The Massachusetts Behavioral Health System: Implications of Mandated Nurse Staffing Ratios

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Massachusetts Association of Behavioral Health Systems

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Executive Summary

An affirmative vote on Question 1, proposed by the Massachusetts Nurses Association's (MNA) and appearing on this November's ballot, would impose nurse staffing mandates on a Massachusetts behavioral health system that is already chronically underfunded and overburdened with higher demand than availability. Running counter to behavioral health clinical standards of care, mandated ratios will not improve patient outcomes and will lead to the **loss of more than 1,000 behavioral health beds**, increased emergency department wait times, and the loss of recovery services that are turning the tide against the opioid crisis.

ED Boarding

Emergency Department (ED) boarding occurs when a patient must wait in an ED until an appropriate inpatient bed is available. If MNA's ballot question passes, behavioral health facilities would see a reduction of services by up to 38% -- or **more than 1,000 of the existing behavioral beds in the state**. Patients going to an ED in need of inpatient psychiatric or substance use disorder services, who already make up a disproportionately large percentage of patients that board in the ED, **would be forced to board there even longer**.

Government-Mandated Ratios Would Exacerbate the Opioid Crisis

Hospital EDs are a first line of response for individuals experiencing crises related to substance use. Since 2011, opioid-related ED visits in Massachusetts have increased by 87%. **Many improvements in services and programs have been made, but the likelihood of their success would be greatly undermined by the requirements of the ratio mandate**. By requiring staffing ratios, an ED that is at the maximum allowed RNs-to-patient ratios would not be able to care for any additional patients in need of care. **ED boarding times would further increase if the inpatient units are also at the maximum ratio capacity**, thereby reducing access to inpatient level care for patients.

Reduction of Services

If behavioral health facilities are unable to recruit the additional RNs required to meet the ratio mandate, inpatient behavioral health facilities will be **unable to admit more than one out of every three patients that the system is currently able to serve**. Most facilities will be forced to **eliminate behavioral health beds and services**, negatively affecting access to behavioral health services in the commonwealth.

The Clinical Team Approach

While nursing care plays an important role in the care of patients with behavioral health disorders, **accreditation and federal and state licensing standards for behavioral healthcare involve a clinical team approach that is not nurse-centric** and predominantly includes additional trained clinical professionals. At a time when there is a shortage of other necessary care providers, hospitals would instead be forced by the requirements of the ballot mandate to spend scarce dollars on **hiring additional RNs instead of the multi-disciplinary care team members that patients actually need**.

The Cost of Government-Mandated Ratios on Behavioral Health

Implementation of the ballot question would cost **$177 million annually** for inpatient behavioral health services, **more than doubling the current cost of RN staffing in these units**. In addition, the Massachusetts Department of Mental Health calculated that the cost of implementing mandated nurse staffing ratios in state psychiatric facilities alone would be an estimated **$46 million annually**, bringing **the statewide total implementation cost on the behavioral health inpatient system to $226 million per year.**

Society as a whole is increasingly aware that the loss of local hospital psychiatric beds will discourage individuals with mental illness from getting treatment, and exacerbate the crisis felt by those suffering from behavioral health disorders who cannot access care.

The misguided ballot question disregards these concerns and its passage would worsen the crisis in our already overburdened behavioral health system.

The Massachusetts Behavioral Health System: Implications of Mandated Nurse Staffing Ratios

The Massachusetts Nurses Association (MNA), a union representing less than 25% of nurses in the state, is proposing a ballot question #1 for the November 2018 election that would impose government-mandated registered nurse (RN)-to-patient staffing ratios on all units of every hospital in Massachusetts. These ratios would be **required at all times** – nights, scheduled and unscheduled nursing breaks, patient transfers, and any other time that nurses may need to step away from patients, even for a few minutes. **The law would also impose heavy fines of up to $25,000 *per violation, per day*, for any infractions.**

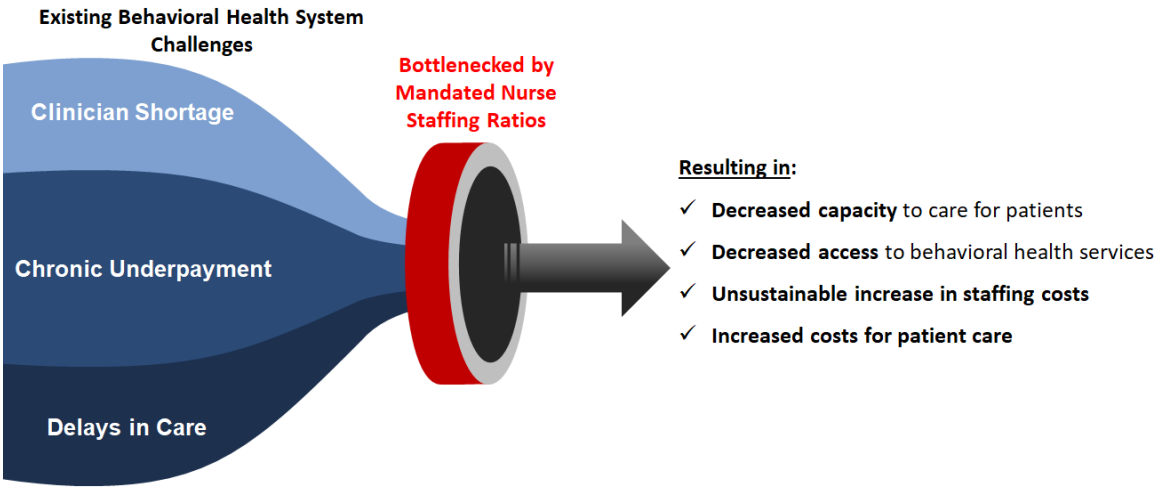
If ballot Question #1 passes, all 67 facilities including, but not limited to, 13 freestanding psychiatric hospitals, psychiatric units within 46 acute care hospitals, and 8 state-owned and operated psychiatric hospitals, would be required to comply with the ratio law. A devastating consequence of this law would be that once nurses reach the maximum allotted number of patients, these facilities would be unable to admit any new patients, even if a patient is experiencing a mental health crisis and needs immediate care. It is also important to note that inpatient substance use disorder services that are provided within a hospital setting also would be subject to government-mandated, RN-to-patient staffing ratios and face the same restrictions. Although the ballot would not apply to community-based mental health and substance use disorder treatment facilities, these facilities would be indirectly affected by the loss of nurses to hospitals, which may consequently result in decreased access to their services.

There are already significant obstacles for patient access to behavioral health services – a term that includes both mental health and substance use disorders – due to a variety of factors. These include the increasing rates of behavioral health disorders, provider shortages within inpatient and community-based settings, and chronic underfunding for behavioral health services.

A mandated requirement to hire additional RNs simply to comply with arbitrarily imposed staffing ratios that are not consistent with clinical standards of care would severely threaten the care model for the behavioral health system. This would have negative consequences for patients trying to access inpatient or outpatient behavioral health services. While nursing care plays an important role in the care of patients with behavioral health disorders, the proposed nurse staffing ratios are not part of national or state accreditation and licensing standards for behavioral healthcare. Rather, these existing standards involve a clinical team approach that is not nurse-centric and includes predominantly additional trained clinical professionals. Mandating RN-to-patient ratios would remove the clinical team-based approach to care in behavioral health settings and delay access to care, even if beds are available, if there are not enough nurses to meet the arbitrary staffing ratios at all times.

Existing problems in access to timely and critical behavioral health services will be exacerbated by government-mandated, at-all-times rigid minimum nurse staffing ratios, which will lead to increased costs and decreased inpatient behavioral health system capacity, negatively affecting the community at large. Even if the mandate were feasible to implement, it would substantially increase healthcare costs to employers, tax payers, and consumers.

Figure 1: Effects of Mandated Nurse Staffing Ratios

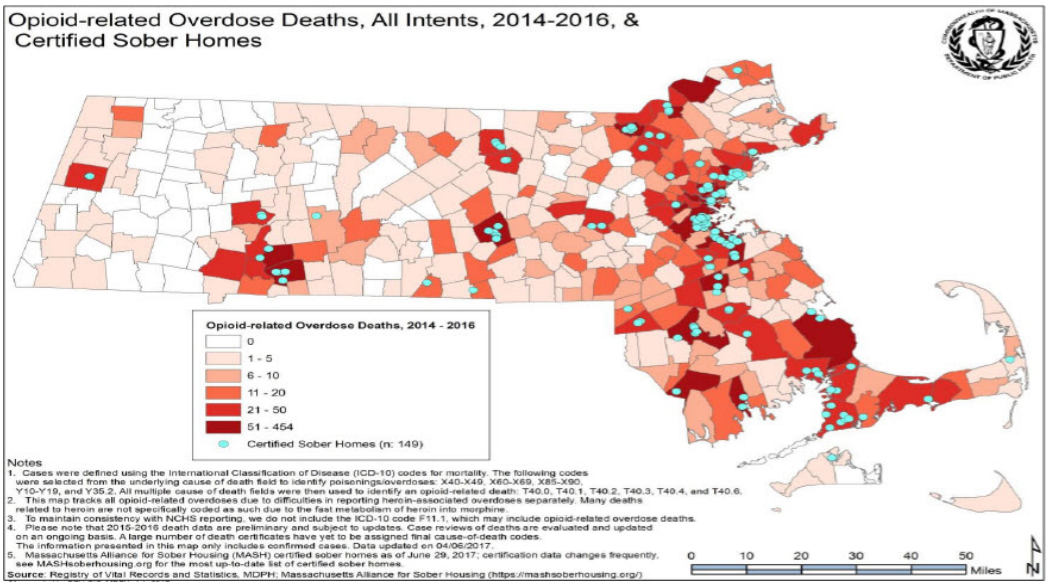


MANDATED RN-TO-PATIENT RATIOS WOULD EXACERBATE EXISTING SYSTEMIC ISSUES, WOULD BE COST PROHIBITIVE, AND WOULD LEAD TO DECREASED CAPACITY OF THE BEHAVIORAL HEALTH SYSTEM

The state is facing a crisis in access to behavioral health services driven by long-standing systemic problems, including the increasing prevalence of behavioral health disorders, mental health provider shortages, and the chronic underfunding of behavioral health services. The MNA's ballot question would impose nurse staffing mandates that are inconsistent with behavioral health clinical standards of care on an already strained Massachusetts behavioral health system with no evidence that it will improve patient outcomes.

The percentage of Massachusetts residents living with a mental health disorder has increased in recent years by almost four times the national rate; from 2010 to 2014, the percentage of adults in Massachusetts with a mental health disorder increased from 17.8% to 20.1%. A new report from the US Centers for Disease Control and Prevention found a significant increase in the rates of suicide across the country. In Massachusetts, the increase in suicides exceeded 30% from

Figure 2: Opioid Crisis in Massachusetts



Source: Massachusetts Department of Public Health

1999-2016.[1] In addition, Massachusetts is one of the states most severely affected by the opioid crisis (**Figure 2**), ranking 8th in the country in age-adjusted per capita deaths due to opioid use.[2]

The **increased prevalence of behavioral health disorders in Massachusetts** is coupled with a **significant shortage of behavioral health providers (including psychiatrists, mental health-trained nurses, and psychologists),** resulting in patients having difficulty in obtaining appointments and facilities having difficulty in recruiting clinicians. The shortages of providers who care specifically for behavioral health pediatric patients is an even more significant problem; a study by Blue Cross Blue Shield Foundation of Massachusetts found that 32% of child psychiatry practices were full and an additional 39% of practices only had one to two openings available. The same study found that 54% of providers plan to either leave the behavioral health field or leave Massachusetts within five years.[3]

Figures 3 and 4 depict the state agencies responsible for regulatory oversight and bed licensure for the Massachusetts behavioral health system, along with the number of inpatient behavioral health beds licensed in each category and the change in the overall number of each type since 2015. Despite the general increase in beds statewide, the commonwealth continues to grapple with **emergency department (ED) boarding of behavioral health patients,** which occurs when a patient must wait in an ED until an appropriate inpatient psychiatric or substance use disorder bed is available. Recent reports have shown that while behavioral health patients make up a small percentage of overall ED patients, they make up a much larger proportion of patients that board in the ED.

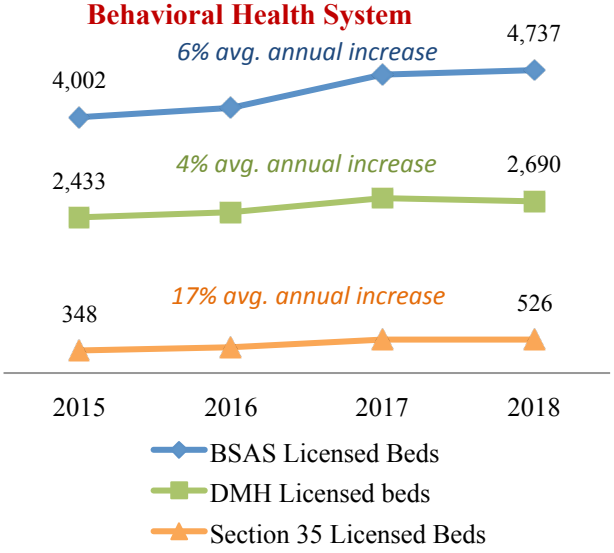
Figure 3: Oversight of the Behavioral Healthcare System

Bureau of Substance Addiction Services (BSAS)
A bureau within DPH responsible for licensing substance use disorder (SUD) beds & programs.

Department of Mental Health (DMH)
Assures and provides access to services & supports to meet mental health needs; licenses psychiatric beds; requires and monitors hours of direct care of the nursing team (RNs, Licensed Practical Nurses, Mental Health Counselors), and has authority to monitor other staffing hours.

Involuntary Commitment Beds (Section 35)
Massachusetts General Laws Chapter 123, Section 35 permits involuntarily commitment of someone with alcohol or substance use disorder with a likelihood of serious harm.

Figure 4: Licensed Beds in the Behavioral Health System



In 2018, the Department of Mental Health (DMH) began to implement a new policy to reduce ED boarding for behavioral health patients by creating a process to expedite admissions to inpatient psychiatric units. DMH will be monitoring and evaluating the policy to gauge its effectiveness and ongoing challenges that need to be addressed. One such challenge that emerged from the first three months of data was the high rate of younger patients boarding in the ED; of the patients who boarded in the ED and for which DMH intervened after 96 hours, 68% were under the age of 23.[4] The biggest barrier to pediatric admissions was simply **a lack of available beds.**[5] Existing **difficulties in recruiting RNs** and other professionals with psychiatric experience are also causing significant access issues for children and adolescents with behavioral health needs.

"While the state is working with facilities to open units that specialize in caring for pediatric patients with mental health conditions, it is very difficult to recruit and retain psychiatrists and nurses to staff these units. It has taken us two years to recruit staff, despite the use of sign-on bonuses and recruiting companies for nursing staff. As a result, many facilities cannot make these beds available. If we are further required to meet the mandated nurse-to-patient ratio as proposed in this ballot initiative, we would not be able to provide this critically needed service for these patients," says Michael Krupa, CEO of TaraVista Behavioral Health Center.

The ill-conceived nurse staffing ratio ballot question is inconsistent with the behavioral health clinical model's complement of other health professionals on the care team. It would require facilities to recruit even more RNs to achieve compliance, and instead of opening more pediatric behavioral health beds, facilities might be forced instead to close existing pediatric beds.

The behavioral health system is already under financial strain. According to a report by the Attorney General's office, "**Consistently negative margins** for behavioral health services across all types of general acute hospitals are indicative of historically low behavioral health reimbursement rates." The report goes on to say, "Among 18 general acute care hospitals that reported inpatient behavioral health margins for commercial and government business from 2010 to 2013 – including academic medical centers, teaching hospitals, community hospitals, and disproportionate share hospitals across all geographies – ***the cumulative margin for all of these hospitals over those four years was negative 39%.***"[6] With such low margins and inadequate rates of reimbursement, behavioral health facilities must monitor closely every possible change in cost.

The MNA's nurse staffing mandate will increase costs on behavioral health facilities. The Massachusetts Health & Hospital Association's (MHA's) analysis of current RN staffing levels in inpatient psychiatric units of acute care hospitals and free-standing psychiatric hospitals shows that **implementation of the ballot question would result in an additional annual cost of $180 million for inpatient-level services, more than doubling the current cost of RN staffing in these units (Table 1)**. Moreover, approximately half (48%) of the increase in RN staffing would be on night shifts **during which most patients are sleeping**, and which are already the most difficult shifts to staff due to nurse preferences. Beyond causing significant staffing costs, the ratios are proposed to be met "at all times," which means that they apply even when nurses take breaks for meals and using restrooms. Any violations can result in fines of up to $25,000 per incident, per day. These penalties could quickly add up to insurmountable costs that would threaten the already underfunded facilities' ability to remain open and provide patient care and services.

In addition, the Massachusetts DMH calculated that the cost of implementing mandated nurse staff ratios in state psychiatric facilities would be an estimated $46 million annually, bringing **the statewide total implementation cost on the behavioral health inpatient system to $226 million per year.** Note that even this devastating cost figure **understates the true impact** as it does not include the costs of implementing ratios within hospital outpatient mental health services (such as mental health adult day care services).

Table 1: Estimated Annual Nurse Staffing Ratio (NSR) Implementation Cost for Inpatient Behavioral Health Facilities

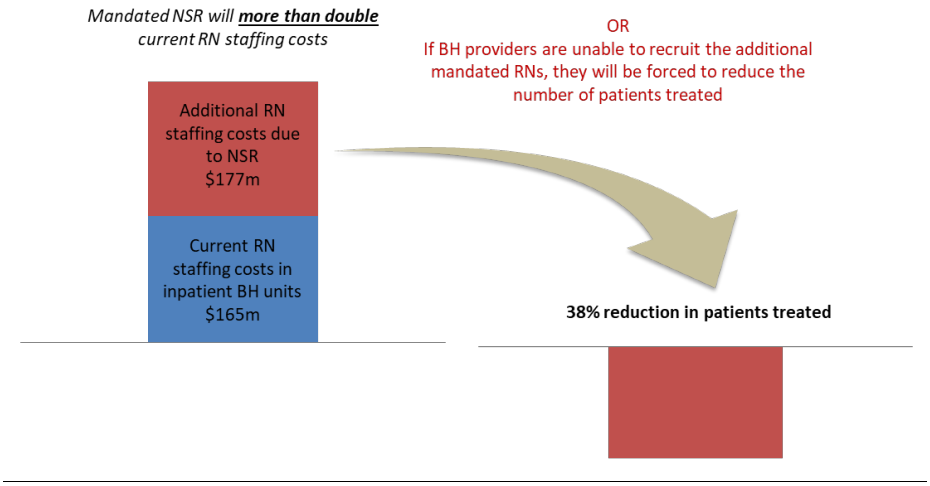
Facility Type	Estimated Cost
Acute Care Hospitals w/ Psychiatric Units	$ 80 Million
Free Standing Psych & SUD Treatment Hospitals	$ 100 Million
Department of Mental Health Hospitals	$ 46 Million
Total	**$ 226 Million**

To pay for the unnecessary increase in RNs, hospitals and psychiatric facilities would need to renegotiate reimbursement rates with payers, if possible. These costs would then likely be passed on to customers through increases in premiums at a time when there is already an unmet need for mental health care or counseling due to cost.[7] This is a documented consequence of nurse staffing ratios implemented in California.[8] If the California experience serves as an indicator, this added cost would ***potentially come without any corresponding increase in quality***.[9]

At a time when there is a shortage of other necessary care providers such as psychiatrists and support staff, hospital executives would instead be forced by the requirements of the ballot mandate to spend scarce dollars on hiring additional RNs instead of the ancillary clinical staff they actually need. For instance, a free-standing psychiatric hospital in Massachusetts reported that it could hire six more doctors, plus more than 100 other clinical staff members (as outlined in Figure 6) with the same funds it would instead need to expend on hiring mandated RNs, simply to meet an arbitrary ratio requirement. Even California, where nurse staffing ratios are implemented, made allowances for other types of nursing staff, such as Licensed Vocational/Practical Nurses and psychiatric technicians, rather than having increased staffing consist 100% of RNs. This allowance recognized the RN shortage and associated costs of RN wages. Another consequence of the MNA proposal in Massachusetts requiring that ratios be met 100% by RNs would be a dramatically increased need for traveling nurses who are significantly more expensive to hire and would result in frequent shifts in staffing rather than a more cohesive team of permanent staff.

If behavioral health facilities are unable to recruit the additional RNs required to meet the ratio mandate, inpatient behavioral health facilities **will be unable to admit more than one out of every three patients that the system is currently able to serve, as providers will be forced to reduce their patient volume by up to 38% or more in the aggregate in order to come into compliance** (**Figure 5**). Most facilities will be forced to eliminate behavioral health beds and services, negatively affecting behavioral health capacity in the commonwealth. More than 1,000 of the commonwealth's behavioral health beds would be lost.

Figure 5: Staffing and Care Consequences of Ratios



*"Implementation of the proposed mandatory nurse staffing ratios will have an **immediate devastating impact** on patient access to psychiatric care in the commonwealth. Currently, there is not sufficient psychiatric inpatient capacity in the state to meet the needs of patients and families. I am deeply concerned that if this ballot question passes, we will see a drastic reduction in available inpatient services, **limiting our ability to provide life-saving acute care for those in crisis.** I would hope that everyone can appreciate the gravity of the consequences, given ongoing challenges with respect to the opiate crisis, youth suicide, and other paramount behavioral and mental health priorities."* – Scott L. Rauch, M.D., President and Psychiatrist in Chief, McLean Hospital and Chair, Partners Psychiatry & Mental Health.

MANDATED RN-TO-PATIENT RATIOS ARE INCONSISTENT WITH BEHAVIORAL HEALTH CARE MODELS, PATIENT NEEDS, AND BEST PRACTICE GUIDELINES

Historically, patients with serious behavioral health disorders were institutionalized in large state or county facilities. Ultimately deemed inhumane, these institutions were largely phased out beginning in the 1960s. The intent was to change the behavioral healthcare model to a more local, community-based one. However, due to a lack of adequate private and public funding for the cost of inpatient and community-based behavioral health services, the capacity to meet the needs of patients with behavioral health disorders does not meet the demand for such services.[10]

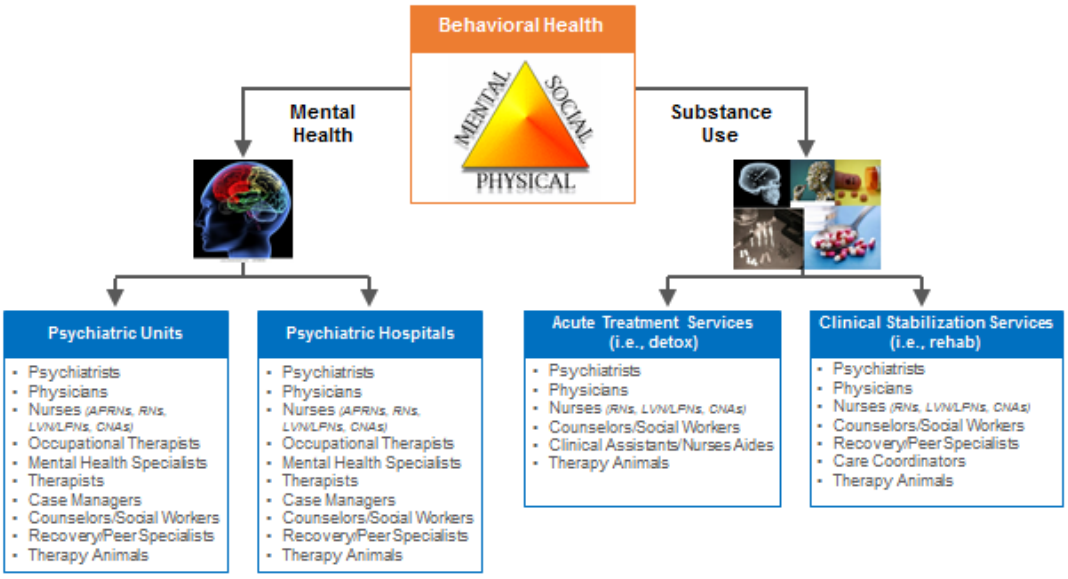
The behavioral healthcare system can be broken into two subsets, although they are often intertwined:

- Patients with serious mental illness are treated as inpatients within a **freestanding psychiatric hospital or a psychiatric unit in an acute care hospital**, but then need an outpatient or community-based treatment option to ensure follow-up care and prevent readmissions.

- Patients with substance use disorder (SUD) may also receive immediate inpatient care in a hospital setting, but are more frequently treated in community-based **facilities that specialize in substance use services such as detox and rehabilitation facilities**.

The care and treatment provided within a behavioral health facility is tailored to specific patient disorders and delivered by a variety of healthcare providers, as depicted in **Figure 6**. Nursing care plays a valued and vital role in the care of patients with behavioral health disorders, but the most effective care model for these patients involves a multi-disciplinary care team that focuses on monitoring daily activities, counseling, group therapy and programs support recovery, and peer support. This is especially true for services provided in outpatient or community-based facilities. These additional care team members can include psychiatrists, social workers, case managers, occupational therapists, and mental health counselors in addition to nurses. For children and adolescents, these teams also include teachers as there are strict regulations requiring this subgroup of inpatients to receive daily education time. These same patients also require specialized family-centered therapy for successful re-integration into their homes once discharged.

Figure 6: Behavioral Health Care System

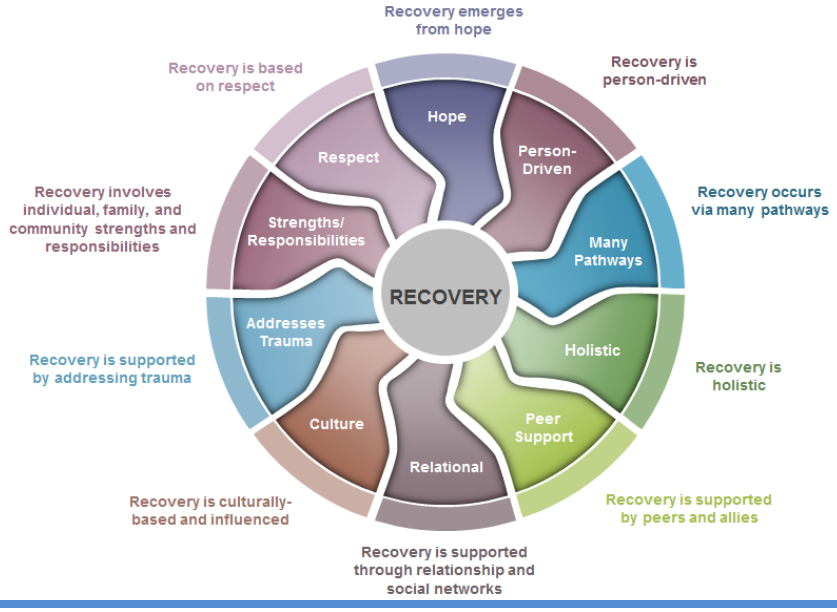


"It's critical that patients with behavioral health conditions are served by a multi-disciplinary team that consists not only of nurses but also social workers, psychiatric occupational therapists, recovery coaches, and other rehabilitation professionals. This multi-disciplinary approach is key to ensuring that patients are not only successful when in the hospital but when discharged back to their communities as well," says Marcia Fowler, Chairwoman of the Massachusetts Association of Behavioral Health Systems and former Commissioner of the Massachusetts Department of Mental Health.

Meeting a mandated ratio of patients to RNs at all times will cause additional stress on facilities as they strive to maintain access for incoming patients, manage both the variation in numbers of patients within a given unit and particular times of day and the complexities of caring for patients exhibiting aggressive behavior, and the logistics of patients that have court appearances. A study on staffing of inpatient psychiatric units states that, "Staffing and running an inpatient psychiatric unit are challenging because of the variety of staff involved and the range of activities**…[S]taff on psychiatric units lead therapy groups; help provide and oversee meals in dining rooms; take patients off the unit for tests, 'smoking breaks,' and exercise groups; conduct regular checks of all patients; and constantly observe disoriented or dangerous patients."**[11]

In 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency located within the U. S. Department of Health and Human Services, established 10 guiding principles of recovery (**Figure 7**) that are applicable to behavioral health patients. These principles encompass a **multi-disciplinary approach to recovery that includes physical, emotional, social, spiritual, and peer support,** and requires teamwork from a **wide range of professionals and paraprofessionals**,

Figure 7: SAMHSA 10 Guiding Principles of Recovery



each with unique training and roles, as depicted in **Figure 6**.

There are many different behavioral health treatment options and some would be at greater risk of being cut than others to pay for the mandated ratios. One such component of treatment is peer support, through which others with "lived experience" of the issue(s) that someone is facing help them in the recovery process. Research has shown that peer support has a range of physical, social, and emotional benefits for patients and is linked to decreased need for inpatient care and better quality of life.[12] Though peer support has been a critical component of treatment for patients with substance use disorders, funding for these services is currently limited – a limitation that would only be exacerbated under an unnecessary and inefficient nurse staffing mandate. Another component is animal-assisted therapy, in which animals, most commonly dogs, are incorporated into counseling sessions as a therapeutic element. Animals can bring about a sense of calmness and stress relief and also help patients learn non-verbal cues and better regulate their emotions. [13]

These and other effective treatment modalities would be at risk of being reduced or eliminated if the ballot question passes and behavioral health facilities are forced to hire more RNs to meet an arbitrary mandate. Hospitals would not be able to hire or maintain the multi-disciplinary care teams that have been so effective within the behavioral health system. As a result, patients would be deprived of the ability to connect with social workers, therapists, recovery specialists, peer coaches, and counselors when they are recovering from an acute mental health crisis and prior to being discharged back into the community.

Recognizing that treatment models differ greatly based on the facility, unit, program, staff experience and, most importantly, the specifics of each individual patient's diagnosis and condition, no federal or state agency, including the Massachusetts Department of Public Health, the Massachusetts Department of Mental Health, and the federal Centers for Medicare & Medicaid Services, has adopted specific nursing or other clinical staff ratios for a behavioral health facility. Instead, the agencies all have allowed flexibility for individual facilities to meet the dynamic needs of their patients.[14]

A position statement from the American Psychiatric Nurses Association on staffing inpatient psychiatric units also states explicitly that it would be difficult to establish any standard staffing ratio and recommends flexibility for adjustments:

> "For quality and safety**, staffing plans will consider the multiple variables that affect staffing needs**, such as psychiatric patient complexity, nursing education, nursing skill mix, physical environment, recovery principles, and the impact of technology in use. The staffing plan **should allow for shift-to-shift flexible adjustments**, typically based on acuity factors, or as measured by admissions, discharges, transfers, comorbidity of illness, and patient care complexity." [15]

California is the only state that currently has a law mandating specific nurse staffing ratios in hospitals and has ratios that are specific to psychiatric units within acute care hospitals. If placing arbitrary limits on the number of patients that nurses can care for is the model for optimal care, then one would expect California to have the best patient outcomes and quality of care in the country, and yet that is not the case. A comparison of standardized evidence-based measures for psychiatric quality of care within California psychiatric units as compared to Massachusetts shows that Massachusetts psychiatric units without the ratios outperform California in clinical practices both during and following inpatient services (**Table 2**).[16] Most research studies assessing the effect of staffing ratios in California conclude that the intended improvements to patient outcomes were not realized despite the significant increases in nursing staff and associated costs.[17]

Further, research has shown that the ratio legislation in California may have led to hospitals downsizing mental health services. In particular, hospitals with low pre-mandate nurse staffing levels were more than 2.5 times more likely to substantially reduce their mental health-related patient volumes than hospitals with higher nurse staffing levels. These findings suggest that the cost increase associated with needing to hire additional nursing staff diverted resources from mental health services, which tend to cost hospitals more than they bring in due to low reimbursement rates and high patient complexities. [18]

Table 2: Quality Comparisons for Psychiatric-Related Measures

	Massachusetts vs. California *Massachusetts Scores…*	**Massachusetts vs. National Average** *Massachusetts Scores…*
Adults with any mental illness who did not receive treatment	**Better**	**Better**
Adults with any mental illness reporting unmet need	**Better**	**Better**
Alcohol Use Brief Intervention Provided or Offered	Worse	Worse
Alcohol Use Screening	**Better**	**Better**
Assessment of Patient Experience of Care	**Better**	**Better**
Healthcare Personnel Influenza Vaccination	Worse	Worse
Highest level typical use of an EHR system	Worse	Worse
Hours of physical-restraint use	**Better**	**Better**
Hours of Seclusion	**Better**	**Better**
Influenza Immunization	**Better**	**Same**
Interoperable health information exchanged with HISP	**Better**	**Better**
Patients discharged on multiple antipsychotic medications with appropriate justification	**Better**	**Better**
Percent of patients receiving follow-up care within 7 days after hospitalization for mental illness	**Better**	**Better**
Percent of patients receiving follow-up care within 30 days after hospitalization for mental illness	**Better**	**Better**
Tobacco Use Screening	**Better**	**Better**
Tobacco Use Treatment (during the hospital stay)	**Better**	Worse
Tobacco Use Treatment Provided or Offered at Discharge	**Better**	Worse

DOWNSTREAM EFFECTS OF DECREASED BEHAVIORAL HEALTH SYSTEM CAPACITY

Worsening of Emergency Department Boarding

Emergency department (ED) boarding occurs when a patient must wait in an ED until an appropriate inpatient bed is available. Mental health and substance use disorder patients make up a disproportionately large percentage of patients that board in the ED. In 2015, 70.5% of patients that boarded in an ED had a mental health or substance use disorder diagnosis, even though this group of patients made up only 14% of overall statewide ED visits. The amplified impact of the behavioral health crisis on children is especially evident in the context of ED boarding. Teenagers make up 21% of all behavioral health visits that board. For cases that board for two or more days, children and teenagers make up 59% of all cases.[19]

Emergency departments are not only an inappropriate setting to care for psychiatric patients, but they can often cause a patient's condition to worsen. For example, a 2010 analysis of psychiatric patients boarding in EDs points to the harm that being in an ED can present to psychiatric patients, explaining that, "emergency rooms are generally loud, hectic environments that are poorly suited to deescalating a mental health crisis." The analysis recommends several means to address ED boarding, many of which entail creating a much more robust community-based mental health system.[20] These community-based services are exactly the type of services that will have difficulty finding appropriate staff if the ballot question passes; affected hospitals would be forced to hire unnecessary additional RNs, drawing them away from vitally important community-based services.

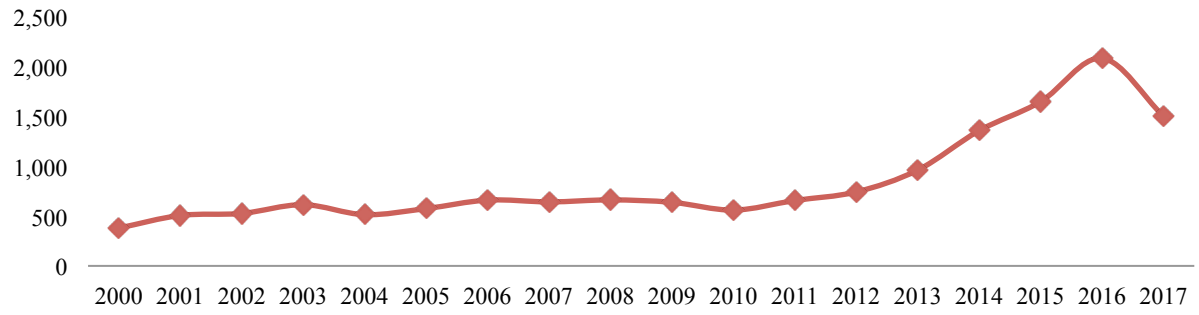
Given the existing shortage of behavioral health clinicians, including RNs, many inpatient behavioral health facilities are currently unable to offer otherwise available licensed beds to patients with acute mental health needs. If MNA's ballot question passes, additional RNs would be needed to comply with the ratio requirement, and not being able to hire these RNs would result in facilities having to reduce patient admissions by 38% or more in the aggregate. This would mean that patients going to the ED in need of inpatient psychiatric or substance use services would board there even longer, exacerbating the already dire ED boarding situation. It is also important to note that the ballot question would require mandated ratios in the ED, and if a patient is experiencing an acute mental health condition, they may not be able to access the closest ED for stabilization if that facility is already at the maximum allowed nurse-to-patient ratio.

Decreased Outpatient Care Leading to Increased Hospital Readmissions

A recent Massachusetts report from the Center for Health Information and Analysis (CHIA) showed that 60% of patients readmitted to hospitals in the state have behavioral health issues.[21] This report and another from the Massachusetts Health Policy Commission specifically address the need for increased access to, and coordination of, behavioral health services to better serve these patients and reduce unnecessary readmissions. Hospital readmissions are both costly and burdensome to hospital systems. Hospitals that perform poorly on readmissions are penalized by payers through decreased reimbursement, which further limits their ability to provide adequate patient care. Also, as discussed above, behavioral health patients are more likely to board in emergency departments, which both further exacerbates overcrowding of emergency rooms and is a barrier to providing behavioral health patients with timely and effective treatment. The proposed nurse staffing ratios could worsen the readmissions cycle; if the amount of both inpatient and outpatient care is reduced because hospitals are not able to hire the necessary staff to meet the potential capacity, then fewer patients will have access to the care that they need and will likely end up back in the ED boarding-and-readmission pipeline.

Worsening of the Opioid Crisis

Figure 8: Opioid-Related Overdose Deaths in Massachusetts



Source: Massachusetts Department of Public Health

Hospital EDs are a first line of response for individuals experiencing crises related to substance use. Since 2011, opioid-related ED visits in Massachusetts have increased by 87%. Due to a number of statewide initiatives, Massachusetts experienced its first decline in opioid deaths in 2017 following several years of relentless increases (**Figure 8**).

In March of 2016, Governor Charlie Baker signed into law An Act Relative to Substance Use, Treatment, Education and Prevention (the STEP Act), a bipartisan piece of legislation passed unanimously by both the Massachusetts House and Senate. This law includes several provisions to stem the opioid epidemic, including: limiting opioid prescriptions to a seven-day supply; using prescriber reports from the state's prescription monitoring program to monitor inappropriate prescriptions; developing non-opioid pain management alternatives; and including implementation standards for substance use disorder evaluations within EDs.

Behavioral health providers have been working closely with the Baker administration to increase access to both mental health and substance use disorder services. From January 2015 through the end of 2017, more than 1,100 licensed beds for psychiatric and substance use disorder services have been added to the Massachusetts healthcare system. An additional 500 new beds specifically reserved for treating individuals with both substance use disorder and mental health disorders are anticipated to open in the next five years. The administration and MHA also plan to work with hospitals to consider ways to expand access to Medication Assisted Treatment (MAT) for patients seeking care and treatment following an overdose. This would include increasing the number of MAT prescribers in both hospitals and primary care/community-based settings.

These initiatives are laudable—but the likelihood of their success would be undermined greatly by the requirements of the nurse ratio mandate. Under the staffing ratios, an ED that is staffed at the maximum allowed ratio would not be able to care for any patient suffering from an overdose and further would not be able to provide MAT or other recovery services. For patients who need acute inpatient level services, ED boarding times would further increase if the inpatient units are also at the maximum ratio capacity. As a result, this will needlessly reduce access to inpatient level care for patients suffering from acute substance use disorder conditions and divert limited resources away from meeting the demand for behavioral health inpatient care by having to hire additional nurses to meet a clinically unwarranted, arbitrary ratio. Research on mandated nursing ratios has failed to demonstrate improvements in quality or outcomes.

Increased Incarceration & Effect on the Criminal Justice System

Inadequate numbers of inpatient psychiatric beds can mean that some people with serious mental illnesses (SMI) become involved with the criminal justice system. This trend is more significant in Massachusetts than it is nationally, with 27% of Massachusetts state prison inmates previously diagnosed with serious mental illness, compared to 22% nationally.[22] Even after stabilization and release, those with SMI involved in the correctional system have difficulty obtaining ongoing treatment, which often leads many to end up back in the justice system.

An analysis completed by The Treatment Advocacy Center and National Sheriffs' Association found that, "in 2004–2005, throughout the United States, there were more than three times more individuals with serious mental illnesses in jails and prisons than in hospitals." With an estimated 38% potential reduction in behavioral health patient inpatient services availability in Massachusetts if the ballot question passes, it is likely that many of the patients that could and should be cared for in psychiatric units would instead become involved or re-involved with the criminal justice system. **This would not only be burdensome on the criminal justice system, but, most importantly, it is inappropriate care for individuals with mental illness. Inmates with**

SMI are more likely to commit suicide than other inmates and are sometimes abused due to lack of training by corrections workers.[23]

Massachusetts uses a court process, commonly referred to as Section 35, for involuntarily committing individuals who need substance use disorder treatment when they are a danger to themselves or others (such as family members). Due to a renewed focus by Governor Baker's administration, the number of beds available for a Section 35 involuntary commitment has increased significantly since January 1, 2015, which has allowed for an increase in enrollments (**Figure 9**). The number of men's beds increased from 258 to 359 beds while women's beds increased from 90 to 167. While the use of Section 35 has also increased, the number of people enrolled in substance use disorder treatment programs in county corrections programs has decreased, as shown in **Figure 10**.[24] Substance use disorder is treated better in facilities designed for substance use treatment than in the corrections system, and the increase in Section 35 beds and decrease in those being treated for substance use disorders in the criminal justice system is important progress.

Figure 9: Number of Enrollments Section 35

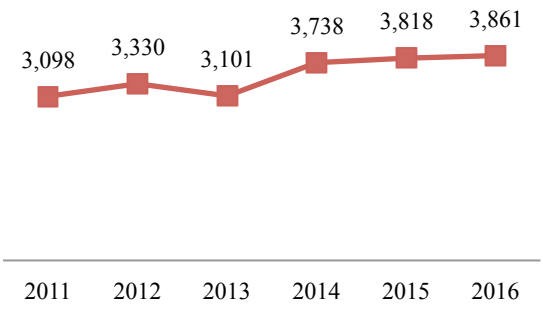
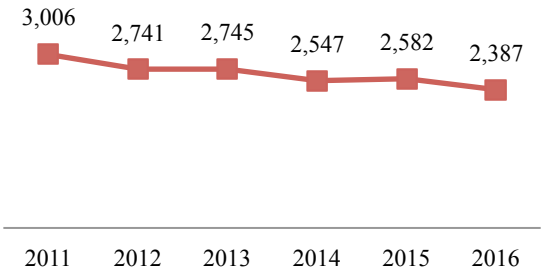


Figure 10: Number of Enrollments SUD Treatment Programs in County Corrections



Unfortunately, due to the epidemic levels of the opioid crisis, there are currently not enough Section 35 beds for men despite the steep increase in such beds over the last several years. The differential treatment of men and women with regard to the use of Section 35 contributes to a stigmatized view of substance use disorders when a person is committed to prison because Section 35 beds are unavailable. Implementation of the MNA's arbitrary nurse staffing ratios would further exacerbate this inequity.

In order for hospital-based substance use disorder facilities to meet the ballot question's requirements, they will have to hire additional registered nurses, and will likely have to hire RNs away from facilities that provide Section 35 beds, thereby threatening the critical progress that has been made in increasing the number of the beds that are available. A reduction in staffed Section 35 beds will likely lead to increases in the number of patients who instead are treated in correctional institutions, thus **rolling back much of the progress that has been made to increase access to appropriate treatment for people with substance use disorders in Section 35 facilities.**

Negative Affect on the Community at Large

Behavioral health disorders have wide-reaching effects on people's education, employment, physical health, and relationships, and hence on the community at large.

The Treatment Advocacy Center, a national organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illness, described the consequences of providing an insufficient number of behavioral health beds for the treatment of seriously ill psychiatric patients, including "***an increasing:***

- Number of mentally ill individuals in hospital emergency rooms waiting for psychiatric beds;

- Demand on police and sheriffs who, for all intents and purposes, become frontline mental health workers;
- Number of mentally ill individuals in jails and prisons; and
- Number of mentally ill homeless individuals." [25]

"Without access to hospital care, acutely ill individuals deteriorate, families and caregivers buckle under stress, ERs fill with acutely ill patients waiting for a bed to open and police and fire responders find themselves increasingly diverted to mental health calls."

-The Treatment Advocacy Center.

There are frequent media reports about communities concerned that closure of local hospital psychiatric beds will discourage persons with mental illness from getting treatment, and exacerbate the crisis felt by those suffering from behavioral health disorders who cannot access care.

The misguided nurse staffing ratio ballot question disregards these concerns and its passage would exacerbate the crisis in our already overstretched and overburdened behavioral health system.

"Not only does the ballot proposal mandating nurse staffing levels ***not match best practices*** *for models of psychiatric and other mental health care, but there is evidence from California that the implementation of nurse staffing ratios there* ***led to decreases in mental health services****, particularly for hospitals that had the lowest levels of nurse staffing before the implementation of the ratios and consequently were the most financially vulnerable. Beyond the scaling down of mental health services, there is compelling evidence from a recent study that the implementation of nurse staffing ratios* ***directly led to the closures of some EDs and full hospitals****, further* ***decreasing access to care for all patients****".*

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