Testimony of Mark Reinstein on HB 5615, 11-5-20, House Health Pol. Committee

Representative Vaupel and members of the Committee,

I'm Mark Reinstein, the former long-time CEO of the Mental Health Association in Michigan, having retired in January.

For the past five years, I've had significant involvement with the issues pertaining to this bill. That's because WXYZ-TV in Detroit has interviewed me for stories about psychiatric hospital complaints, rights violations, injuries and deaths, and because I've reviewed all psychiatric hospital death reports to LARA – 211 in all – for the period 2015-19. I am also familiar with the State Office of Recipient Rights report on protective procedures, or the lack thereof, in the Harbor Oaks private psychiatric hospital in Macomb County.

My work on this has shown me that licensing of private and community psychiatric hospitals should no longer remain with LARA. It doesn't have the expertise and/or motivation to do anything about complaints, patient injuries and the loss of life. I have seen multiple investigative reports from LARA, and they are shockingly poor, shockingly incomplete, with no remedial action ever recommended or taken. They focus on whether policies exist, not whether those policies were violated. Responsibility for licensing of these hospitals must return to mental health and recipient rights experts in MDHHS. HB 5615 would do this. The Mental Health Code presently says this is a responsibility of the MDHHS director, but that he or she can farm out the work – the situation we've had in Michigan for several years.

The other major thing HB 5615 would do is codify requirements for hospital death reporting to MDHHS, not LARA. The Mental Health Code presently has little in this area.

When I reviewed the past five years of death reports to LARA, I was dismayed to note 211 reports, over 40 a year. Seventy-five percent of the deaths occurred in the hospital; 25% in the community soon after hospital discharge. Seven percent of the deaths were suicides; there were another 5-7 drug overdose deaths, which may have been suicide.

The reporting form used by LARA strikes me as part of a perfunctory exercise that isn't taken seriously. For example, three deaths were reported as occurring while someone was in restraints, yet the reporting hospitals said restraints had nothing to do with the deaths. Did LARA ever flag these cases and do further investigation? I fear not.

In another example, LARA asked if death investigations had been or would be conducted and if hospital recipient rights offices had been notified. The answers were overwhelmingly yes, but the reports don't tell us what, if anything, recipient rights did with the information, or the results of any formal, internal death investigations. Did LARA ever do any follow-up? I fear not.

To give one more example, many of the deaths were of senior citizens, with one hospital clearly leading the way in such deaths. Did LARA ever single out senior deaths, or the hospital that contributed more of these than any other, for follow-up investigation? I fear not.

Having gone through all those death reports, I have three amendments to propose for HB 5615:

*Sec. 720(1), to the list of reporting requirements, I'd add "Medications and dosages administered to the recipient while hospitalized"

*Sec. 720(1)(l), add a second sentence, "If action is pending on the results of a hospital investigation or review, the findings of that investigation or review and the action yielded must be reported supplementarily

*Sec. 720(1)(m), add a second sentence, "If a recipient rights investigation or intervention is undertaken, the results of that investigation or review must be reported supplementarily"

Lastly, a word about SB 813, which is through the Senate and resulted from the WXYZ-TV reports. It is a well-meaning but incomplete attempt to do something here. It is far narrower than HB 5615 and will do far less than HB 5615 to ameliorate problems.

I thank Rep. Green for introducing this bill. It is badly needed. Over 40 vulnerable, disordered individuals are dying annually because of potentially substandard hospital care; because they are possibly being discharged prematurely from private and community psychiatric hospitals; and potentially because the mental health system lacks adequate outpatient services for them. Any complaints from the powers-that-be about administrative burdens, bureaucratic turf preferences or micro-management pale in comparison to the needless loss of lives.

I would remind everyone that, for many years, it was mental health experts who were licensing psychiatric hospitals, receiving relevant data from them and investigating potential problems. All HB 5615 is doing is returning these matters back to the mental health experts, as it once was. This is literally a life-and-death matter, and I respectfully urge adoption of Rep. Green's bill. Thank you.