From: Fiona Mcleash [mailto:printsfinenfanci@gmail.com]
Sent: Thursday, May 28, 2009 7:57 PM
To: Eohhshearings, (EHS)
Subject: DMH hospital

I was an inpatient at Tewksbury State Hospital five years ago.Then, I found the lack of appropriate 1:1's,Didactic Group
Therapy,and adequate time spent with Case Managers lacking in what was supposed to be a "Therapeutic" setting. Most of the time spent there was in "Survival Mode" at the warehouse.
Although I was sent there to resolve my nine plus Major Life issues,I did not receive ANY counseling regarding my personal issues. Instead,when I was involved in "Group" therapy,it mainly seemed to revolve around
behavioral issues of a Sophomoric nature.
Also, I believe that if I had more significant case management, with focus on re-establishing myself in the "outside" world,then,maybe I would not have had to take taxpayers money for my eight months spent there.
The unfortunate part of that scenario is ,I feel that am still psychologically paying for the scars from that horrifying experience.
To sum it all up,I believe that DMH should focus on "recovery" issues in a therapeutic environment with more focus on adequate housing or transitional housing within the community. There also should be a better focus on job re-entry skills
for people of diverse backgrounds. That includes those with professional backgrounds such as myself. I found that the way the then staff approached my "re-entry " skills was by them asking me to use my professional skills in running a group.This time was not appropriate since I was there for my healing.
Also,environmentally,I found the fight for clean air,healthy food choices,and when need be a "Quiet Room" for individuals to center themselves a necessity.
I strongly believe that state hospitals should be left only as a last resort for people requiring Medical monitoring of their conditions.Those individuals that are more acute,then,perhaps a community "Step house" may be a better solution
to the funding cutback and a more "recovery" oriented environment .I believe that there could be various degrees of types of "step housing" all following the recovery role model with medical monitoring as need be.
Well, I sincerely hope that this helps!

Sincerely,

E.A.Russell,aka.,Fiona M.

From: Pinson, Naomi [mailto:Naomi.Pinson@state.ma.us]
Sent: Wednesday, June 03, 2009 12:58 PM
To: Eohhshearings, (EHS)
Subject: re: open hearing on DMH services
Sensitivity: Confidential

Hello, I am writing some comments not as an employee of the Department of Mental Health but as a secondary and primary consumer of mental health services, i.e a mom and a recipient of those services, a psychosocial rehabilitation practitioner and a long time member of both patient and family advocacy groups such as M-POWER, NAMI, MFOFC and GB-ARC.

I would like to deliver these at the upcoming hearing in Haverhill on June 12th.

I have heard that the Department is planning to build a mega hospital (300 or so beds) in Worcester. This is inconsistent with good service delivery for a number of reasons. First and foremost is that **in order to recover, people must have access to natural supports**. "Natural Supports" is a Public Health term denoting ones friends and ones family, those who provide support that is build in to community, outside of "services." Thus, providing mental health services to people ***in their own communities*** is essential, including and especially intermediate care hospitalization. Intermediate care, or state hospitalization, connotes perhaps the most vulnerable time for any person's recovery trajectory. This is where decisions get made as to what a "least restrictive environment" would look like for the person. The person needs, at the very least, access to their own communities of choice. While some of the patients in the proposed/planned hospitals may be from the Central Massachusetts area, it seems likely that most will not be. I would imagine that the state does not plan to keep all the current state hospitals, with their enormous expenses, up and running along with this. This means that people from across the state will be transported and housed in Worcester.

Links between mental illness and poverty are well known. The more economically disadvantaged the individual/family/community is, the worse their mental health issues will be, the more uncertain the outcomes. The friends and families of these new denizens of Worcester State Hospital will not have the wherewithal to visit, to keep connected, and to provide natural supports to their loved ones. The person/patient will be increasingly isolated in a "mental health services" ghetto that seems more intent on serving its own needs than that of the patient/client/resident/student.

How is this "family friendly," another ideology/mission the Department has stated that they are in agreement with? Or don't these poor folks, who lack a political voice count? If they don't count within the 'body politic,' and for sure we know that they do not, then they should at least count to Jane and Joe Average Taxpayer. We after all are the ones who must foot the bill for poor choices being made by mental health service planners. The healing effects of connection with Natural Supports, not to mention the fiscally responsible aspects of them, have been known to mental health policy planners for many

decades. Were they consulted? Was the community of consumers of mental health services and their friends and family members consulted about this “Brave New World” plan to have such a hospital, to spend the community purse in this arguably counterproductive and fiscally irresponsible manner?

I find it vastly ironic that at a time when the Department is publically embracing “Recovery Oriented Services” they are planning to do something so very opposite the both the philosophy and the practice of recovery. As the founder and first director of one of the first Peer Support projects in the nation I can tell you, recovery is a “we” proposition. While the “we” can include service providers, **and must** if Person Centered Planning is to be carried out, its first guarantee must be to provide access to the person’s community.

Secondly, the Olmstead ruling which is supposed to protect people with mental health disabilities from exploitation, from being compelled to receive a higher level of care (i.e. institutional or nursing home care) than they actually need or are entitled to, which we are now more than ten years away from, **must be implemented**! Not only is providing appropriate levels of service in the community fiscally responsible and humane, it now the Law of the Nation since the deciding by the Supreme Court! The funding that could be going towards creating and maintaining models of natural and community supports will be siphoned off into the building and maintenance of an old style “asylum” type of institution, where “staff convenience” *and not* recovery are the primary foci. This is NOT what we, people with diagnoses of psychiatric disability and their friends and family members need or want; this is the complete opposite of the “Massachusetts Miracle” for us.

As any mental health advocate knows, most staff/patient conflicts come out of the reality that many services center around “staff convenience” and not around student’s/client’s/patient’s real needs. I have seen this in educational services, in residential services and in hospital services for multiple decades now. Yet, when service delivery plans are Person Centered, the overall plans, which must include planning to provide access to the community, recovery can and does take place. Alcoholics Anonymous, for example, which is self supporting through its own contributions, gives us an excellent example of this reality. This reality must be made to match up with the desires expectations of the medical/psychiatric community which wants to study “mental illness” in vivo and at their convenience! Look, they must be thinking, Worcester is an ideal site, doesn’t it have the Irving and Betty Brudnick Brain Center and the University of Massachusetts Medical Center (recent recipient of the Nobel Prize for excellent in biologic medicine) right there? Sure, we all want answers to the sometimes severe mental health problems which can plague us individually and collectively. But, we already have some of the answers already in Olmstead and in the massive amounts of social scientific study that demonstrate connections between adequate income, community and mental health outcomes.

Naomi Pinson

From: rhonda bourne [mailto:rhondabourne@gmail.com]
Sent: Wednesday, June 03, 2009 7:23 PM
To: Eohhshearings, (EHS)
Subject: FOLLOW UP TO PUBLIC HEARING JUNE 3

I want to thank the commission for allowing me to speak today. I was extremely disappointed by the turnout. I am not sure what is keeping people away from discuss this issue that has far reaching implications. I know where I work within DMH the sentiment was that no one was interested in what DMH employees have to say and additionally that the commission's purpose was to provide a seal of approval to a plan that has already been made. Two things have reinforced this belief:

NO DMH representation on the commission. I am not denigrating or being dismissive of anyone's experience, but believe me, there is nothing that even approximates inpatient experience at DMH in 2009, not even inpatient experience @ DMH in 2006.
Word has gone out that each large DMH facility is to provide a plan to close 30 of its beds by July 1st, 2009.

On a personal note; I want to let the commission know that "consumers" come in all stripes, including seasoned mental health professionals. I feel a strong need to be open about my own mental health issues in order for my words to be heard more strongly. When I became ill, shortly after graduation from college, I spent the folowing year at Glenside, Mt. Auburn Hospital, Tufts NEMC, and Met State. I became involved in inpatient psychiartry as a mental health worker when MHW from Glenside helped me to geta job at Central Hospital as a mental health worker. That was in My 1980. I have done inpatient work ever since and earned my Master's degree in social work. In those days, I hid the reality that I lived with a mental illness. I lost a job opportunity at one point because it was found out that I was taking psychiatric medication and was too high a risk even though I had not taken one sick day during the previous year. I sued the Department of Mental health through MCAD over an issue of being disciplined with the loss of a day's pay because I was having a hypomanic episode and yelled at the Center Director after she yelled at me. I felt as DMH they shoud have been able to recognize that I had a mental health issue, and not that I was being simply difficult. I did not win the case with the MCAD, but DMH was told that I was protected by the ADA. Since that incident, I speak openly about living successfully with a mental illness. I hate the word "consumer." I have been fortunate enough to have the saem psychiatrist for 30 years. She is my doctor and I am her patient. My living with mental illness gives me a voice for my experience. If I perceived every person living with mental illness to need what I need and nothing more, than I would see mental health needs very differently. Sadly, I see people who can no longer express themselves, who don't tend to basic ADLs unles someone assists them. I have patients who cannnot organize their thoughts, are terorized by delusions that never go away, patients who want no one's help not professional or peer, patient's with severe learning disabilities, ongoing substance abuse, loss of family, no education including being illieterate graduates of the Boston Public Schools. Who speaks for the neediest of the mentally ill; the kind of patients we used to assoiciate with the "backwards." They do continue to exist despite PR to the contrary and it is

heartbraking to see and to try to offer some kind of relief and support to the patient and the family. Some might want to believe that the mental health system made them this way, but my view is that their illnesses are poorly understood, and sadly inadequately responsive to medication.

In addition to being a mental health professional living with mental illness, I am also a family member of a DMH client. As a family member, I can attest to the unbeleievable unresponsiveness of the mental health system to the concerns and involvement of family. Even as a mental health professional well emersed in the mental health dsystem, I have seen my nephew discharged over and over again from short term acute care hospitalizations. I have seen him medicated with 40 mg Haldol, 20 mg Zyprexa, 6 mg risperdal, and 75 mg lamictal and 2mg ativan resulting in outrage! I had to call Dr. Foti and demand that my nephew get intermediate care. He received far better, more thoughtful and comprensive care at Quincy mental health center than he ever received at the Arbour, Bournewood, or HRI. It should just not be that hard to get competent help for a person suffering a severe acute episode of mental illness. As an added frustration, when I complained to the Board of Registration about this unsupportable chemical cocktail that my nephew was "treated" with. They sent me a letter saying the doctor had responded to their questions and they would take no further action. When I asked to review the doctor's response, they told me I could not see it due to HIPPA, despite the fact that I was a party to the complaint. They have ignored all of my subsequent communications.

I realize that what I have written here is not on point, but it does provide a context to my views, which are born out of my experiences as a person living with mental illness, 29 years working on inpatient units, and being a family member of a person living with mental illness.

Rhonda J. Bourne, LICSW
14 Lawrence Street
Waltham,MA 02451
(781)910-1283

From: Green River [mailto:grheea@yahoo.com]
Sent: Friday, June 05, 2009 1:49 PM
To: Eohhshearings, (EHS)
Subject: DMH Inpatient Study Commission

We spoke with many DMH consumers regarding the study being done and these are the responses we got:

"Transitional Aged Youth outreach and transportation to and from meetings, classes and appointments. Also help with filling out forms and paperwork for entitlements and college classes is really needed and apprecitated." - Kasey Amanzo, age 22, Greenfield, MA.

"Social time and outings to meet and spend time with people who are in my same situation (at Green River House). Also having transportation to appointments, work and therapy." - Gary Alex, age 56, Greenfield, MA.

"The best thing is the clubhouse, I would like to see more outings for social time" -Alex Stevens, age 19, Turners Falls, MA.

"Colazal support group is very helpful, having a visiting nurse to speak with when needed is very comforting. I know that I don't have to worry about my blood pressure or side effects from medication." - David Farrar, age 48, Greenfield, MA.

" I love the clubhouse, it lets me meet other people my age and supports me with work and school. I also love training and working as a peer mentor, I feel like I can give back to others." -Patrick Clark, age 26, Greenfield, MA.

"The best is Green River House, I would like to see more athletic programs and sports available for people that suffer from mental illness."- Guy Oulette, Sunderland, MA.

"I enjoy the clubhouse, it gives me people to be around so that I don't isolate. I would like to see more trips." -Ken Anderson, age 50, Greenfield, MA.

"I rely on rides from my outreach worker to get groceries, go to appointments, get medications and go to the clubhouse. I really like the idea of peer mentors, it just makes since that we have experienced this so now we can help others going through it." - Anne Nawotny, age 44, Greenfield, MA.

"I feel that I need people to talk to not just my therapist, I go to the clubhouse for this. I would like to see more trips for people that don't have transportation." - Marilyn Sumrall, Greenfield, MA.

"Cooperation between staff and clients (at the clubhouse) works for training rehabilitation. I would like to see more rehab for members." - Jeff Weld, age 61, Greenfield, MA.

This is the input that we got from our members in the greenfield area. Our members appreciate the opportunity to be heard and are looking forward to the outcome.

Green River House
37 Franklin Street
Greenfield, MA 01301
(413)772-2181

From: Eileen Nicole Simon [mailto:eileen@conradsimon.org]
Sent: Sunday, June 07, 2009 5:45 AM
To: Eohhshearings, (EHS)
Subject: DMH Inpatient Commission Comments

I plan to attend the public hearing on Friday, June 12, in Haverhill. Following are the comments I want to submit to the Study Commission on Inpatient Needs:

1. My son who has autism will always need some level of care – unless he can get professional help to become gainfully employed.
2. He was progressing well at Westborough State Hospital until he was discharged to a "community" group home six and a half years ago (early in 2003).
3. In those six years, a cousin graduated from high school, attended four years of college, and obtained a Masters Degree.
4. During the same six years, my son has been sequestered in a locked-alarmed-door house, with no goals other than to remain a "consumer".
5. Westborough State Hospital was a community with long-term professional staff.
6. Staff at the group home have minimal educational training or experience.
7. Staff turnover at group homes is high, as they seek better pay in other jobs.
8. My son has run away from his group home three times during the past year – most recently he was missing for 7 weeks and 2 days – a frightening experience for all concerned.
9. During my search for him during those 7 weeks, I saw how many severely impaired people are living in shelters, South Station, Logan Airport – and I was told to look for my son in places like laudromats – any warm refuge from cold nights in March and April.
10. My son has diabetes – most worrisome while he was out there without access to medical care.
11. Inpatient capacity has been grotesquely underestimated by DMH – how many of the swivel-chair wizards responsible for closing the state hospitals have seen what I have seen during the 7 weeks my son was missing?
12. Recovery should be possible for my son if he can get realistic help with socialization skills and preparation for remunerative employment – the primary need of anyone living in our capitalistic society.

A possible solution? Long-term care insurance should be mandatory for every child born, as an alternative to tax-funded care systems for people impaired by mentally illnesses.

Sincerely,
Eileen Nicole Simon

cc: Gov Patrick's Office
--
Conrad Simon Memorial Research Initiative
To seek understanding of brain system impairments in autism.
http://conradsimon.org/

From: Archer, Daniel (DMH) [mailto:Daniel.Archer@state.ma.us]
Sent: Tuesday, June 09, 2009 2:25 PM
To: EOHHSHEARINGS@STATE.MA.US.; Tallman, Jay (DMH)
Subject: DMH Inpatient Commission Comments

Comments to the Inpatient Study Commission

I would like to address my comments primarily to the issue of public safety. The Department of Mental Health provides many evaluations for forensically involved patients; it provides continuing care treatment for clients entering via the court as well as clients whose mental health needs cannot be met in facilities operated by the Department of Corrections.

For people who are confined at a DOC facility, the stay at a DMH inpatient unit is most often a relatively short one. But for forensic patients who have entered the system in other ways, such as via court, the average stay is longer than for patients without forensic involvement.

The Department of Mental Health plays an important role in public safety. For example, DMH has taken on the role of providing treatment for many sex offenders. Even while arranging continuing outpatient services for this population, placement in the community is both difficult and expensive.

This presents the potential for a bifurcated system. A major reduction in continuing care beds- perhaps equal to the capacity of the new psychiatric facility- will leave a much higher percentage of the inpatient population as forensic patients. It does not appear that there will be a dramatic decrease in the number of forensic patients receiving continuing care services in coming years, especially since many advocates believe this population is currently under-served.

Clearly the disposition of forensic discharges is a much slower process than for other patients and there does not appear to be pressure to create fast-track discharges for this group of patients. The recommendations of the Commissioner's Task Force on Safety and Risk Management seem to support the idea that a slower discharge track will exist in the future.

With a greatly reduced number of beds, especially if consolidated to one facility, the potential exists for a two track system in which forensic patients have access to continuing care beds while most non-forensic patients will be relegated to acute care regardless of need. The alternative may be simply leaving forensic patients to the correctional system.

An increased percentage of forensic patients may bring pressures to dismantle many of the protections for the individual that DMH has created over the years. An indication of this possibility can be found in the report of the Task Force on Safety and Risk Management. Some recommendations (although without a consensus) clearly move away from existing rights and the concept of client-driven care. In a system with a higher percentage of forensic patients, there is a real possibility that these kinds of changes will not only be made but may spread over to the diminished numbers of non-forensic patients. It is not inconceivable to imagine a rationale that states that non-forensic patients move at a faster pace, so changes would only need to be suffered temporarily.

Maintaining more than one continuing care facility might allow a more appropriate mix of patients and thus avoid adding to the already existing stigma of hospitalization.

Reintegration into the Community

The closure of most continuing care facilities will have an effect on discharge planning and transition. Currently patients are able to attend day programs in the community. These are the same programs that they have attended prior to hospitalization or will attend when they return to the community. There does seem to be a consensus that this is an important component of the discharge plan.

However, with just one facility for continuing care patients, this part of transition will not be possible logistically. Transportation from the new psychiatric facility to programs in the Southeast, Northeast and Boston would be too costly and time consuming. Similar issues present themselves with visits to and overnight stays at identified community placements.

For some patients one centralized facility will create obstacles for family to visit and/or participate in family therapy. For many patients, especially those who plan to return to a family home, this kind of involvement is a critical part of treatment and discharge.

I hope that the Commission's recommendations will be made in a manner that the changes are not intended to be permanent but rather are intended to be responses to the Commonwealth's loss of revenue. A decision to close units in the existing facilities rather than close or consolidate entire facilities- which would not bring immediate savings- would allow for a more careful analysis of the existing need for continuing care beds.

It is apparent from testimony given to the commission that there is a strong lobby to close virtually all continuing care beds in favor small community settings. But the reality is that sometimes people need secure settings to recover.

Finally, I respectfully suggest to the Commission that how these recommendations are framed is very important. I hope that there will be a place to note that the economic challenges are at least partly responsible for such changes. I think it is important the need for a mental health system and the needs of the mental health system in the public eye. In general the needs of people with disabilities are not front-and-center. The more that reductions based on lack of revenue are presented as simply innovation and positive change, the easier it is for tax payers and the body politic to ignore these needs.

Respectfully submitted,

Daniel Archer

Worcester State Hospital

June 9, 2009

From: Judith McKendry [mailto:jdmckendry@verizon.net]
Sent: Tuesday, June 09, 2009 3:25 PM
To: Eohhshearings, (EHS)
Subject: DMH Inpatient Commission Comments

To: Department of Mental Health Inpatient Study Commission
From: Judith McKendry,
member NAMI of Central Middlesex,
member Metro Suburban East Site Citizen Advisory Board

Over the past several years, many state hospitals have been closed and former patients have been successfully integrated into the community with intense DMH supports. However, severe cuts in the DMH budget jeopardize the well-being of those individuals, as well as others who require intense community supports. Those supports are falling victim to lack of state funding. Without proper supports, these individuals are more vulnerable to experience more frequent crises and need periods of hospitalization.

With general hospitals cutting their psychiatric services and number of beds, it is more important than ever to maintain at least the current level of DMH inpatient beds. Please do not reduce inpatient capacity any further.

Department of Mental Health
Inpatient
Study Commission
c/o Jay
Tallman Central
DMH Office 25
Staniford Street
Boston, MA 02114

Dear Mr. Tallman:

Not being able to attend one of the three public hearings (none of which is in Boston, interestingly), I am sending you my response to the potential closure or consolidation of a state DMH hospital.

As a parent of a now-deceased son who suffered almost thirty years with schizophrenioa, I am well aware of the inadequate spaces for the many Massachusetts patients that required hospitalization. When I recall the times we sat in an emergency room waiting with Matthew for a placement in a hospital with a locked ward, I am amazed that DMH could again be considering lessening the supply of hospital rooms.

No one can fail to be aware of the state's budget problems, but I do believe that reasonable people cannot fail to be aware that cutting hospital space is simply increasing costs in other directions such as homelessness, police action and incarceration, never mind emergency care.

I hope that DMH will reconsider this rash proposal. Recent action relative to Cambridge and Somerville Hospitals was an equally alarming development, and makes me wonder just how such decisions are reached.

Lois F. Pu11iam

-----Original Message-----
From: Mary Hall [mailto:mhh777@verizon.net]
Sent: Wednesday, June 10, 2009 10:30 AM
To: Eohhshearings, (EHS)
Subject: DMH Inpatient Commission Comments

Dear People:

My suggestion is that it may be possible to improve outcomes of civil commitments to mental hospitals, with moderate expense in the initial stages of hospitalization.

Consider what happens in a section 12 short-term commitment. An individual is compelled by the state to go to a hospital. The police most likely are involved. The message to the afflicted person is that (s)he is being punished by the state for having done something wrong. Then, at the hospital, the individual is expected to turn on a dime, from experiencing punishment to receiving medical care. A well person could be forgiven for not understanding this process; subjects of section 12 commitments are going to be somewhat confused or oddly oriented, or they would not be subject to compulsion from the state.

My plea is that, if you are going to expect afflicted persons to turn on a dime as described, that it is not enough to wave a magic wand and sprinkle fairy dust. The section 12 person needs to have contact with some help from outside of the system that is engaged in incarcerating and helping him/her, at the time of hospitalization, in order to be able to navigate his/her situation with competence. The help could come from a consumer-survivor, or from any empathic person. The helper simply needs to have some tangible level of independence from the mental health system, to understand what are the choices that are available to the committed person, choices including but not confined to the initial decision to be a voluntary or involuntary patient, and to have a will to be with the section 12 individual at the level where (s)he is at.

I would propose undertaking a pilot project to see if supplying this extra resource can help shorten hospital stays and further cooperation between patients and hospital staff.

Sincerely,

Mary Hall

From: Stokes, Mitchell (DMH) [mailto:Mitchell.Stokes@state.ma.us]
Sent: Wednesday, June 10, 2009 11:42 AM
To: Eohhshearings, (EHS)
Cc: Mitchell, Kenneth (DMH); Rauch, Dale (DMH); Foti, MaryEllen (DMH)
Subject: DMH Inpatient Commission Comments

To the members of the DMH Inpatient Commission:

I would urge the commission to consider creating an inpatient unit that would offer respite to individuals who become violent on other DMH or community units, along the lines of the former DMU/ISTP unit at Medfield State Hospital. In the absence of such a unit there is increased pressure on clinicians who have been assaulted to seek to have criminal charges brought against their patients, so that those patients--at least the males--can be sent to Bridgewater State Hospital. The clinicians in question often feel compelled to take this course in spite of believing that a transfer to BSH is not in their patient's best interest therapeutically.

The favor of an acknowledgement of this suggestion would be appreciated.

Mitchell Stokes MD
Staff Psychiatrist
Adult Unit A
Westborough State Hospital

From: Chesebrough, Connie (DMH) [mailto:Connie.Chesebrough@state.ma.us]
Sent: Thursday, June 11, 2009 7:50 AM
To: Eohhshearings, (EHS)
Subject: state psychiatric hospitals

As a long time psychiatric social worker at Taunton State Hospital, I want to make a plug and some points that should not be overlooked about the remaining, struggling Massachusetts' state psychiatric hospitals. Due to the existence of many long term employees in these facilities, first of all, there is a priceless wealth of experience with the chronically mentally ill that is unmatched in our state. Secondly, because psychiatric patients with health insurance are first sent to private hospitals for treatment, where their insurance is used up, their stays are too short, and they are discharged before really stabilizing or understanding the chronicity of their illness or how to manage it properly. Finally these patients end up in state facilities, where the stays may be longer, but the job is properly done. Chronic mental illness and un- derstanding of it by the patient, when possible, just is not a quick fix. For too many chronic patients who return to the community after too short, inadequate, private hospital stays, the turbulence they and their families continue to go through, to say nothing of the police action, court action, and often correctional actions required, is a sad waste of taxpayer, Medicaid and Medicare dollars.

From: Welch,Robert J. [mailto:RWelch@hallmarkhealth.org]
Sent: Thursday, June 11, 2009 9:32 AM
To: Eohhshearings, (EHS)
Cc: Welch,Robert J.; Pozniak,Richard A; Harnett, David; Nowell, Dauren; dmattedo@aol.com; Walsh,Cornelia; Summersby, David
Subject: DMH Inpatient Commission Comments

Dear Sir or Madam,
Please find my comments attached,
Thank You,
Robert J. Welch, M.D.
Chief of Psychiatry
Melrose-Wakefield Hospital
Hallmark Health System

Submitted Testimony for DMH Inpatient Commission
Robert J. Welch, Hallmark Health, June 3, 2009

The current Massachusetts Department of Mental Health (DMH) faces many challenges in both its community and hospital systems. While it is commendable to support as many clients as possible living in the community, it appears that insufficient attention has been paid to the difficulties in doing so appropriately. In my testimony I will rely on numerical data provided by state agencies to elucidate these challenges. As current Chief of Psychiatry at a community hospital (Melrose- Wakefield Hospital in Melrose, Massachusetts), and as the former Chief of Psychiatry at Tewksbury State Hospital from 1998 to 2004, I feel that I have experience on both sides of this issue.

The Massachusetts mental health system has evolved from an institutional system which relied on large state psychiatric hospitals to one which attempts to appropriately place and maintain clients in the community. Unfortunately the evidence suggests that the system is largely ineffective in achieving this goal.

The April 2006 DMH Inpatient Psychiatric Facility Report stated that "the Department's capacity can safely be reduced to 740 beds, assuming a 93% occupancy rate". At present, the Department has 788 beds, and the occupancy rate is over 100%. In 2002, Tewksbury State Hospital had 180 beds, with an average daily census of 158, or an occupancy rate of 88%. At that time, Tewksbury Hospital could admit patients who required intermediate care immediately, as we always had open beds. Presently Tewksbury Hospital has a census of 116. The State's own data indicates that they run at 100% capacity. This in fact is inaccurate, as staff members have acknowledged that the DMH hospitals often run over census (and over their licensed capacity), in part to accommodate patients referred from the criminal justice system. Tewksbury Hospital often has 122 to 124 inpatients. This of course means that they are unable to take any patients from community hospitals until they have discharged down to a census of 116. Given that they do not decline criminal court referrals, this may not be achieved for many months. Patients referred from the community acute hospital system generally wait 70 to 90 days for transfer. During this time, they are maintained on acute units watching

dozens of other patients be admitted and discharged in a setting where the average length of stay is only seven days. This is neither therapeutic nor humane.

DMH produces a report (the DART report) which is supposed to list the number of patients referred for intermediate care and awaiting an admission decision from the State hospital, and also includes the a number of patients accepted and awaiting transfer. DMH's own numbers however are quite inaccurate. On May 15, 2009, the DART report indicated that there were 12 active referrals to Tewksbury Hospital for intermediate care, and six patients accepted and awaiting transfer. DMH does not however include patients referred or accepted from their own DMH acute units. On May 15, 2009, there were actually 24 active referrals to Tewksbury Hospital, and 12 patients accepted and awaiting transfer. Many of these "active referrals" are patients who DMH is declining to accept for transfer, and who are thereforemaintained for weeks on acute units while DMH is "reviewing their admission". Community acute units are expected to review and decide on admission referrals within 30 minutes. DMH reviews can take up to four weeks. They have declined to set any standard or guideline for their review process. In addition, as frequently happens, they may decline a referral, thus leaving a seriously mentally ill homeless person on the acute unit with no appropriate disposition. DMH's own data indicate that they do not have the capacity to accept appropriate patients for transfer in a timely manner.

A comparison of Massachusetts' inpatient bed capacity with that of New Hampshire is instructive. From 1990 to 2008, New Hampshire's inpatient state hospital capacity increased 20%, from 176 beds to 212 beds. During that same time, admissions to the New Hampshire State Hospital increased 266%, from 850 a year to 2,260 year. In 2008, Massachusetts' inpatient bed capacity has decreased to 788 beds. As Massachusetts has five times the population of New Hampshire, proportionally Massachusetts would need 1,060 inpatient beds.

A major concern for community providers is that while the Department of Mental Health discharges patients to the community with intensive support services such as the PACT team or the CRS team, the State's own data indicates that these programs are largely ineffective in maintaining patients with severe and persistent mental illness in the community. Data provided by the Massachusetts Behavioral Health Partnership (MBHP), which oversees the Medicaid program, indicates that DMH clients have a grossly disproportionate rate of readmission to acute community hospitals. Over the last 13 months, 11% of MBHP/DMH clients discharged from acute units have been readmitted within seven days of discharge. This compares to 7 to 8% of non-DMH MBHP clients who will be readmitted within seven days. Put differently, one out of every nine DMH patients who are discharged after an acute hospitalization will be deemed unable to function in the community within seven days of discharge. The 30 day rate for readmission is even more concerning. MBHP's data indicates that 30% of all MBHP/DMH clients will be readmitted within 30 days of their discharge from a community hospital. This compares to 18 to 21% of non-DMH/MBHP clients. Again, this means that one-third of all DMH/MBHP clients discharged from acute community hospitals will be readmitted in an acutely decompensated state within 30 days of discharge. I contend that if a general medical hospital had a similar rate of readmission within seven or 30 days, this would be seen as a major health crisis. Readmission rates

for DMH/MBHP clients are 50% higher than for non-DMH/MBHP clients . These numbers are drawn directly from MBHP's available reports.

While I have drawn upon numerical and statistical information to support my concerns, it is the human cost of this failing system which is most important. Many of the clients have been placed into “community” settings, single apartments in communities where they have never lived, have no friends or family, and where they end up extremely isolated. Because of recent changes in the DMH vendor system, many DMH clients in group homes, who have lived for years in the same setting with the same staff, are now being forced to move to new group homes in other communities, or to watch as their staff, with whom they have had positive and effective relationships, are completely replaced.

I appreciate your attention to these extremely serious matters. Having worked in both the community and State mental health system for 20 years, I believe it is clear that DMH and MBHP's own data indicate that neither the State inpatient system, nor the community outpatient system, has the capacity to effectively and appropriately treat these people with severe and persistent mental illness. Please feel free to contact me if you have any questions,

Respectfully Submitted,

Robert J. Welch, M.D.
Chief of Psychiatry
Melrose-Wakefield Hospital
Hallmark Health
Office: 781-979-3338
E-mail; rwelch@hallmarkhealth.org

From: Packer, Ira [mailto:Ira.Packer@umassmed.edu]
Sent: Thursday, June 11, 2009 10:22 AM
To: Eohhshearings, (EHS)
Subject: Inpatient Forensic Beds

To the Inpatient Study Commission:

I would like to take this opportunity to provide some input to the Commission regarding the use of DMH inpatient forensic beds. By way of introduction, I served as Assistant Commissioner for Forensic Services at DMH, from 1993-1996, and had the pleasure of working for some of that time for your chair, former Commissioner Sudders. I have continued to work within the public sector in Massachusetts since that time, including serving for many years as the Director of Forensic Services at Bridgewater State Hospital. Currently, I am a Professor of Psychiatry at UMass Medical School, and in that capacity I serve as Chair of the DMH Committee which oversees training and certification of public sector forensic psychologists and psychiatrists in the Commonwealth. I have worked for 24 years in the public sector in Massachusetts, predominantly with forensic populations.

I would like to address the issue of planning for inpatient forensic beds. This involves two separate types of beds: 1) acute evaluation beds, and 2) continuing care beds for forensic patients who have been committed for treatment.

1) Acute Evaluation Beds:

A. I understand that questions have been raised about reducing the statutory period for such evaluations from the current standard of 20 days. I think this is misguided and not likely to have much of an impact. Although it may seem as if the courts are sending these individuals to the DMH facilities just for evaluation of competency to stand trial, in reality most of these individuals are acutely symptomatic and require treatment. The court clinics do a good job of triage, so that those who don't require such treatment are diverted from hospitals. Many of the patients admitted under section 15(b) can be successfully treated within the twenty day period and returned to the community. Shortening the period of evaluation will most likely lead to a higher percentage of these individuals being committed to the hospital (since they will not have stabilized by the earlier date), resulting in an increase, rather than decrease, in hospital days. Indeed, in the current system, some of these patients remain in the hospital for further evaluation past the 20 days (for instance, using the mechanism of Chapter 123, sec. 16(a)), and are then returned to court without requiring a six month commitment. When I worked at Bridgewater State Hospital, we discovered that we could reduce the overall length of stay for some patients by <u>increasing</u> the observation period (as the statute does allow for extensions of the 20 day period), thus resulting in fewer commitments. Thus, I would suggest that reducing the evaluation period will not result in any significant decrease in total bed days and could indeed backfire and result in more bed days being used.

B. If the Commission is considering statutory changes, I would suggest consideration of the following:
    i. Limit the use of inpatient evaluations for §15(b) to felonies and only those misdemeanors for which the defendant is held without bail pending the evaluation. Currently, inpatient forensic beds are used for very minor misdemeanors (such as Trespassing, Disorderly Conduct) for which the rationale for an extensive forensic evaluation is missing. Those misdemeanors which would not otherwise result in bail should be diverted to acute psychiatric hospitals for treatment as a civil patient. This will likely result in some increase in use of acute beds, but this would use up much less resource than the current system.

    ii. Criminal responsibility evaluations should only be ordered if the defense either requests it or gives notice of an intention to plead Not Guilty by Reason of Insanity. This would bring Massachusetts in line with most other states. Currently, Criminal Responsibility evaluations can be ordered, rather routinely, without a specific request from the defense attorney (or even over the objection of the attorney). In many of these cases, the attorney then instructs his/her client not to participate in the evaluation. These Criminal Responsibility evaluations are particularly time consuming, as they require much more extensive investigation (including obtaining previous treatment records, which often do not arrive until the end of the evaluation period).

C. Planning for number of evaluation beds needed: I strongly recommend that the Commission carefully consider a mechanism for assessing needed bed capacity for forensic evaluations. Although the statutory changes proposed above may result in a modest reduction of beds, this will, at best, take quite a while to accomplish given that it would require legislative approval. Furthermore, a general reduction in inpatient beds, as well as likely reductions in community resources due to the ongoing budget cuts, will likely to lead to an increase in mentally ill clients who end up with criminal justice involvement (which will then mean that many of these individuals will then re-enter the hospitals through a forensic evaluation). Thus, it is likely that over the next few years, there will be an increase, rather than decrease, in need for inpatient forensic evaluations. If DMH does not have adequate beds for these patients, the inevitable result is that these individuals will be sent to Bridgewater State Hospital, which is both not in the interest of the individual, and a poor use of resources.

2) Continuing Care Forensic Beds: This refers to those individuals who have completed their evaluation period and are now committed to DMH for treatment. It also includes those who are transferred to DMH from Bridgewater after a period of

treatment there (which may be as short as a few months, or as long as many years). Any planning should take into account the number of forensic patients at Bridgewater who are likely to be discharged to DMH facilities. I will provide one anecdotal example from my experience at Bridgewater. One of the DMH areas requested a meeting with Bridgewater to discuss an increase in admissions to their facility of Bridgewater patients, thus limiting their ability to accept civil patients from acute hospitals. We convened a group of administrators and clinicians to examine the pattern. We discovered that indeed there had been an increase in the number of patients admitted to Bridgewater from this area for forensic evaluation (which inevitably meant that more of them would be treated and then ready for step-down back to the DMH facility). More significantly, we learned that the DMH Area had reduced its continuing care bed capacity by 18 beds several months earlier. Suffice it to say, that the "problem" the Area had been experiencing could be wholly accounted for by this bed reduction. I bring this forward as a cautionary note about the need to take into consideration that any planning for forensic continuing care beds within DMH needs to account for those patients who will enter through Bridgewater and the criminal justice system.

Thank you for your attention to this input.

Sincerely,

Ira K. Packer, Ph.D.

Ira K. Packer, Ph.D., ABPP (Forensic)
Clinical Professor of Psychiatry
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655
(508) 856-8747

From: rfriedma@bidmc.harvard.edu [mailto:rfriedma@bidmc.harvard.edu]
Sent: Thursday, June 11, 2009 12:15 PM
To: Eohhshearings, (EHS)
Cc: Greenberg, William; pmcmulli@bidmc.harvard.edu
Subject: RE: DMH Inpatient Commission Comments

I am attaching a copy of comments from the Chief of Psychiatry, William Greenberg, M.D.

William E. Greenberg, M.D.
Psychiatrist in Chief, Department of Psychiatry
Beth Israel Deaconess Medical Center

June 10, 2009

Barbara A. Leadholm, Commmissioner
Department of Mental Health
25 Staniford Street
Boston, MA 02114

RE: Comments for the Inpatient Study Commission

Dear Commissioner Leadholm:

On behalf of my colleagues and staff of the Department of Psychiatry at Beth Israel Deaconess Medical Center, I would like to thank you and the Department of Mental Health for giving us the opportunity to provide comments for the Inpatient Study Commission.

As you know, Beth Israel Deaconess Medical Center has a deep and longstanding commitment to serve the severely and persistently mentally ill and support the public sector in their work with these patients. We share the Department¹s goal of providing appropriate care for our patients in the midst of an unprecedented crisis in public sources of funding and will work with all of our partners across the spectrum of behavioral health care delivery to tackle these challenges in the best interests of our patients and their families.

You have requested comments on the adult inpatient and community systems of care in order to determine an appropriate inpatient capacity for the department. From the perspective of an adult psychiatric unit in a general hospital, we would note several important issues:

* The intermediate care system continues to be an essential component of the spectrum of inpatient care. There are patients whose needs are not met in short term inpatient units and for whom community resources are insufficient to provide safe and adequate treatment settings.

* These patients face long waits and hurdles to enter into intermediate care. There should be a much more efficient process of establishing DMH eligibility, getting clinical information to the centers and units, and making these decisions. All too often technicalities slow down and hamper the process, and hurdles exist leading to waiting periods that do not serve the interests of patients and families. We often see clinical exacerbation and setbacks as patients enter the mode of waiting until an intermediate care bed becomes available.

* There are patients who are discharged from intermediate care only to reappear rapidly for admission to an acute psychiatric unit. There should be a clear DMH policy to return the patient to intermediate care immediately if a patient requires psychiatric admission within 30 days of discharge, without restarting the process of an intermediate care application. The intermediate care staff know the patient and the situation, and therefore are in the best position to arrange a short admission where that is possible, and if a lengthier admission is needed, intermediate care is the appropriate site.

* In particular, there is a population of patients who are so challenging in their danger to themselves or others that it is very difficult to find an acute psychiatric unit that will accept them. They spend long stays in the ED or go to units not equipped to deal with them, resulting in disruptions to those units and temporary closure of beds to which other patients in need of admission could have been admitted. We strongly recommend to the Department consideration of reopening a ³Difficult to Treat² unit as DMH had in the past, or considering alternatives like a private sector ³Difficult to Treat² unit with financial incentives to staff a unit more intensively and structure its clinical programs in such a way as to treat these patients safely and without disrupting the treatment of other patients who do not need that level of intensity.

* On the community side, there are small roadblocks that continue to decrease efficient transitions from inpatient to outpatient care. For example, DMH group homes will not accept patients on Fridays, requiring a patient (who would not otherwise need an inpatient setting were the group home available) to remain in the hospital until the next week. Whereas the inpatient settings work on a time schedule of hours, the outpatient clinics and programs work on much slower time frames. If there were a DMH policy that outpatient clinics would be in touch with inpatient teams within 24 hours of being notified of a patient¹s admission and that they would provide an outpatient appointment

within 24 hours of being notified of a patient¹s pending discharge, this would greatly expedite the process of handoffs and transitions of care.

* From the standpoint of the general hospital emergency room, there are obstacles to getting some patients into an appropriate inpatient setting. One is the essentially universal refusal of any institution to take an uninsured patient from an emergency room; these patients stay in our ED for great lengths of time until a bed opens on our own unit or they no longer need admission. Another is the refusal of some psychiatric units to accept a patient with MRSA or VRE infections; these patients require basic infection control measures that any licensed unit should be able to provide. Since these may include at times a requirement for a single room, there is a strong financial incentive for units to claim that they cannot manage the nursing needs of these patients. We strongly urge DMH licensing to make clear that any unit that feels it cannot manage this basic nursing care cannot be licensed.

Again, thank you for the opportunity to offer these comments, and I would welcome the opportunity to discuss these issues with you in more detail. We look forward to continued dialogue and collaboration with you and your staff to resolve and identify solutions to these challenges.

Very truly yours,

William Greenberg, MD

Cc: David Matteodo, MABHS
Lynn Nicholas, MHA
Anuj Goel, MHA

From: patches1956@aol.com [mailto:patches1956@aol.com]
Sent: Thursday, June 11, 2009 8:26 PM
To: Eohhshearings, (EHS)
Subject: Fwd: lLINDA LOLLI'STESTIMONY IN CENTRAL MA

-----Original Message-----
From: Patches1956@aol.com
To: EOHHSHEARINGS@statemsus
Cc: cathy.levin@comcast.net; ruthiepoole44@yahoo.com; nickig@transformation-center.org; cassiecramer@hotmail.com; dede-alley@comcast.net
Sent: Mon, 8 Jun 2009 2:49 pm
Subject: lLINDA LOLLI'STESTIMONY IN CENTRAL MA

TO WHOM IT MAY CONCERN: THIS IS MY TESTIMONY ON JUNE 4TH AT THE STATE HEARING.
I AM PRESENTING A CONSUMER POINT OF VIEW AND I HAVE STRUGGED WITH TRAUMA AND
HAVE BEEN USING RECOVERY PRINCIPLES WHICH HAS HELPED ME MORE THAN ANY HOSPITALIIZATION. WHEN I WAS HOSPITALIZED I WAS DRUGGED AND ALL MY RIGHTS WERE TAKEN AWAY. THE STAFF DID NOT LISTEN TO ME. I QUICKLY LEARNT THAT YOU HAD TO PLAY THE GAME SO THAT THEY WOUL;D LET YOU OUT OF THE HOSPITAL. VERY
LITTLE RECOVERY TAKES PLACE IN A HOSPITAL. I AM ONLY SPEAKING FROM MY PERSONAL EXPERIENCE. hOSPITALIZATION IS A TREMENDOUS WASTE OF MONEY. COMMUNITIES PROGRAMS WORK BETTER AND TEND TO BE MORE RECOVERY ORIENTED.

RESPECTIFULLY YOURS,
LINDA LOLLI

From: Ricci, Dottie (DYS)
Sent: Friday, June 12, 2009 2:07 PM
To: Tallman, Jay (DMH); EOHHSHEARINGS
Jane E (DYS); Dolan, Edward (DYS); Chase, Marilyn (EHS)

The Commonwealth of Massachusetts

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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SECRETARY

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Department of Youth Services
27 Wormwood Street, Suite 400
Boston, MA 02210-1613

617.727.7575
FAX#: 617.951.2409

al Health Inpatient Study Commission
25 Staniford Street
Boston, MA 02114

RE: DMH INPATIENT STUDY COMMISSION

Dear Mr. Tallman,

Thank you for your invitation to submit written testimony regarding the Department of Mental Health's Inpatient Study Commission. I appreciate having the opportunity to provide information about the Department of Youth Services' (DYS) recently completed Facilities Master Plan. DYS has been working closely with the Department of Capital Asset Management (DCAM) and the Executive Office of Health and Human Services (EOHHS) in an effort to replace antiquated facilities and I want to share with you our plans for the DYS facilities on the Department of Mental Health's (DMH) Taunton and Westborough campuses..

During FY2009, (DYS) and DCAM engaged the services of the architectural firm Ricci Greene Associates to conduct an in-depth analysis of all of the DYS facilities and to prepare a DYS Facilities Master Plan, which would include:

- Re-use and repair of existing buildings that can continue to provide functional benefit to the DYS population;
- Development of new state of the art juvenile justice facilities that support the DYS mission, to replace buildings which can no longer be repaired;
- Design of a facilities system that is able to adapt to changes in both the number and nature of the DYS population; and
- Improvement in the distribution of beds and services within and between DYS' five (5) regions.

DYS Southeast Region- New Facility
DMH Taunton Campus-

For the DYS Southeast Region, Ricci Greene Associates recommends the construction of a new 80-bed facility for males on the grounds of Taunton State Hospital that would contain program space for pre-trial detention, revocation and secure treatment. This new facility will also include space for the DYS Southeast regional administration. Currently, the DYS Southeast Region's administrative staff, pre-trial detention, secure treatment and revocation programs are housed in three (3) buildings on the DMH Taunton campus. Each building has serious deficiencies and is significantly past its useful life. By way of example, the Howland Building was constructed in 1894 and houses a pretrial detention program and a revocation program. DYS programming and residential space are severely compromised in this building which was not designed for a juvenile offender population. The facility lacks central air conditioning, the heating system is woefully outdated and the building is not ADA compliant. As a result, the facility is scheduled to be demolished this year. The clients will be moved to another facility on the DMH campus until a new facility is funded and built on the Howland building site.

DYS Central Region- Repair and Replace
DMH Westborough Campus

For the Westborough Campus, Ricci Greene submitted a proposal that took into account the consolidation of the DMH Westborough programs at the new Worcester State Hospital in 2012. Therefore, the DYS Facilities Master Plan provides for a consolidation of the DYS programs on the DMH Westborough campus to one site. The proposal in the Master Plan is for DYS to move all of its programs from Allen Hall (DYS) to the Daniels Buildings (DMH) next to the Sharp Building (DYS) and adjacent to the Zara Cisco Brough facility (DYS). Such a move will allow the Commonwealth to realize the future best use of the Westborough property while retaining the DYS consolidated programs in the northeast corner of the campus. In the event that this would occur, DYS will seek funds to temporarily upgrade the Daniels Building to house our clients until a new building can be built to replace both the Sharp and the Daniels buildings.

The Sharp building was constructed in 1958 for DMH use and is another example of a DYS facility which was not designed for a juvenile offender population. It is not ADA compliant, does not have central air conditioning and needs significant investment to replace all of the windows in the building. Due to the conditions of both the Sharp and the Daniels buildings and their lack of suitability to provide adequate rehabilitative program space for DYS clients, the DYS Facilities Master Plan recommends their replacement with a single new facility.

Again, thank you for the opportunity to present written testimony regarding the DMH Inpatient Study Commission. I would be pleased to provide further details about DYS' interest and plans for these locations. Thank you.

Sincerely,

Jane E. Tewksbury
Commissioner

From: RonnaWallace@aol.com [mailto:RonnaWallace@aol.com]
Sent: Friday, June 12, 2009 2:14 PM
To: Eohhshearings, (EHS)
Subject: Testimony for the Inpatient Study Commission

Please accept the attached testimony from the Mass College of Emergency Physicians regarding the Dept. of Mental Health Inpatient Study Commission.

Medicine's Frontline

Massachusetts College of Emergency Physicians

860 Winter Street • Waltham, Massachusetts 02451

781-890-4407. Fax 781-890-4109.www.macep.org

TESTIMONY TO THE DEPARTMENT OF MENTAL HEALTH
REGARDING THE INPATIENT STUDY COMMISSION
June 12, 2009

Thank you for the opportunity to present testimony relative to the Department of Mental Health (DMH) Inpatient Study Commission.

The Mass College of Emergency Physicians (MACEP) supports the intent of the Study Commission. Indeed, it our mutual goal to provide patients with a responsive mental health delivery system that embraces the values of recovery, choice and self-determination. MACEP also supports the Community First Plan, which helps guide patients thru the maze of community and inpatient mental health systems, and increases choice and patient and family involvement.

Over the past year, MACEP has been an active participant in meetings with the Department of Public Health, the Department of Mental Health, the Massachusetts Hospital Association, the Mass Behavioral Health Partnership, and many other stakeholders including Mental Health Advocate groups such M-Power, to improve the care of behavioral health patients in Massachusetts emergency departments. These meetings have helped to improve communication between patient advocacy groups, providers and the administration.

MACEP supports the guiding principles of the DMH Inpatient Study Commission, including increasing access to a full range of quality services to meet their individual needs; implementation of a consumer centered and recovery oriented system; and empowering patients with dignity; and effective management of limited resources.

The Massachusetts state budget is in a crisis. Bluntly, the goals of the Study Commission will be difficult to reach with existing resources, no less further cuts which may come with the passage of the Fiscal Year 2010 budget. All too often, patients are forced to "board" in emergency departments while staff searches for appropriate placements. Sometimes patients will be stuck in ED's for days at a time, frustrating patients and their families and ED physicians and nurses. This problem is especially acute for patients with co-morbidity and other extenuating conditions.

One of the Inpatient Study Commission's recommendations is the consolidation of existing inpatient facility capacity to support the opening of the new state of the art psychiatric facility in central Mass in the spring of 2012. MACEP would caution the Study Commission not to reduce the number of inpatient beds before complete assurance that other community based resources are already built, and fully operational. Closure of any existing non-acute hospital based resource for behavioral health patients will worsen boarding, increase emergency department wait times, and most importantly, negatively impact patient care. Finally, MACEP encourages the Commission to consider geographic accessibility. Appropriate resources for behavioral health patients should remain geographically accessible for all patients and their families.

Thank you for your attention to our concerns. We look forward to working with the DMH to ensure full access to appropriate behavioral health services for all patients.

From: Eileen Nicole Simon [mailto:eileen@conradsimon.org]
Sent: Friday, June 12, 2009 8:03 PM
To: Eohhshearings, (EHS)
Subject: DMH Inpatient Commission Comments

Below are additional comments I want to submit for consideration by the DMH Inpatient Commission. Thanks.

Eileen Nicole Simon
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Listening to comments made at the EOHHS hearing on June 12, I remembered statements made by a psychologist from Harvard back in the 1970s when Metropolitan State Hospital was being closed. He pointed out that state hospitals were built in the 19th century to care for people with incurable epilepsy.

Incurable epilepsy in the 19th century was one manifestation of the disorder known as general paresis or "dementia paralytica" [1].

General paresis was found in 1913 to be caused by neurosyphilis [2].

Without a cure, patients with neurosyphilis continued to be cared for in state institutions [3].

Penicillin was discovered in the 1940s to be the long sought after "magic bullet" for syphilis [4].

State hospitals continued to care for patients with chronic schizophrenia, and many people held high hopes that chlorpromazine (Thorazine) and other pharmaceutical inventions.

No magic bullet for schizophrenia has yet been found.

Schizophrenia is often associated with developmental problems. The increasingly invasive procedures used in obstetrics and neonatal care should be carefully scrutinized.

Autism has now become an epidemic, and obstetric and neonatal procedures should certainly be scrutinized as possible factors leading to impairment of the brain in children who develop autism.

The auditory system of the brain is most vulnerable to damage by oxygen insufficiency at birth, and Impairment of the auditory system may impede a child's ability to learn to speak.

Anomalies in auditory processing are associated with auditory hallucinations in schizophrenia, and perinatal problems should be looked for as a predisposition.

Inpatient capacity will have to be maintained for children with autism, most of whom will require lifespan care.

Once more: Long-term care insurance should be mandatory for every child born, as an alternative to tax-funded care systems for people seriously impaired by mentally illnesses.

References

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Southard EE, Solomon HC. Neurosyphilis, modern systematic diagnosis and treatment presented in one hundred and thirty-seven case histories. WM Leonard, Boston, 1917.

Rose AS. Penicillin treatment of neurosyphilis. In Merritt HH et al. Neurosyphilis. Oxford University Press, New York, 1946. pp. 416-425.

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Conrad Simon Memorial Research Initiative
To seek understanding of brain system impairments in autism.
http://conradsimon.org/

Testimony to the Department of Mental Health Inpatient Study Commission

My name is William J. Taylor, and I am the President and CEO of Advocates, Inc, a large provider of human services in Eastern Massachusetts. Advocates currently employs over 1000 staff, and uses $55 Million in resources to serve over 10,000 people in the Commonwealth. Advocates has provided mental health services, since its inception in 1975, and currently provides an array of community mental health services including residential, emergency, respite and clinic.

In-patient capacity can be reduced only if the full array of community supports is available and adequately funded. Those supports must include robustly funded residential services designed to meet the varying needs of individuals currently housed on inpatient units. There must be adequate clinic services, including adequate doctors, nurses, and therapists. Emergency services must have the capacity to meet the larger needs of people currently receiving their services on closely monitored hospital units. Respite services must be available and robust. Internal medicine services must be available. Peer support services must be available throughout the community support system, and finally community services must be recovery oriented and person centered. They must be designed to meet the unique characteristics that each person brings to the table.

DMH just recently procured its residential system. The rates established in that procurement are likely not sufficient to provide the support and monitoring staff necessary for people long used to inpatient levels of support and monitoring. Special rates will likely be required. Discharging people with lighter needs in exchange for people with greater needs would likely lead to catastrophic errors in care and treatment.

Clinic services are currently grossly underfunded. They suffered a 5% rate cut over the last fiscal year. More clinics are closing and few are able to allocate the resources required to effectively treat people, who have spent significant portions of their lives on DMH inpatient units.

Emergency services were just reprocured and economically balanced to effectively address the community care system that has been in place for the past decade. It is likely that the discharge of great numbers of people from State psychiatric hospitals will test that balance.

Over the past decades we have all learned that respite services are an essential component in helping recently hospitalized people in adjusting to their new community environment. Respite programs are most effective when peer specialists work closely with trained professionals to aid in that adjustment.

We have learned that people with severe mental illnesses die 25 years prematurely. And they most commonly die from physical disease, not psychiatric illness. It is essential that a cadre of internal medicine doctors and specialists be available to counsel and treat diseases.

All these community services are most effective when provided in a person centered approach, meaning that people get what they need in order to recover from their mental illness.

The needs of those still in state psychiatric hospitals are usually greater than those currently served in the community. They can be well served in the community only if those community services are recovery oriented, person centered and funded adequately.

Thank you,

William J. Taylor. President and CEO
Advocates, Inc
One Clarks Hill
Framingham, MA 01702

Btaylor@advocatesinc.org
www.advocatesinc.org
http://advocateshumanservice.blogspot.com

First, We Listen

Advocates' mission is to
help people achieve their hopes and dreams within the fabric of their communities.

We partner with people with disabilities, elders, and those with other challenges to overcome personal obstacles and societal barriers so that they can obtain and keep homes, engage in work and other meaningful activities, and sustain satisfying relationships.

We work to inspire communities to create opportunities for contribution and participation by all.

From: monica briggs [mailto:m_briggs@hotmail.com]
Sent: Tuesday, June 16, 2009 12:10 PM
To: Eohhshearings, (EHS)
Subject: Testimony from Brockton, June 9

Monica A. Briggs, CPS
CPS Trainer and Coordinator
Transformation Center
98 Magazine Street
Roxbury, MA 02119

My name is Monica A. Briggs, and I testified before the Committee on Tuesday, June 9th in Brockton. I have lived experience with mental illness which includes over 30 hospitalizations in many institutions in Massachusetts over the past 20 years. Although these hospitalizations were necessary in my acute states, I have been healed and inspired by the many alternatives to hospitals that I have experienced over this same 20 year period. I have reached the conclusion, especially since my training as a CPS (Certified Peer Specialist), that it is alternatives to hospitals that we need to invest in, not keeping the current inpatient facilities open and definitely not building new ones.

In my life experience I have learned a great deal about what is effective in treating mental illness. In my CPS training we learn about the 5 stages in the recovery process, which helps us understand "where people are at" in order to best partner with them in their journey to wellness. The most difficult stage is actually not the first one, the "Impact of Diagnosis," which is devastating but usually brief. The second stage is the most challenging and interminable—it is call the "Life is Limited" stage and is characterized by hopelessness, despair, paralysis, an inability to envision a future or even see that change is possible. It takes persistence and a compassionate process of open-ended questions and reflective listening to inspire hope and guide the person in recovery through this bleak time and into the next stage of "Change is Possible."

From the consumer perspective, the mental health system has been stuck in the "Life is Limited" stage for far too long, and we have been questioning the practices of this change-resistant system for many years, with little result. Another provocation of change is when what usually works fails, and this has happened with the hospital system for far too long. Now we are faced with the "loss" of hospital beds, which in the recovery model, is actually an opportunity to try something radically new—namely, utilizing peer resources and peer workers. Some of these include: The Recovery Learning Communities (RLCs) established in the six DMH regions over the past 2 years, Peer Facilitators, who facilitate peer-run groups (in the community and in acute settings) in these regions, Certified Peer Specialists, a new profession of qualified peer workers, peers in Emergency Rooms, the development of peer respites (successful in several states), Clubhouses, getting Medicaid vouchers for Personal Care Assistants for those in recovery, and many more projects being developed.

The money saved from closing hospital beds must be invested in these community-based services that are truly recovery-based and consumer run.

In order to truly advance to a stable stage of recovery, the mental health system has to embrace the hope and take the risks necessary to empower those with lived experience to be a part of the wellness we strive for.

Thank you for your time.

Monica

From: Quitadamo, Valerie (DMH) [mailto:Valerie.Quitadamo@state.ma.us]
Sent: Tuesday, June 16, 2009 6:18 PM
To: Eohhshearings, (EHS)
Subject: hearings

I would like to advocate for the new hospital. I am an RN that has been working in DMH for 15 years. I have seen a lot over the years. We need to maintain the number of beds allotted to ensure that the sickest of the sick are able to get treatment. As it stands not we are seeing a revolving door effect with clients being admitted and not quiet being stabilized when they are released only to see them come back again. Medications play an important role with many to improve the quality of their lives. Many come into services because they refuse to take medications in the community and there are no safeguards in place in the community to ensure they take their meds after discharge. Hence they end up back in the system by getting recommitted, readmitted for medication stabilization or in trouble with the law and find themselves on forensic referrals. Whether the focus is community or hospital we should be focusing on making sure that we have staff in place to carry out these goals. It would be helpful if the doctors in the community would not reduce and discontinue client's meds once they get discharged into the community. It takes a long time to stabilize some people and all the work DMH does, can get undone very quickly in the community. I know there is no control over this aspect of care but maybe it should be looked at. Please be aware the homeless population increases with each new political downsizing that Boston initiates. Thank You for you time. Sincerely, Valerie Quitadamo RN

From: Patches1956@aol.com [mailto:Patches1956@aol.com]
Sent: Tuesday, June 16, 2009 10:39 PM
To: Eohhshearings, (EHS)
Cc: cathy.levin@comcast.net
Subject: testimony at inpatient hearings

This is Linda Lolli's testimony on June 4, at the inpatient hearings.

Testimony of Linda Lolli, board of directors of M-POWER, to the Inpatient Study Commission at DMH—June 4, 2009

Governor Patrick and the department of mental health are proposing to cut more community mental health services. These cuts in services mean the state will have to pay much more money for MassHealth, prisons, police, etc. Without community services, drug use and alcoholism will increase. Death from suicides, homicides, domestic abuse, and other violence will increase. Homelessness will become more common and people will die from the cold this winter on the streets. Crime will flourish because people will be more desperate without the social safety net. Prostitution will increase. Think about it! Do you really want to live in a society like this? It has already started to happen.

Stashing people away in state hospitals is the worst solution to the problem of needing a social safety net for people who are poor because they cannot work because they are disabled by mental illness. It is time to find more creative solutions. State hospitals are a very bad way to try to heal the emotional trauma which the psychiatric community calls “mental illness.” Hospitalizations take away peoples’ human rights. Hospitals often over medicate their patients to control them. Right now, hospitalization is the most expensive solution to the problem and is often a revolving door. People go into the hospital for a short time and get released into the community. Without community services, they go right back into the hospital. I call this the yoyo effect. This solution definitely does not work or even make sense and Masshealth is paying through the nose for these hospitalizations. It is time to find a more effective alternative!

I propose that we look at other solutions to hospitalizations like Rose House in Poughkeepsie, NY. Rose House is a peer respite. There are nine successful peer respite’s houses in USA and five peer respite houses overseas. Peer respite is a cheaper solution to expensive hospitals. It’s like a retreat where the person is surrounded by a loving environment where the staff is our peers who have suffered from emotional trauma and recovered. These peers can help others from their experience to recover. It is much more effective for the models of wellness to be on an equal footing with the clients. One of the least helpful aspects of mental hospitals is that the “well” staff is highly credentialed. The impression taken away by the patients is that to be “well” the patients must go to universities and get advanced degrees! It is much better to build equal and mutual relationships with peers. Rose House is based on a holistic approach. In contrast to the sterile medical model, Rose House uses alternative therapies based on recovery, such as art, music, yoga, meditation, Reiki, etc. Studies show alternative therapies are effective at

promoting wellness and less difficult to experience on one's self-esteem than medical disempowerment in hospitals. Traditional therapy such as counseling and medication is also available. However, medication is used at a minimum. There are no locked wards, so it doesn't feel like jail.

The peer respites approach is far more humane than hospitalizations and work much better. Clearly, from hospitals do not work—this is clear from the statistic that 20-30% of psychiatric patients are re-hospitalized within 30 days. In contrast, after staying at Rose House, our peers are stronger and more resilient. They are more independent and use fewer services.

I applaud programs that help people live in the community. The Bridge program and PACT use the supportive housing model in the community to keep people out of hospitals. In my experience, they definitely work. We need programs back that were recently lost to budget cuts like day programs, and vocational programs so we can contribute to the MA tax base instead of being a budget drain. Clubhouses, which suffered 9c cuts, are helpful, and should be funded. Also, Recovery Learning Communities like the one in Central MA have been even more helpful program to me, personally, than clubhouses. All these programs are part of the social safety net. They keep people well and out of hospitals. These programs make it possible for people to actively contribute to the economy as well as volunteering when we can. The mental health culture needs to change to a recovery oriented one based on community services.

I feel that everyone in MA should get as good care as our governor's wife. Good medical care should not be just the privilege of the wealthy.

The following is a poem I wrote about the benefits of peer-support.

RECOVERY
Recovery to me is healing,
Healing comes from within our hearts,
Both inside and outside.
My heart flows with life, love, and happiness,
Resulting from the fellowship of peers and friends,
They know that I have been in the pit of darkness and confusion,
Because they have been there, too.
Together we explore new ways to cope.
Through this process we become stronger and more vibrant,
Ready to face anything life throws at us.
This is the miracle of peer support.

Linda Lolli

From: Nicolar, Linda (DMH)
Sent: Wednesday, June 17, 2009 8:49 AM
To: Tallman, Jay (DMH)
Subject: InpatientCommission.doc

June 16, 2009

To the Department of Mental Health Inpatient Study Commission:

We are writing on behalf of the Quincy Mental Health Center Site Board to provide information relevant to your study of the Massachusetts State inpatient system. To begin with, we do understand that the current fiscal environment requires a careful examination of DMH expenses and the unfortunate need to downsize. Our primary contention would be that the State is making an error in continuing to strain an already thinly stretched DMH system to the point of breaking down. However, given the economic realities, we believe it is important to share information related to the superb value and indispensible service which QMHC provides the community.

- With the future closing of Westborough State Hospital, QMHC will offer the only inpatient beds left in the traditional geographic MetroSuburban Area
- Treatment at QMHC offers a briefer, less expensive option than hospitalization at a state hospital, and QMHC has served as a diversion step for many clients who otherwise would have gone to Westborough
- As was witnessed in the past with Medfield State Hospital, the services provided by QMHC in terms of patient care were crucial to facilitating the closure of the facility
- QMHC has been consistently cited as being within the top few percent of inpatient facilities within the country as certified by the Joint Commission, most recently in February, 2009
- Last year's Centers for Medicare and Medicaid Services survey at QMHC was flawless, and the surveyors described their visit as "one of the most pleasant" they had experienced in 18 years
- QMHC has made outstanding gains in restraint reduction with an average of 107.5 hours of restraint per year for the first half of the past decade, and a reduction to an annual average of 26.7 hours for the past five years. The facility achieved an all time low total of only 17 hours of restraint for the entire 2007 calendar year.
- Over the past four years, admissions to the facility increased by more than 35%
- The Center has brought in increasing revenues over the past several years and now contributes $2M to the trust fund annually, subsidizing nearly half the cost of operating the facility
- QMHC fills a niche that no state hospital or private acute facility provides in offering both acute and intermediary care to individuals with poor treatment response elsewhere, or those who have exhausted their insurance

- The CMHCs offer community-based treatment options for persistently ill individuals, and a recovery focus is at the core of care
- QMHC has become a regional leader in the Recovery movement, fully integrating recovery programming into its inpatient group schedule, setting up monthly Recovery Dialogues between staff, clients, and peer professionals, and being the host site for the MetroSuburban Recovery Learning Community
- QMHC has increasingly developed programming to address physical health and wellness issues in addition to mental health concerns, and has been a trendsetter in creating the "Spread the Health" program, donating quality exercise equipment to other mental health facilities
- We hear over and over again about the excellent clinical care provided by QMHC, care which is not currently matched by private acute hospitals which are not suited to handle the clients QMHC typically serves
- Unlike the private, acute facilities, which provide short term treatment often dictated by insurance coverage, QMHC offers treatment based on clinical needs even if insurance benefits have been exhausted
- Should the commission determine that bed reductions are necessary given economic needs, only those who are most ill will receive inpatient care, suggesting that longer lengths of stays may be unavoidable given the population shift
- While medical advances, especially in psychopharmacology have helped lead to reductions in the need for long term state hospital beds earlier decades, no such advances have occurred recently, leaving a baseline number of individuals which does not seem to be declining, suffering from serious illness who will continue to need intermediate care

Thank you for your consideration of these issues as you do your best to determine how to handle the inpatient needs for the future. We firmly believe that CMHCs, and QMHC in particular, serve an invaluable role in providing a full continuum of care for the citizens of the MetroSuburban area and the Commonwealth of Massachusetts. For clinical, economic, service, and geographic reasons we hope that you recognize the essential role served by QMHC and will continue to support its mission:

Quincy Mental Health Center (QMHC) is committed to providing the highest quality, community-based psychiatric care available to adults with serious mental illness. Treatment is offered in a respectful environment in which clients and staff work together to develop and follow a plan for improvement, growth, and recovery. We value diversity and encourage individual choice and responsibility whenever possible. Our goal is a non-coercive milieu in which peer input plays a central role in service delivery and quality improvement. QMHC strives to be a leader in progressive mental health treatment by meeting and exceeding state and national standards of care.

Respectfully submitted,

Metro Suburban Area South Site Board

Sue Maginnis
Fanny Zambuto
Pamela Page
Kathy Sullivan
Alice Messias
Joan Struzzerio
John Sogegian

From: Nicole Glasser [mailto:nickiglasser@hotmail.com]
Sent: Wednesday, June 17, 2009 3:11 PM
To: Eohhshearings, (EHS)
Subject: inpatient study commission testimony

Massachusetts Department of Mental Health Inpatient Study Commission
June 17, 2009

Written Testimony from
Nicki Glasser
Boston, MA
nickiglasser@hotmail.com

Deinstitutionalization in the 1970's taught us that closing hospital beds without providing adequate and good quality resources and supports in the community leads to tragic increases in homelessness and time spent in jails and prisons for people diagnosed with mental health conditions . In order to avoid greater numbers of people ending up in these situations some people are advocating to this commission to maintaining inpatient beds. But the real question is: what can we do to *prevent* hospital stays, shorten inpatient length of stays, and help people to recover in the community and become the full members of the community they deserve to be?

I spent many years cycling in and out of hospitals. While it is true that I was often extremely depressed, addicted to drugs and alcohol, and suffering from the aftereffects of childhood abuse (though the latter was not often recognized) the central and most changeable challenge in my life was not having safe affordable housing and often finding myself at risk of homelessness or actually homeless. I'd have all these wonderful and sometimes not so wonderful professionals meeting with me, people with expensive salaries trying to find out what was wrong with me, doing all kinds of tests. And I would say, *I need a safe place to live*. No one seemed to hear, or if they did it was not responded to because they couldn't do anything about it. Nearly all of the 20 hospitalizations I experienced could have been avoided with safe affordable housing and meaningful supports as I defined them in the community. Other problems I experienced: demoralizing day treatment programs that were more like day care; lack of substance abuse programs designed to help people with significant mental health challenges; years of being misdiagnosed led to a permanent medical condition from a medication that was not even appropriate for what I was experiencing (this condition will cost significant sums over my lifetime to manage); and finally a service system that mimics in many ways the childhood abuse that brought me (and many others) to services to begin with, this tragic reality makes people sicker rather than creating conditions for healing. Unfortunately, all these problems continue to exist. With great effort I am recovering my life despite these barriers. It has taken longer and has cost

taxpayers more than it needed to and at times the effort has just about killed me. The long term stress has had a devastating impact on my physical health. Simple things like a gym membership, yoga, a car, secure affordable housing, and a skilled and compassionate therapist have done more for me than hundreds of thousands of inpatient treatment dollars.

People in recovery have for decades been developing and finding for themselves the answers prevent long term disability and avoid or minimize hospital stays. These answers are as varied as the sky is large – i.e. peer run respites, money follows the person, recovery learning communities, personal care attendants, peer specialists, holistic approaches - but come down to two key themes: one, we must create healing communities backed up by a system that supports health rather than responds to crisis and devastation; two, people diagnosed with mental health conditions can teach others about what helps and what hinders recovery and must be given paid leadership roles to do so.

The current system creates lifelong disability and an impoverished underclass through poverty, crisis focused care, treatment that focuses mainly on medication to the exception of most everything else, and lack of supports in the community such as safe affordable housing. The incomprehensibly complex rules of Social Security along is a major impediment to people's recovery, as is the discrimination private insurers partake in when they don't cover mental health care at the same level as other health conditions. I am sorry to say I have been caught in what they call the "benefits trap"; we are many.

Ultimately to truly transform, the mental health system must empower people with mental health challenges to assume paid leadership roles in crafting policy, leading change and delivering services. The days of tokenism must be left behind. "Nothing about us without us" is not an empty platitude but rather a roadmap on what it means to cleanse ourselves from the discriminatory attitudes that have dogged people with mental health challenges for centuries.

The fact that the state is about to spend over 300 million dollars on building a new state hospital facility is a sad testament of the misguided direction of mental health policy in this state. While people who find themselves in hospitals deserve to be in a decent facility, ultimately the decisions of this commission will reflect our values: health, recovery and community living or warehousing people and responding only when crisis has already broken down the doors of individuals, families and the communities. Where and how the money flows will say it all.

From: Wolff, Whitney (DMH) [mailto:Whitney.Wolff@state.ma.us]
Sent: Thursday, June 18, 2009 8:13 AM
To: Eohhshearings, (EHS)
Subject: DMH Inpatient Commission Comments

To the DMH Inpatient Commission,

I am respectfully submitting the following comments to you regarding Taunton State Hospital not only from the vantage point of serving presently as Taunton State Medical Director, but also of having worked in other corners of DMH over the past 28 years. In the early 1980's I was a mental health worker at Mass. Mental for several years. I then went to medical school in Worcester (UMass), worked as an intern at the Shattuck Hospital (rotating through Bay Cove psychiatric units), returned to Mass. Mental for my psychiatric residency, then went to work as a psychiatrist on the DMH units at Tewksbury Hospital for 16 years. I came to Taunton a year and half ago.

I have tried to simplify my impression of Taunton Hospital's relative strengths as follows:

1. Taunton Hospital is genuinely & successfully organized around principles of recovery -- this is not a simple slogan. The Taunton Hospital Joint Commission survey (last fall) was more complimentary and laudatory than any I had previously experienced. This seemed due in large part to the surveyors' appreciation of recovery principles in action. I accompanied the Joint Commission physician as she toured the hospital, who was a thoughtful and committed surveyor, well-experienced in public sector psychiatry and detail-oriented by nature. Through her eyes I could see the patient-centered clinical creativity of the hospital shining through over and over, in manner which could not be feigned, and which was a major factor in a remarkably positive survey..
2. Taunton Hospital has developed and maintained excellent relations with its local community, such that the hospital not only reaches out to be a resource and good neighbor to the community, but the community itself reaches back in to the hospital provide charitable support to patients in a number of valuable ways. From my experience elsewhere, this relationship is a precious thing, which should not be taken for granted, and which reflects a lot of hard work.
3. Taunton Hospital possesses a number of specialty strengths which might not be apparent from afar, and which are not a matter of window-dressing – they are programs of real value and substance. They include a) the forensic services, which run at a high level of expertise and efficiency, and provide excellent forensic and risk-management support to the non-forensic units as well, b) the Taunton Hospital Mentally Ill-Problematic Sexual Behavior Program, which has been addressing MI/PSB problems in a well-informed and thoughtful manner for long before that acronym ever arrived, c) the Taunton Hospital DBT program, which never wants for referrals or dedicated

clinicians, and which has been the clinical fulcrum for many a difficult discharge, d) the clinically invaluable (and state of the art) functional assessments provide by the Taunton Hospital OT department (in general a remarkably dynamic, creative and forward-thinking department), e) the Recovery Center, d) the psychopharmacologic expertise and educational enthusiasm of the Assistant Medical Director (Dr. Osser), who has maintained a very active in-house journal club/case conference/ CME program for years, and who has also forged an affiliation with the South Shore Harvard Residency program (South Shore residents rotate through Taunton Hospital, while Taunton attending psychiatrists lecture at the South Shore residency) – and the list goes on and on…

I do have a general concern that Taunton Hospital may be under-represented and/or under-appreciated within decision making forums such as yours. I would be very eager to speak to any member of the commission that might have questions for me.

Sincerely,

Whitney Wolff M.D.,

Medical Director
Taunton State Hospital

From: matthew mcwade [mailto:matthewmcwade5@gmail.com]
Sent: Thursday, June 18, 2009 9:55 AM
To: Eohhshearings, (EHS)
Subject: inpatient hearing comments

Hello

My name is Matthew McWade and I am a consumer/provider (I work as a peer).

I would have to say that less beds is a big plus as long as you meet that diminishing service with more community supports and services. I advocate for less beds but not for the sake of less beds. Consumers productively utilize services so cutting services in general is not the solution (just cutting beds) but replacing one archaic service with a newer, more productive service is the right step to take. I see long term hospital stays, commitments, etc…as overused and at times unnecessary. Long term commitments do not cater to recovery and a productive life in the community. I was committed to Medfield before it closed and met several individuals who had been there for years on end, one individual who had been there 13 years, who had no hope of ever getting out. Then Medfield closed and they had no other hospital to go to so they were sent to residential's where they are now living healthily in the community (I bumped into some of them through a day program I attended a few years after Medfield).

More community services that promote recovery is my basic advice. Truly trusting your services to work translates to trusting consumers in the community.

Thanks
Matthew McWade

From: michael o'neill [mailto:moneill@edinburgcenter.org]
Sent: Thursday, June 18, 2009 2:22 PM
To: Eohhshearings, (EHS)
Subject: testimony

The EDINBURG CENTER

1040 Waltham Street • Lexington, MA 02421-8033 • (781) 862-3600

June 18, 2009

Department of Mental Health Inpatient Study Commission
C/O Jay Tallman
Department of Mental Health
25 Staniford Street
Boston, Massachusetts 02114

Dear Mr. Tallman,

Thank you for the opportunity to provide comments to the Department of Mental Health (DMH) Inpatient Study Commission. As a longstanding community mental health provider, The Edinburg Center has played a significant role in the transitions of many individuals leaving state hospitals for life in the community. We encourage actions that move our state closer to full compliance with the *Olmstead* decision and applaud the Commonwealth's commitment to the Community First initiative.

Based on past experience, we anticipate the need for an expansion of community services to accommodate individuals who will be leaving DMH facilities. While this is something we have participated in before, this is an unusually challenging time for service providers across the state. Budget reductions, various service procurement activities and uncertainty regarding the future have combined to put tremendous pressure on agencies such as The Edinburg Center. Despite these challenges, if the right steps are taken to plan and implement anticipated transitions from inpatient settings to the community, extremely positive outcomes can be achieved.

We ask you to consider the following when planning for the anticipated inpatient/community realignment:

- Ensure community programs are involved with the review of individuals identified for potential discharge in this process, including the opportunity to

review inpatient and other records, to meet the individual and staff, and attend inpatient team meetings

- Ensure adequate forums are provided to allow for a reasonable exchange of ideas about the readiness of persons for discharge, including what could be an increase in the number of forensic and other difficult dispositions, the risk they present and how these risks can be shared

- Ensure that a set of standardized assessment of 'readiness for discharge' tools and referral documents are developed and implemented for use during the discharge process

- Provide adequate transition time, ideally beginning no later than three months before a discharge is to take place

- Ensure a standard methodology for determining fair and reasonable rates is developed to provide services to these individuals in the community

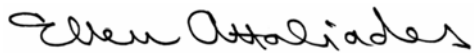
- Ensure that standardized evaluation tools are used to measure the success of persons in the community post-discharge from an inpatient setting

- Implement universal risk management protocols covering contracted service providers and the Department.

Should you have any questions or require additional information, please feel free to contact me at (781) 761-5110.

Again, thank you for this opportunity to provide comments.

Sincerely yours,



Ellen Attaliades
Chief Executive Officer

From: Cheryl Stevens [mailto:cheryl.andy@gmail.com]
Sent: Thursday, June 18, 2009 3:12 PM
To: Eohhshearings, (EHS)
Subject: Close state hospitals - more community respites

Dear Commission,
I gave verbal and written testimony Wed. June 10 at Holyoke Community College.

I am now submitting an electronic incomplete copy of a 2005 Report that was submitted to the DMH Commissioner (Beth Childs MD at the time) written when I worked for the Dept. of Mental Health as the Western MA Director of Consumer Affairs.

This report was the final combined testimonies of Western MA consumer/survivor/ex-patients who had gathered in focus groups from 2004-05 to give input on mental health system transformation in MA. The Appendices provide pertinent supportive articles and written testimony when people were not available to come to the meetings due to transportation issues.

The very first recommendation made concerns **upholding *Olmstead*, eliminating state hospitals** and reducing in-patient beds in favor of vastly increasing community-based respite beds and recovery-oriented peer support services.

The very first Appendix (Appendix 1) - included in the hard copy coming by snailmail - is a hand-written draft of a **community peer support** program written by then Quabbin House member Ray Lawton. Quabbin House is a fountain-house Clubhouse located in Orange, MA. Such a scheme remarkably pre-saged Recovery Learning Communities (RLC's). RLC's are regional DMH programs that are peer-developed, peer-run, and peer-evaluated centers of excellence throughout MA (see www.westernmassrlc.org to view website of one example of such a Center located in Western MA).

To compensate for the incompleteness, I include a photo taken in Worcester that expresses my sentiments and those of my peers relative to the question of in-patient beds. A picture is worth a thousand words...

Good luck with the task you are charged with.

When else has the economic climate, political leadership and the voice of the people affected been so more in alignment. Seems to me to be like the Perfect Storm of progress.

NO MORE HOSPITALS!!

Please, we can - and MUST - do better (and cheaper) in the community.

Thank you.

Cheryl Stevens
(former DMH Western MA Director of Consumer Affairs)
7A Laurel Rd.
Haydenville, MA 01039

From: deborahd@transformation-center.org [mailto:deborahd@transformation-center.org]
Sent: Friday, June 19, 2009 2:06 PM
To: Callinan,Marianne (DMH)
Cc: Traina, Lucille (DMH); deborahd@transformation-center.org
Subject: In-Patient Testimony due today

Date: Friday June 19, 2009
To: In Patient Study Commission
From: Deborah Delman, Executive Director, The Transformation Center
RE: Close state hospitals, invest in community mental health support services

If you build it they will come. Patients can get exemplary care in Massachusetts state hospitals, however there are so many negatives involved that Massachusetts needs to transfer investment away from in-patient beds to investment in community based services and supports.

We must invest all savings from hospital closure directly into community based services to stop the rise in mental health services needs and to stop use of costly emergency room services. We must continue the work of integrating people with lived experience of mental health and dual mental health/ addictions recovery in our workforce to achieve this end.

Term Definition:
By the term "community-based services" we mean:
community-based, trauma-informed, person-driven, culturally and linguistically relevant, family-valuing, dual mental health and addictions, recovery-oriented services delivered by a mix of vendors and self-directed selection of vendors including peer-operated vendors and where Certified Peer Specialists and peer support workers are valued employees. From here on in we will refer to all this as "community-based services."

In the past, closing state hospitals resulted in some financial commitment to the people who were in the hospital, but inadequate investment in community based services that prevent hospitalization overall. This would be unacceptable.

There must be a solid commitment to funding hospital prevention and person-driven recovery oriented supports. People that experience serious suffering from mental illnesses and their families / support systems must depend upon community resources to sustain community tenure and limit suffering.

Financing must not drive discrimination

Current financing arrangements around the IMD exclusion and Medicaid funding of mental health services drive the fact that most components of Massachusetts Community First initiatives will not / are not accessible for people at risk of state hospital institutionalization. Insurance in private acute care hospitals has driven the increase in use of locked doors for those of us that do not need a locked door. Personal Care Attendant (PCA) services are not available for most people with psychiatric conditions.

We urge the state to take assertive actions to achieve least restrictive community supports:

1) Invest in early support for resilience in young people and young adults – following the lead of the Massachusetts Centers for Excellence and a system-wide practice in Finland.
2) Do not lock doors when it is not called for: invest in a broad variety of peer-operated and other community respite models. Include accompaniment models such as is used at Windhorse in Northampton Mass.
3) Ensure that Medicaid and state funds can be used for Peer Specialists and Peer Specialist Services
4) Using expertise of peer specialists, better distinctions must be made regarding times when a person needs clinical care versus times when a person needs support and/or assistance
5) Ensure that Medicaid waivers or state funding options enable Personal Assistance Services (PCAs) to be used whether or not "hands on care" is needed
6) Ensure that Medicaid and state funds can be used for Certified Psychiatric Rehabilitation Practitioners (CPRP) to help people build skills, resources and supports for community based life
7) Cultural and linguistic communities experience extreme deprivation of mental health support. Developing community based support means developing small specialty response teams in collaboration with and by community based culturally connected peers. Effective support and treatment can not be achieved through an interpreter.
8) Follow the lead of the Multicultural Research Center at Cambridge Hospital and the outcomes of "The Right Question Project" – and follow the MBHP initiative with CommonGround - to support empowerment of people in shared decision-making
9) Develop and guide legislation that enables people to create psychiatric Advance Directives
10) Address recidivism by increasing the amount of assistance a person receives when they are discharged from a hospital – look to MBHP's peer bridger outcomes – "When I got out of the hospital I couldn't get any help for anything. I needed a ride and I needed a mattress to sleep on. I was sleeping on the floor and I felt awful and I just needed a mattress to stay out of the hospital again."
11) Good crisis intervention includes a 24/7 warmline service where a person can get support without needing to pretend to immediate risk of harm to self or others. Look to MBHPs feasibility study on warmlines

12) Invest in the Framingham Jail Diversion model of pre-arrest support. This is incredibly effective and the best way to truly support both police and mental health crisis support teams while assuring the best outcome for people in urgent need
13) Intermediate care must happen close to home – use locally sited 15 bed specialty units when locked door or longer term clinical care is needed. "...I was in a state hospital for seven years and it was a huge burden on my husband to drive over an hour to see me..." "I was in a no-win situation with anorexia ...staying in-patient stopped a terrible cycle, and I finally slowed down enough to take charge of myself..."
14) Put dual recovery practices for mental health and addictions recovery in practice in small specialty hospital and community based options.
15) Ensure that people hospitalized for forensic evaluations or people that exhibit harmful behavior against vulnerable people are not located in units with vulnerable people. Again, smaller specialty locations make this possible.
16) Trauma informed care must be integrated in all services, and DMH can issue a protocol and be resourced to monitor the provider community including emergency rooms, to ensure that people are not traumatized by the services themselves, and that people who self-injure are offered healing responses.
17) DMH must continue its work to reduce and eliminate restraint and seclusion, not only in its hospitals but in the broader community.

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From: Karen Talley [mailto:ktalley@dlc-ma.org]
Sent: Friday, June 19, 2009 5:00 PM
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Karen Talley

Disability Law Center
Testimony to the DMH Inpatient Study Commission
June 19, 2009

Thank you to the members of the Commission for the opportunity to submit these comments, which summarize my oral testimony presented before the Commission in person on June 9, 2009 at the Southeast Area public hearing. These comments derive from my experience as an attorney for the Disability Law Center, which is the federally mandated Protection and Advocacy agency for Massachusetts. In carrying out DLC's mission to provide information and advocacy to individuals with mental illness, our agency maintains a regular presence in all of the state hospitals. We also provide services to individuals in other facilities and communities throughout the Commonwealth through our regular intake process. I have had a weekly presence at Taunton State Hospital since 2003 and most of my comments grow out of my experience with that facility.

On the positive side, I believe Taunton has made great strides in the areas of restraint reduction and is committed to trying to implement a recovery-oriented model of treatment. The leadership, at both the hospital and area levels, has supported these initiatives and made excellent use of staff and community resources. I would like to particularly commend them for hiring a highly qualified peer liaison and for supporting a hospital-based recovery resource center. In these respects, Taunton can serve as a model for other facilities and has a valuable role to play in the larger service-delivery system. I would also like to stress the importance of continuing to have a facility that serves the Southeastern area. Southeastern area clients who need continuing care would find themselves largely cut off from important family support and community connections if their friends and loved ones had to travel from the Cape and surrounding areas to another part of the state.

In addition, Taunton State Hospital has maintained excellent relations with the surrounding community. Many clients who are admitted to Taunton from other areas or who have no specific area of tie have found the Southeastern area to be welcoming and to have relatively affordable housing options. As a result, many of these clients have chosen to stay in the area upon discharge. This housing affordability and acceptance of persons with psychiatric disabilities stands in contrast to other

areas of the state and plays an important role in recovery and community re-integration following hospitalization.

At the public hearing, former clients and family members testified about the important role that Taunton played in their recovery. At its best, a continuing care facility can provide the space and time that allow for true recovery to take hold. It can be an antidote to the fractured care and revolving door admissions that too often characterize mental health treatment in the Commonwealth today.

Quality continuing care can also provide the education, support, rehabilitation and community connections that prevent people from entering into or returning to the criminal justice system. This is critically important, as ever larger numbers of individuals with psychiatric disabilities find themselves in prisons and jails that are ill-equipped to care for them. Incarceration too often leads to a downward spiral that can result in disciplinary infractions and segregation, which then leads to further psychiatric decompensation and longer-term incarceration. Prisoners with mental illness are frequent victims of assault, both by other inmates and correctional staff. They may also develop potentially life-threatening infections, such as MRSA, and receive poor treatment for chronic conditions, such as diabetes. Finally, individuals with mental illness in prisons and jails are at high risk for suicide and may not survive their incarceration. To the extent that continuing care facilities can prevent the further "criminalization" of individuals with mental illness, we believe that this is a valuable role, and can be an effective use of state resources, provided the person is not hospitalized any longer than necessary.

Because we realize that resources are limited and we understand that the Commission is looking at utilization of state hospital beds, we also want to highlight the areas of inefficiency that we see in the current system. These inefficiencies have a real cost, both in terms of dollars, and perhaps more importantly, in terms of people's lives. An area in which there is considerable room for improvement at Taunton is the length of stay and the practices and culture that contribute to people being hospitalized far longer than is necessary in many cases. It has been my observation that while some clinical teams make efforts to provide active treatment that is geared toward community reintegration at the earliest possible time, others are still operating with a mindset that views the length of stay in terms of years, rather than weeks or months.

These clinical teams often have infrequent or extremely time-limited contacts with clients and review goals on a monthly or even quarterly basis. In between reviews, there may be little active treatment that engages the client in working toward mutually understood and agreed-upon goals. There is a great deal of "down time" in which people are unoccupied and are receiving custodial care only. It is not uncommon to talk with clients who don't know what their treatment goals are, or who have treatment goals that have been imposed on them, with little buy-in or support. Monthly or quarterly treatment reviews are often perfunctory, with the client being "invited in" at the very end, only to be told about the various ways in which their performance hasn't measured up. Many clients become understandably alienated by this process and decline to attend the reviews

or endorse the plans. Obviously, three-month intervals are inadequate in a modern system that is subject to *Olmstead's* mandate to provide community re-integration at the earliest possible date. There are many "issues" that clients can continue to work on in community-based treatment, yet some clinical teams still seem to hold unrealistically high standards for discharge. Examples include: ADL standards that are not necessarily related to the person's ability to live in the community; development of particular types of "insight" that may never be achievable due to cognitive limitations; resolution of troubled family dynamics that are unrelated to risk.

In addition to these quality of care and "cultural" shortcomings, there are other bureaucratic and political factors that lead to unnecessarily long inpatient stays. These include the "diversion" of Northeast Area clients to Taunton for what appear to be political reasons, and unnecessary delays in the Mandatory Forensic Review (MFR) process. DLC has had extensive correspondence and several meetings with the DMH Central office on these issues and has laid out our position that these two systemic failings implicate the legal rights of clients under *Olmstead* and other civil rights provisions. For the purposes of this Commission's work, we note that these failings also have enormous human and economic costs associated with them. We strongly urge the Inpatient Study Commission to review these issues with the Department and recommend steps that can be taken to reduce the unnecessary hospitalization that results from Northeast diversion and MFR delays.

Our office would be happy to provide members of the Commission with any further information that it may need on any of these issues and to answer any questions that members may have. Thank you again for your work on behalf of our clients and for the opportunity to provide this input.

From: renee laplume [mailto:strawberrypen101@yahoo.com]
Sent: Monday, June 22, 2009 3:01 PM
To: Eohhshearings, (EHS); Renee Marie LaPlume
Subject: Re: Written Testimony for the Inpatient Study Commission

Testimony to Inpatient Study Commission

Renee Marie LaPlume

June 18, 2009

My Background/Current work:

Teacher/Educator - Boston University Center for Psychiatric Rehabilitation Recovery Center
Peer Educator/Staff Educator/Group Facilitator - Vinfen and the North Shore RLC Human Rights Committee Community Member/Volunteer for DMH, Baycove and Vinfen, Committee Chair for the former North Charles, and Volunteer for so many other groups and affiliations it would be burdensome to list them here

Some aspects of my Testimony reiterated for your record and consideration:

You need not save a bed for me.

I have recovered despite the present state of the system, its style and policy contributing in creating probably more than 85% of my disease. I have healed. I will never need a mental health hospital bed again.

I healed not with psychiatrists, though I have them now from the private sector supporting me, not with medications, none are prescribed, not with inpatient stays which typically offer no treatment at all, but with self made, self created RECOVERY…

I found meaning in my life, I found work, I found community, I found art, creativity, good sense, nutrition, exercise and Love, I found supporters and I found friends.

I fear there is nothing I will be able to say to prevent this expensive hospital being built, so all that I can say is, if you must do it, then please, allow 20% of it at least to serve the needs and requests and requirements of the consumers you claim to serve directly. Give back part of this project to the RLC's, give it to people like me. We can offer yoga classes, herbal classes, nutrition, exercise, specialized trainings that can help former consumers to find meaning in their lives, to find work, find healing for their hearts and minds, and community again… Give us a piece of this new venture at least and force

yourselves not to make that granting a token or tiny semblance of what it truly needs to be.

In the ancient tradition of Tai Chi, each movement is flowing, gradual, continuous, coming out of the movement just before it and moving slowly into the one that follows, while all the while staying perfectly present with exactly what you are doing at any given point in time. You 'shift your weight' gradually, in a flowing movement, so that you have 10 or 20% in one foot before you move by shifting your core weight towards that foot and that is how the changes are made, thoughtful always of what every different part of you is doing…

You should be thinking of moving and acting in this way too. Decide first in which direction you are going, then first shift your attention and your gaze to that direction. Do not move without conscious forethought and premeditation. Don't throw 350 million dollars into the creation of a hospital without at least considering where we are going to want to be in a few more years from now. Fact is, we do not want or need or benefit from more hospital beds, whatever you create there will be many to say, plenty to say, no shortage of people saying that that is what we need, but building hospital beds is preparing for chronic people, a continued industry, and this by no means is who we are or what we need.

Please, as you go forward with creating this state of the art hospital which regardless of its plan and preparation is still 100% behind our current times and forward knowledge as professed within Psychiatric Rehabilitation (community models and client choice), the Peer movement (people helping people in a non stigmatizing arena) and all manner of alternatives which we have scientifically proven heal (like meditation and the mind body response). Give some of this space and community support back to us to have the opportunity to prove to you and to each other that we can heal, we do heal.

Give us a piece of this development to create our vision of recovery and prove that we can succeed and heal permanently, not needing to be managed forever by doctors and clinicians, people on the outside, not central to our lives or our autonomy. Do this so that you can shift your weight more fluidly, less violently, towards solutions that solve our problems, solutions that heal, solutions that collaborate, over the long term. Do not just keep placing fancier and fancier band-aids on an ever increasing health crisis that will never get resolved until we ourselves look inward and figure out together how to shift our weight and change directions with regard to these collective problems of our society. Problems caused together must be resolved together.

We would like the opportunity provided us to practice, employ, learn and share alternatives, like those which we as peer providers have found can heal. Allow us to define for you where is the need and the demand. Please force yourselves to attend to this as it is the brightest way to solve the problem. First understand it, what it is, allow us to help you discover from whence the solutions will originate, which is within our own populations of survivors and help us to transform our lives. If you absolutely must build this hospital then do it in such a way that leaves openings for you to be able to shift your

weight gradually to the ways that we are asking you to begin to look towards and then to move in today, ways with proven results.

For myself I could have healed from mental illness 12 years before I did. I see no reason that I should have suffered even one full year with a label and the current method of treatment which really hasn't changed all that much in 20 years. Hospitals are a dangerous place for a person who truly wants to recover and heal completely. Hospitals encourage stigma and separation, and these things are more harmful to a human than is a mental health disease. Please consider carefully how you can embrace now what consumers are asking for, we want community and connection, not stigma and segregation. We want to be productive members of society. We have found that essentially this cannot be done with hospitals and could be prevented entirely by funding and allowing the community supports we need.

Thank you for taking the time to read my pleadings.

Although I will never need a hospital bed again, I know many who might need one occasionally and even they would prefer alternatives, knowing instinctively that it is something else, something simpler and more integrated that actually helps them truly heal. We all deserve to be heard, if the system is here to serve us, we should be first and foremost among your minds as you consider policies and practices which will be greatly effecting the future of our lives.

We would like to request that you will take the time to find our voices and understand the import of our pleadings. Plan policies that will allow you, if not now, then at least tomorrow, in the shortest time line that you can manage, to be by our side, implementing and supporting the strategies that we are telling you have cured us, helped us to find our lives again and to be contributing members of society, rather than a drain to it.

Hospital beds are from yesterday, in fact it is they that are the drain indeed, financially; they will also not solve our problems, no way. The impact they have had on us in our most vulnerable states when we were in need of true and lasting help and change is devastating, upon the very parts of ourselves that we come to you so desperately in need to assist in healing and addressing; our spirits, our emotions and our minds.

I would like this Commission to find the ways to provide support for us as we seek to find meaning amongst each other within our own communities and social networks. For this alone is going to solve our problems permanently, so we can readily join the ranks of the helping and help you to cede the growing numbers of mentally ill whom are entering our ranks each day, now starting with children whom are not even yet at school age. Consider what we are saying and find ways to fund our agenda and it will prove a savings to you as you will see us recover and leave your rolls, and join your employee ranks in service instead, as I myself did many years ago.

Thank you for hearing my testimony. Please contact me if I can be of any further assistance to this Inpatient Study Commission.

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Subject: Testimony for DMH Inpatient Study Commissioin

Testimony for the Massachusetts Department of Mental Health Inpatient Study Commission
June 23, 2009
Kevin J. Howley

I believe that the 38 years I worked at the Worcester State Hospital affords me a rather unique perspective and one by which I might provide the Commission some further helpful insight for their consideration of inpatient capacities of the Commonwealth's public psychiatric hospitals. As a consumer advocate and Facility Feasibility Commission member, and with the building of Worcester's new psychiatric hospital, I would again like to make a case for the importance of rethinking the culture of treatment-particularly within the inpatient setting-and redefining its relationship to the community. I believe that it is essential to do this before/or during any realistic discussion of reducing the numbers of continuing care beds available to treat the mentally ill.

In 1968 when I began my career at the Quimby building in the old Worcester State Hospital complex over 1000 patients lived there. When I left the Department in 2005 there were approximately 150. During this time I witnessed spurts of "deinstitutionalization" and the various phases of downsizing-due perhaps to advances in mental health treatment-but often prompted by budgetary constraints.

Although I worked in a variety of capacities (SPED teacher, Area Investigator, Children's Services Coordinator and Human Rights Officer), it was the latter experience which informed me best as a founder of the Coalition to Save Worcester State Hospital when in 2003 the intent was to close WSH due to budget constraints. We were compelled to advocate not only for the hospital to remain open but even to go as far as to suggest building a state of the art hospital. And here we are on the threshold of a dream becoming a reality!

My primary point in writing is to attempt to keep alive the notion that it is so important for mental health stakeholders to challenge the status quo to develop a state of the art model of care-particularly for this new state of the art psychiatric hospital-and that money can be better spent if we are willing to look at the whole system of care with fresh eyes. We need to end the eternal funding struggle between the community and the hospital each arguing that they are more deserving than the other…obviously the old system has supported this dichotomy and is only one example through the years which has reinforced the view held by consumers and providers that there is a wall, a barrier if you will,

between (the old state) hospital and the "community". In fact, I believe that optimal recovery will only occur when the system no longer supports this structure and instead leads the way toward a new model of care. The opening of the new Worcester Psychiatric Complex creates vast opportunity for change on this magnitude and makes more sense even as the economic picture looks dismal. I think that the time for reassessing and restructuring has been NOW for at least as long as we knew that there was going to be a new state hospital. We should regain the momentum that we used to get a new hospital and shape a new fluid and barrier less model of care for the Commonwealth's citizens who have a mental illness.

In 2006 I proposed and widely distributed some suggestions which could be used to ensure that we don't' end up with just another "institutional" psychiatric hospital-as modern as it will be when it opens-and redefine the essence of the pivotal role that this hospital can provide in a restructured model of inclusion within the community….shared resources, shared roles.

I am attaching a copy for those who can receive it. It includes an outline of my thoughts to jump start the discussion amongst stakeholders and dreamers of change.

For those unable to open the attachment, some highlights:

Redefine the model of care, treatment and recovery for the 21st Century and prepare this new "hospital" for its pivotal role within the "community" to facilitate these changes.

In addition to continuing treatment, resign the new psychiatric facility as a mental health triage center, as an education and training center for employees et al, as a regional mental health resource library, as a state of the art center for advocacy and research.

Kevin J. Howley
Consumer Advocate
June 23, 2009