Danna E. Mauch, PhD
President and CEO

Ambassador (ret.) Barry B. White
Chairperson of MAMH Board of Directors

November 22, 2021

The Honorable Julian Cyr
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 312-E
Boston, MA 02133

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

Submitted via MyLegislature

Dear Chair Cyr, Chair Madaro, and Members of the Committee:

Re: Testimony in support of H.3962 -- An act relative to ending unnecessary hospitalizations and reducing emergency department boarding

I write in support of H.3962, An act relative to ending unnecessary hospitalizations and reducing emergency department boarding, heard today by the Committee on Mental Health, Substance Use and Recovery. Thank you again for the opportunity to appear before you and testify on the Act.

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.

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 creates a mechanism so that individuals in crisis can go directly to regional crisis stabilization programs for assessment and care, rather than being sent on an involuntary basis, and often by the police who are ill equipped and too busy to manage these crises, to overburdened hospital emergency departments (EDs).

Regional crisis care is care that can be accessed 24/7, that connects people immediately with services in their area, and that is least restrictive. It meets people where they are, with a wide array of services depending on need, including peer supports, outreach, and follow-up. And regional crisis care fits with the current behavioral health emergency services assets that will be part of the comprehensive crisis services response and new front door to the behavioral health care system envisioned by the EOHHS Roadmap.

H.3962 promotes community-based crisis care by requiring that mental health professionals explore and exhaust community-based treatment alternatives such as telehealth, one-to-one observation, mobile crisis intervention, urgent care, family involvement and peer support, before seeking involuntary transport by law enforcement. Were such transport to occur, the person would be taken to a regional crisis stabilization program. If a mental health professional were not available to do this evaluation, a law enforcement officer could bring the individual directly to the crisis stabilization program for evaluation there. The crisis stabilization program director or designee would evaluate the individual. If that evaluator concluded the program could not prevent the individual from harm to self or others or if the individual didn't want the voluntary treatment the program was offering, the person would be transferred to an inpatient psychiatric facility (or to an ED if there were no inpatient psychiatric facility availability). If transported to an ED, the existing right to a hearing attaches.

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 the quality of care and quality of life. 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 also 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]

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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

Second, by serving people with mental health issues in community crisis centers rather than in hospitals, when possible, the bill helps ensure Massachusetts' compliance 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 process benefits all persons who use crisis services. People with behavioral health needs can be more immediately served in specialized, community-based centers designed to attend to mental health and substance use crisis situations with voluntary services. These individuals will not be held waiting without services in overcrowded EDs, a persistent problem now being documented by the Massachusetts Health & Hospital Association's weekly behavioral health boarding reports.[3] Hospital emergency medical care can be saved for people who in fact 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 a system of regional crisis stabilization programs and in doing so, will promote the development and expansion of such programs and the other community-based services upon which such programs rely. These community-based crisis services are coming to fruition as the result of a wide range of initiatives. Crisis stabilization programs and urgent care services are envisioned by the EOHHS Roadmap, the Middlesex County Restoration Center pilot, and the 988-crisis hotline implementation, and by other state legislation being considered this session. Likewise, federal COVID and other dollars are being allocated with specific designations to develop and expand such services.

In addition to these likely outcomes, other provisions of H.3962 provide significant potential benefit. The 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.

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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.").

Additionally, 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 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. As you may know, funding of $5 million for such a databased a similar requirement was recently included in the Senate ARPA bill, S.2580 (1599-2026).

For all the above reasons, I respectfully request that you report H.3962 favorably out of committee. If MAMH can provide any additional information, please do not hesitate to contact me.

Thank you.

Sincerely,

Danna Mauch, Ph.D.
President and CEO

c: Rep. Marjorie Decker