National Alliance on Mental Illness
Massachusetts

WAY BEHIND:

Report on the State of Mental Health in 2014

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Revised Edition: May 27, 2014

In 2009, the National Alliance on Mental Illness (NAMI National) analyzed information on mental health services in the nation and graded all states based on their performance. Massachusetts received a B. That was before Massachusetts slashed its funding for the Department of Mental Health (DMH) by $20 million. Since that time, growth in funding has lagged behind every other New England state. This report shows that, despite modest progress in discrete areas since 2009, Massachusetts has a long way to go.

DMH Budget: Last in Growth in New England since 2009

The Department of Mental Health has still not recovered from devastating budget cuts in 2009, and remains dead last in percent growth of funding for mental health services in comparison to all other states in New England.

State Funding for Police Training: Lowest in New England

Massachusetts has cut 250 specialized training courses and has the lowest legislative appropriation for training per police officer in New England. One promising opportunity lies in the pioneering work being done by the Municipal Police Training Committee (MPTC) on mental illness response training, in partnership with DMH and NAMI Massachusetts.

Community-Based Services for Adults: Disappointing Returns

DMH's primary service for adults with serious mental illness is called Community Based Flexible Supports (CBFS). It accounts for the largest proportion of state-supported adult mental health services. Sadly, there is a lack of oversight and monitoring data to evaluate quality and outcomes.

Psychiatric Inpatient Beds:

Public Beds—Pressure from an Incomplete Community System

Private Beds—Disastrous Shortages

Public: The number of public psychiatric inpatient beds has decreased by 40% since 2005. The adequacy of the remaining beds depends directly on the adequacy of community based services – residential as well as community outpatient, acute care psychiatric beds and home services. There is broad agreement that our community services network is inadequate.

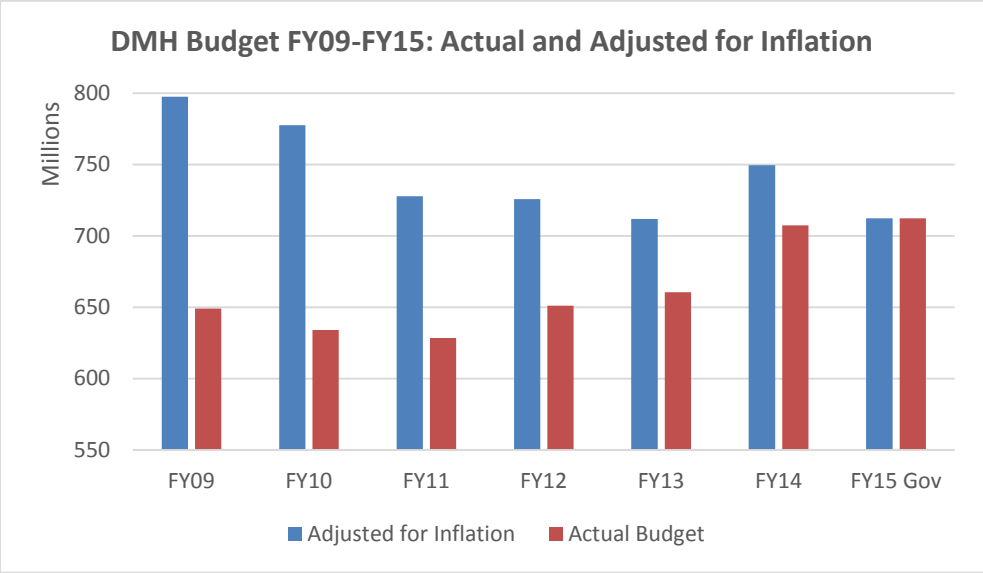
Private: Massachusetts has a grave shortage of acute care psychiatric inpatient capacity, leading to individuals being boarded for unreasonable lengths of time in emergency departments.

Emergency Services Program (ESP): A Bright Spot, but Room for Improvement

ESP is one successful program for individuals suffering from mental health crises. ESPs have short response times and offer mobile services 24/7 to individuals at their homes, workplaces, or schools. However, ESPs currently only serve 25% of adults in the community instead of in hospital emergency departments.

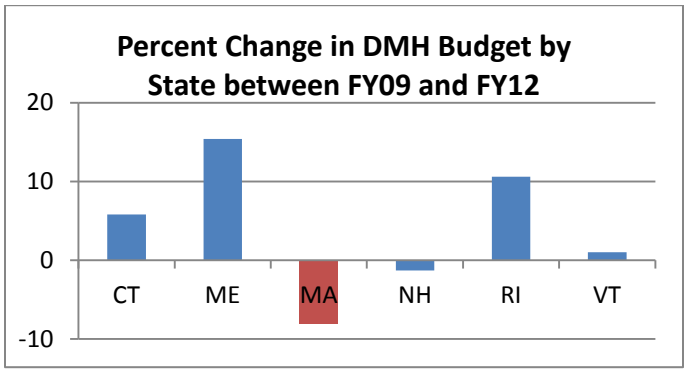
I. Department of Mental Health Budget

Between FY2009 and FY2011, the Department of Mental Health experienced devastating cuts from which it has still not fully recovered. Governor Patrick's proposed FY2015 budget would provide DMH with a 1.2% increase from the current fiscal year, an increase of $8.5 million; this level of proposed funding does not keep up with costs from inflation and is insufficient for the needs of the state. It will lead to 215 children and families as well as 250 adults losing their DMH services.[1] The chart below shows the actual DMH budget and compares those appropriations with their values adjusted for inflation. When taking that measure into account, the Governor's proposed FY15 DMH budget is about $85 million less than it was in 2009.



Source: Massachusetts Budget and Policy Center

It is important to note as well that Massachusetts remains dead last in New England in terms of growth in mental health budgets, just as it did in 2009 when NAMI last evaluated the state's mental health system.[2] This means that other New England states have increased their appropriations for mental health services, but the Massachusetts DMH budget has experienced negative growth between 2009 and 2012 (adjusting for inflation).



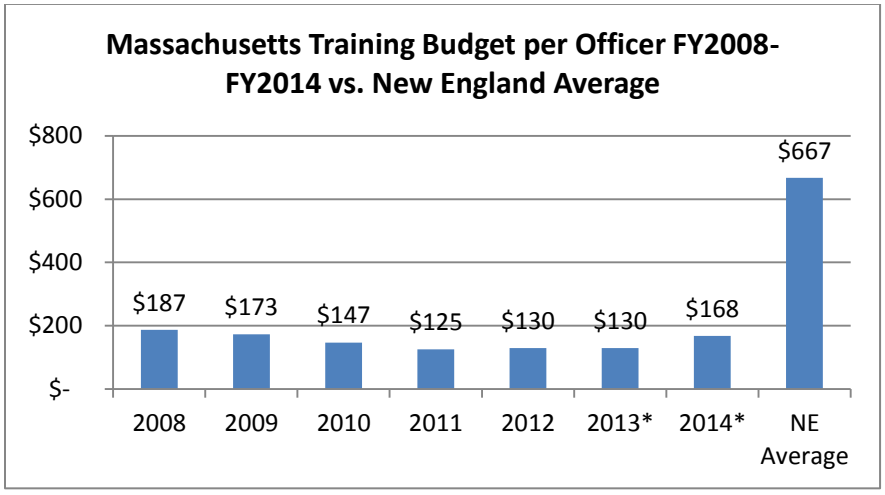
[1] Association for Behavioral Healthcare Letter to State Ways and Means Committee on FY2015 Budget Proposal: http://www.abhmass.org/images/members_only/state_issues/abhlettertohwm-swmfy15budgetfinal1.31.14.pdf

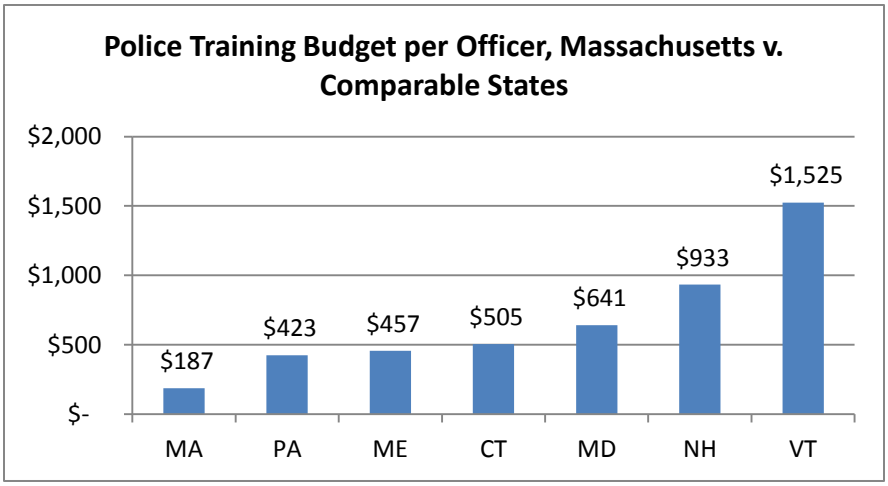
[2] "State Mental Health Cuts: The Continuing Crisis." National Alliance on Mental Illness, November 2011. http://www.nami.org/Content/NavigationMenu/State_Advocacy/State_Budget_Cuts_Report/StateMentalHealthCuts2.pdf

Source: State Mental Health Cuts: The Continuing Crisis, November 2011, a report by the National Alliance on Mental Illness

II. State Funding for Police Training

The trend in legislative funding available for police training generally in Massachusetts is getting worse: the number of specialized courses offered by the Municipal Police Training Committee (which include training on how to respond to individuals with mental illness in crisis) has decreased from 283 courses to 30 between FY2012 and FY2013.[3] In addition, according to the most recent Bureau of Justice Statistics Census, Massachusetts has the lowest dollar investment in Police Training in the nation.[4]





Source: EOPSS Special Commission on Massachusetts Police Training, July 2010
*Estimates based on average percent growth in police force.

Fortunately, pioneering work done by the Municipal Police Training Committee (MPTC) in conjunction with DMH and NAMI Massachusetts is ameliorating the situation. MPTC is offering a new curriculum on Police Response to Persons with Mental Health and Emotional Disturbances to be taught by licensed mental health clinicians alongside certified police officers at both the full- and part-time reserve Police Academies. However, there is still a glaring need for legislative appropriations for police training.

[3] Executive Office of Public Safety and Security Performance Report, January 15, 2014. http://www.mass.gov/eopss/docs/eops/eopss-performance-report.pdf

[4] Special Commission on Massachusetts Police Training: Results and Recommendations. http://www.mass.gov/eopss/docs/mptc/statewide-police-training-report-final.pdf, July 2010

III. Community-Based Flexible Supports (CBFS) for Adults

Community-Based Flexible Supports (CBFS), offered by DMH, provide rehabilitative interventions and supports for adults authorized for DMH services who are assessed as needing this service. CBFS is the largest of the adult services available through DMH. In FY 2014, the client capacity for CBFS is 11,814. CBFS is a voluntary service and it is expected that the number of individuals served will reflect movement into and out of the service. The total number of individuals served in any given year will always be higher than the capacity. CBFS accounts for $260 million (of $703 million total) in the Department's FY 2014.[5] This model is delivered through 44 contracts with 20 private vendors and eight state operated programs which offer a variety of community based services to DMH-eligible clients, including Individualized Action Plans (IAPs) to determine client needs and goals as well as housing and employment supports. All CBFS clients meet DMH's service authorization requirements, meaning that they suffer from a serious mental illness (SMI), which is defined as having a diagnosable mental, behavioral, or emotional disorder which "results in functional impairment which substantially interferes with or limits one or more major life activities."[6]

DMH created this service model in 2009 and implementation was advised by a steering committee, whose members included representatives from CBFS provider agencies, DMH staff, the Transformation Center and Recovery Learning Communities (RLCs). The steering committee serves as a forum where peers can share consumer experiences with CBFS and providers can share strategies and practices.[7] The contracts specify that 14 domains should be monitored and reported to DMH[8] (See Appendix). These domains include client outcomes measures in a first attempt to capture more than just process measures. While client outcomes are not published on the DMH website, there is survey data from adult clients and families available.

In order to better understand the CBFS system and its client outcomes, NAMI Mass submitted a Massachusetts Public Records Law data request to DMH for the client outcome domains that the Department is required to maintain by the CBFS contract. DMH provided the client outcome data displayed in the chart below. Other measures (e.g. staffing) are collected using other means and are regularly reviewed with CBFS providers. The current level of reporting is a promising beginning in evaluating the CBFS system.

Following the murder of a group-home worker in 2011, the Commissioner of Mental Health established the DMH Task Force on Staff and Client Safety to review the Department's policies on safety. The Task Force reported that "years of budget cuts have resulted in:

- Inadequate numbers of and inadequate pay for direct-care staff
- Inadequate numbers of clinical staff with relevant training and experience
- Deficiencies in the overall number of acute and intermediate hospital beds and community-based services and beds

[5] Funding reported by DMH.
[6] Federal Register Volume 58 No. 96 published Thursday, May 20, 1993, pages 29422-29425
[7] DMH Connections, February 2010.
http://archives.lib.state.ma.us/bitstream/handle/2452/103648/ocn711076356-2010-02.pdf?sequence=1
[8] Commonwealth of Massachusetts Department of Mental Health North East Essex North Site B Community Based Flexible Supports Request for Response, 2010-NEA-ESSEX NORTH SITE B-3054-RE-BID (2), October 13, 2009

- Decrease in the role of psychiatrists and other highly-trained professionals in the care and treatment of individuals with the most serious mental illnesses
- Requiring some staff to work under conditions that do not provide for adequate safety."[9]

DMH describes CBFS as "the cornerstone of the department's community mental health system for adults."[10] Although there is limited data from the first few years of the program, CBFS represents a promising opportunity for individuals with mental illness to seek recovery outside of the institutional system. NAMI Massachusetts hopes that DMH can continue to refine the measures with which they evaluate CBFS, and that outcomes reflect positive systemic change.

CBFS Client Outcome Data

Domain	FY10 Average	FY11 Average	FY12 Average	FY13 Average	Change
% of CBFS clients with continuous community tenure (no admissions or incarcerations during the quarter)	85%	85%	85%	85%	0%
% of CBFS clients with an admission to an acute-care inpatient psychiatric facility during the quarter	9%	9%	9%	7%	-2%
Median (mid-point) length of stay of acute-care inpatient psychiatric admissions during the quarter	9 days	9 days	9 days	9.5 days	0.5 days
% of CBFS clients with an arrest during the quarter	0.8%	0.7%	0.9%	0.6%	-0.2%
% of discharges from CBFS in which the client met treatment goals or continued in treatment with a new service	-**	-	35%	34%	-1%
% of CBFS clients who report positively about participation in treatment planning	71%	67%	70%	68%	-3%
% of CBFS clients who report positively about person centered planning	79%	77%	79%	77%	-2%
% of CBFS client who are employed	-	12%	11%	11%	-1%[11]
% of CBFS clients who are employed and have maintained their employment for 11 months or more	-	57%	58%	56%	-1
% of CBFS clients residing in a Group Living Environment	-	29%	26%	26%	-3%
% of CBFS clients residing in housing that he/she controls (owns/rents with private funds, family owns/rents with private funds, including Section 8 subsidies)	-	57%	61%	60%	3%
% of CBFS clients with smoking identified as a need area in the Comprehensive Assessment that "desire change"	-	23%	21%	22%	-1%
% of CBFS clients who engage in physical activity one or more days per week	-	79%	79%	81%	2%
% of CBFS client with substance use identified as a need area who are taking action or maintaining sobriety	-	38%	40%	42%	4%

[9] Report of DMH Task Force on Staff and Client Safety: June 2011. Available: http://media.wbur.org/wordpress/1/files/2012/12/report-safety-task-force.pdf

[10] DMH website. http://www.mass.gov/eohhs/consumer/behavioral-health/mental-health/community-based-flexible-supports.html

[11] The State Mental Health Implementation Report, 2011, states that the goal is to increase the employment rate of CBFS clients by 1% each year; with a baseline rate of 12% in 2011, the goal for FY13 was 14%; therefore, the deficiency in this domain is actually 3%.

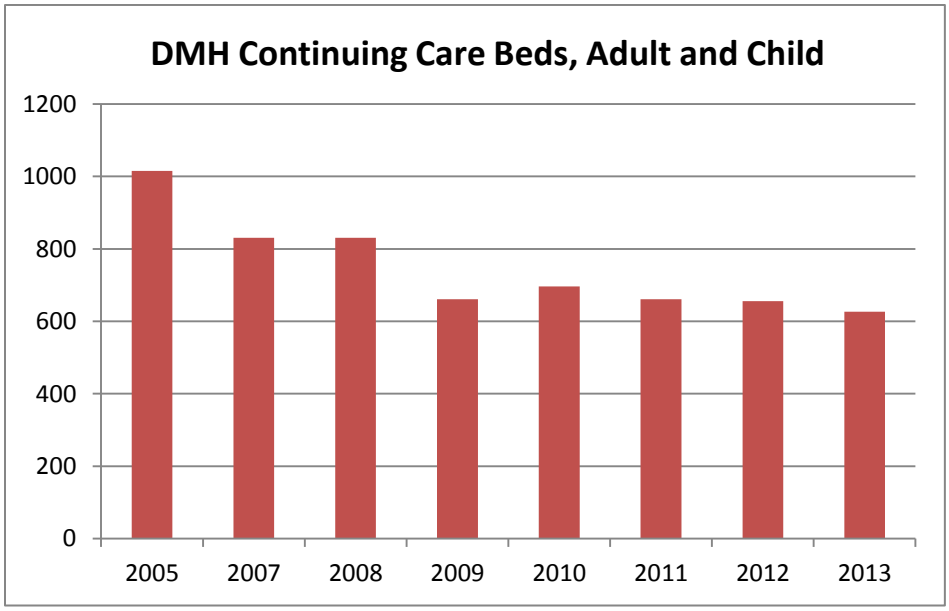
Source: DMH Response to NAMI Public Records Law Data Request, April 2014
***Measure not collected that year*

IV. Psychiatric Inpatient Beds

There are two types of psychiatric inpatient beds: acute and continuing care. The Department of Mental Health (DMH) has responsibility for the entire spectrum of psychiatric treatment either through the direct provision of inpatient treatment or through its licensing authority over general hospital psychiatric inpatient units or free standing psychiatric hospitals. Public continuing care beds are operated by DMH and private acute psychiatric beds are regulated and licensed by DMH, but not operated by DMH.

A. Public Continuing Care Beds

DMH provides continuing care inpatient psychiatric treatment at facilities such as the Worcester Recovery Center and Hospital, Taunton State Hospital, and Lemuel Shattuck Hospital. The average length of stay for adult patients in this type of facility is 133 days.[12] Since 2005, Massachusetts has closed about 40%, or 400, of its continuing care beds. Many of these losses are consequences of budget cuts. Individuals have been discharged to the community without a proportional increase in funding for community-based supports. **The current level of available continuing care inpatient treatment beds may be inadequate because there is a lack of a reliable community-based network.**



Source: DMH Licensing Office, 2013

[12] US SAMHSA Uniform Reporting Statistics 2012: Massachusetts. http://www.samhsa.gov/dataoutcomes/urs/2012/Massachusetts.pdf

B. Acute Care psychiatric inpatient Beds

Acute psychiatric care occurs primarily in general hospitals with psychiatric inpatient units or in free standing psychiatric hospitals. An "acute episode" is characterized by an emergency crisis with an average length of stay of 30 days or fewer, but most patients average fewer than 10 days in an acute bed.[13] Across the Commonwealth, hospitals have been closing inpatient psychiatric beds or entire units, including the recent closure of North Adams Regional Hospital's 20 bed inpatient unit.[14]

Due to the lack of available acute care psychiatric hospital beds, patients experiencing mental health crises are frequently "boarded" in emergency departments—meaning that they can spend "days, and sometimes weeks"[15] in a hospital emergency department waiting for the care they need. The Massachusetts Executive Office of Health and Human Services (EOHHS) admits that "behavioral health patients in emergency departments can face long delays waiting for disposition to appropriate settings."[16] In 2011, the Massachusetts chapter of the American College of Emergency Physicians (MACEP) surveyed all Massachusetts emergency department medical directors and found that:

- The mean occupancy of emergency department beds by behavioral health patients was 16.25%; one institution reported that 52% of its beds were occupied by behavioral health patients.
- The maximum length of stay in an emergency department for an individual psychiatric patient was 20 days and 19 hours.
- 33% of boarders stayed more than 24 hours; 6% stayed for more than 3 days, and 2% stayed for more than 5 days.[17]

With up to half of emergency department beds being occupied by patients experiencing behavioral health issues, neither those patients nor other emergent patients can possibly receive the care they need. The lack of available acute care beds in the state leaves these patients in acute crisis with nowhere to go.

[13] Hudson, Christopher G. "Trends in Acute Psychiatric Inpatient Care in Massachusetts." *Psychiatric Services 2004*, Vol. 55, No. 11, November 1, 2004. http://ps.psychiatryonline.org/article.aspx?articleID=89325

[14] DMH Licensed Hospital Census, January 2014.

[15] Epstein, Stephen K. "Case Study: Psychiatric Boarding in Massachusetts Emergency Departments." *Urgent Matters*, George Washington University School of Medicine & Health Sciences, April 19, 2012.

[16] "ED Length of Stay Issues for Behavioral Health Patients." Commonwealth of Massachusetts, Executive Office of Health and Human Services, January 2, 2013. http://www.mass.gov/eohhs/docs/eohhs/behavioral-health/bh-discussion-01022013.pdf

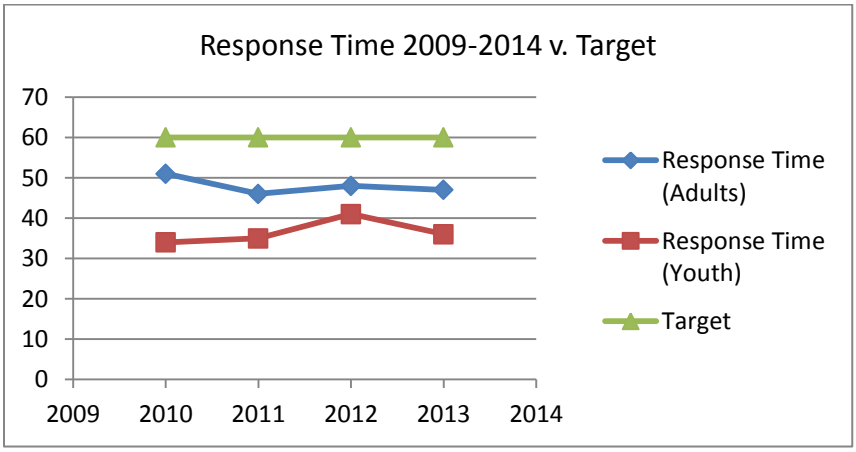
[17] Rathlev, Niels. "Psychiatric Patient Boarding in Massachusetts EDs: 'A Point in Time.'" MACEP, https://host2.firewebsitehosting.com/~macep/index.php?option=com_content&view=article&id=209:psychiatric-patient-boarding-in-massachusetts-eds-a-point-in-time&catid=67:whats-new&Itemid=27

V. Emergency Services Programs (ESP)

Emergency Services Programs provide mobile behavioral health crisis services, including intervention and stabilization. Services include a toll-free number staffed by professionals with clinical training and crisis respite beds; these services are both available 24/7. There are 21 ESP catchment areas which cover every city and town in the state. Each ESP is community-based and recovery-oriented; the goal of ESP is to provide assistance to individuals experiencing mental health crises, ideally before they go to the emergency department. ESP providers work with individuals across their lifespan to assess crises, develop risk management and safety plans, provide psychiatric consultation and urgent psychopharmacological interventions as needed, and will respond to individuals at their home, workplace, or school.[18] Assessment by an ESP is required for MassHealth members.

ESP services include Mobile Crisis Intervention (MCI) for children ages 21 and under. Adults can also receive mobile crisis services. These services include onsite, face-to-face therapeutic response, referrals to all medically necessary behavioral health services and supports, and Family Partners who help support youth in crisis and their families.

ESP providers seek to arrive at crisis locations within 60 minutes of a call; ESP response times have continued to improve since 2009, on average responding to adults in less than 50 minutes. Although response times are impressive, only one-fourth of ESP encounters occur in the community (i.e. at the home, workplace, or school of the individual in crisis), as opposed to in hospital emergency departments, for adults.[19]



Source: Emergency Services Program (ESP)/Mobile Crisis Intervention (MCI) FY2013 Public Statewide Data Summary

[18] Massachusetts Behavioral Health Partnership Emergency Services Program Overview, http://www.masspartnership.com/provider/pdf/ESP%20Overview%20Standard%20Presentation%2072909.pdf

[19] Emergency Services Program (ESP)/Mobile Crisis Intervention (MCI) FY 2013 Public Statewide Data Summary.

VI. Recommendations

Massachusetts is way behind in terms of providing individuals with mental illness with the services and supports they need. In order to improve the state of mental health, we recommend the following actions:

- Increase the Department of Mental Health budget for FY2015 by $15.9 million
- Invest $2.7 million in specialty courts such as mental health, drug, and vet courts
- Enact S.1189 (An Act Relative to Police Training) to consistently and adequately fund police training
- Enact H.836 (An Act Requiring Mental Health Parity for Disability Policies) to eliminate discrimination for people with mental illness who collect long term disability
- Enact S.1959 (An Act Ensuring Parity for Mental Health and Substance Abuse Treatment) to create a private right of action for any parity violations
- Enact H.840 (An Act to Require Health Care Coverage for Emergency Psychiatric Services) to require all private commercial insurers to cover Emergency Psychiatric Services

If these issues become higher priorities and receive adequate funding, Massachusetts could dramatically improve access to quality mental health services throughout the Commonwealth.

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Appendix

CBFS Measures required to be reported to DMH according to the Commonwealth of Massachusetts Department of Public Health North East Essex North Site B Community Based Flexible Supports Request for Response, 2010-NEA-ESSEX NORTH SITE B-3054-RE-BID (2), October 13, 2009.

Measure	Reported
Individual client outcomes to inform the IAP	No
Efficient use of programmatic resources	No
Effectiveness of services	No
Workplace development, including staff recruitment, retention, training, and competencies	No
Modification of delivery services for individual clients	No
Increase in percent of clients who move to a less restrictive living arrangement	Yes
Increase in percent of clients who achieve their individualized discharge criteria and are discharged from CBFS in accordance with their discharge plan	Yes
Increase in amount of third-party revenues collected (e.g., food stamps, fuel assistance, community nursing services)	No
Increase in community tenure (e.g., reduction in psychiatric hospitalizations, number of hospital days, re-arrests)	Yes
Increase in percent of clients who are non-smokers	No
Increase in percent of clients who participate in wellness and fitness activities	Yes
Increase in percent of clients who are employed (goal is to increase employment by 1% each year)[20]	Yes
Increase in participation in self-help groups for addictions	No
Increase in percent of clients who report satisfaction with their level of participation in their treatment planning.	Yes

[20] State Implementation Report, 2011.