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November 15, 2023

The Honorable Adrian Madaro
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 33
Boston, MA 02133

The Honorable John Velis
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 519
Boston, MA 02133

Submitted to jointcmte-mentalhealth@malegislature.gov

Dear Chair Madaro, Chair Velis, and members of the Joint Committee:

Re: Testimony in support of H.1980, An Act relative to ending unnecessary hospitalizations and reducing emergency department boarding

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for strong and steadfast leadership in advancing the health of people with behavioral health conditions and their families across the Commonwealth. I am writing to respectfully submit this testimony in support of **H.1980, An Act relative to ending unnecessary hospitalizations and reducing emergency department boarding**. In addition, we take this opportunity to provide written responses to several questions posed of MAMH at the October 30, 2023 hearing on the bill.

Formed over a century ago, MAMH is dedicated to promoting mental health and well being, while preventing behavioral health conditions and associated disability. We are committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. We seek to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers to the protections and benefits of citizenship due to their race, ethnicity, gender identity, or disability status. MAMH has a demonstrated track record of furthering its mission by convening stakeholders across the behavioral health and public health communities; disseminating emerging knowledge; and providing subject matter expertise to inform public policy, service delivery, and payment methodologies.

H.1980 amends section 12 of Chapter 123 to ensure timely clinical services and supports in the least restrictive setting

This bill amends Section 12 of Chapter 123, the mental health statute, to help ensure that individuals facing a mental health crisis receive timely clinical services and supports in the least restrictive setting appropriate to their needs. To this end, this bill requires mental health professionals to exhaust less restrictive, community-based alternative prior to pursuing involuntary psychiatric hospitalization for a person in crisis. These alternatives could include: the 988 Suicide and Crisis Lifeline; the Behavioral Health Help Line of the Roadmap for Behavioral Health Reform; services offered through Community Behavioral Health Centers (CBHCs) including mobile crisis intervention, behavioral health urgent care, and community crisis stabilization; peer respite and other peer-run alternatives to emergency department visits and hospitalization; Children's Behavioral Health Initiative (CBHI) or Behavioral Health Services for Children and Adolescents (BHCA) services; family supports; and technologically-supported behavioral health services. This requirement recognizes the recent expansion of community-based crisis support services in the Commonwealth and encourages their use, whenever appropriate.

If the mental health professional has exhausted all community-based alternatives, before sending a person to a hospital ED, police officers or emergency medical technicians (EMT) must pursue a community-based alternative. This destination, currently described in the bill as a "regional crisis stabilization program," would be a location that is available 24/7 and that connects people immediately with clinical and other support services. We imagine that a CBHC or an urgent care clinic might provide such services. The Middlesex County Restoration Center pilot might be another such location.

If a police officer believes that failure to restrain a person would create a likelihood of serious harm by reason of mental illness and there is no mental health professional available to evaluate the person, the officer may take the individual to the nearest CBHC for evaluation and treatment. The CBHC could retain the person. However, if staff are unable to ensure the person's safety, the police officer or EMT may transport the person directly to the nearest inpatient psychiatric facility with a bed available or, if there is no availability within a 30-mile radius, to a hospital ED.

The bill also offers due process protection if hospitalization results. Within 12 hours of arrival in the ED, staff must inform the person of the right to speak with an attorney and to request a hearing. If the person remains in the ED for 48 hours, they have the right to a probable cause hearing to determine if the person meets the criteria for emergency detention. Upon a patient's request, ED staff must seek counsel from the Committee for Public Counsel Services. The hearing must be held at the hospital by the next business day, with virtual or in-person attendance.

H.1980 improves the system of care for people in crisis

This bill improves the system of care for people in crisis in significant ways. First, by requiring that mental health professionals explore community-based alternatives before removing someone to an institutional setting, it improves quality of care. People stay connected with their community and their service providers. They may also make new community connections that can serve them over time. Research has found that receiving voluntary treatment in the community -- rather than in restrictive,

crowded, and potentially coercive EDs -- has therapeutic advantages.[1] Reaching out to community supports also helps people maintain community tenure.[2]

Second, by serving people with mental health issues in community crisis centers rather than in hospitals, when possible, Massachusetts complies with the *Olmstead* requirement of the Americans with Disabilities Act. The integration mandate of the Supreme Court's *Olmstead* decision requires that states make ongoing efforts to serve people with disabilities in the least restrictive settings possible.

Third, by diverting people from hospital EDs, this bill benefits all persons who use crisis services. People with behavioral health needs can be more immediately served in specialized, community-based centers designed to address mental health and substance use crises with voluntary services. These individuals will not be held waiting without services in overcrowded EDs, a persistent problem documented by the Massachusetts Health & Hospital Association's weekly behavioral health boarding reports.[3] Hospital emergency medical care can be saved for people who actually have that level of need. Police can attend to the crises that they are expert at as well, by stepping away from involvement in mental health crises and the time-consuming hospital admission process. To the extent that community-based alternatives mental health treatment services are lower in cost than hospital services,[4] the same dollars can potentially serve more individuals in need.

Fourth, this bill encourages reliance on local, community behavioral health programs and services and in doing so, would promote the development and expansion of such programs and the other community-based services upon which such programs rely. Community-based crisis and urgent services are coming to fruition as the result of a wide range of initiatives: provisions within Chapter 177 of the Acts of 2022, the EOHHS Roadmap implementation (including CBHCs and the Behavioral Health Help Line), the Middlesex County Restoration Center pilot, and the 988 Crisis and Suicide Lifeline.

In addition to these likely outcomes, other provisions of H.1980 provide significant potential benefit. An additional requirement that DMH collect and report to the Legislature data regarding section 12 applications and any actions DMH takes in response would help us better understand the demographics of those subject to section 12 (such as race, geography, disability, and age) and those who file section 12s. This information is useful in making decisions about resource allocation to help keep people healthy and avoid unnecessary hospitalization.

Finally, the requirement that DMH maintain a database of inpatient psychiatric facilities to show availability capacity at such facilities would help reduce ED boarding by allowing for faster identification

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[1] *See*, e.g., SAMHSA, National Guidelines for Behavioral Health Crisis Care: Best Practices Toolkit (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf at 29 ("These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.")

[2] *See* R. Bruffaerts *et al*., Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service, General Hospital Psychiatry (2005), https://sci-hub.se/https://doi.org/10.1016/j.genhosppsych.2005.04.003 at 272 (in study of patients with recurrent utilization of a psychiatric emergency services, researchers found that short community stays after release from emergency inpatient care were exclusively predicted by arrangements for care accessed after release and not by patient characteristics)

[3] Mass. Health & Hospital Association, Capturing a Crisis: MHA's Weekly Behavioral Health Boarding Reports, https://www.mhalink.org/MHA/IssuesAdvocacy/State/Behavioral_Health_Boarding/MHA/IssuesAndAdvocacy/Capturing_a_Crisis_MHAs_Weekly_Behavioral_Health_Boarding_Reports.aspx?hkey=40f7493a-e25b-4a28-9cda-d7de41e622d2&utm_source=Informz&utm_medium=Email&utm_campaign=Campaign%20Name.

[4] *See, e.g.,* SAMHSA, *supra* note 1, at 10 ("The ever-escalating cost of inpatient healthcare for individuals who are unable to access needed community-based services in a timely manner.").

of appropriate placement and therefore faster transfer from ED to inpatient facility, should such care be needed. It also would allow DMH to have a better understanding of use and need. Through Chapter 102 of the Acts of 2021, the Legislature has allocated $5M for an online portal to facilitate the coordination of services for children, adolescents, and adults who are boarding in Emergency Departments (EDs), providing real-time data on behavioral health beds (with beds categorized by care level, licensing authority, age restrictions and geographic location).[5]

Questions posed by Committee members addressed

Given that the Commonwealth is facing a workforce crisis, would this bill burden on our community-based providers?

We acknowledge the workforce crisis and the burden it is placing on our community-based behavioral health system. We applaud the Legislature's attention to this crisis and the allocation of substantial ARPA funds to begin to address it through scholarships, loan forgiveness, and other programs. While it will take time to see the results of these new initiatives, we cannot delay implementing changes that invest in community based behavioral health care settings, as our acute hospitals are unable to timely admit patients, leaving too many people waiting in emergency rooms. This backup in emergency rooms is occurring because the acute hospitals are unable to discharge patients due to the lack of available options for community aftercare. We know that voluntary services delivered in the community are less traumatic, more effective, and more protective of rights than involuntary inpatient services.

This bill seeks to redirect people in mental health crisis out of hospital EDs and into established community services. We know that hospital EDs are currently completely over-burdened, which creates risks for persons who legitimately need emergency medical services. This bill helps alleviate that problem, as well as the logjams in the entire inpatient mental health continuum of care that begin with too many people entering EDs.

This bill relies on a combination of alternatives, many of which – for reasons independent of this bill – are growing stronger day by day. As DPH transitioned our suicide call centers to 988 call centers for the July 2022 initiation of the line, the state recognized and facilitated a transition from volunteer to paid full-time staff. For the Behavioral Health Help Line opening in January 2023, it recruited and trained clinical and other staff. The state's new 26 Community Behavioral Health Centers (CBHCs) also opened in January 2023 to provide emergency care irrespective of insurance type. MassHealth and private insurance fund ongoing care. Our state also has new 71 behavioral health urgent care clinics. All these services have secure funding streams and plans to recruit, train, and retain workers. The plan is for these services to become more established, gaining ability to handle greater capacity over time. Should this bill be enacted this session, we would anticipate that over time these providers would gradually see an increase in use, but that change would likely be gradual and is something that these providers are planning for independent of this legislation.

Over time, our system needs to move care from inpatient settings to the community and shift spending accordingly. We certainly need to support our community providers as this transition occurs, but if we do not shift patient care, we cannot effectively shift funding.

[5] MAMH, Massachusetts Spending Plan to Promote COVID-19 Recovery: Impact on People with Behavioral Health Conditions (Updated July 25, 2022), https://www.mamh.org/assets/files/ARPA-brief-draft_FINAL_12-22-21_Update.pdf at 2-3.

What do you expect the cost of this bill to be?

We know that inpatient care, particularly ED services, are more expensive than community-based services and for that reason we expect that this bill will save on medical costs. A 2023 report submitted to the Legislature on the state of crisis services in Massachusetts found that the average cost of an mental health emergency department visit with the ambulance was $4,597.[6] Moreover, the average inpatient psychiatric hospital rate per day was $1,057, with the estimated average cost per inpatient stay in a psychiatric hospital estimated at $7,665.[7] The crisis services report provides examples of diversion initiatives (in the form of crisis stabilization services) in other states that have resulted in cost savings.[8]

It is true that we may not be able to simply take dollars saved from inpatient settings and move them to community services, but we are creating and taking advantage of opportunities for public and private insurance coverage of community-based care. So, we anticipate that there will be cost savings for the state from this shift to community-based care.

This bill also should save on other types of costs. If we reduce the number of people who enter EDs, we reduce the number who are subject to the civil commitment process. That will save on legal and administrative costs associated with the judicial process. Since fewer people will be civilly committed, it will also reduce the costs to the state of inpatient psychiatric chronic care services in DMH run and contracted facilities. (While this bill does provide due process protections earlier in the involuntary psychiatric admission process, those protections do not require the resources of a full civil commitment hearing; we anticipate that diversion also will reduce the numbers of people who would pursue such hearings and the new hearing process itself may reduce the number of people subject to civil commitment).

When people can remain in the community, working at their jobs, and fulfilling their familial and community responsibilities, society saves on other costs as well. Last, because voluntary community-based care is more effective than involuntary inpatient care, treatment costs should be reduced as well.

If it comes to the point that someone is filing a Section 12, hasn't that person pursued and exhausted the kinds of community-based alternatives this bill envisions?

Massachusetts residents who are experiencing a mental health crisis are involuntarily detained and taken to EDs pursuant to Section 12(a) approximately 60,000 times each year. We believe that many of these hospitalizations could be avoided. Certainly in some cases, treating clinicians and families may have fully exhausted other alternatives before resorting to section 12, but we know this is not the case in many instances.

A recent study of the Middlesex County Restoration Center Commission is instructive; reviewing the cases of people who were subject to a mobile crisis intervention and then sent, in most cases, to EDs, the disposition of individuals reveals that only 41% were subsequently admitted to an inpatient hospital, while 30% were referred to outpatient and community-based treatment, 9% were referred to 24-hour diversionary services, and 9% were referred to residential treatment.[9]

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[6] Mass. Association for Mental Health & Technical Assistance Collaborative, Report of the Community Policing and Behavioral Health Advisory Council in accordance with Section 117 of Chapter 253 of the Acts of 2020 and Section 25 of Chapter 19 (June 30, 2023), https://www.mass.gov/doc/ma-crisis-system-report/download at 47. Ambulance cost based on MassHealth fee. *Id.*

[7] *Id.*

[8] *Id.* at 48.

[9] PowerPoint, Middlesex County Restoration Center: Strategic Consensus Building - The Foundation for Feasible Implementation of a Crisis Diversion Facility

Often, people resort to section 12 because they are not sure what to do and they do not know how to access services other than through the ED. (This is not only the case for psychiatric care of course – we often turn to our ED for all sorts of services.) This bill helps families by requiring clinicians to consider appropriate and accessible alternatives. Relying on clinical expertise for this purpose benefits the individual and all those who care about them. This exercise may be one the clinician has already engaged in as part of treatment but requiring this investigation before pursuing a Section 12 is prudent. Section 12 comes with its own risks of trauma, institutionalization, loss of rights, and, perhaps most notably, delay in accessing services.

This bill does not prevent the use of Section 12; it simply ensures that a person in crisis is best matched to the services needed. The Commonwealth has recognized the importance of community-based services by investing in their expansion; the 988 Crisis and Suicide Lifeline, the Behavioral Health Help Line, mobile crisis intervention, CBHCs, urgent care sites, continued support of CBHI and BHCA services, peer services like respites and Recovery Learning Communities, and commitment to telehealth are all examples of this investment. We hope that providers and others would have considered these services before Section 12. This bill will help ensure that they do.

For all the above reasons, I respectfully request that you report H.1980 favorably out of Committee. If MAMH can provide any additional information, please do not hesitate to contact me.

Thank you for your consideration.

Sincerely,

Danna Mauch, Ph.D.
President and CEO

c: Rep. Marjorie Decker

(Sept. 29, 2022) (on file with MAMH) at 24. Smaller percentages declined services, were referred to intensive outpatient/partial hospitalization, or were arrested. *Id.* We note that this data reflected outcomes of people who were predominantly in EDs (89%), but also included small percentages of people who were starting from an inpatient medical unit (2%) or Emergency Service Provider/Community Based Location/Urgent Care Center (8%). *Id.*