

Report of the Massachusetts Department of Mental Health Task Force on Staff and Client Safety

June, 2011

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INTRODUCTION

On January 20, 2011 Stephanie Moulton, a twenty-five year old mental health counselor, lost her life, allegedly at the hands of a resident at the group home where she worked. The shock and grief of her family, as well as her friends, co-workers and other group home residents can only be imagined. This tragedy also staggered the entire DMH community, including its partners, friends and supporters.

In response to the homicide, DMH Commissioner Barbara Leadholm convened this Task Force on Staff and Client Safety. She asked the Task Force to review and systematically assess all current policies and practices relative to staff and client safety in the DMH Community System of Care and to develop potential mechanisms to improve current practices, policies and processes. The Commissioner instructed the Task Force to complete its review within three months and to focus on safety within the community system in general, and not on the precipitating event itself.

As co-chairs of the Task Force, Commissioner Leadholm appointed Kenneth L. Appelbaum, M.D., Clinical Professor of Psychiatry at the University of Massachusetts Medical School and The Honorable Paul F. Healy, Jr., Retired Justice, Framingham District Court. Other members appointed to the Task Force by the Commissioner include representatives from DMH, the provider community, consumer organizations, unions, professional societies, and the State Legislature. Task Force members all felt a great responsibility to conduct as comprehensive a review as possible in the time that we had.

Terrible incidents, such as the recent homicide, can result in excessive concerns about the safety of all individuals with mental illness. These concerns sometimes lead to calls for extreme and unnecessary restrictions on autonomy and community access. With appropriate supports, almost all individuals served by DMH can live safe and meaningful lives in the community. The Task Force kept this truth in mind while we simultaneously sought ways to enhance safety for the relatively few individuals who do pose serious risks of harm to themselves or others due to their mental disorders.

The Task Force was directed to address community safety. Our efforts therefore focused more on the needs of those few individuals who present a high risk of violence, rather than on the many who do not. This is not to say that our findings and recommendations have no relevance to other individuals served by DMH. Much of what we recommend would, in our opinion, improve care for all people served by DMH. For some individuals, however, our recommendations impact on safety for them, their peers, and all who work with them.

A few Task Force members work for the Department of Mental Health. Most do not. We accepted the Commissioner's request for us to serve as volunteers on this project because we believe in its importance. We did the best we could with the time and resources available to us, which was enough for us to feel confident offering the recommendations contained in this report. We did not, however, have the time or the breadth and depth of expertise to review unique issues of safety in the child or juvenile system. *We therefore recommend that DMH initiate a separate process to thoroughly review safety in their child and juvenile service system.* We also did not have the resources to survey individuals

served by DMH regarding their safety-related issues and concerns. We encourage DMH to conduct such a survey.

At the start of our process, we divided ourselves into several subcommittees each assigned to focus on a major content area. Task Force members typically served on more than one sub-committee. One or both Co-Chairs attended all outside meetings, which ranged from publically announced open hearings in four parts of the state to meetings with providers and constituency groups as described in the Sources of Information Section. Task force members attended some but not all of these, depending upon interest and availability. The Co-Chairs also disseminated or made available to the Task Force materials they received from surveys, groups or individuals. The recommendations contained in this report, and the rationales for them for the most part came forward from the subcommittees for review, discussion, revision and approval by the Task Force as a whole. We set a threshold of endorsement by at least 75% of members who actively voted either “yes” or “no” on each recommendation and its supporting rationale. The discussions were at times contentious, with strong differences of opinion being expressed. However, we worked to find common ground in arriving at the final recommendations, and our process was inclusive, respectful, and democratic.

Task Force members used different terms – for example: client, patient, person with lived experience (of mental illness) – in discussions and early drafts. We decided to use the neutral term “individual” throughout the final document since it conveys the values that a person is more than any one role and that it is possible for a person to recover to a “satisfying, hopeful, and contributing life” (Anthony, 1993).

PUTTING SAFETY IN CONTEXT

The work of the Task Force and this report could have unfortunate and unintended consequences. This possibility troubles us enough to offer some cautionary points. We ask all who read this report to please keep these points in mind. Doing so may lessen the possibility that our process leads to harmful, rather than beneficial, results. We hope that our report will enhance safety for the few who need it without compromising conditions for the many who do not.

1. Most individuals with mental illness pose no greater risk of violence than any other members of our society :

Tragic events, such as the one that led to the formation of this task force, can become the impetus for positive change. They also, unfortunately, can exacerbate misconceptions about people with mental illness. All members of this task force share a concern that our findings do not add to such misconceptions. We hope that our work honors the memory of Stephanie Moulton by enhancing safety without worsening unjustified stigma.

With this concern and hope in mind, we state unequivocally that *most individuals with mental illness pose no greater risk of violence than any other members of our society*. There is no controversy about this. Research studies support the clinical experiences of those of us who have spent careers in the mental health field and the personal experiences of many individuals with mental illness and their friends and families. If anything, many individuals with mental illness, including those served by DMH, are more likely to be victims than perpetrators of violent acts.

We also know, however, that for a relatively small group of people, serious mental illness does have an association with aggressive behaviors. These individuals have past histories of violence occurring when their contact with reality has been distorted or lost due to untreated psychotic symptoms. Active alcohol and substance abuse can significantly increase the likelihood of violence. When adhering to treatment and not abusing substances, the added dangerousness of these individuals dissipates. In addition, another small group of individuals have histories of violence not directly tied to the symptoms of their mental illness. Even when psychiatrically stable, they may pose a risk unless other factors are addressed (such as substance abuse, association with negative peer influences, sexually problematic behaviors, etc.). For both of these groups, providers must obtain relevant historical and clinical information to properly incorporate risk management strategies into treatment planning.

Community providers repeatedly echoed our concerns that the tragic events leading to the creation of the Task Force and the work of the Task Force itself not add to misguided stigma associated with mental illness. They know, as do all of us who work in this field, that mental illness itself rarely leads to violent behavior. The Task Force will have failed in its mission if our work and report adds to stigma or results in curtailed opportunities for individuals served by DMH to live meaningful lives of their own choosing in the community.

In visits and other interactions with individuals from DMH affiliated programs across the Commonwealth, we met scores of dedicated providers. They work under often challenging conditions with increasingly scant resources, and they rarely receive the recognition they deserve. Those of us who have known some of them for many years count them among our most respected colleagues. They know well the needs and characteristics of the population they serve, and we would do well to listen to what they have to say. Their message to our Task Force came through loud and clear. They ask us all not to let our legitimate concerns about the small cohort of potentially violent individuals spill over to persons who pose no special risk.

Individuals served by DMH, along with their many supporters, have the most at stake. Terrible and tragic events sometimes lead to overreactions that affect all of them, regardless of whether they pose a danger. We should not allow this to happen.

We hope that all who read this report recognize the limited population to which much of it refers. The individuals who pose serious risks, especially to others, do not represent the typical individual with mental illness. We need to do a much better job of helping, treating, and monitoring those who do pose serious risks without compromising the autonomy and recovery of those who do not.

2. Restrictive or coercive measures alone will not suffice:

Individuals served by DMH need services that engage them in meaningful ways. Those individuals who pose safety risks also require sufficient support and monitoring from an integrated team of clinical and recovery-oriented staff. Restrictive settings and coercion by themselves do not work well. The need for hospitalization or enforced treatment diminishes when an array of effective services is provided. The few individuals who meet strict criteria for restrictive or coercive interventions need those measures least and do best with a comprehensive array of other options. The path to true safety requires adequate staffing and services.

3. Task Force recommendations that require new resources should be implemented only if additional funding becomes available:

We did not identify unnecessary or over-funded services from which resources can be diverted. To the contrary, we also found needs for additional resources unrelated to safety concerns. Therefore, we do not recommend addressing the safety concerns that we identified through cuts in other areas. This would merely exchange one problem for another. A shift in allocation of already insufficient system resources could also have the unintended effect of creating new safety concerns as other services contract. Enhancing some services by diminishing others only moves risks from one place to another. Thoughtful, thorough, and public analysis of the likely consequences of changes in funding priorities should occur prior to any such moves.

If fiscal constraints require, *priority can be given to higher risk individuals*. Additional funding can focus on the small group of individuals served by DMH that has an elevated risk of violence. Risk assessments can identify a portion of these individuals. An integrated system model would provide safer, as well as better, care for them, along with increased safety for their peers and providers. The greatest return in

enhanced safety will come from concentrating limited *additional* resources on this discrete group. It would be a tragic, and unintended, outcome, however, if the added costs to meet our recommendations came from diminished funding for other already under-resourced DMH services.

4. The expense of immediately implementing all of our recommendations should not become a reason to implement none of them:

We understand that in the current economy the Commonwealth may well lack the resources to address all of the problems that we identified. We appreciate the fiscal realities that confront policy makers and that many priorities compete for the same limited resources. The fact that too much needs fixing, however, does not justify fixing nothing at all.

DMH can adopt many of our recommendations without appreciable cost. We urge the department to identify and quickly implement these items. We recognize that the department cannot implement other recommendations without new funding. For those items, we urge the department to do as much as it can and to advocate forcefully for needed resources.

The task force discussed limiting our recommendations only to items that would require minimal, if any, additional resources, and to the most critical of the more costly items. If we did this, however, we would not complete our task. Our charge was to *review all current policies and practices and make recommendations that would enhance safety*. Our process might have been very different if we had considered only no-cost and affordable recommendations. We have chosen to complete our charge as given to us. By doing so, we may risk dismissal of our report as unrealistic in scope. By not doing so, we would leave many important issues unaddressed. As individuals and as a group we put much time, energy and thought into our mission. The events that led to the formation of the task force and the risks at stake required no less from us. We cannot now remain silent in an effort to spare us all from making tough choices. Where we identified reasonable recommendations to address unsafe practices, we make those recommendations. We understand that the Commonwealth may not have the resources to implement all of our recommendations at this time, but we leave it to another day and another process to decide what can and should be done with our findings.

5. Do not fund enhancements in services recommended in this report through reductions in the overall number of individuals served by DMH.

For reasons described throughout this report, DMH needs to improve its ability to safely meet the needs of some of the people it serves, as well as to fulfill its mission. They could accomplish this by serving fewer individuals more effectively, which some Task Force members advocate. Most, however, believe that DMH requires additional funding, not cuts in its overall service capacity. DMH already lacks the ability to serve everyone who meets its eligibility criteria. The Task Force believes that it would be a mistake to add to this shortcoming. Enhancements in safety and services available to some individuals served by DMH should not come at the expense of fewer people served.

EXECUTIVE SUMMARY

Most people served by DMH have no greater risk for violence than any other members of our society. They may suffer when services decline, but they do not pose appreciable risks to others. For a smaller cohort of people, service deficiencies do create safety concerns. This group includes individuals with histories of serious violence associated with significant symptoms of mental illness, often exacerbated by poor adherence to treatment and active alcohol and substance abuse. The perception of many executives and others from the provider community is that ongoing bed closures at state psychiatric hospitals have pushed some of these people out before they or the services needed to sustain them are ready. Other factors such as current commitment law, individuals competently declining recommended treatments/services, and competent but criminal behavior may have also contributed to subsequent adverse outcomes in community placements from State Hospitals. Nevertheless, the findings of this Task Force support the perception that the DMH community system of care does not adequately meet the current safety needs of some individuals, resulting in increased risk for them, their service providers, and their peers.

In comments sent by email or left on a web-based survey of community staff, at public hearings, and at meetings with community provider staff in Worcester, Shrewsbury, Framingham, Fitchburg, Waltham, Westfield, Springfield, Boston, New Bedford, Taunton, Cambridge, and Dedham we heard widespread concerns about safety and difficulties in providing some individuals with meaningful access to critical services. People spoke repeatedly of inadequate funding resulting in staffing patterns insufficient in number, training and experience. They pointed to increasing caseloads of people with more acute needs than any of them can recall. They described a system that has rightly focused on recovery and community care but that is unable to consistently provide more intensive services when needed, including both acute and longer-term psychiatric hospitalization. They described breakdowns in communication and coordination of care among the multiple providers that serve the same individuals with serious mental illnesses. Administrators for community mental health agencies and acute hospitals reported significant difficulties in meeting the needs of this population with existing resources. They grapple with professional and moral imperatives to provide treatment despite serious bed shortages and financial resources that fail to cover associated expenses.

None of this should come as a surprise. In recent years, DMH has undergone significant changes in the context of repeated budget cuts. Some past practices that are no longer in place served to increase the cohesion of the community system, the continuity of care, and safety. Some of our proposed recommendations address these issues and may require additional funding or involve practices of entities such as MassHealth, Medicare, private insurers, and private psychiatric hospitals that DMH does not control. However, some Task Force proposals relate to policies and practices that DMH and its provider agencies can directly address.

This Task Force report provides a detailed account of troubling findings and important recommendations. In broadest terms, we found that:

- Years of budget cuts have negatively impacted service delivery and safety issues in the following areas:
 - 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.
 - 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;
- There is an absence of system-wide use of a well-designed risk assessment process;
- There is lack of clarity in policies and procedures for incorporating risk variables into Individualized Action Plans;
- There is lack of sufficient access to and sharing of critical safety information;
- There is lack of adequate coordination of care across different components of the service system.

The Task Force endorses and supports the concept that whenever possible individuals should receive services in community settings rather than in hospitals. For this to work in a way that truly promotes recovery, the Commonwealth needs a well-resourced and well-integrated system of services and treatment, including peer-delivered services. To succeed, however, this must be accompanied by sufficiently enhanced outpatient funding and staffing, as well as retention of and access to a sufficient number of inpatient beds for those individuals who continue to need them for either brief or prolonged hospitalizations. The need for well-staffed community services and supports becomes even more critical for individuals with severe illnesses and histories of violent behaviors. Many individuals recently discharged from DMH inpatient beds, along with those likely to be discharged if there were a further reduction in beds, require more intensive supports to be successful in the community. Nothing we do can entirely eliminate the risk of harm. If inadequate funding, however, results in insufficient staff and services to safely support and treat such individuals, we can expect that potentially avoidable adverse events may occur.

Many of the challenges within the DMH system identified in this report have developed over years of budget cuts. In addition, a significant system change occurred in July, 2009. At that time DMH restructured and re-procured its community services under a Community Based Flexible Supports (CBFS) program that became “the cornerstone of the Department’s community mental health system for adults.” CBFS services have the goal of fostering “independent living and recovery from mental illness.” We fully support these goals. CBFS is a valuable, recovery-based model that provides flexibility in meeting the needs of individuals. The implementation of the new CBFS model and its funding structure, however, has resulted in some unintended inequities among comparable CBFS contracts within the state that affect staffing and safety. This may need further study, analysis and correction.

Although no measures can fully guarantee safety, much could be done to improve the current situation. A few of our recommendations address matters on which people, including Task Force members, have strong and opposing opinions. Reasonable positions exist on both sides of these issues, and some Task Force members have objections to one or more of the recommendations contained in this report.

One area of controversy within the Task Force involved our explicit charge from DMH to address “the guardianship process and the issue of mandated community treatment.” The question of involuntary outpatient commitment engendered especially strong feelings. The Task Force neither endorses nor rejects creation of an outpatient commitment law in Massachusetts. This is a complex issue requiring knowledge and expertise beyond that of the current Task Force. Instead, our efforts focused on clarifying and expanding the utility of available mechanisms (*Rogers* guardianships) as one choice in a broad array of treatment options.

Another area of controversy within the Task Force involved access to Criminal Offender Record Information (CORI), a question also explicitly identified for review in the charge given to the Task Force. Those opposed to access to use of CORI and Sex Offender Record Information (SORI) in risk assessments raised concerns that included the following:

- Obtaining this information may further stigmatize individuals with mental illness;
- Asking prospective individuals served by DMH to sign releases for information may cause some of them to decline services;
- CORI and SORI information can lead to mistaken conclusions when positive findings reflect events in the distant past or when extenuating circumstances lessen their seriousness;
- Many people lack knowledge about how to interpret CORI and SORI findings and how to recognize their limitations.

Task Force members in favor of access made points that included the following:

- Knowledge of past history of violent behavior provides critical information for risk assessment and management;
- In some cases, CORI and SORI records provide the only indication of significant past behaviors that the individual does not acknowledge;
- Professionals experienced in risk assessment understand the limitations of CORI and SORI information, appropriately use it to explore otherwise unknown behaviors, and do not form conclusions based solely upon it;
- This information is used to plan appropriate services, not to deny services.

As with some other issues, we settled upon a recommendation acceptable, if not fully satisfactory, to at least 75% of actively voting members.

Many of the recommendations in this report, however, address basic principles of effective care, treatment, and safety on which we have strong consensus. We can sum up in a single sentence what this system, or any public mental health system, needs:

Individuals served by DMH need meaningful access to a full array of recovery-oriented services and treatment provided by adequate numbers of skilled and experienced hospital and community professionals funded to provide coordinated care as an integrated team.

The best way to enhance staff and client safety in the DMH community system of care involves access to a broad spectrum of services along with delivery of care by well-staffed, fully-resourced, and highly-trained interdisciplinary teams. Everything else contained in this Task Force report and recommendations simply elaborates on the details of these basic principles, and on deficiencies that currently exist in these critical elements.

The specific recommendations in this report address six broad categories described below that reflect concerns repeatedly expressed to the Task Force.

1. *Overarching Issues:* The DMH community system has significant safety risks due to severe underfunding. Addressing these risks will require resources from the Commonwealth and a priority commitment on the part of DMH.
2. *Staffing and Coordination of Care:* Current funding does not allow recruitment or retention of a sufficient number of experienced and qualified staff. Mechanisms do not exist to support necessary coordination of care across the DMH service delivery system.
3. *Access to Information:* Providers and programs often do not receive crucial information about individuals' histories, including factors related to potential violence.
4. *Access to Services:* Needed services, such as outpatient clinical care and hospital beds, are underfunded and difficult to access.
5. *Training:* Staff do not receive adequate training on safety, and sufficient resources to provide such trainings do not exist.
6. *Current Practices:* Some current practices impede delivery of important clinical care and treatment or do not provide mechanisms for timely safety-related interventions for individuals who present high risks of harm.

All sections of this report, except for the statement of the co-chairs, along with all recommendations and their rationales have been endorsed by at least 75% of all Task Force members, including both co-chairs. Each of our seventeen recommendations appears along with its rationale in the following "Recommendations" section.

RECOMMENDATIONS

Recommendations appear in bold, immediately followed by the rationale for the recommendation. Each recommendation and its supporting rationale was endorsed by at least 75% of the Task Force members. The co-chairs were among that 75% or greater majority on all recommendations.

- 1. DMH should issue a public written response to the Task Force recommendations within 8 weeks of receipt of this report. We also recommend that within 6 months of receipt of the report and then again at 12 and 24 months, DMH issue a public, written document indicating the progress on each of the recommendations.**

Rationale: The recommendations in this report focus on fundamental safety concerns. Delays in implementation could result in otherwise avoidable adverse outcomes. DMH review and progress reports on these Task Force recommendations should be a priority for the department.

- 2. The Commonwealth should significantly increase funding over the next five years in the publicly-funded mental health system. This investment should primarily be targeted towards the Department of Mental Health and MassHealth. These funds should be utilized for (at a minimum, but not limited to), the following:**
 - a. Providing adequate numbers of experienced, well-trained, and competitively paid direct care staff in community-based services, including peer-specialists, case managers, and clinical social workers;**
 - b. Supporting multidisciplinary teams that include psychiatrists or Advanced Practice Nurses;**
 - c. Integrating alcohol and substance abuse services for those who need them;**
 - d. Streamlining reimbursement mechanisms for collateral services by psychiatrists and other providers;**
 - e. Providing funds for DMH to augment reimbursements to psychiatrists and other clinical providers to be active participants in all continuity of care tasks.**

Rationale: For reasons described throughout this report, DMH needs additional funding, to help ensure safety, as well as to fulfill its mission. Many of the ensuing recommendations offered by the Task Force *can be implemented only with a significant investment in publically-funded mental health services* as they will require funding that is not currently available to the Department or provider organizations.

Funding for DMH has been reduced by almost \$60 million over the past three years. As a Task Force, we received compelling testimony from a wide range of stakeholders about the current strains that exist within DMH-funded programs due to these budget cuts. We also heard disturbing testimony about shrinking access to vital outpatient and inpatient mental health services due to inadequate funding of such services by MassHealth.

We know, moreover, that the publicly-funded mental health system was already under-resourced prior to the most recent round of budget cuts. DMH historically has had resources to provide services to only a small fraction of Commonwealth citizens with serious mental illness. In 2005, *DMH itself estimated that 44,731 adults in Massachusetts had a need for publically funded mental health services*. Current funding levels allow DMH to serve less than half that total, approximately 20,000 individuals in FY10.

A direct relationship exists between having an adequately funded public mental health system and the ability of the Department and providers to offer quality programs that enhance the safety of individuals receiving services, program staff, and the general public.

The Massachusetts Senate, in its version of the Fiscal Year 2012 budget, has already acknowledged that DMH needs additional funding to meet its mission. The Senate's budget proposal, which is now in legislative conference committee, recommends that funding for DMH be increased by \$16.5 million in FY12 above FY11.

Increased funding in FY12 as proposed by the Senate would be an important first step in addressing many of the recommendations included in this report. To fully address all of the Task Force's recommendations, however, the Commonwealth must make a sustained investment over a number of years in the public mental health system.

New funding is needed to increase staffing levels within DMH-funded programs. A robust workforce, including peer-specialists, case managers and clinical social workers is essential to ensuring safety.

Equally important is that individuals being served have true access to services delivered by psychiatrists. Meaningful integration of clinical and recovery-oriented services is essential for individuals being served by DMH. Increased funding and streamlining of reimbursement mechanisms is required to ensure that such integration is the rule and not the exception.

An investment in the publicly-funded mental health system will ultimately yield savings in other areas of the state budget. A robust public mental health system that more safely and effectively serves individuals living with a mental illness will divert many individuals from the public shelter system, from hospital emergency rooms, and from involvement with the criminal justice system.

3. The Commonwealth must increase beds and services across the system as well as work with the private sector to further develop the complete continuum of care. Safety is compromised because the overall number of community based services/beds, acute hospital beds, and intermediate care beds do not meet the current demands.

Rationale: The Task Force endorses and supports the concept of Community First and believes that whenever possible individuals should receive services in community settings rather than hospitals. For Community First to work in a way that truly promotes recovery, however, the Commonwealth needs a

well-resourced and well-integrated system of services and treatment. This means a robust array of community-based services, including peer-delivered services, and when necessary, sufficient access to acute or intermediate hospital levels of care.

The information we have received from numerous sources is that the Commonwealth *does not currently have a well-resourced and well-integrated system of services and treatment*. This is in part the result of budget cuts that have significantly impacted the availability of services, including hospitalization and related resources, for individuals served by the Department of Mental Health, as well as inadequate reimbursement rates from both MassHealth and commercial insurers for outpatient and inpatient mental health services.

The lack of resources impacts all levels of care, and deficiencies in any part of the system have ramifications throughout. For example, when DMH intermediate care hospitals are filled to capacity (in part because there are insufficient placements in the community for individuals who are ready for discharge) and cannot accept timely transfer of individuals from acute hospitals, this creates a “domino effect.” The acute care hospitals’ resources then are stretched, making it more difficult for them to admit individuals into their care. This can lead to individuals being “boarded” in emergency department (ED) settings, sometime for several days. (The data supporting this claim are detailed in the section on Summary of Information Obtained by the Task Force.) In these situations, a safety issue is created by maintaining a potentially self-injurious or assaultive person with active symptoms of mental illness in a busy ED setting. This does not meet the needs of the individual, delays treatment, and also disrupts the care of other individuals in that setting.

Currently, the system is fragmented. It must be strengthened in a way that effectively meets the needs of individuals receiving DMH-funded services. A complete, well-resourced continuum of services is the only way to address the safety concerns that the Task Force heard from various stakeholders in public hearings and meetings.

4. DMH, providers, staff, and the recovery community should develop guidelines to foster a culture of accountability and mutual respect among all parties, to promote a safe environment.

Rationale: Many providers and staff expressed concerns about the lack of interventions or consequences for individuals receiving services who are disruptive. In some residential settings for example, an individual receiving services may persistently break house rules including those related to smoking, use of alcohol and illicit substances, and threatening or assaultive behaviors. Many people from the recovery community expressed concerns that a staff member may not always be adequately trained or fully respectful. This lack of training or mutual respect only adds to the safety concerns. When infringements occur all parties need leeway to pursue interventions for the purposes of everyone’s safety, regardless if it may arise from a lack of mutual respect, a person’s mental illness, or a staff’s lack of training. If an individual receiving services willfully disregards house rules or threatens or assaults others for reasons unrelated to an underlying serious mental illness, or if a staff member does

not show proper respect for reasons unrelated to inadequate training, they should incur consequences. Particularly concerning is repetitive, unacceptable behaviors, which must require a response – either clinical interventions or consequences. Autonomy without responsibility simply becomes a license to misbehave, and undermines personal growth and recovery. Ultimately, each and every staff member and individual receiving services must have the immediate ability to insure a safe and respectful environment for everyone.

5. Necessary coverage levels for group living environments, home visits, and transports should be determined through ongoing formal risk review. For circumstances that do not require double-coverage, the risk review determination should specify the required level of training or experience for the individual providing single coverage.

Rationale: Safety concerns related to working alone were among the most common apprehensions expressed by staff on site visits and in written comments to the Task Force. On our survey of community staff, well-over half of the written suggestions, made by hundreds of staff, involved requests for more and better trained workers and restriction or elimination of solitary shifts and activities. Urban workers tended to have heightened levels of concern about working alone, especially with respect to home visits, compared to their rural counterparts. Some community organizations and workers consider single coverage acceptable in low crime neighborhoods and with stable clients who have established good relationships with their service providers.

Under some current practices, special requests or circumstances must arise before assignment of a second staff person to a shift or activity, such as community visits. This places the onus on staff to seek additional coverage, which is not always available. Limited staffing discourages some of these requests and leads to routine acceptance of unsafe conditions.

Instead of relying on direct care staff, some of whom lack clinical expertise, to identify circumstances that warrant more than single staff coverage, professionals who have risk-assessment expertise should explicitly identify clients, activities and places that do not require double coverage. Suggested considerations include:

- Severity and recency of threatening or assaultive behavior;
- Severity and recency of criminal activity;
- Active substance abuse;
- Non-adherence with medications or other needed treatment;
- Expressed hostility;
- Factors in the home (e.g., roommates, family, aggressive dogs, weapons);
- Neighborhood (e.g., high crime area);
- Time of day.

When a risk-assessment determines that a situation requires only single-coverage, the assessment should also specify a minimum level of experience with the population being served and/or licensure status of the solitary staff person. Staff also need an efficient and rapid mechanism to request and obtain double-coverage at times when they feel uneasy despite a risk-assessment that approves single coverage.

6. All direct care staff must have a reliable way to rapidly summon assistance when needed, such as an electronic alarm. Staff who transport individuals receiving services, or who work in the community, need safety procedures, features, and/or equipment appropriate to their settings.

Rationale: No statewide standards exist regarding safety procedures, features or devices. Procedures for client transport and home and community visits, as well as group living experiences, need to be jointly developed and approved by DMH, providers, staff and peer representatives. Important factors to consider include:

- A reliable, fail-safe, means of summoning assistance at all times of operation for employees in the field who need assistance or who are in a residential setting. This might include, depending on setting:
 - Cell phones with speed dial to an emergency number
 - Other alarm systems that alert a central office
 - Consideration of adequate lighting
- Log-out procedures, such as:
 - name and address of client being visited
 - scheduled time and length of visit
 - mobile phone number
 - an agreed safety code word
 - vehicle details
 - if providing transport for a client: proposed route, destination, and likely arrival time
 - any changes to timetable
 - expected time of return to the office.
- Reports to the office via phone after each visit.
- Employees instructed, at their sole discretion, not to enter locations where they feel threatened or unsafe.
- Double coverage whenever an employee feels insecure regarding factors such as:
 - time of activity,
 - location,
 - nature of the clients health problem, history of aggressive or assaultive behavior, or potential for aggressive acts.
- Hand held alarm or noise devices, other effective alarm devices, and other protective devices should be considered for all field personnel.

- 7. Each DMH Area should have a mechanism for regularly scheduled collaborative meetings between clinical leadership of the Area and the local provider network, including peer provider staff and DMH risk-assessment professionals, to resolve risk management issues for individuals receiving services.**

Rationale: There should be shared responsibility between the providers and DMH for ongoing consultation regarding individuals with high risk profiles, including those who are homeless and those who have a substance abuse disorder. We have learned of various successful models employed within different Areas of DMH, and we encourage discussion among the Areas and providers to adopt the best elements of each Area's practices. Ideally, the process would be a collaborative one in which the clinical leadership of the Area meets with clinical leaders of the provider network and others with relevant expertise to discuss risk management issues for individuals being served. Such issues may be raised by either provider or DMH with the goals of developing a person centered risk plan, identifying emerging systemic issues, and sharing professional decision making across DMH and the provider network.

DMH has a breadth and depth of expertise in risk-management areas that contract community providers cannot duplicate. These DMH experts, including those who work in inpatient and forensic settings, can play a valuable role in the ongoing, as well as initial, assessment and management planning for individuals that warrant their involvement. When DMH lacks a relevant expert, DMH must have adequate funding to contract for the expertise.

- 8. DMH, in collaboration with the provider community and stakeholders, should develop clear policies to facilitate communication of relevant clinical information across the continuum of care. In addition, DMH should develop a quality assurance mechanism to ensure that information sharing is indeed occurring.**

Rationale: Continuity of care requires sharing of relevant information across all levels of care, including institutional providers, community providers, and providers who serve homeless clients. Currently, there is a lack of clarity about what information can be shared. For instance, we have received information that some hospital teams will share risk assessment consults (such as Mandatory Forensic Review reports or Independent Forensic Risk Assessments) readily with community providers, while others believe they cannot share this essential type of information. DMH, in collaboration with the provider community and stakeholders, should seek to maximize the information that can be shared, consistent with existing laws, and clarify and educate staff at all levels about the rules of information sharing. Furthermore, DMH should develop a monitoring mechanism to ensure that these standards are being implemented in practice.

- 9. The DMH referral process to community providers should be modified to include the following elements:**
- a. Complete and standardized risk assessments should be administered at the time of service authorization. Where appropriate, these assessments will include review by specially trained psychologists and psychiatrists, who have access to CORI and SORI. The risk assessment should be shared with providers at the time of referral.**
 - b. Individuals determined, through risk assessment and consultation with providers, to need specialized care should be placed only in community-based settings, or with specialized teams, designed and staffed to serve them safely.**
 - c. Providers should have sufficient time, from time of referral, to plan and enroll individuals referred to them in appropriate services. The Department and the provider community should engage in a process that ensures the time period for enrollment, including enrollment in CBFS services, is both fair and reasonable.**
 - d. Entry to services and transitions across services should occur with careful attention to timeliness and well coordinated and integrated handoffs.**

Rationale: Rationales supporting the above recommendations can be read by associated letter (a, b, c and d) below.

a) Over the past three decades, the use of the “unstructured clinical judgment” approach to violence risk assessment (that is, leaving it up to individual clinicians to assess risk based on usual clinical techniques, without providing specific guidelines) has been consistently discredited. Although no one instrument or tool has universal acceptance, best practices in developing risk management plans involve a structured approach to collecting data, including historical information. We therefore recommend that DMH move quickly to adopt a structured, standardized, and evidence-based approach to conducting risk assessments. A previous DMH Task Force on Safety and Risk Management (2005-2007), developed a risk identification tool, which is currently under revision by DMH, and can be adapted for the current purposes. In addition to including information about clinical diagnosis and substance use issues, the assessment should include obtaining data from all available sources about history of: self- injurious behaviors; physical violence towards others; use of weapons; sexual offending behaviors; fire-setting; and stalking. To address these items, inquiry should be made regarding history of arrests, convictions, incarcerations, and restraining orders.

Most individuals applying for DMH services will not have such histories. However, for the minority who are so identified through this risk identification tool, further review by a psychologist or psychiatrist with specialized expertise in risk assessment is warranted. For this group of individuals, access to their formal criminal records (specifically Criminal Offender Record Information and Sex Offender Registry Information) should be made available to the psychologist/psychiatrist conducting the review. We want to emphasize that information obtained from a CORI or SORI is not a basis for denying eligibility for DMH services. Furthermore, data from a CORI record is not meaningful by itself. Rather, the CORI or SORI is just one source of data; in most cases it will simply corroborate what the individual has reported. In

other cases, it may reveal new information which will result in further discussion with the applicant to clarify risk factors.

We make this recommendation with the recognition that an individual's history of violent behaviors, including a criminal history, does not mean that the person continues to pose a risk. Rather, a proper risk assessment entails more detailed inquiry (primarily with the individual directly, bolstered by whatever other sources of information may be available) by a qualified clinician into the circumstances surrounding the concerning behaviors. This assessment should identify the specific risk factors for violent behavior for the individual, should be shared with both the individual and the community agency to which the individual is referred for services, and incorporated into the Individualized Action Plan.

b) In addition to implementation of a standardized risk assessment tool, it is essential that the process by which DMH refers individuals to community-based provider organizations for services be transparent and collaborative in an effort to ensure that individuals receive services that best promote recovery in a safe environment.

c) Providers must have sufficient time to plan for, and enroll individuals referred to them in appropriate services. Currently, agencies providing CBFS services are required to begin serving individuals referred to them by DMH within 72 hours of referral. We have learned that 72 hours is frequently not enough time for providers to obtain adequate information in order to be able to make appropriate decisions to ensure the safety and well-being of the individual referred, other individuals already receiving services, program staff, and the general public. We have been assured that DMH has committed to working with provider organizations to specifically review and modify the 72 hour referral process. We support this effort and urge both DMH and providers to address this issue in a timely manner to ensure providers have sufficient information available to them when individuals are enrolled in their programs.

d) Transitions in care, and/or changes in care providers, are predictable periods of increased vulnerability for individuals, where the chances of "slipping through the cracks" and anxiety are heightened. Carefully planned changes, with adequate time for thorough and thoughtful transfer of information, are essential. This must be accomplished in such a manner that the individual served does not experience undue delays and time-lags, and that s/he has certainty about the next step in his/her treatment and recovery processes.

10. DMH should establish guidelines for direct admissions to state hospitals as part of integrated treatment plans for specific individuals.

Rationale: As already described, a small group of individuals have histories of serious violence associated with episodes of treatment non-adherence. At times, they need rapid access to care, treatment, and monitoring in a hospital. The enhanced risk-assessment processes described elsewhere in this report can identify these individuals. It would improve safety throughout the system if these

individuals have direct and ready access to state hospitals, which are best prepared to serve them, when necessary.

11. DMH should conduct statewide reviews on all current collaborative practices in place with other entities, including state agencies, and make any needed enhancements to these efforts to address the following issues on behalf of vulnerable populations:

- a. **Work with homeless shelters and other entities on initiatives that facilitate engagement of individuals who choose not to become clients of DMH. These initiatives should include, but are not limited to, ready access to crisis services, and consultation as needed;**
- b. **Work with providers and direct care staff to jointly develop engagement and intervention strategies for those individuals enrolled in DMH services who choose to not engage in services, yet by history pose safety risks to themselves or others;**
- c. **Work with police departments to increase jail diversion programs, and promote adequate and sensitive emergency response and assistance, including transportation of individuals to Emergency Departments or hospitals under state commitment statutes;**
- d. **Work with the Department of Correction and County correctional facilities on mechanisms to obtain de-identified aggregate data about DMH clients in their systems, to assist in monitoring adverse outcomes. Such data can additionally assist DMH staff to ensure service capacity that promotes effective community re-entry and integration;**
- e. **Strengthen collaborative planning and implementation strategies with organizations in the mental health treatment community and the recovery and rehabilitation partners in implementing the recommendations of this Task Force.**

Rationale: Rationales supporting the above recommendations can be read by associated letter (a, b, c and d) below. All recommendations and rationales aim at increasing DMH's collaboration with other entities.

a & b) Some individuals qualify for DMH services but choose not to seek them. They often present in other state-funded programs, including the Commonwealth's shelter system. Other individuals approved for and referred to DMH-funded community programs choose not to engage in them. Recognizing the right of individuals to refuse services, the safety issues presented by a few such individuals does require attention. The safety of these individuals, those who serve them in non-DMH funded programs, and the general public, may be more at risk due to their disengagement from DMH services. Efforts to address the needs of such individuals should include an acknowledgement of shared risk between the Department and provider organizations.

c) The relationship between the police and mental health services varies across the state. Clinical and DMH-contract staff in some areas have good relationships with local law enforcement, particularly where there are specialized Jail Diversion projects in place. Elsewhere, things do not function as

smoothly or at all. In some areas police have refused to transport individuals under the authority of state commitment laws. In several instances, community staff report that the police have stated they will not “provide taxi services.” This has resulted in unstable individuals remaining in community settings unequipped to safely manage them, or, even worse, staff attempting to do transports in their own vehicles. Safety of staff and clients in DMH community programs require reliable assistance from police and other emergency services when needed.

d) Data about clients who end up in jail, prison or Bridgewater State Hospital can help monitor adverse outcomes and can assist in identifying factors associated with risk of incarceration. In the past, DMH has tracked these data, and they should develop mechanisms to do so again.

e) As found by the Task Force, organizations in the mental health treatment community have valuable information on the fitness of the DMH system. Their perspectives can help DMH identify gaps and shortcomings in its services. DMH should use its existing mechanisms, or any expanded mechanisms, to work with such organizations in implementing the recommendations of this Task Force.

12. DMH should provide funding for orientation and refresher trainings related to safety-related issues and respectful engagement. These trainings should be developed in conjunction with providers, staff, and peer representatives, and offered to all DMH and provider staff.

Rationale: The Task Force received requests from staff throughout the system for enhanced training in safety. Many individuals spoke of an increasing incidence of behavioral aggression in clients who now receive their services primarily in the community instead of in hospital settings. They also spoke of high staff turnover and a less experienced workforce associated with low salary compensation, which further exacerbates the need for safety training.

The DMH community system of care lacks a statewide safety training program; instead each provider agency handles this on its own. DMH has the *expertise* and must be provided funding to develop a standard training curriculum and program that reflects current best practices.

DMH will also need to cover training costs, including the cost of back-fill coverage for staff that are pulled away from their work-shifts to attend training activities. Existing contracts with DMH providers do not take these expenses into account.

We recommend that safety trainings occur both as part of new employee orientation and as part of annual refresher training activities, and that elements include at least the following:

- Basic information on mental illness, symptoms, and addictions;
- Recognizing and documenting violence risk factors;
- Crisis intervention techniques;
- Role of trauma;
- Setting-specific safety action plans;

- Reviews of policies and procedures related to safety.

Training techniques to consider include active learning methods such as role plays, involvement of clients who can share their perspectives, and competency assessment of skills.

13. All DMH funded or operated community-based services should have safety-related policies and procedures. DMH should ensure the adequacy and implementation of the core features of these policies and procedures.

Rationale: Individual DMH funded or operated community programs have a different quantity and quality of policies and procedures that address safety. Each provider organization also varies greatly in their array of and approach to policies and procedures that address safety. DMH requires its contracted providers to have their own protocols that address a wide range of clinical and risk management issues, but it provides little, if any, oversight and review of those provider protocols. The Department needs to ensure that each organization's safety-related policies and practices throughout the state meet uniform and basic standards. To accomplish this, DMH together with its provider organizations should work to streamline and focus policies and procedures on safety issues that are involved with the provision of care and treatment, while minimizing creation of unnecessarily complex or burdensome paperwork.

Depending on the nature of the program, we recommend consideration of at least the following broad areas to be included in standardized policies and procedures:

- Risk assessment practices, both initial and ongoing;
- Obtaining and sharing safety-related information about a person served with all appropriate staff;
- Dealing with threatening, abusive, or aggressive behaviors;
- Dealing with situations that involve alcohol or other substance use;
- Dealing with potentially unsafe environments, neighborhoods, locations;
- Criteria for when staff should not work alone in a situation, circumstance, or task;
- Obtaining assistance at times of crisis;
- Reporting safety concerns internally and proactively;
- Obtaining consultation or supervision regarding safety concerns;
- Involving individuals served in strategies to decrease risk;
- Safety-related admission and discharge procedures for programs and services;
- Dealing with other situations that raise safety concerns;

14. Safety considerations must be an integral part of Individualized Action Plans (IAP). The Department, providers, staff, and the peer community should collaboratively develop and implement guidelines regarding IAPs and person centered planning to ensure that they address safety issues.

Rationale: The intent of this recommendation is to have DMH clarify its own policies and convey in a clear manner to providers that safety and risk considerations should be incorporated into the IAP when clinically appropriate. Based on discussions with provider leadership and staff, as well as DMH personnel, we have discovered widespread frustration and confusion about incorporating risk factors into the IAP. Providers repeatedly noted that they have been told by DMH that they cannot incorporate risk items into the IAP unless this is explicitly requested by the individual. We note that DMH regulations (104 CMR 29.11 and 29.12) specifically indicate that providers can place items on the IAP that are driven by the clinical assessment, and the client can then choose to accept those, or appeal their inclusion. As part of training on IAP development, awareness needs to be raised within DMH and the providers about these regulations.

15. DMH should amend the language of the PCP (Person –Centered Planning) process to clarify that interventions to keep the individual and others safe should be implemented in a timely manner, and should not be delayed until the risk is imminent.

Rationale: Currently written descriptions of the Person Centered Planning (PCP) process state that when a treatment team determines that “the individual’s decisions may put him or her at risk” they “must seek to balance supporting the dignity of risk – taking risks is a normal, life growth experience – with the obligation to keep the person and the community safe.” The PCP approach requires treatment providers “to clearly understand and distinguish between ‘risk’ and ‘safety’ issues.” Risk issues are described as “more subtle areas of concern when...an individual is making decision that may jeopardize his or her recovery...yet there are no imminent safety issues (e.g., dangerousness to self or others) present.” Risk taking is “both tolerated and encouraged.” DMH descriptions go on to state, “‘Safety’ issues, in contrast, refer to unique circumstances where an individual presents an imminent risk to self or others when in the midst of a psychiatric crisis.” At this point it becomes “*a provider’s ethical and societal obligation to intervene on a person’s or the community’s behalf*” [emphasis in the original].

This distinction between “risk” and “safety” lacks clarity. Treatment providers in the community told us that they believe that the DMH PCP approach in essence asks them to determine the moment of imminence and to take immediate action at that precise moment. By the time a person has decompensated into a “psychiatric crisis” and poses an “imminent” risk, however, it is often too late to avert harm that might have been avoided with earlier intervention. Requiring clinical providers to wait until an inevitable crisis has arisen while imposing upon them an “obligation to intervene on a person’s or the community’s behalf” would be asking them to do what cannot be done. Attention to working with an individual on a Wellness Recovery Action Plan (WRAP) and Crisis Plan (Advance Directive for care) may offer a means for working on this “risk”/“safety” issue in a collaborative way.

Clinical providers are able to identify patterns that are likely to repeat. A few individuals with serious mental illness have recurrent and severe relapses that include violent behavior after stopping medication or other treatment or when using alcohol and other substances. When a pattern such as this has become clearly established, effective risk management involves intervention at the earliest stages in

the cycle. Waiting until the pattern again reaches the crisis point would flirt with tragic outcomes. This would be a questionable strategy even in a secure hospital setting that includes constant professional monitoring. Such an approach becomes even more untenable when done in community settings staffed only by persons, often alone, with less clinical assessment skills or professional training.

16. DMH in conjunction with its providers should revise current critical incident reporting to heighten focus on serious incidents. These data should be aggregated and analyzed on a periodic basis, used to inform performance improvement activities, and disseminated across the system.

Rationale: The current approach to critical incident reporting includes requirements to report events that have little, if any, clinical, safety-related, or other significance. More needs to be done on a central, statewide basis with the data that is collected.

Community staff frequently expressed frustrations with requirements to report events that they consider non-significant. Each incident report takes 20 minutes or more to complete, taking time away from direct services with clients. Data related to these incidents are often reviewed and discussed at DMH Area levels, resulting in helpful follow-up and interventions. Statewide use and analysis of the data, however, requires improvement. Some staff also claim they have received critical feedback holding them accountable for the adverse events, which should not be the case.

Critical incident reports need to focus on meaningful events and lead to analyses of causes and, if appropriate, interventions to decrease frequency. They should be part of broader performance improvement activities. These activities need to focus on improving the system, and avoid blaming the reporter. Providers and staff should have ongoing input on setting criteria for the type of incidents to report and study.

Community staff also repeatedly told us that they spend too much of their day on paperwork. In addition to critical incident reports on minor events, they spend time on daily shift notes, daily Medicaid reimbursement forms, and other mandated forms. DMH, in conjunction with its providers, should review these requirements and seek ways to streamline them to eliminate non-essential documentation requirements in addition to non-significant incident reports that have minimal clinical relevance. This joint DMH/provider review can focus on maximizing time for staff to provide direct services with clients.

17. The Department should work with providers, peer representatives, clinical staff, and family organizations to develop and explain protocols to ensure that when a *Rogers* order is in place, that the terms of that order are being met by all parties.

Rationale: Massachusetts has a well-established, legally-recognized, guardianship process, referred to as *Rogers* guardianships, that allows for the administration of antipsychotic medications for individuals who lack competence to make their own decisions. This is typically used for individuals who lack

awareness of their illness and need for psychiatric medication. When such an individual also may have a history of violence associated with episodes of treatment non-adherence, *Rogers* guardianships should allow the ability to require treatment in the community when necessary to maintain the safety of the client or others, including the ability to have an individual with a *Rogers* guardianship brought to a hospital for treatment. Some provider organizations have successfully employed this strategy although in very limited cases.

The Task Force recommends that DMH take the lead in working with clinicians, providers, peer representatives and family organizations in an effort (1) to identify and establish clear protocols around the *Rogers* petition process and (2) to establish explicit protocols to be followed in instances where the terms of individual *Rogers* orders are not being met.

The Task Force neither endorses nor rejects creation of outpatient commitment law in Massachusetts. This is a complex issue requiring knowledge and expertise beyond that of the current task force. Instead, our efforts focused on clarifying and expanding the utility of available mechanisms (*Rogers*) as one choice in a broad array of treatment options.

STATEMENT BY THE CO-CHAIRS

For almost four months we have had the privilege of serving as co-chairs of a thoughtful and hard-working Task Force. Our members represented a broad and diverse spectrum of entities, including the Department of Mental Health (DMH), all of which care deeply about the public mental health system in Massachusetts. In our discussions, we addressed several important concerns that came up repeatedly in the course of our review. Our overall charge to assess “current policies and practices” also made specific mention of such concerns, including “appropriate access to and utilization of criminal history information (CORI)... [and] the guardianship process and the issue of mandated community treatment.” Some Task Force members had strong and opposing opinions on these and other questions. Although all of our recommendations and all other sections of this report have been endorsed by at least 75% of our members, including both of us, we have members who remain opposed to some recommendations.

The process of our review, the attempt to reach as broad of a consensus as possible, and the generation of this report involved far more time and effort than most Task Force members might have imagined. Without exception, every one of us became deeply engaged in our mission, clearing time from busy schedules, gathering information, and attending meetings. We did our best as co-chairs and as a group to ensure active participation and collaboration in all that we did, including the completion of our report and recommendations. We benefited from each others’ perspectives, leaving us all better informed. Everything that appears elsewhere in this report represents the end result of our collective effort. Every member of the Task Force contributed in some way to our information, recommendations and opinions.

In this co-chair statement, however, we speak only for ourselves. We attempt to summarize what we learned during several hundred hours of Task Force-related activities over the past four months, including visits to programs and oral and written feedback from over a thousand residential and rehabilitation staff, individuals served by DMH, clinical providers, and other stakeholders across the Commonwealth. We also attempt to reflect the voices of hundreds of people with whom we spoke. Our comments are informed by all that we saw and heard. We both traveled throughout Massachusetts visiting provider organizations, touring their programs and meeting with their staff and the people they serve individually and in groups ranging from a few to several score individuals. One or both of us, sometimes in conjunction with others on the Task Force, spoke with members and representatives of organizations that provide clinical services to the DMH population, including the Association for Behavioral Healthcare (representing many DMH provider organizations), the Massachusetts Association of Behavioral Health Systems (representing inpatient mental health and substance abuse facilities), the Massachusetts Psychiatric Society, and the Massachusetts College of Emergency Physicians. We had contact with or received statements sent to the Task Force from many stakeholder organizations. Together with other Task Force members, we conducted four public hearings across the state. Aided by colleagues at the University of Massachusetts Medical School, Dr. Appelbaum helped design, implement and analyze the results of a community staff survey that had 949 participants, many of whom added their narrative comments. On one occasion Dr. Appelbaum spoke with Stephanie Moulton’s mother, and on a second occasion we both spoke with her joined by Stephanie’s father and brother.

The information that we obtained in the course of these activities provides the foundation for what we say here. No matter where we went or who we spoke with, the same themes came up. Many of the people we met or heard from described a crisis in the Massachusetts public mental health system. Based on all that we saw and heard, we agree with that assessment. Serious fiscal, structural, and procedural problems compromise care and treatment and create worrisome safety risks for a small group of individuals who have elevated potentials for violence. The current situation has arisen after years of steady erosion in services. Defunding and dismantling of many effective past programs and practices have led to a fragmented system that can no longer adequately meet some crucial needs of the people it serves. The result of this process threatens safety for DMH clients, staff and the public at large.

During the past four months, we repeatedly heard the same concerns. Providers of DMH services, along with people served and stakeholders, shared distress about deficiencies in staffing, availability of important information, coordination of care, and access to services. Providers struggle to plan safe and appropriate services at times when they lack complete histories, including risk factors, on some individuals who they serve. Community staff expressed confusion about new policies that they believe impede their ability to directly address the serious disorders and functional impairments that make individuals eligible for DMH services in the first place. Some administrators for community mental health agencies that have offered professional services for a score or more years have thoughts of closing shop rather than furnishing what they see as ever deteriorating and sometimes unsafe services. Conscientious acute hospital administrators feel overwhelmed with the sheer volume of seriously ill and medically and behaviorally unstable individuals coming in from the community. Psychiatrists and other clinicians who have devoted entire careers to working within the public sector struggle with whether to continue working under conditions that they believe do not allow them to dispense appropriate treatment. Community providers worry about the movement of high-risk individuals from hospitals to community settings ill-equipped to safely serve them and not able to provide effective monitoring and care. Many providers expressed a need for a way to compel timely treatment for the few individuals who have a history of violence associated with non-adherence to treatment for serious disorders.

Some community staff told us in person and in our on-line survey, that they desire better access to risk information, including CORI and SORI reports, on individuals receiving services in the community. As we've noted, this issue was explicitly included in the charge given to the Task Force, but it was also one that generated strong differences of opinion within the Task Force. The Executive Summary section of this report describes essential elements of these opposing positions. As co-chairs, we believe that allowing automatic access to CORI and SORI information only to professionals with expertise in risk assessment strikes an appropriate balance among these competing concerns. These reviewers can explore significant positive findings in more detail. They can then summarize the relevant findings and history as part of a standardized risk-assessment record available to all providers, including hospitals, who work with the individual receiving DMH services. This can help ensure that individuals with significant histories receive the services necessary to keep them and others safe. Task Force recommendation 9a is a positive step in this direction. It minimizes potential misunderstanding or misuse of CORI and SORI information by limiting access only to specially trained psychologists and

psychiatrists who can then follow-up on that information as needed. Under recommendation 9a, CORIs and SORIs will be reviewed only in those instances where individuals are already known to have histories that raise concerns. Sometimes, however, the CORI or SORI provides the sole indication of past incidents that warrant further inquiry and review. As co-chairs, we believe that CORI and SORI reviews by specially trained psychologists and psychiatrists should be a routine part of all risk assessments, rather than done only in instances where risk factors have already been identified.

We also repeatedly heard descriptions of a system with insufficient funding to cover needed services. Employers cannot hire the number of staff needed to provide safe coverage for some settings, activities, or shifts, and they cannot offer competitive salaries that allow them to recruit and retain well-trained and experienced staff. Current salaries lead some direct care staff members to work two jobs just to make ends meet. Funding does not cover the expense of providing needed safety features, such as alarm devices for staff to rapidly summon assistance. Safety training activities for staff are limited by lack of funds to support them. Reimbursements for many clinical services, such as those provided by psychiatrists and other community mental health center providers, do not cover overhead and expenses. Both clinical and non-clinical staff express frustration about their inability to coordinate care because of unfunded collateral services, such as attendance at team meetings and other consultative activities by clinicians. Payments to acute hospitals do not reflect the actual costs of providing inpatient care and treatment for some DMH clients. Access to crisis, respite, acute inpatient, and intermediate inpatient beds does not meet existing needs. These are some of the things we regularly heard related to current funding.

Many of these deficiencies represent the end result of changes, including changes outside the control or authority of DMH, that have occurred over years or even decades. The most recent of these changes involved further loss of resources associated with the otherwise positive creation of the Community Based Flexible Supports (CBFS) program. While closing some existing DMH programs and reportedly cutting \$8 Million per year in related funding, DMH solicited bids for CBFS services from its contractual providers. The Request for Response (RFR) stated, "DMH is not issuing specific qualifications and staffing patterns for CBFS," but also specified that contractors "must provide Rehabilitation, Support, Supervision, Housing/Room and Board to their assigned clients as needed to facilitate each client's recovery in a safe and clinically appropriate manner...[and] must accept all referrals within its negotiated capacity." Representatives from provider organizations across the Commonwealth told us, however, that CBFS funding and contracts do not allow them to safely meet these goals. When responding to the RFR, contractors knew how much funding DMH had available, including the loss of the \$8 Million that had supported some services being replaced by CBFS, and they consequently knew how much they could bid and still remain competitive. They described facing a stark choice. Despite knowing that the funding would be inadequate, they could profess, as required in the RFR, to provide "safe and clinically appropriate" services to "all referrals" regardless of their level of need. Alternatively, they could bid at the true level of costs to meet RFR requirements and price themselves out of the range that DMH could afford to pay. The absence of RFR staffing standards lessened DMH's role in establishing minimally adequate conditions for safe services, thus contributing to contractor underbidding. Despite the language in the RFR, we heard repeatedly from provider organizations that the system has serious

deficiencies in staffing and covered services, most notably clinical care, that fail to “facilitate each client’s recovery in a safe and clinically appropriate manner.”

This situation has developed despite good intentions. Dr. Appelbaum has known some community providers for years or even decades, and as part of the work of the Task Force, we both spent many days visiting and meeting with all levels of staff at several contractor organizations across the Commonwealth. Without exception, we found caring and competent individuals and organizations long dedicated to providing quality services to the DMH population. In all organizations, we also found people deeply troubled by the dilemma of continuing their mission in the face of what they see as steady erosion in resources and dismantling of critical practices and services. It will provide no benefit to the state if these contractors close shop. DMH, for its part, can fund only as much as its budget allocation allows.

Even the best of intentions, however, cannot by themselves result in adequate services. The reported loss of resources associated with the transition to CBFS represents only the most recent of a series of cutbacks in DMH funding. Along with deficiencies in reimbursement practices outside the control of DMH, these cutbacks have collectively led to a situation in which DMH clients and service providers face avoidable risks that place them all in unnecessary jeopardy. If we care about safety, we cannot pretend that all is well. The current system is fragmented and underfunded, resulting in insufficient safeguards for some who need them.

The problems that we repeatedly heard about as co-chairs can be fixed. The most important resource to do this already exists within the individuals who supply services. DMH, its contract and peer providers, community mental health centers, acute psychiatric hospitals, and other community providers that work with the DMH population all have dedicated staff, including many with valuable experience. Some of these dedicated and accomplished individuals participated in our task force. They do the best they can with often scant resources. We have no concern about their willingness and ability to serve. They need our support, however. The recommendations of this Task Force, if implemented, can provide them with such needed support. If our Task Force process helps to accomplish this, everyone engaged in the DMH system will benefit, while also enhancing safety for the few individuals who need it.

Kenneth L. Appelbaum, M.D.

The Honorable Paul F. Healy, Jr.

SOURCES OF INFORMATION

The Task Force met as a group in Shrewsbury, unless specified otherwise below, with some members participating by conference call. Our meetings, which lasted at least two hours and up to five hours on a few occasions, occurred on the following dates:

- March 3, 2011
- March 16, 2011
- March 31, 2011
- April 20, 2011
- May 5, 2011
- May 25, 2011
- June 9, 2011
- June 13, 2011 (Boston)
- June 14, 2011
- June 22, 2011

The primary sources of information for the Task Force are described in more detail below, but in broad categories included all of the following:

- Program visits;
- Meetings with community staff and clients;
- Public hearings;
- Meetings with groups of chief executive officers from DMH contractual provider organizations;
- Meetings with groups from professional organizations;
- Discussions with leaders of stakeholder organizations;
- Discussions with leadership staff from DMH;
- Statements sent to us by email or postal mail;
- Surveys of community staff;
- Review of DMH documents and statistics;
- Review of documents and policies of provider agencies;
- Literature reviews.

The co-chairs, individually or together, scheduled and/or participated in the following activities. Other Task Force members participated as indicated. All Task Force members had access to the other sources of information noted below:

1) Community Program visits:

The co-chairs conducted tours and met primarily with administrative and direct-care staff, as well as individuals served on some tours, often in groups ranging in size from a few to over 50 participants. Other Task Force members also conducted some tours and visits separate from those of the co-

chairs. Dr. Appelbaum participated on all of the following dates and locations and Judge Healy participated in all visits except April 12th, April 19th and April 22nd:

- March 17, 2011: Community HealthLink, Worcester;
- March 30, 2011: Advocates, Framingham;
- April 8, 2011: Edinburg Center, Waltham;
- April 11, 2011: Carson Center, Westfield;
- April 12, 2011: Bay Cove Human Services, Boston;
- April 14, 2011: Community Counseling of Bristol County, Taunton;
- April 15, 2011: Vinfen, Cambridge;
- April 19, 2011: Community HealthLink, Worcester;
- April 22, 2011: Riverside, Dedham.

2) Meetings with community staff:

The co-chairs met with staff during all visits noted above, and also set aside time for community staff to schedule confidential interviews with them on Thursday, March 24, and Thursday, April 7, 2011.

3) Public Hearings:

One or both co-chairs, along with other Task Force members, conducted public hearings on the following dates, times, and locations:

- April 5, 2011, 4 – 6 pm: Fitchburg, MA
- April 11, 2011, 4 – 6 pm: Springfield, MA
- April 13, 2011, noon – 2 pm: New Bedford, MA
- April 14, 2011, 6 – 8 pm: Boston, MA

4) Meetings with groups of chief executive officers from DMH contractual provider organizations:

The co-chairs met with representatives from DMH community provider organizations on March 25, 2011 and on April 25, 2011.

5) Meetings with groups from professional organizations:

- April 21, 2011: Massachusetts Psychiatric Society (MPS): Dr. Appelbaum met with the President and the Public Sector Committee of MPS
- May 6, 2011: Massachusetts Association of Behavioral Health Systems (MABHS): Dr. Appelbaum and Judge Healy, along with other Task Force members, participated in a meeting/conference call with members of MABHS, which represents 47 inpatient mental health and substance abuse facilities in the Commonwealth

6) Discussions with leaders of stakeholder organizations:

Dr. Appelbaum spoke in person or by phone with the following individuals from the indicated organizations:

- Robert Fleischner, Center for Public Representation;

- Marylou Sudders, President/CEO, Massachusetts Society for the Prevention of Cruelty to Children (MSPCC);
- Marie Hobart, M.D., President, Massachusetts Psychiatric Society (MPS);
- Tanya Pearson, Executive Director, Massachusetts College of Emergency Physicians (MACEP).

7) Discussions with leadership staff from DMH:

In addition to ongoing informal consultations, telephone conference calls for group discussion of specific topics occurred on the following dates, with the indicated participants:

- March 29, 2011: Kenneth Appelbaum, Ira Packer, Jon Grossman, Barbara Fenby, Debra Pinals, Jay Tallman, Lester Blumberg.
- May 9, 2011: Kenneth Appelbaum, Ira Packer, Derri Shtasel, Vic DiGravio, Regina Marshall, Laurie Hutcheson, Rita Barrette, Kim Clougherty.

8) Statements from stakeholders: The Task Force established and publicized a special email address to receive statements from individuals and organization. We received and reviewed those statements, along with ones sent to us by postal mail or given to us at public hearings. In addition to many statements submitted by individuals, we received statements from the following stakeholder organizations:

1. Center for Public Representation, Committee for Public Counsel Services, Mental Health Legal Advisors Committee, and Disability Law Center: joint submission on “Involuntary Outpatient Commitment: Legal and Policy Analysis”;
2. National Association on Mental Illness of Massachusetts(NAMI-MA);
3. Association for Behavioral Healthcare (ABH);
4. Service Employees International Union (SEIU) Local 509;
5. Massachusetts Association for Mental Health, SEIU, ABH, MPS, NAMI-MA, MABHS, MSPCC, and Metro Boston Recovery Learning Community: Joint letter sent to Commissioner Leadholm;
6. Disability Law Center;
7. National Empowerment Center;
8. United Automobile Aerospace and Agricultural Implement Workers;
9. Western MA “RLC”;
10. Massachusetts Psychiatric Rehabilitation Association;
11. Board of Selectmen of the Town of Brookline;
12. Advocates, Inc., Framingham.

9) Phone calls with Stephanie Moulton’s family:

- May 27, 2011: Dr. Appelbaum spoke with Ms. Moulton’s mother;
- May 31, 2011: Dr. Appelbaum and Judge Healy spoke with Ms. Moulton’s mother, father and brother

10) Surveys of Community Staff: The Task Force conducted the following surveys:

- An on-line safety survey for all community staff. The Task Force asked DMH and provider organizations to inform their staff about how to access the survey. We left the survey open for responses for over a month, and 949 community staff persons took the survey.
- An on-line survey for community psychiatrists and other outpatient clinicians. We received 160 responses to this survey, including 114 psychiatrists, 37 therapists, 1 nurse, and 1 registered nurse clinical specialist.
 - i) A separate on-line survey for non-clinical community based staff.
- A survey distributed to all DMH funded and/or operated adult community programs/services to solicit their feedback and recommendations regarding safety concerns related to Staffing, Staff Training, and Policies and Procedures.

11) Review of documents and literature: The Task Force requested and received access to extensive documents, policies, statistics, and other information from DMH and provider organizations. Task Force co-chairs and members also conducted limited literature reviews on some focused topics and accessed relevant guidelines of government and professional organizations at local, national and international levels. Due to time and resource constraints, we did undertake comprehensive reviews on these topics.

SUMMARY OF INFORMATION OBTAINED BY THE TASK FORCE

It is beyond the capacity of the Task Force to summarize all of the information, statements and opinions that we received and reviewed. Instead, we provide this focused summary of the following areas:

- Overview of the DMH community system;
- Critical Incident data;
- Themes from meetings with staff and stakeholders;
- Results from our on-line staff surveys.

Overview of the DMH Community System and recent changes:

DMH offers the following brief description of its programs and services to meet the needs of clients and help keep them engaged in treatment:

“Community Based Flexible Support Services (CBFS): The DMH community service system: Rehabilitation, support and supervision with the goal of stable housing, participation in the community, self-management, self-determination, empowerment, wellness, improved physical health and independent employment. Individuals receiving DMH services live in a range of housing situations from group living environments (GLEs) to their own residences.

Respite Services: Respite Services provide temporary short-term, community-based clinical and rehabilitative services that enable a person to live in the community as fully and independently as possible.

Program of Assertive Community Treatment (PACT): A multidisciplinary team approach providing acute and long term support, community based psychiatric treatment, assertive outreach, and rehabilitation services to persons served.

Clubhouses: Clubhouse Services provide skill development and employment services that help individuals to develop skills in social networking, independent living, budgeting, accessing transportation, self-care, maintaining educational goals, and securing and retaining employment.

Recovery Learning Communities (RLC): Consumer-operated networks of self help/peer support, information and referral, advocacy and training activities.

DMH Case Management: State-operated service that provides assessment of needs, service planning development and monitoring, service referral and care coordination, and family/caregiver support.

Emergency Services: Behavioral health crisis assessment, intervention, and stabilization services, 24 hours per day, seven days per week, 365 days per year. Services are either provided at an ESP physical site or in the community (mobile capacity).

Homelessness Services: Comprehensive screening, engagement, stabilization, needs assessment, and referral services for adults living in shelters.

Child & Adolescent Services: Services include case management, individual and family flexible supports, residential, day programs, respite care, inpatient services and intensive residential treatment.

Forensic Services: Provides court-based forensic mental health assessments and consultations for individuals facing criminal or delinquency charges and civil commitment proceedings; individual statutory and non-statutory evaluations; mental health liaisons to adult and juvenile justice court personnel.”

Unfortunately, budget cuts over recent years have steadily eroded many of these services. Since FY2009, DMH has lost approximately \$60 million in funding and reduced its workforce by more than 800 FTEs. Some of the resulting service cuts include the following:

- *Case Management:* reduction in staffing and services;
- *PACT Teams:* elimination of two programs in Western MA and Metro Boston and reduction in a third program;
- *Education and Employment, Day Rehabilitation, and Drop-In Centers:* services eliminated
- *Community First Initiative:* reduction in funding for services that assist individuals to live as independently as possible in the community, rather than in a hospital
- *Community and school therapeutic support:* reduction in services;
- *Child/Adolescent Intensive Residential Treatment Program:* closed;

This shrinkage in services has occurred simultaneously with a reduction in state psychiatric hospital beds. The total number of DMH inpatient beds has declined as follows:

- 1990: 2,272
- 2003: 1,107
- 2004: 964
- 2008: 848
- 2010: 834
- 2011: 626

Critical Incident data:

One way to assess current conditions within a system like that of DMH, involves tracking and analysis of critical incidents. The Department of Mental Health collects critical incident reports and maintains a database with the information; however, they have not looked at the data to identify patterns, client and staff characteristics, high risk times, places, circumstances, etc. They also do not use the data to evaluate the effects of system changes or inform ongoing program development and quality

improvement activities. As a result, DMH could not provide the Task Force with conclusions that could be drawn from their raw data.

DMH aggregate data for calendar years 2005 - 2010 show as much as a three or four-fold increase in the numbers of important critical incidents in community settings, including violent behaviors, police involvement, and psychiatric hospitalizations. DMH has explained that changes in reporting requirements (Commissioner's Directive #20), initiated in 2009, make it difficult to determine whether these findings reflect actual increases in events or merely improved reporting. As noted, DMH has not conducted an analysis of the causes of these increases. Community staff, however, repeatedly told us in direct contacts and via surveys that there has been an increase in frequency and severity of some critical incidents independent of any increase in reporting.

The number of acute psychiatric hospitalizations for DMH clients in the community has also been increasing, as well as the recorded number of admissions of DMH clients to Bridgewater State Hospital (BSH) for evaluation of criminal charges. We received data for calendar years 2005 – 2010 on acute psychiatric hospitalizations showing a steady increase from 181 in 2005 to 968 in 2010. The data we received on admissions for criminal charge evaluations at BSH covered calendar years 2007 – 2010. This too showed a steady increase from 29 in 2007 to 122 in 2010. DMH, however, has indicated that the data on BSH admissions, has been “deduced” and may reflect “a combination of better access to arrest data...improved communication...and the possibility of an actual increase in...admissions.”

Although DMH conducts quality improvement activities, they do not have a standardized or coordinated process for this. They do limited integration and review of the data they collect. They do not routinely summarize statewide contract-monitoring findings, or use those findings to inform re-contracting, system redesign, resource allocation or quality improvement. During the tenure of this Task force, however, DMH has begun to identify ways to use and analyze the information they collect. Their plans include new quality improvement activities and coordination with their provider organizations.

Themes from meetings with staff and stakeholders:

The information in this section consists largely of statements and opinions expressed to the Task Force, as opposed to findings independently verified by the Task Force. Several themes, comments, and concerns came up repeatedly during visits with community staff and other stakeholders, including those outlined below. A more detailed description of some of these areas follows the outline.

- Staffing:
 - Inadequate numbers
 - Concerns about routine use of single-staffing in some situations, especially:
 - Group residences, home visits, or transportation with unstable, recently hospital discharged, threatening, or aggressive individuals
 - Group residences and home visits in unsafe neighborhoods
 - Home visits by identifiable staff who carry and deliver controlled substances to individuals in high-crime areas

- Insufficient compensation resulting in difficulty, if not inability, in recruiting and retaining staff with experience, training, and licensure
 - High turnover
- Inadequate sharing of information
 - Providers not always informed of an individual's history of significant violence (e.g., homicide, arson, sex offenses)
 - Formal and shared risk assessment process with involvement by providers and DMH does not always occur
- Need for more in-service safety trainings
- Increasing incidence of threatening and assaultive behaviors
 - Higher levels of acuity in the population served in the community
 - No central quality improvement reviews related to increase in incidents
 - Incident reporter sometimes criticized for allowing the incident to happen
- Hospitalization concerns:
 - Discharge of individuals from DMH facilities without community settings or resources that can serve them safely
 - Difficulty getting people into the hospital when needed
 - Acute psychiatric units unequipped to meet the needs of increasing numbers of high-acuity individuals in community settings
- Poor coordination of care
 - Absence of mechanisms for communication and coordination of care among community providers, outpatient clinicians, and hospital staff
 - Limited, if any, opportunity for community staff to get guidance from the individual's psychiatrist
 - Limited, if any, opportunity for psychiatrists to elicit observations and concerns of the community staff who work with the individuals they treat
 - Insufficient coordination of care at times of admission and discharge from hospital
- Insufficient outpatient psychiatry resources
 - New individuals referred for community services without a designated psychiatrist involved in their care
 - Delays of many weeks before new appointments take place
 - Medications may run out
 - Community psychiatry caseloads of to 500 individuals leaving psychiatrists with little more than 15 minutes per month per individual served
 - MassHealth reimbursement rates that do not cover clinic expenses
 - Resulting in clinic closures or limits on accepting new referrals
- Excessive new paperwork demands that pull time away from direct services with clients
 - Documentation of daily rehab services needed for DMH to receive federal Medicaid reimbursement
 - Incident reporting required for minor, non-significant events

- Environmental safety concerns
- Crisis intervention resources
 - Variable police response
 - Delays up to several hours in mobile crises service response due to crisis team workloads
- Lack of Cost of Living Adjustments (COLAs) for community based services;
- 9C cuts that eliminated all rehab and supported education and employment (SEE) services in 2008;
- Reduction of 100 DMH case managers over 2009 and 2010;
- Widespread cuts in DMH management roles over the past several years;
- Closure of two PACT programs in 2010.

One of the most significant concerns we heard about the impact of stretched resources involves situations in which staff work alone. This occurs in three settings primarily:

1. *Outreach/home visits*, which generally occur alone in CBFS, PACT, DMH Case Management, Homeless Outreach Teams, and Emergency Services.
2. *Transport of clients to appointments, shopping, etc.*, a common practice for staff to do alone in their personal cars.
3. *Group living environments*, which often have one staff person working alone. Although some programs have double staffing, this seems less common, in the eastern part of the state at least, than it was pre-CBFS. At least one reason for this was redeployment of residential resources by providers to develop and support flexible teams.

The Department has undergone significant reorganization and redesign of community based services as part of the 2009 Request for Response (RFR) for CBFS contracts. The RFR included additional requirements to offer employment, enhanced clinical (including trauma-informed care), wellness opportunities, peer specialists, recovery focused services, de-congregate group homes, and to deliver measurable outcomes. Although most constituents we heard from welcomed these features, some described an adverse effect that the additional expectations have further stretched resources. Concurrently, reimbursement challenges for clinical services to the DMH population have resulted in substantive financial losses at most outpatient clinics, and some closures. Psychiatric emergency services have experienced a significant spike in volume and commonly experience challenges with finding an empty bed in the acute care inpatient network.

Staff throughout the DMH system shared their everyday experiences of trying to accomplish more with fewer resources. They described compromises that they make each day to juggle priorities, attending successfully to some, while others of equal concern don't receive the attention they warrant. They shared their worries directly and honestly, many offering that the tragedies that led to the Commissioner's development of this Task Force, could have easily happened in many parts of the system. Experienced leaders and clinical experts expressed surprise that the incidence of violent

tragedies is as low as it is, given the acuity of risk that a cohort of the people they serve evidence and the under-resourced community system. They describe the safety net as fraying. Although they make significant efforts to attend to risk concerns proactively and as situations emerge, they attribute some of the low incidence of such tragedies to “luck.”

We also heard repeatedly from staff that most people they serve do not represent a danger to themselves or others and that single staffing works well them. *Yet, it is in situations where staff work alone (home visiting, providing transportation, and in group homes), where the most predominant vulnerability regarding safety for clients and staff unfold.*

Although service providers across the Commonwealth attempt to deploy resources flexibly with additional support in single staffing situations, they report that they have inadequate base staffing and financial resources to do this in a sustaining way. They spend much of their clinical leadership time assessing and attempting to mitigate risk concerns. They believe that they operate with sub-optimal resources to attend to the behavioral acuity of many of the people they serve. Barriers to the remedy of staff working alone in risky situations include staff vacancies, absenteeism, and management decisions, as well as funding inadequacies.

We found no national or evidence-based practices regarding staffing for community residences. These exist for inpatient settings and for nursing homes. Some providers indicated, however, that the considerations that go into their staffing at these sites include:

- Accessibility to additional staff in the event of a crisis or brewing crisis (through on-call, redeployment of staff from other sites and their physical proximity to the location in need);
- Environment of the facility (e.g., features of the physical layout that may influence safety and staffing concerns, such as a large four story rooming house with Single Resident Occupancy);
- Neighborhood (e.g., urban concern, higher crime areas);
- Alcohol and substance use and abuse by residents;
- Current and past criminal involvement by residents ;
- History of violence, including context (e.g., someone who has a history of violence when not taking their medications, but now takes them consistently, lessening their risk)
- Number of clients served, which impacts availability of staff given other duties (e.g., if there are 12 people in a group home and single staffing in the evening, approximately 2 – 3 hours can be spent on medication administration with 4 and 8pm routine dosing times; another 1.5 hours spent in assisting people with meal preparation, dinner, and cleanup; approximately 0.5 – 1 hr spent documenting the rehab activities through services notes or summarizing events and communications in the shift log).
- Functional level, medical concerns, and behavioral acuity of persons in the house;
- Response time from local first responders.

The Massachusetts College of Emergency Physicians (MACEP) conducted a recent survey of all Massachusetts ED medical directors regarding psychiatric boarding (i.e., individuals in need of and accepted for admission but waiting for a bed). Sixty-five Medical directors representing 94% of

Massachusetts EDs responded to the survey regarding the status on Monday morning, April 11, 2011 of psychiatric boarding in their EDs. MACEP reported that the following conditions existed on that date in Commonwealth EDs:

“The total number of boarders and boarding hours were 180 and 5335 respectively. Mean occupancy i.e. the percent of total licensed ED beds occupied by psychiatric boarders was 13% with a maximum of 47% in one institution. The maximum length of stay for an individual patient was 8 days, 22 hours (and occurred in the same ED with 47% occupancy). Overall, 40% of boarders had stayed >24 hours, 10% >3 days, and 3% >5 days. We also asked if any boarders were pediatric patients. 7 of the 180 boarders were between the ages of 13-19, boarding between 12-100 hours.”

A MACEP report of these findings concludes, “This is arguably one of the most important issues we face today... Psychiatric boarding is a priority issue for emergency physicians.”

Results from our staff surveys:

Our *on-line-survey* of community psychiatrists and other outpatient clinicians received 160 responses, including 114 psychiatrists, 37 therapists, 1 nurse, and 1 registered nurse clinical specialist. As a group, they expressed dissatisfaction with the current community system of care, with the following themes prevailing:

- Fragmentation in the delivery of care and treatment;
- Poor flow of clinical information among inpatient, outpatient, and CBFS providers;
- Lack of integration of psychiatry in CBFS services, along with undervaluation of the role of psychiatrists;
- Inadequate reimbursement for direct clinical services;
- Lack of reimbursement for important collateral services (e.g., record reviews, consultation with other providers, attendance at team meetings, time spent arranging for an individual’s hospitalization, etc.);
- Excessive paperwork requirements, including generating Medicaid billing;
- Staffing inadequacies within the CBFS program.

Our *on-line safety survey* of all community staff at DMH-affiliated programs had 949 respondents, representing all components of the DMH community system. Thirty percent were male and 70% female. The findings included the following:

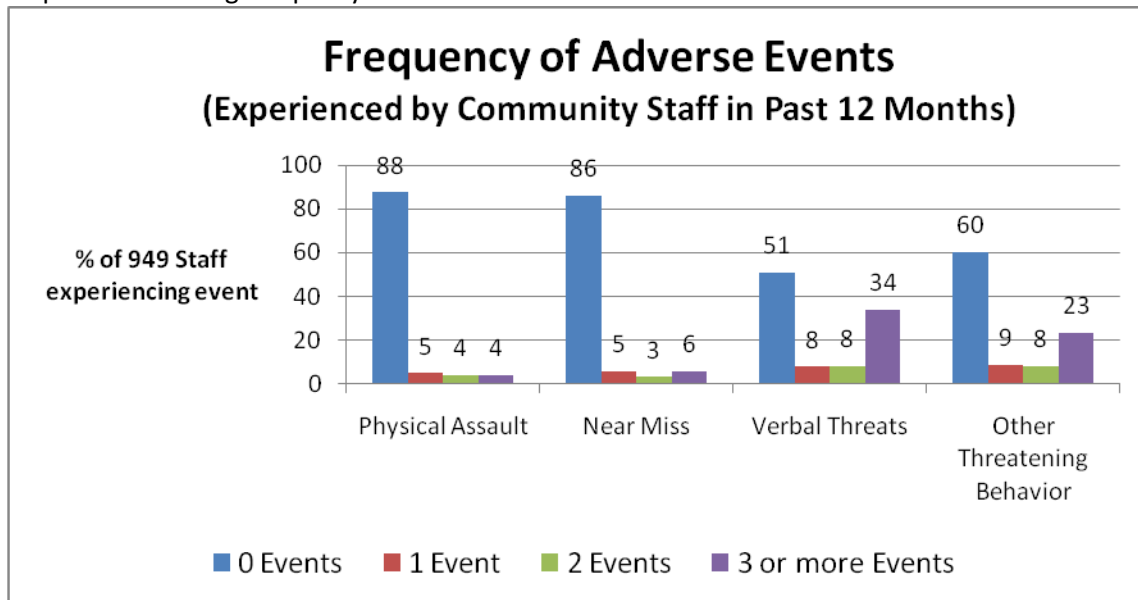
- 80% percent have an Associate’s Degree or higher;
- 31% have a license in a mental health or rehabilitation field;
- 76% percent “sometimes,” “often” or “always” work alone;
- 17% of the total sample feel “somewhat” or “very” unsafe at work, with the remainder feeling “mostly” or “very” safe;
- Among those who have been in their current jobs for at least a year, 25% feel “somewhat less” or “much less” safe now and 11% feel “somewhat more” or “much more” safe now;
- Only 30% report that they “always” have information about a client’s history of violence;
- Over half of respondents rated staffing levels, gender balance amongst staff, safety of the physical plant/space where they work, and availability of timely consultations as “very” or “extremely” important but over half were “not satisfied” or only “somewhat satisfied” with current conditions;

- Just under half rated safety training and availability of emergency assistance as “very” or “extremely” important but over half of all respondents were “not satisfied” or only “somewhat satisfied” with current conditions.

Participants in this survey had the opportunity to offer suggestions about how to improve safety or to make “other comments.” We received 747 of these suggestions and comments. They echoed what we heard from staff in other settings, with about 80% of comments expressing concerns about insufficient staffing, including concerns about working alone. Other frequently made suggestions addressed more training; better access to client histories, including CORIs; improved safety devices at work sites and for home visit or client transports; more rapid responses by crisis teams and police; consequences for threatening and assaultive behaviors or illicit substance use in residential settings; and decreased paperwork.

The 949 survey participants included 722 who provide direct care services to clients. Findings within this subgroup varied minimally from the findings in the group as a whole. Direct care respondents who work in CBFS residential settings (n=333), however, tend to be less well-educated (57% with an Associate’s degree or higher as compared to 80% among all survey participants). *Almost one in four of these individuals experienced assaults and/or “near misses” in the previous 12 months, with slightly over 1 in 20 experiencing 6 or more of these events.*

The following table shows the frequency of assaults and related events experienced by all survey respondents during the past year:



- Physical Assault:** “Punched, kicked, choked, struck with an object, cut, sexually assaulted, injured while breaking up a fight, etc.”
- Near Miss:** “You weren’t touched because someone helped out or the person missed you.”
- Other Threatening Behavior:** “Brandishing a weapon, aggressive acts without physical contact, other threatening, non-verbal actions”

ACKNOWLEDGEMENTS

Many people within DMH assisted the Task Force by providing us with information and responding to our questions and requests. We could not have completed our assignment without their cooperation. We especially thank Regina Marshall, DMH Chief of Staff and Task Force member, for the central role that she played as our contact and liaison within the department. Laurie Hutcheson, Assistant Commissioner for Quality Management and Policy, spent countless hours rapidly tracking down documents and information that we requested and providing us with invaluable assistance. Jay Tallman, DMH Policy Director, assisted with tasks ranging from minutes for meetings to making arrangements for public hearings. Everything went off without a hitch due to his efforts.

Many DMH provider organizations opened their doors to the Task Force for tours and meetings with their staff and individuals served. We appreciate their willingness to so readily accommodate our schedule, activities and requests for information and access. Their willing and unreserved cooperation greatly facilitated our review.

Research staff and faculty at the University of Massachusetts Medical School (UMMS) assisted Dr. Appelbaum in the design, implementation, and analysis of an on-line safety survey of DMH-affiliated community staff. The Task Force would not have been able to conduct the survey or obtain this valuable information without the generous donation of volunteer time from these individuals. UMMS also provided the Task Force with space, administrative support, technical assistance, and additional resources for meetings and other activities. This support allowed the Task Force to function efficiently and complete its mission in a timely manner.

Scores of individuals and organizations provided the Task Force with the benefit of their perspectives on the matters under our review. They provided us with thoughtful comments at public hearings and in written submissions. They met and spoke with us freely when we had questions. We appreciate their interest in our process and the time they devoted to share their insights with us.

Finally, we thank the hundreds of DMH-funded program staff and individuals served by DMH who took time to meet and speak with us, participate in surveys that we conducted, and submit written comments to us. Their cooperation, more than anything else, made our review possible. We also thank the multitude of other staff and individuals served by DMH that time did not allow us to meet with directly. Their sheer numbers and interest exceeded the time that we had to accommodate them. It is for all of them, however, that the Task Force worked. They provide and receive the services that we reviewed. They deserve our full appreciation and support. We hope that our process and report does justice to all that they do.