rooms, the medical floors of hospitals and the acute units.
5. In western MA the Parkview Unit has 30 beds. Western MA has only 30 of the 788 continuing care beds in the state. It is almost impossible for Berkshire Medical Center to get patients into Parkview; we only experience the use of that DMH facility about 3 times per year. Western MA not only needs those beds but would benefit from a more proportionate share of those valuable beds.
6. In addition, the waiting list for Parkview underestimates the severe and persistently mentally ill "stuck" on our inpatient unit as some of those severely mentally ill are determined by DMH to be "unlikely to benefit from rehabilitation" and thus are not eligible to be on the waiting list for a bed at Parkview.
7. A rural hospital like Berkshire Medical Center has a unique responsibility to provide care in its catchment area. We urge the state not to divert monetary resources away from the general hospital when its support for mental health and substance abuse treatment has been robust and done so at a loss. The current economic crisis eliminates BMC's ability to fund those services which it has over the past 15 years.
8. There has also been an increase in violence on the acute inpatient units over the past three years. Earlier, BMC had responded and excelled in answering the

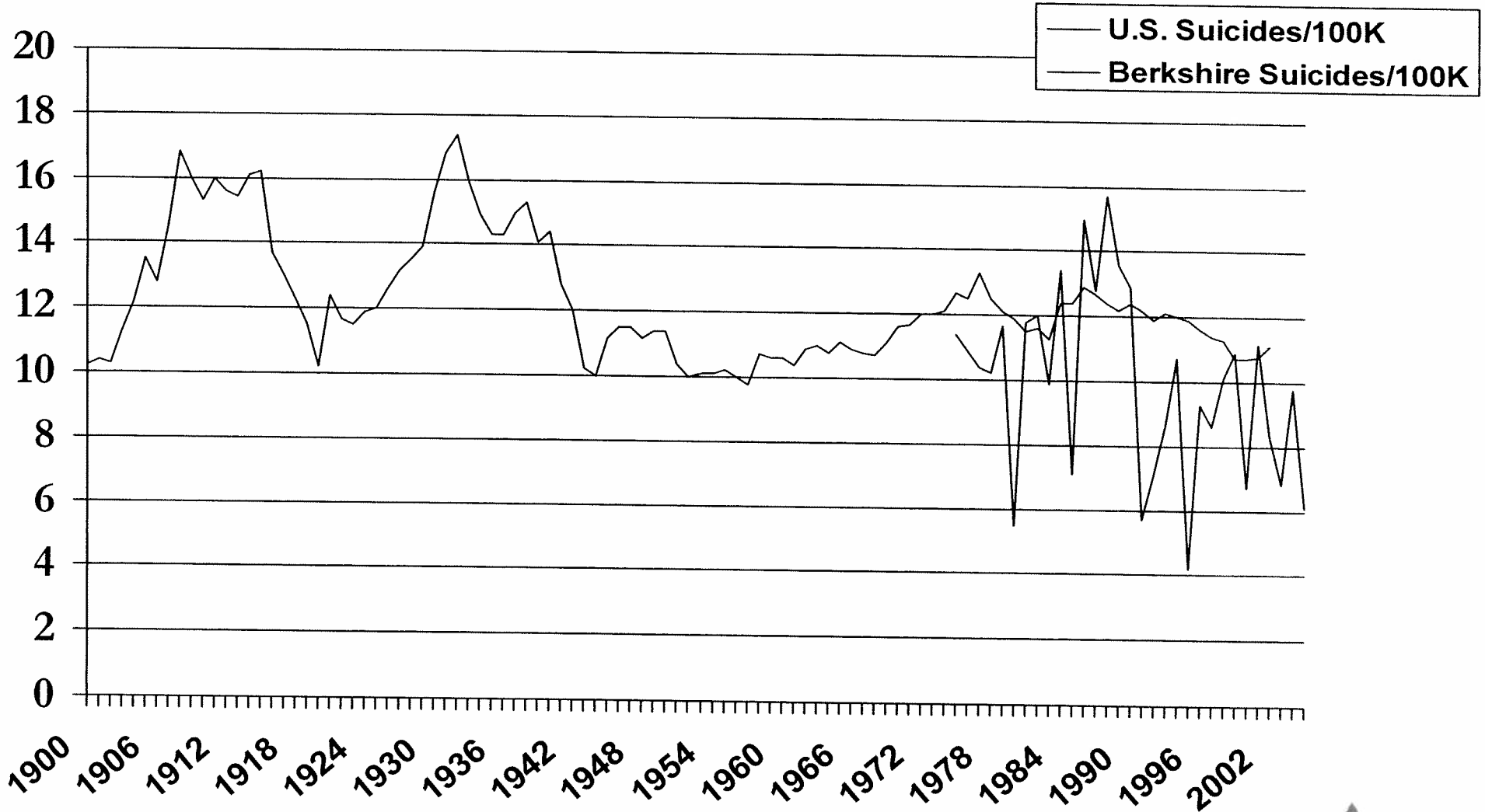
Commisioner's call for reducing restraint and seclusion, winning awards from DMH and achieving reductions two to three standard deviations below the state average. Over the past three years, several senior, very experienced nurses have been seriously assaulted, sustaining severe injuries. At least four times sheriff's deputies were hired for days to sustain a safe environment on the inpatient unit. We ask DMH to develop a reliable way to transfer the highly violent patient from the general hospital setting to a more secure DMH facility.

9. In brief, we are summarizing a precarious situation in the Commonwealth's history. We recommend: sparing DMH continuing care beds, increasing residential beds, and facilitating the transfer of extremely violent patients to more specialized DMH units. We look forward to working with DMH to improve the system even in the face of the economic crisis we all face.

Respectfully,

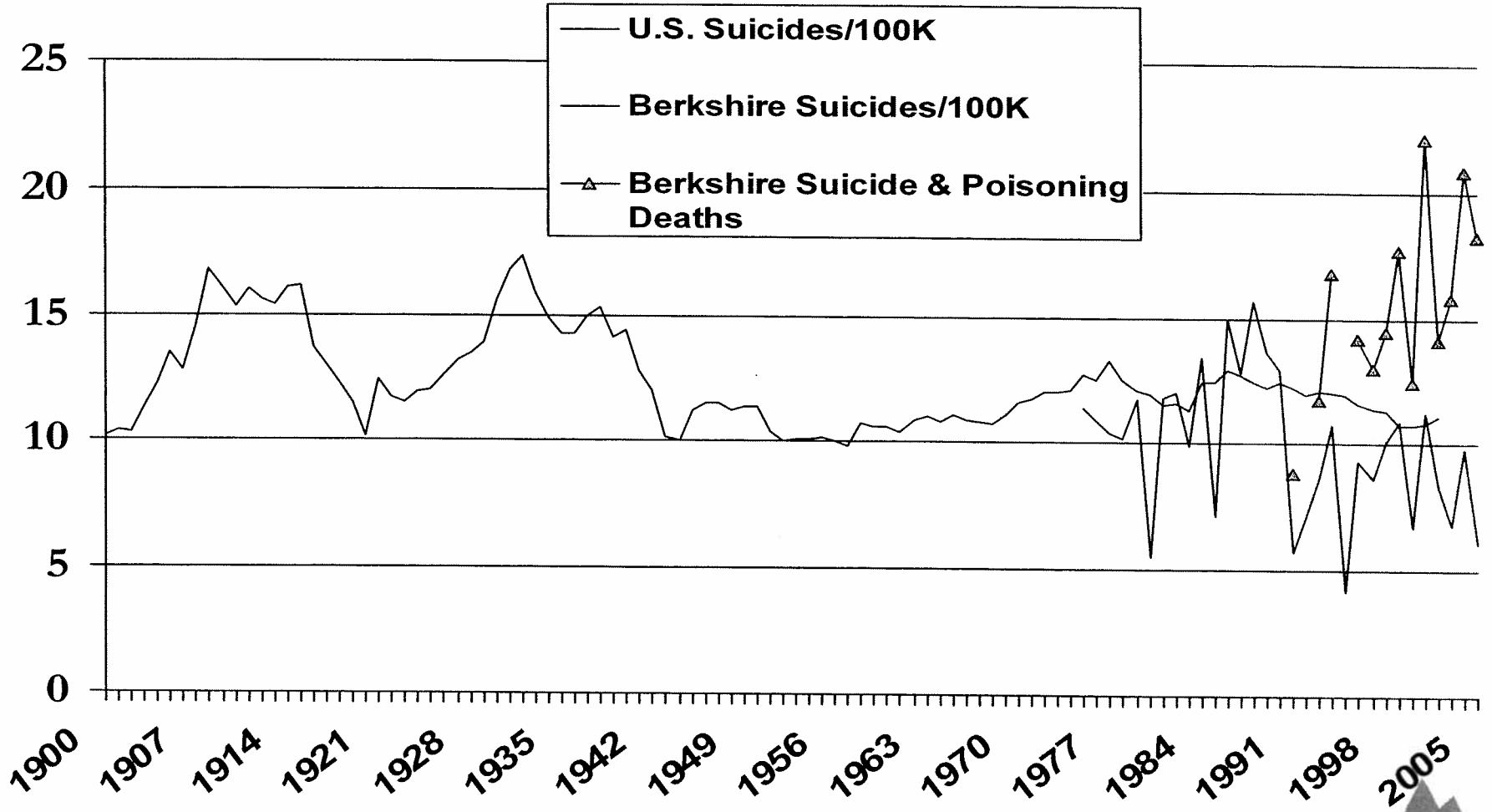
Alex N. Sabo, MD

Suicide Rates in USA: the 20th Century



Sources: National Center for Health Statistics;
www. Suicidemethods.net/tables/sui-homi.htm

A Measure of Psychosocial Stress: National Suicide Rate compared with Berkshire Rate & Combined Berkshire Suicide & Poisoning Rate 1990-2005



Sources: National Center for Health Statistics;
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M-POWER

Nothing about us without us

Massachusetts People/Patients Organized for Wellness, Empowerment and Rights

TESTIMONY FOR DMH INPATIENT STUDY COMMISSSION JUNE 2009

M-POWER, founded in 1987, is a statewide member-run organization of people with lived experience of mental health diagnosis &/or extreme states. We advocate for political and social change within the mental health system, the community and statewide.

We appreciate the opportunity to submit testimony to the Department of Mental Health Inpatient Study Commission. We truly embrace the Disability Rights Community's axiom, "Nothing About Us Without Us"! It is our belief that as people with mental health conditions, we know what is best for us. We are concerned that there are only two members of the commission who openly identify as people with mental conditions. We feel strongly that decision-making bodies such as this should be at least 51% people with lived experience. For this reason it is our hope that from this point forward, those of us who hold the greatest stake in decisions on how best to spend the limited resources that are available for mental health services will make up the majority of the decision-makers.

Several M-POWER members noted how ironic it was that Commissioner Leadholm held a meeting with the mental health advocacy and provider community to explain the purpose and scope of the DMH Inpatient Study Commission on the same day the groundbreaking ceremony was held in Worcester for the new state hospital. In a time of shrinking revenues, the state is spending $302 million to build a new institution (not including the $30-50 million already spent in design and preparing the site). It seems this commission whose charge is to determine the appropriate inpatient capacity of the Department should have been convened before committing so many millions to build a new state hospital. Just think of the number of peer-run respites or other healing communities which with some creativity could have been developed if that $350 million was spent in other ways.

We were please to read Commissioner Leadholm's confirmation of DMH's vision of transforming the system by creating flexible, recovery-based and person-centered services supporting consumer choice. The state's fiscal realities are making it clear that DMH can no longer spend $167 million each year to keep people in inpatient facilities. State hospitals must be closed.

There is a right way and a wrong way to close state hospitals. Even the word "deinstitutionalization" conjures up the image of homeless persons with obvious symptoms of mental illness and substance abuse living in the streets or in jail as a result of closing state hospitals without adequate community supports. It doesn't have to be that way. Massachusetts successfully transitioned people who had been hospitalized in Medfield State Hospital for many years to living in the community. Folks were given the supports they needed and were successful.

The money saved from closing state hospitals must be invested in flexible person-centered recovery-oriented supports. The money cannot go into the state's general fund as currently

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community programs are underfunded and have just experienced drastic cuts.

One type of support for individuals transitioning out of the hospital used very successfully in New York State is a Peer Bridger Project in which a trained peer specialist provides one-to-one support to a person ready to be discharged. This relationship begins several months before the discharge date and continues for several months after discharge. This is an excellent way to address the concerns and fears a person who has been in the hospital for months or years may have about being able to make it on the outside. The Genesis Club in Worcester and the Lighthouse Clubhouse in Springfield run Peer Bridger projects under a DMH contract entitled "Peer Support in After Care". Such programs need to be expanded throughout the state.

As a result of the 1999 Supreme Court's Olmstead decision the state is compelled to ensure that people with disabilities receive services in the least restrictive setting. In no way can state hospitals be considered the least restrictive setting. One objective listed in Massachusetts' *Community First Olmstead Plan* is "to increase the availability and diversity of residential support options". It is our understanding that over 200 people are currently stuck in DMH facilities. They are ready for discharge but have nowhere to go. Essentially, these folks are being warehoused at several hundred dollars a day.

Currently there is tremendous shortage of safe, decent affordable housing in Massachusetts. This remains a huge barrier to success in living in the community. DMH clients and other low-income people wait many years for subsidized housing. Money saved by closing hospital beds must be diverted to greatly increasing the number of rental vouchers available to people with mental health conditions. Also we need to think creatively—the old way of thinking about "independence" is moving from living in a state hospital to a highly structured group home with other adults not of one's choosing. Then the view is that people should move to their own apartment with residential supports. One size fits all just doesn't work. Why is the definition of "independence" always seem to include living alone in an apartment? For many people this can lead to isolation and worsening of one's mental health condition. Also, who would chose to live in a group setting with people you don't know and maybe don't like? The current idea of group homes needs to be revisited. Consumers must have choices as to where they live and with whom. They must be able to choose what type of supports they will receive.

One community support that does not exist but would prevent hospitalization is personal care assistance (PCA) for people with mental health conditions. Currently Medicaid regulations stipulate that to be eligible for PCA services, a person must need "hands on care". This excludes most people with psychiatric disabilities. The few of our members who have PCA services have them because they have a physical disability as well as a mental health condition. One person uses her PCA mainly to support her through difficult periods of anxiety and depression. For her the companionship and support is more important than the help she receives getting in and out of the bathtub or mopping the kitchen floor. The peer support she gets from her PCA has kept her from using emergency services and kept her out of the hospital. Many consumer/survivors could

greatly benefit from having a PCA. Massachusetts needs to act now to obtain a waiver from the federal government so that MassHealth regulations can change to cover people with mental health issues.

A second Medicaid waiver is needed to allow Certified Peer Specialist (CPS) services to be billable to Medicaid. Other states such as Georgia and Arizona have such waivers, and they have been able to greatly expand the number of peer specialists working in the community. We are excited that the new Emergency Service Program (ESP) contracts require ESPs to hire peer specialists, and the new Community Based Flexible Support (CBFS) contracts also require providers to hire peer specialists; however a Medicaid waiver would encourage providers to hire many more peer specialists. The role of a peer in supporting a person cannot be underestimated. Many of us have found peer support to be a central factor in our recovery.

Some people have expressed concerns that the system is blocked—that there are people in acute hospitals that are not ready for discharge and not getting better. Their insurance has run out and the private facilities are footing the bill. These same people argue that this has lead to longer waits in emergency rooms. They say these folks need to be sent to a state hospital. Why can't we be more creative? What about developing peer-run respites and other healing communities which allow for fresh air and various methods for healing? Why is hospitalization in a state institution have to be the answer?

This Commission has an important responsibility. It is our hope that the Commission recommends the closure of state hospitals and ensure that the money saved goes to expanding community mental health services and support.

It is M-POWER's belief that the key to recovery and wellness is COMMUNITIES NOT LOCKED WARDS!!