June 28, 2021

The Honorable Representative Adrian C. Madaro, Chair
Joint Committee on Mental Health, Substance Use and Recovery
State House Room 33
Boston, MA 02133

The Honorable Senator Julian Cyr, Chair
Joint Committee on Mental Health, Substance Use and Recovery
State House Room 312-E
Boston, MA 02133

Re:

In Support of S.1283/H.2089 An Act to ensure the constitutional rights and human dignity of prisoners on mental health watch

In Support of S.1267/H.2063 An Act transferring Bridgewater State Hospital from the Department of Corrections to the Department of Mental Health

H.2121 An Act relative to assisted outpatient therapy

Dear Representative Madaro, Senator Cyr, and Honorable Members of the Joint Committee on Mental Health, Substance Use and Recovery:

Thank you for the opportunity to submit testimony on these important issues on behalf of the National Alliance on Mental Illness of Massachusetts (NAMI Massachusetts).

NAMI Mass is a grassroots organization and our members are individuals with mental health conditions, their family members, loved ones and caregivers. One in five adults experience a mental illness, almost 44 million adults each year. In the Commonwealth, we have approximately 467,000 adults and children with severe mental illness or serious emotional disturbance.[1] As NAMI members and families, we are often the people on the front lines of dealing with our mental health system and encountering the barriers to accessing mental health services.

[1] Massachusetts State Mental Health Block Grant proposal from the State Mental Health Planning Council, 2021. Data covers 2018-2019.

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S.1283/H.2089 An Act to ensure the constitutional rights and human dignity of prisoners on mental health watch

Massachusetts has one of the highest rates in the country of suicides in our prisons and jails according to a 2015 Department of Justice report. The rate of 30 suicides per 100,000 prisoners is the fourth highest rate in the nation. A November 2020 report from Department of Justice documented in detail the current and ongoing mistreatment and prolonged holding of individuals in a mental health crisis on mental health watch. This report contains disturbing examples of extreme mistreatment, including corrections officers encouraging prisoners to engage in self-harm. In addition, mental health watch is essentially solitary confinement, where prisoners are confined to a cell for 23 hours at a time and for extended periods of time. We know that holding people in solitary confinement is traumatizing under any circumstances; holding individuals with behavioral health conditions adds another level of trauma. Please read the report in full; I'm sure you will be as shocked and disturbed as I was and continue to be.

If an individual is ill enough to need mental health watch, then they should be receiving treatment and care, not be in solitary confinement, practically naked while being goaded into self-harm.

This bill will prohibit our prisons and jails from placing possibly suicidal prisoners in these conditions, ensure all decisions made about the treatment of such prisoners are made by qualified mental health professionals, and remove officers from watching suicidal prisoners if the officers violate suicide prevention policies. The bill requires mental health watch procedures, specifically the suicide prevention policy, to be written, include screenings and treatment, as well as define appropriate levels of supervision. This bill focuses on ensuring the long-term implementation of these reforms, beyond the outcome of a consent decree between the Department of Justice and the Department of Corrections. Without legislative action, any remediation measures would expire in 2 years.

NAMI Massachusetts has made these bills a legislative priority for this session and strongly supports these bills and we urge you to consider these bills for a favorable report out of your committee.

S.1267/H.2063 An Act transferring Bridgewater State Hospital from the Department of Corrections to the Department of Mental Health

Bridgewater State Hospital (BSH) is not a "hospital" but a medium-security prison for men. Much of the general population believes that BSH is where the criminally insane, wildly violent and dangerous prisoners are sent. However, the majority of BSH patients have never been convicted of a crime, but instead are committed after being found incompetent to stand trial or not responsible for their actions. In many cases, they are charged with only minor infractions.

Despite these population characteristics, BSH has long been known as a rough place where guards often strapped patients down or locked them in isolation cells for misbehavior — and where some patients met gruesome deaths. In 2013, patients at Bridgewater State Hospital were placed in restraints or isolation more than 100x the rate of patients at other MA state mental

health facilities. In March 2017 to address many of these concerns, the state brought in an outside company, Correct Care Recovery Solutions (CCRS), to provide quality treatment, security, and shift the culture at BSH to reflect a real commitment to treatment instead of punishment. Though CCRS has made tremendous progress, even CCRS itself acknowledges that challenges still exist in transforming BSH, especially when addressing issues that require collaboration with outside agencies and organizations. Many of these barriers can be attributed to Bridgewater still being under the control of the Department of Correction (DOC), which lacks the same capacity as the Department of Mental Health (DMH) to address the needs of their patients.

For these reasons, NAMI Massachusetts supports this legislation to transfer the responsibility for operation and oversight of Bridgewater State Hospital to the Department of Mental Health. We urge you to consider a favorable report for these bills.

H.2121 An Act relative to assisted outpatient therapy

My son has schizophrenia. As a parent, I am all too familiar with the concerns we have for our family members, particularly those who do not believe they need help. These concerns are valid and real and continue to be a challenge for families and the behavioral health system.

For several years, I have taken a personal interest in the topic of Assisted Outpatient Treatment. Most states in the US have this legislation, which means it has been widely studied and discussed. While many studies will clearly outline the financial benefits to states in public service cost reduction, few studies focus on the efficacy for the individual. As a parent, what would be the point of forced treatment, unless it would actually work? The evidence for AOT being the moment that puts an individual on the path to recovery is murky at best. It is not a magic bullet that helps individuals consistently find their path to recovery. And there are many, many more stories about the trauma experienced by individuals when subjected to involuntary treatment. We can do better.

I have met parents who have a child living in a closet or basement, never coming out and refusing meals. We should and must do something to help these individuals and their families. However, rather than focusing on forced treatment, we might consider a non-coercive relentless outreach, peer-led approach. In Westchester County, NY, such a program has been established as an alternative to AOT, called INSET (materials attached). This program meets individuals where they are, including when they don't think they need any help, have peer specialists continually connect with them until the individual decides how they would want their life to change. Truly, no one wants to live in a closet. But telling people they have to engage does not work. They have to decide when it's time and how that engagement will look.

Many of the states that have implemented AOT have found that it becomes a "jump the line" solution. Those who do not want help are forced into accessing scarce resources, while others who want services now wait months to get an appointment. When resources are scarce, even considering a relentless outreach approach, which can require months of building a connection,

seems impossible.[2] AOT is grounded in a system that does not have enough capacity and seeks to be a quick fix to a complex problem. Rather than pass AOT in Massachusetts, let's build specific capacity for this exact population through an INSET or other peer-led, peer respite-style program. Families will have a place to turn, get the help they need to help put their loved one on a path to recovery, and individuals will be in control of their engagement voluntarily. It takes patience to meet people where they are. There are no quick fixes.

NAMI Massachusetts would be honored to help to establish a person-centered program that is peer-led based on authentic peer support and the Certified Peer Specialist code of ethics to help individuals with no or little awareness of their behavioral health needs. We hope you will consider addressing this real problem in a modern and humane way and would consider modifications to this legislation to that effect.

Sincerely,

Monica Luke
Board Chair, Advocacy Committee
NAMI Mass Board of Directors

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[2] Roca has effectively used relentless outreach to engage with hard-to-reach, at-risk youth. They have a decade of data illustrating the effectiveness of such an approach.