Gov. in the practice of reacting. 1743-1744-1745

GOOD EVENING. I AM HAPPY TO BE HERE TONIGHT AND WOULD LIKE TO SHARE WITH YOU SOME OF MY OBSERVATIONS ON THE COMMONWEALTH'S MENTAL HEALTH SYSTEM. WHAT IS NEW WITH THE SYSTEM? WHAT IS ITS STATUS? IS IT GOOD? IS IT BAD? ARE THERE PROBLEMS? AND IF THERE ARE PROBLEMS, HOW CAN THE GENERAL ASSEMBLY ADDRESS THESE PROBLEMS TO FIND SOLUTIONS?

WHAT ARE THE ANSWERS TO THESE QUESTIONS? INITIALLY, MANY WILL ANSWER THE LAST TWO QUESTIONS WITH A RESOUNDING YES - - YES, THE SYSTEM IS BAD AND YES, THERE ARE PROBLEMS. THEY WILL POINT TO THE MARKED INCREASE IN THE NUMBER OF HOMELESS ON OUR CITY STREETS AS ONE GLARING EXAMPLE THAT OUR MENTAL HEALTH SYSTEM IS FAILING US. WELL, I AM NOT SURE THAT I CAN SUBSCRIBE TO THE ASSERTION THAT WE HAVE A BAD SYSTEM, BUT, I WILL AGREE THAT THERE ARE PROBLEMS.

THESE PROBLEMS CAN BE NARROWED INTO ONE AREA - CONTINUUM OF CARE. IN THIS ERA OF DEINSTITUTIONALIZATION IT IS ESSENTIAL THAT WE HAVE ASSURANCES THAT OUTPATIENT SERVICES ARE BEING DELIVERED TO THOSE MENTALLY ILL PERSONS IN NEED OF THEM. THE SCENARIO OF THE PATIENT DISCHARGED FROM A PSYCHIATRIC HOSPITAL NEAR RECOVERY, ONCE DISCHARGED RECEIVING LITTLE OR NO ADEQUATE COMMUNITY BASED OR OUTPATIENT SERVICES; WITHOUT ADEQUATE TREATMENT DETERIORATING TO THE POINT OF CRISIS WHERE RECOMMITMENT TO A PSYCHIATRIC HOSPITAL IS AGAIN REQUIRED, HAS APPEARED SO OFTEN IT HAS EARNED ITS OWN BUZZ WORD AS A TITLE - THE "REVOLVING DOOR" SYNDROME.

I WOULD LIKE TO FOCUS ON TWO APPROACHES TO RESOLVING THIS SO CALLED "REVOLVING DOOR" SYNDROME. FIRST, WE NEED TO CONSIDER INNOVATIVE WAYS OF STRUCTURING COMMUNITY BASED SERVICES IN RELATION TO INPATIENT SERVICES TO ASSURE THAT THE TRANSITION FROM INPATIENT CARE TO COMMUNITY BASED CARE TO INDEPENDENCE REFLECTS A CONTINUUM OF CARE AND NOT A DISCONTINUATION OF CARE. SECOND, WE NEED TO CONSIDER INVOLUNTARY OUTPATIENT COMMITMENT AS PART OF THE OVERALL EMPHASIS ON COMMUNITY BASED SERVICES. I ~~WILL TAKE A LOOK~~ AT SENATE BILL 422, ~~WHICH~~ DETAILS with THIS CONCEPT ~~IN LEGISLATION~~.

HOW DO WE DEVELOP INNOVATIVE APPROACHES TO COMMUNITY BASED AND OUTPATIENT SERVICES? WELL, I SEE THE FIRST STEP AS LOOKING AT EXISTING PROGRAMS WHICH HAVE ENJOYED A GREAT DEAL OF SUCCESS.

THERE ARE TWO SUCH PROGRAMS OPERATING IN OTHER STATES WHICH HAVE CAUGHT MY EYE. THE FIRST PROGRAM IS OPERATED BY THE NORTHERN RHODE ISLAND MENTAL HEALTH CENTER. ALLOW ME TO BRIEFLY READ FROM A DESCRIPTION OF THIS PROGRAM:

Forsyth - aides working over-time

1. How much over-time is being payed out? no freeze on aides -
2. Horizon - 29 beds - Kelsh -
   4 more beds.
   pay - $10,000 per yr. -
   D'Donnell -
3. medicaid
4. Ed McDonnell - MH/MR
   - Jim Bruce
   Faust - $77 - lost
   $33 per day to
5. H.B 837 - Jesse Zarr
6.

Northern Rhode Island Mental Health Center
Woonsocket, Rhode Island

The Northern Rhode Island Mental Health Center combines the national policies of deinstitutionalization with those of noninstitutionalization to provide treatment services and alternatives for the chronically mentally ill. During deinstitutionalization, the Mental Health Center developed various community-based treatment programs, including:

*Residential services, including group homes, halfway houses, and supervised apartments;
*Case management and client advocacy services, which involve home visits and other measures to ensure the meeting of basic needs;
*Medical-psychiatric services, including medication maintenance clinics; and
*Day treatment programs providing socialization, prevocational services, etc.

Noninstitutionalization measures, involving alternatives to hospitalization, were also incorporated into the philosophy of the Mental Health Center. These programs and services include:

*Use of community hospitals, including psychiatric units in a general hospital, designated beds in a general hospital, or a community physician treating the patient in a state hospital;
*Crisis beds or emergency beds, located in their halfway houses, either to avert the primary crisis or to reduce the length of stay in state hospitals (The Community Mental Health Center has diverted 175 people from such expensive care in 1984);
*Mobile treatment team or crisis intervention team who work with the local police, board and care homes, and other community sources to immediately deal with the crisis;
*Consumer directed programs that provide socialization activities for the clients.

The Northern Rhode Island Community Mental Health Center reports that, with this type of program in place and combined with day hospital services, states will be able to meet the needs of the severely mentally ill and drastically reduce the number of mentally ill homeless and institutionalized patients. ~~Approximately 75 percent of their budget serves around 400 mentally ill clients, while the remaining 25 percent is used for 800-900 non-mentally ill clients.~~

For more information about the program, contact Chris Stephens at the Northern Rhode Island Community Mental Health Center, 181 Cumberland Street, Woonsocket, RI 02895, or call (401) 766-3330.

THE SECOND PROGRAM, THE MAINE CRISIS STABILIZATION PROGRAM, OPERATED BY THE MAINE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION IS SIMILAR TO THE FIRST.

Maine Crisis Stabilization Program
Augusta, Maine

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In several counties of Maine, there now exists an alternative to hospitalization for those facing a psychiatric crisis. The Department of Mental Health and Mental Retardation, under the auspices of the Office of Community Support, has established services that will enable mentally ill individuals in crisis to receive 24-hour stabilization and respite care without requiring admission to a hospital.

Through the Crisis Stabilization Program, a variety of services will be available, including:

- Respite apartment in each area;
- Homemaker services through respite apartments;
- Support from crisis intervention personnel;
- Support for the family of the person in crisis;
- Information and referral to various community agencies; and
- Follow-up services and support from the available community mental health services.

Screening, assessment, and referral of the client in crisis will take place at the primary point of contact in the counties being served. Although much of the Maine mental health system is unable to respond after hours and on weekends, the Crisis Stabilization Program can now fill this needed gap in services and will meet people in their homes or wherever needed. The Bureau of Mental Health is currently convening an advisory group to provide feedback on how the program is working.

TWO FACTORS MADE THESE PROGRAMS PARTICULARLY ATTRACTIVE TO ME. FIRST, AND MOST IMPORTANT, THESE ARE AGGRESSIVE IN NATURE AND PROVIDE ADVOCACY SERVICES. I FEEL WE CANNOT EXPECT THE RESPONSIBILITY FOR THE MAINTENANCE OF COMMUNITY BASED AND OUTPATIENT TREATMENT TO FALL SQUARELY ON THE SHOULDERS OF THE MENTALLY ILL PERSON. MANY TIMES AN AVERAGE PERSON LACKS THE DISCIPLINE TO MAINTAIN A DIET OR EXERCISE PROGRAM OR ANY OTHER REGIMENT THEY ARE SUBJECT TO. CERTAINLY WE CANNOT EXPECT A MENTALLY ILL PERSON TO HAVE ~~UNDYING~~ DISCIPLINE. PROGRAMS WHICH PASSIVELY OFFER OUTPATIENT SERVICES AT THE MENTAL HEALTH CENTER OR THE PSYCHIATRIC HOSPITAL ARE

PROGRAMS DOOMED TO FAILURE. IT IS IMPORTANT THAT PROGRAMS ARE AGGRESSIVE. THEY MUST MAKE HOME VISITS TO ENSURE THAT PRESCRIBED MEDICATION IS BEING TAKEN. THEY MUST MAINTAIN CONTACT TO DEVELOP STRONG RELATIONSHIPS WITH CLIENTS TO ENSURE THAT THEY SHOW UP FOR TREATMENT. FINALLY, THEY MUST INTERFACE WITH THE PSYCHIATRIC HOSPITALS TO ENSURE THAT THERE IS A SMOOTH TRANSITION FROM INPATIENT TO OUTPATIENT CARE WITHOUT AN INTERRUPTION OF TREATMENT. THESE PROGRAMS HAVE THIS AGGRESSIVENESS.

THE SECOND ATTRACTIVE FACTOR OF THESE PROGRAMS IS THEY INVOLVE THE FAMILY OF THE MENTALLY ILL PERSON. I FEEL THE STRONGEST SOURCE OF SUPPORT TO A MENTALLY ILL PERSON IN A COMMUNITY SETTING IS THE FAMILY. AS SUCH, THE FAMILY NEEDS TO BE INVOLVED IN THE PLANNING OF TREATMENT AND IN THE PROVISION OF TREATMENT ITSELF. THIS INVOLVEMENT WILL FURTHER ASSURE THAT TREATMENT DOES NOT STOP AND CAN ONLY FURTHER ENHANCE THE QUALITY OF TREATMENT.

THE PROGRAMS I HAVE JUST MENTIONED ARE IMPORTANT STEPS BUT CANNOT BE CONSIDERED AS A CONCLUSIVE SOLUTION TO THE "REVOLVING-DOOR" SYNDROME. OTHER AREAS MUST BE EXPLORED AS WELL. ONE SUCH AREA IS INVOLUNTARY OUTPATIENT COMMITMENT. THE MENTAL HEALTH PROCEDURES ACT CURRENTLY ALLOWS FOR INVOLUNTARY OUTPATIENT COMMITMENT, HOWEVER, APPLIES THE ACT'S CLEAR AND PRESENT DANGER STANDARDS TO SUCH COMMITMENT. THIS MEANS THAT A MENTALLY ILL PERSON CAN ONLY BE INVOLUNTARILY COMMITTED TO OUTPATIENT TREATMENT IF WITHIN THE LAST 30 DAYS THEY INFLICTED OR ATTEMPTED TO INFLICT BODILY HARM ON ANOTHER INDIVIDUAL OR THEMSELVES AND THERE IS A LIKELIHOOD THE ACT WILL

BE REPEATED. PERHAPS SUCH INVOLUNTARY COMMITMENT AFTER THE FACT IS TOO LITTLE, TOO LATE. WE OWE SOCIETY A GREATER DEGREE OF PROTECTION THAN THIS.

LEGISLATION INTRODUCED BY SENATOR JOHN STAUFFER, SENATE BILL 422, WHICH IS CURRENTLY PENDING IN THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE, PROPOSES TO AMEND THE MENTAL HEALTH PROCEDURES ACT TO SOMEWHAT RELAX INVOLUNTARY COMMITMENT STANDARDS FOR OUTPATIENT TREATMENT. SIMPLY, THE BILL STATES THAT A PERSON PREVIOUSLY ADJUDICATED SEVERELY MENTALLY DISABLED IN ACCORDANCE WITH THE CURRENT PROVISIONS OF THE MENTAL HEALTH

PROCEDURES ACT MAY BE MADE SUBJECT TO INVOLUNTARY OUTPATIENT TREATMENT IF HE IS CAPABLE OF SURVIVING IN THE COMMUNITY AND IF HIS TREATMENT HISTORY INDICATES THE NEED FOR TREATMENT IN ORDER TO PREVENT DETERIORATION WHICH COULD PREDICTABLY RESULT IN A SITUATION WHERE DANGEROUSNESS IS CLEAR AND PRESENT AS DEFINED IN THE CURRENT ACT. IT IS HOPED THAT THIS LEGISLATION WILL HELP TO PREVENT INAPPROPRIATE INTERRUPTION OF TREATMENT WHICH LEADS TO A CRISIS SITUATION - HOMELESSNESS OR OTHER DANGEROUS SITUATIONS.

IN CONCLUSION, THESE ARE JUST A FEW AREAS WHERE I FEEL WE CAN COMBAT THE "REVOLVING DOOR" SYNDROME AND ENSURE THAT MENTALLY ILL PERSONS RECEIVE NECESSARY TREATMENT. I AM SURE THERE ARE OTHER AREAS. THAT IS WHY IT IS IMPORTANT THAT WE SOLICIT THE INPUT GROUPS LIKE THIS ONE SO THAT THE GENERAL ASSEMBLY CAN MOVE EFFICIENTLY AND RESPONSIBLY TO RESOLVE THE "REVOLVING DOOR" SYNDROME.