PETERSHAM TOWN HALL

SPECIAL PERMIT APPLICATION PRESENTATION

DECEMBER 9, 2014

PROJECT: THE RETREAT AT PETERSHAM
BEHAVIORAL HEALTH
ADDICTION RECOVERY CENTER
211 NORTH MAIN STREET
PETERSHAM, MASSACHUSETTS

BEFORE:

MARYANNE REYNOLDS, Chair
BRIAN MacEWEN
DONALD EATON

CAROL A. JEFFREY
REGISTERED PROFESSIONAL REPORTER

P R O C E E D I N G S

THE CHAIR: Welcome back. We're going to now have the continuation of the public hearing on the application of Heywood Healthcare. And if you have a PowerPoint you'd like to do?

MR. FLICK: Mm-hmm.

THE CHAIR: Okay, go ahead. Nancy, do you want to take this copy for the library?

MS. ALLEN: I do. Would it help if I try some light changes for the audience? I'll do a little quick experiment.

DR. BIALECKI: I am Dr. Rebecca Bialecki, I am the Vice President of Community Health at Heywood Healthcare. Part of my job is to work on the development of the Quabbin Retreat. So my presentation tonight is going to largely be around the process portion of the program and what the programming will look like at the site.

Really the vision statement was developed around the entire center as a whole, which states, "To address the growing unmet need for behavioral healthcare in North Central

Massachusetts, Heywood Healthcare will develop a premier regional destination for substance abuse and mental health treatment and rehabilitation through its new campus in Petersham. In partnership with local stakeholders and leading providers, Heywood will establish a full continuum of programs to expand access to services and elevate the quality and caliber of care offered to its communities."

The core principles include addressing core mental health and substance abuse needs of our region; to make it financially accessible to patients; it collaborates with other programs on campus to provide coordinated care; committed to preserving the exterior aesthetic of the property whenever possible; supports the local economy by utilizing local vendors and resources whenever possible; and recognizes the unique needs of rural Petersham.

So the way that I have organized this presentation is really to look at all three phases of the proposed design. I know that I've received the questions in advance, and I think they were just organized a little bit

differently.

So really what we have here are the three phases of the build-out. The initial phase or Phase I is in the purple color. I'm hoping that people in the audience can see this. So that's largely here, as well as the other office space over here.

Phase I is going to be initially a residential substance abuse unit for adults, and outpatient treatment, which would access services such as the kitchen, dining, recreational areas, as well as some administrative offices over in the other building, which I think was originally the mansion space. Is that what that's kind of referred to as?

Phase II is the light blue building, which is out here, and that's intended to become the intensive out -- I'm sorry, that's going to be the adolescent residential unit.

And Phase III is in red over here, that's the inpatient unit, because for anything healthcare really, you have to have a steel-framed structure. That building currently has a steel frame, and the rest does not.

So in Phase I, which would be the beginning and probably about a year of construction and development to establish a residential adult substance abuse unit. It would be up to 35 beds, although 35 beds -- we have space for 24 beds is really the realistic number that we're targeting per unit in response to the needs of the community.

It would also include expanding Heywood's existing partial hospitalization program and intensive outpatient programs to meet the growing demand for these services, provide routine outpatient services, which may include psychiatry and related clinical services for mental health and substance abuse. So that would be Phase I.

Phase II, the options include a residential adolescent substance abuse program, which would be approximately 20 beds, because it's that single building that's out on the side. As you face the property, it's to the right.

Phase III is then the more intensive renovations that would be required to build the inpatient detox unit of ten beds, to provide for

medical support for patients prior to transitioning to residential programs, so this would be the adult detox unit, as well as an inpatient mental health unit, again up to 20 beds, expanding the existing unit at Heywood to address the current shortage of inpatient capacity.

To really look at the whole project as a whole, an overview, mental health and addiction treatment are rooted in rehabilitative education. It really is about changing skills and changing how people think about the choices they make and better educating them to take a different path going forward.

All the behavioral health treatment models are based in evidence-based proven treatment approaches that are cited as "best practices" within the field.

Behavioral health treatment is an integral part of overall health and wellness and must be coordinated with primary care. That's part of what Heywood has been very committed to, and certainly the Board of Trustees has made an ongoing commitment to make sure that behavioral

health really is part of overall health.

Each personalized treatment plan, specific to each individual's physical, psychological and spiritual needs, also includes clinical care for co-occurring mental health conditions such as depression or anxiety disorders, which is what one of the unique pieces of this continuum of care model brings is really looking at co-occurring disorders. So people who are using substances to perhaps self-medicate for other mental illness, it's all in one place, so it can be addressed seamlessly.

Supportive and complementary rehabilitation programs will be included, including we just had a conversation the other day confirming some plans with Seeds of Solidarity to build a wellness garden at the site and offer related nutrition and health programming, as they do at the other campuses currently part of Heywood.

Intake and referral will be handled at the sending site. Most patients will be arriving from a hospital setting or other detox unit and will need to be referred to the program by

clinical teams.

There might occasionally be a referral that comes in from an outpatient provider. Currently our system allows for CSO to do mobile crisis intervention. For example, if they met with a patient of theirs who felt that they were escalating to the point where they needed a more intensive treatment, they could refer in there. But it will not be a walk-in center where people will arrive to have the intake done on site.

All treatment will be a team model with each care team developing a treatment plan unique to that individual's diagnosis.

Care teams will be responsible for preparing discharge plans for all patients. Transportation assistance to the pre-determined next step of placement would be offered. So, again, no one is discharged to the street, because that's not the way this model works.

As part of a comprehensive treatment approach, a wide array of services at the retreat to augment treatment and to support recovery include psychiatric, psychopharmacological assessment, medication management, case

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management services, including ongoing consultation with the referring physician, and aftercare planning. Again, that's really a strong part of that discharge plan.

Group-based supportive therapies, psycho-education, and life skills training are certainly key. Family education and support for the support network that each patient will have as they transition back to their home community, vocational assistance or training as needed.

Nutritional assessment, education, toxicology, testing when indicated, and patients will be supervised by staff at all levels and will remain on site for the duration of their treatment of rehabilitation. Outdoor and indoor recreational opportunities need to be provided for patients at every level of care.

In Phase I, when we develop residential services, they are intended to offer supportive and therapeutic setting for adults, typically 18 and over, who would benefit from additional support while transitioning to independent living. Treatment options focus on improving the skills to make better life choices.

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Residential program in Phase I would provide treatment for adults struggling with substance abuse disorders and addiction who have completed a detox program for a period -- the detox program is typically up to 72 hours. The residential piece would be from up to 21 days, although the typical length of stay that I'm hearing right now is more like ten days. And that has a lot to do with insurance-funded treatment and what they'll pay for for someone to stay.

Development of an individualized treatment plan, it will provide educational support as the patient gains independence from addictive substances, learns to manage the stress of an active life without returning to the drug or alcohol dependence, attain personal, career and recovery goals.

The program features are in-depth individual assessment, group therapy, medication stabilization, education, illness management, psychopharmacology services, abstinence education, life skills education, after-care assistance, relapse prevention, and self-help

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meetings.

So when these people are living at the site 24-7 for the period of their treatment, you know, 10 to 14 days, they have a really intensive regimen that they're involved with all day.

Intensive outpatient services is the other part of Phase I, and they're intended to include a partial hospitalization and intensive outpatient addiction programs.

Typically folks arrive around 9:00 o'clock in the morning, leave the property around 3:00 o'clock in the afternoon, and during that time, they have intensive therapy, both group and individual, while they're there throughout the day. But they have progressed to a point where they're capable of being at home in the evening and being out in the community unsupervised after that. But this is really sort of that next step from residential treatment offered.

There are things like the START intensive outpatient program which aids in the early phases of sobriety and recovery from substance abuse. It's a three-week program designed to educate individuals in an effort to

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develop insight and skills necessary to remain abstinent from drugs and alcohol. Early recovery groups for substance abuse treatment focused on relapse prevention and harm reduction.

The START intensive outpatient treatment program again is strong on developing the skills necessary -- and I think I didn't switch that one.

The partial hospitalization program provides daily assessments by a clinical staff, psychotherapy, life coaching in a therapeutic milieu. The program acts as a step-down for any individuals leaving an inpatient setting or as an early intervention to avoid potential hospitalization.

When we get to Phase II, Phase II would really include the development of an adolescent substance abuse service. And residential treatment would be appropriate for youth experiencing health, emotional, behavioral, family, developmental or social problems as a result of alcohol or other drug in use and whose issues have not been able to be addressed in a less intensive community-based level of care.

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They're short-term substance abuse treatment services for medically stable youth, so these are not kids who would need some other medical interventions for their health and safety. And a youth's typical length of stay is about 30 days in the program based on the treatment needs.

Qualified staff create an individualized treatment plan for each adolescent. Every youth participates in highly structured, developmentally appropriate individual, group, and family clinical services.

An in-house educational coordinator is responsible for developing educational objectives with the adolescent's school from his or her home community. Continuing care services are provided to help the youth in recovery upon completion. Again, the same kind of team planning around discharge and next steps are a critical part of the team and treatment.

Services include relapse prevention education, follow-up planning, integration to community resources and/or outpatient programs, and certainly the families in this case are even

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more critical in the educational process of this kind of rehabilitation.

Continuing care services are provided to help the youth in recovery on completion. Again, the kinds of things that they include, follow-up planning, integration to other community resources or perhaps outpatient services, family support, referrals to those community-based programs, following transition to the home are part of the comprehensive model.

Special emphasis is placed on creating healthy lifestyles and positive decision-making. In support of this, an assortment of groups and activities are offered during the week that draw on a variety of evidence-based interventions and rehabilitative education models that have proven effective in controlling symptoms and increasing levels of health. And these are all nationally recognized science-based curriculum.

When we get to Phase III, this is the part of the structure that would take the most intensive sort of construction on the site. It would be development of the steel-frame building, and would be for the inpatient programs that are

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being offered.

Inpatient units will be locked facilities. An inpatient detox unit provides safe, medically supervised detoxification as well as treatment of patients with dual diagnosis. Typical length of stay is three to five days.

Clinical evidence supports the fact that smoking cessation during detox from alcohol or drugs can reduce the relapse potential from both chemicals. Smoking is not permitted on or off the unit during patient's hospitalization. And nicotine replacement therapy is available to all patients upon admission. And that's currently the way the inpatient unit works at Heywood as well.

Physician-directed treatment team with 24-hour nursing care, licensed counselors, and case managers. Treatment includes individual and group counseling, family support and education and aftercare planning. And they may also attend daily in-house NA and AA meetings.

To expand the current inpatient setting at Heywood, this gives a little bit of an overview about some of the patients that are

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currently on the site there. This would just be an extension or expansion of that model.

The adult inpatient unit at Heywood services patients 16 and older for acute short-term treatment. The Heywood Mental Health Unit prides itself on providing professional understanding of the emotional aspects of psychiatric illness with the most current and clinical standards of care, provided in a warm and inviting environment.

Heywood's Mental Health Unit has been designated as a Best Practice site by the Mass. Department of Mental Health, the Mass. Association of Behavioral Health Services, Mass. Behavioral Health Partnership, and currently has a contract with MBHP to provide care for all Mass. Health patients, with many other insurers as well.

Heywood's Mental Health Unit has been recognized for achieving excellent outcomes for patients as evidenced by measures such as the length of stay of 6.45 days versus a predicted rate of 7.3 days, and a seven-day recidivism rate of 5.91 versus a predicted rate of 7.31. Low

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recidivism means that fewer patients leave the facility and then have to be readmitted within seven days for further treatment.

When we look at the types of licenses that we had presented previously, we looked at all of the licenses again and decided to remove the Class VII because it just isn't feasible for this site. All the other licenses are things that have been presented in the past, and include various voluntary and involuntary treatment models.

Some additional regulatory oversight is provided by the Mass. Department of Public Health, and their Bureau of Substance Abuse Services, which is one of the departments within the Department of Public Health.

And I'm going to turn it over to Attorney Flick, as soon as we figure out if there are questions perhaps for me.

THE CHAIR: I think there will be, but do you want to just finish the presentation?

MR. FLICK: Okay. What I want to talk about is basically some of the legal framework that is involved in this project, in particular

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with the ZBA's purview over the use of the property. And I'm going to turn to statutory provision that's called The Dover Amendment.

The Dover Amendment is enumerated in Mass. General Laws Chapter 48, Section 3. It states that, "No zoning ordinance or by-laws shall regulate or restrict the...use of land or structures for...for educational purposes on land owned or leased by...a nonprofit educational corporation; provided, however, that such land or structures may be subject to reasonable regulations concerning the bulk and height of structures and determining yard sizes, lot area, setbacks, open space, parking, and building coverage requirements."

The key in The Dover Amendment is that no zoning ordinance or by-law can regulate an educational use. That is essentially what The Dover Amendment says. The question becomes what is an educational use.

There are two requirements that have to be met in order for the Dover Amendment to apply. First, the use must be for educational purposes. Second, the land and/or structure used

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for the educational purposes must be owned or leased by a nonprofit educational corporation. And this is one court case that discusses this. It's a relatively recent case from 2009.

We're going to talk about the second qualification first. And all of this is done to gain an understanding as to whether or not the use that was just described by Dr. Bialecki falls under The Dover Amendment, and, therefore, cannot be regulated by the DBA.

Under the second qualification, the land and/or structure used for the educational purposes must be owned or leased by a nonprofit educational corporation. This is satisfied if the nonprofit corporation's articles of organization permit it to engage in educational activities.

This is probably one of the most well-cited cases in Dover Amendment litigation, Gardner Athol Area Mental Health Association versus The Zoning Board of Appeals, 1987. No, I was not involved in that case.

This is an excerpt, and I have copies to present to the ZBA. This is an excerpt from

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Heywood Healthcare, Incorporated, Amended Articles of Organization, which I believe were amended in 2012.

"The corporation is formed and shall be operated exclusively for charitable and educational purposes as defined under Internal Revenue Code Section 501(c)(3) to support and further the purposes of The Henry Heywood Memorial Hospital, Athol Memorial Hospital and other corporations of which the corporation is the sole corporate member, provided, in each case, that such organization is qualified under Code Section 501(c)(3)."

So essentially this is a nonprofit organization that is an umbrella over other nonprofit organizations that are involved in charitable and educational purposes.

Second qualification, and this is perhaps the most robustly discussed qualification when it comes to Dover Amendment matters. Is the land or structure used for the educational purposes -- well, we'll just talk about -- I'm sorry, we're going to talk about the first qualification. Let me just wrap this one up.

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So Heywood Healthcare is a not-for-profit educational organization. Heywood Healthcare, Inc., is the operating entity of Quabbin Retreat, so it satisfies the second qualification of The Dover Amendment. The question is does it satisfy the first qualification of The Dover Amendment, which is is the use for educational purposes.

In order to satisfy the first qualification, The Dover Amendment requires the educational purposes protect only those uses serving primarily educational purposes, i.e., does the proposed use have as its dominant purpose a goal that reasonably could be described as educationally significant.

This is a very recent case, 2012, that involves the Regis College was developing essentially an assisted living facility on its campus or on land owned by contiguous to campus. Only the residents of that were allowed to enroll in the college, as well as the center was going to be used for education of students in elder care services.

The relevant question: Does the

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proposed use have as its dominant purpose a goal that reasonably could be described as educationally significant. Well, let's look at the purpose.

A summary of the purpose of the Quabbin Retreat, based upon Dr. Bialecki's presentation, rehabilitation of persons suffering from behavioral health disorders, including substance abuse and addiction. The goal of rehabilitation is to build skills to improve self-sufficiency, build coping mechanisms, and develop healthy stress response in a safe, stable, and healing environment, with the end result being a person who is able to face their individual behavioral issues with the tools necessary to cope in healthy ways. So that is in a nutshell the purpose of the Quabbin Retreat.

So what constitutes an educational purpose. Massachusetts courts have consistently refused to limit Dover Amendment protection to traditional or conventional educational regimes, citing again the Regis College case. A proposed use of land or structures may have an educational purpose notwithstanding that it serves

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nontraditional communities of learners in a manner tailored to their individual needs and capabilities.

Also citing the Regis case, The Dover Amendment has been applied to certain facilities for the disabled and the infirmed, notwithstanding that the education afforded by such institutions differed markedly from that offered by traditional academic institutions.

What constitutes educational purposes. Again going back to the Gardner Athol Area Mental Health, rehabilitation surely falls within the meaning of education. And that is quoted directly out of the Gardner Athol Area Mental Health case, citing the Harbor Schools case which goes back to 1977. So as you can see, this perspective of the Massachusetts courts that rehabilitation is educational dates back to 1977. So it's been a long-standing holding of Massachusetts courts.

A more recent case, actually not that much more recent from 1980, this case was developed shortly after the prior case Harbor Schools that stated rehabilitation surely falls

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within the meaning of education, this case involved the Fitchburg Housing Authority versus the Zoning Board of Appeals in Fitchburg, it considered whether or not the operation of a residential facility in which formerly institutionalized but educable adults with histories of mental difficulty will live while being trained in skills for independent living, such as self-care, cooking, job seeking, budgeting, and making use of community resources. This again is a well-cited case to address that addresses issues regarding The Dover Amendment.

In the Fitchburg Housing Authority case, the court stated that the fact that many of the residents of the facility will have been residents of mental institutions and will be taking prescription drugs does not negate its educational purpose or make its dominant purpose medical.

The court also stated that the fact that the facility will provide residential accommodations does not interfere with its educational use. In his conclusion on the case, Judge Wilkins said, "The proposed facility would

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fulfill a significant educational goal in preparing its residents to live by themselves outside the institutional setting. Instruction in the activities of daily living is neither trivial nor unnecessary to these persons. On the contrary, for the prospective residents of the proposed facility to learn or relearn such skills is an important step toward developing their powers and capabilities as human beings. Inculcating a basic understanding of how to cope with everyday problems and to maintain oneself in society is incontestably an educational process." I wish would have been the one to say that, but I give Judge Wilkins the credit.

So we ask the question again: Does the proposed use have as a dominant purpose a goal that reasonably could be described as educationally significant? And the sub-questions help us answer that. Will the facility, meaning the Quabbin Retreat, prepare its residents to live by themselves outside the institutional setting? Yes. Will the facility's residents receive instruction in the activities of daily living? Yes. Will the facility's residents

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develop an understanding how to cope with everyday problems and to maintain oneself in society? Yes.

So of the 86 proposed beds, and I know the number's a little bit different in Dr. Bialecki's presentation, 86 is the maximum beds that are currently in the facility. That does not mean that we will be utilizing all 86 beds. I think the number was about 66, 67 beds. That may be a more realistic number. But of that number, only ten beds will be available for inpatient detoxification.

That is a significant -- that is less than even 25 percent of the proposed beds that are being presented tonight. Of the remaining beds will be dedicated to behavioral health treatment or rehabilitation. So 88 percent of the 86 beds will be dedicated to treating and rehabilitating -- treating or rehabilitation, I believe those are synonymous terms in mental health, treating and rehabilitating, because treatment is rehabilitation, rehabilitation is treatment, of persons with behavioral disorders.

Therefore, the dominant purpose of the

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Quabbin Retreat can reasonably be described as educationally significant. The Dover Amendment -- so, therefore, The Dover Amendment applies. The use of the facility that is being proposed cannot be regulated by the Petersham Zoning Board of Appeals, but what the ZBA can do is issue reasonable regulations concerning the bulk and height of structures. We're not changing any of that. Determining yard sizes, lot area, setbacks, open space, parking, and building coverage requirements. That is pursuant to Mass. General Laws, Chapter 40A, Section 3.

Moving on to just a few questions that were raised at the last ZBA hearing, and that was the one just before Thanksgiving, question was raised about the issue regarding removal of trees. When this project initially began, the hope was and the expectation was that the septic system would be able to be located where the existing septic system is currently located, which is right here where you see these two red outlined squares.

The problem is now that the DEP has become involved with the water source and

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regulating that, you go back to these two circles: One being area one in which no activity can occur; and the second being this larger area here, this protected area, where we can't do any significant construction or anything that would impact the water supply.

So, therefore, from a regulatory standpoint, the septic system cannot be put anywhere within this outside circle. So, therefore, based on the DEP's rulings, it has to be located outside that circle and will then necessitate the removal of trees that were not intended to be removed when we initially started this project.

There was also a question raised as to the fees. The fees that are involved in this project, one time occupancy permit for the Town of Petersham is a $25 fee. The building permit is a one-time fee of approximately $30,000. That is a fee that will be paid in phases as each phase is completed. It's based upon the square footage of construction.

The food service inspection is an annual fee to the Board of Health, and that's

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$150. Fire inspection, really not sure what's going to be involved with that. I haven't had a chance to talk to the chief to see if there is a fee for any types of inspections. There typically aren't inspections from local fire. But that's something that we're still looking at.

There will be a one-time sign permit fee of $25. Driveway permit fee of $50. Fire compliance one-time fee of $75. Electrical inspections, $450. Gas inspections, $150. Plumbing permit, $300.

These are all based upon the current table of fees from the Town of Petersham. Water and septic permits is to the DEP. There's no local involvement in these, because it's all DEP inspection and DEP permitting. It's up to $18,000, depending on some of the things that we're still waiting on DEP to make a determination of, but that's about the maximum, $18,000 and some change. So the total initial fees that would be paid prior to construction would be $49,225.

And as far as the annual monitoring of the water and septic permits, that will be

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conducted by a third-party engineering company that's contracted by Heywood that would provide reports on a quarterly basis to DEP and/or remote monitoring process with DEP. It would not involve any local inspectors.

So the next steps, the DEP permit process, water source or septic treatment, parking lot and external renovations for safety, dealing with ground water runoff and lighting, complete and internal renovations for safety, sprinkler system, and fire safety systems.

Step four, complete internal renovations for Phase I services, administrative offices, outpatient treatment areas, recreation areas, food service, and the residential unit. And step five, hiring process, and then on and on with Phase II and Phase III. And that is the conclusion.

DR. BIALECKI: I had a couple of additional questions that I just wanted to make sure I included as part of the presentation. These were some of the questions that were sent in advance.

As far as gender, it is intended that

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the units would be co-ed units, but there would be separation for shower, bathing facilities, and bedrooms would be separated a bit, depending on gender.

Can Heywood refuse admission? Only in the event that a patient was presenting with issues that would not be appropriately addressed by the treatment services and rehab offered at the unit.

So typically when a referral comes in from a crisis provider or from another facility, they have a pretty good understanding of what's there, so generally there's not a need to have to refuse treatment. But on the occasion that there might be someone who has some issue that's beyond the scope of what can be offered at this site, then refusal of admission is certainly an option.

The other one was around how does the rural or retreat setting advantage treatment. As mentioned earlier, and certainly in John's presentation, it was noted that these services being built in a healing environment is the best way to help people put their lives back together and get back on track to be able to rejoin their

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home, community and family. And being in a rural setting certainly is conducive to that. Along with a lot of the other treatment modalities that are really rooted in holistic health providing real benefit to all of the residents of the site.

So I'm hoping that that really -- and I think the other questions were really addressed within the presentation of each phase.

THE CHAIR: Thank you.

MR. MacEWEN: Thank you.

THE CHAIR: Are there any questions from anyone here in the public?

Roy? Please state your name and your address for the record.

MR. NILSON: I was planning to do that. Roy Nilson, N-i-l-s-o-n, 21 Common Street. A question for Rebecca, and then a question for John.

The way I counted them up, you said 64 beds or maybe 75 beds, but not 86 beds. And I'm wondering how many beds are we talking about?

DR. BIALECKI: 86 beds was the total capacity of the facility.

MR. NILSON: Understood.

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DR. BIALECKI: And when we looked at breaking it down phase by phase, it was closer to 66.

MR. NILSON: So 20, 20 and 35.

DR. BIALECKI: Yes.

MR. NILSON: Or 24. John, are you asserting that the zoning board has no authority over this project at all or more narrowly that they have no, under Dover, no authority to regulate operations beyond the size and scope of the building?

MR. FLICK: Correct. It's they cannot -- the Zoning Board of Appeals under The Dover Amendment cannot regulate the use of the facility as far as the programs that are going to be provided within the facility itself, and the treatment methodologies, et cetera.

MR. NILSON: Thanks.

THE CHAIR: Any other? Paul?

MR. YOUD: Yeah, I had a number of questions.

THE CHAIR: Just please identify yourself.

MR. YOUD: Paul Youd, 16 Hardwick

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Road, Petersham. And that I guess was just the particulars for Rebecca. So there is going to be an adult locked unit, mental health, and the capacity there is 20 people, and that's for all three phases. So at the end of the third phase, that capacity would be 20?

MR. FLICK: Let me go back.

DR. BIALECKI: Phase III.

MR. FLICK: I think that was --

MR. BROWN: Further.

DR. BIALECKI: So the inpatient, the locked inpatient unit is ten beds.

MR. FLICK: Ten beds.

DR. BIALECKI: That's the steel structured building.

MR. YOUD: Yes. And that's for the adults, which the mix is of 17, 18 year olds.

DR. BIALECKI: Yes.

MR. YOUD: Okay, that's what I was looking for. And the referrals there are from community support options, is that what you said?

DR. BIALECKI: Not just them.

MR. YOUD: But emergency service units.

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DR. BIALECKI: Could be crisis services, it could also be places like Adcare or other like facilities. It could also come in from an individual --

MR. YOUD: Section 12 or something like that?

DR. BIALECKI: Yes. Yes.

MR. YOUD: And then you still had -- I heard you say you were going to eliminate the DMH License VII. But do you still intend by the end of the third phase then to also build a locked unit for minors?

DR. BIALECKI: No.

MR. YOUD: So you don't need the license?

DR. BIALECKI: That's why we dropped the VII.

MR. YOUD: How about the VI, there's a DMR License VI which is for minors.

DR. BIALECKI: In the event that there are -- some of the treatments depend on older adolescents being included in the adult population --

MR. YOUD: Yeah, but that's the --

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DR. BIALECKI: -- when it's appropriate, that's the limit.

THE CHAIR: I'm sorry, just for purposes of the reporter, only one person can speak at a time. It's difficult, I appreciate the dialogue, but we do need to not have people talking over one another. Sorry.

MR. YOUD: I apologize.

THE CHAIR: Paul, why don't you restate your question.

MR. YOUD: Okay. So I understand that -- I understand that there will be older adolescents on the adult unit. But in the original PowerPoint presentation like at the last meeting and probably the one before that, there was also listed a DMH License VI, which is for minors age, you know, like three up to like 16. And my question is is it your intention still to go forward and do that?

DR. BIALECKI: No.

MR. YOUD: So you're withdrawing, you're going to take that one --

DR. BIALECKI: The request initially from the ZBA was to provide an exhaustive list of

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every license we may apply for. That's what we did. At this point, I'm trying to narrow the scope so that people really understand what the intent is. It's never been our intent to treat pediatric population in a locked mental health facility.

MR. YOUD: Okay.

THE CHAIR: So I actually had a list of questions that I provided you ahead of time. I think you've referenced them. I'm going to ask them. I understand that you answered a lot of it, but for my own purposes, I need it organized in a certain way, so hopefully we can kind of zip through it.

I think, Paul, some of what you're driving at is related to that. So why don't I just start there, okay.

I apologize, by the way. I tried to print this up before I came, like my computer died and I couldn't get it started, so I have it on my phone. So, Rebecca, thank you, for --

DR. BIALECKI: I do have the hard copy.

MR. YOUD: Maryanne, you want this?

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THE CHAIR: No, thanks, I'm good.

MR. BROWN: She has a hard copy.

THE CHAIR: Do you? You don't need it? No, no, I'm good on my phone. You all know I'm actually working on this, I'm not looking at something else.

Okay, so for your locked unit, which was --

DR. BIALECKI: Here's my issue with the way these were organized and why I think it's going to be impossible to answer them in that way. It's because there is no locked unit one, locked unit two. There's only one locked unit on the entire project, and that's not until Phase III.

THE CHAIR: Okay. Let's ask what is the relevance to us of the phases? Because isn't -- there must be something, because you emphasize that quite a bit.

So what do you think the relevance is? Why aren't we just -- we understand that you're going to do this over time perhaps, you know, you're making clear that it's not all going to happen at one point, so that to the extent that

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there's a variance or a special permit granted, you're working on it. But why do we care about phases?

MR. FLICK: It's simply a way to describe the project in a way that categorizes it in the way that Heywood is categorizing it in its collective mind as far as this project going into place in phases. It really has no bearing on the ZBA's decision-making process whatsoever in large part because other -- well, as far as the use of each of the phases.

To the extent that each of the phases dealt with any dimensional changes or anything like that, then, yes, it would have some bearing as far as just an overall understanding of the project.

But as far as it simply provides an easier framework in which to communicate the use of the premises, understanding that it's our position that the use is outside of the regulatory purview of the ZBA, but nevertheless, in order to be a transparent and good member of the community hopefully, we're wanting to be open and provide this information.

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So, really, that is the overall purpose of it is to serve more as a mechanism to more easily and efficiently describe the way that the facility will operate.

THE CHAIR: Okay. Well, for purposes of our discussion, could we just assume that you've completed the three phases and so we're looking at it as you're fully under steam.

DR. BIALECKI: Right.

THE CHAIR: And I think also for purposes of discussion, we need to sort of agree that we may disagree on the application of The Dover Amendment. You made it very clear what your position is.

I'm not going to debate you on that right now, or ever maybe, I don't know. But I think that to the extent that some of these questions seem misdirected because they're not adequately taking into effect The Dover Amendment, I'd appreciate if you'd just let me ask them and get an answer.

MR. FLICK: Understood. Yeah.

THE CHAIR: Thanks. All right. So would it be helpful if we just identified it

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instead of by locked unit one and so forth, if we said license -- DMH License II and follow through the different licenses that you've identified, could you then speak to age range and capacity and gender and so forth?

DR. BIALECKI: Yes, which I believe was covered, but I'm happy to do that.

THE CHAIR: Good, because --

DR. BIALECKI: I mean, I --

MR. BROWN: Can I just ask what is the relevance of the question? So why is that important to the discussion, like that granular level? I'm just curious.

THE CHAIR: Because that you're asking us to grant a special permit for usage you're describing, although it sounds like you're maybe not asking for your use to actually be permitted, you're just asking for particular -- whether there's any conditions on setback and so forth.

But I think we're going forward with the understanding that you're asking for special permit on your use, proposed use, so these questions are designed to clarify what your use actually is.

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And Brian is pointing out to me that in the by-laws, under Special Permit, at sub-paragraph D as in David, limitation of size, number of occupants, methods of operation, hours or days of operation, lighting, signs, or extent of facilities are conditions or safeguards that may be included in a special permit.

Okay, so for -- and I apologize to everyone that to the extent that you find this tedious, it just has to be, because when we get around to actually writing this up, whatever the decision is, it's going to be extremely helpful that it's kind of organized in a way that we actually make sure that we understand what you're saying and what we're deciding. Basically informed decision-making, okay.

All right, so on a DMH License II, what would be your proposed license capacity?

DR. BIALECKI: Are you looking at this first section? Because it's described Licensure II, III, IV and limited VI.

THE CHAIR: Do you want me to group them together for the question? We did that, and I thought you said it was hard for you to address

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it that way.

DR. BIALECKI: It is.

THE CHAIR: So we can group them in the way they were grouped or we can go license by license.

DR. BIALECKI: The issue is that more than one license might apply to one unit.

MR. FLICK: Can we just recess for a minute? I'd like to talk to my clients for just a second.

THE CHAIR: Absolutely, sure. So we're going to go off the record just momentarily, and we'll continue -- what do you want, five minutes, ten minutes?

MR. FLICK: Give me ten.

THE CHAIR: Ten minutes.

(Recess taken.)

THE CHAIR: We're back from our break. Should I reask my question?

DR. BIALECKI: So the difficulty for me in answering it in the way that is categorized by licensure type is difficult because there are several overlapping licenses. Even in your documentation, you've clustered several licenses

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together, which is factual, that's how it works.

So some of the capacity would not be organized in this way for a unit specifically, because the licensing overlaps. So the numbers that I gave in the presentation as far as the number of beds per each unit is accurate. I think to try to break them out in a different way here would be almost impossible to do, because you might have a different number of people who fall under a classification and at any given day, so the units and the numbers and the breakdown that I did in the presentation was exactly what our intent is.

It would be the same thing as if you tried to pre-define at Heywood Hospital the number of hip replacements you're going to do and procedures in any given period of time. We don't know because we don't know what patients are going to present with that need.

You do have a maximum capacity or a caseload that you could take for the physician who does that procedure, and if it was too high, you would have to refer to other facilities that do that work. The same thing would apply here.

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But I can go through and certainly answer -- you know, these are --

THE CHAIR: I'll try to modify.

DR. BIALECKI: -- fairly repetitive questions, so I can certainly answer those.

THE CHAIR: And I'll try to work with the way that you're framing it.

DR. BIALECKI: Okay.

THE CHAIR: So let's say we've grouped them -- all right, we've grouped DMH Licensures II, III, IV and limited VI together. Do you agree that that's sort of a sensible way to group licenses?

DR. BIALECKI: Those certainly are all those that could overlap clearly. Those would all fall within a residential treatment realm.

THE CHAIR: Okay. So for voluntary and involuntary adults. And how does that match to your phases? Because when you've mentioned Phase I, II and III, and no need to limit it to one, but is it Phase I?

DR. BIALECKI: It does start in Phase I. Phase I and II actually.

THE CHAIR: And II. But not III?

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DR. BIALECKI: Right, because by Phase III, it's that locked unit.

THE CHAIR: Which would be something else.

DR. BIALECKI: Mm-hmm.

THE CHAIR: And so in terms of age range --

DR. BIALECKI: Older adolescents through adults.

THE CHAIR: And what actually is that in terms of years?

DR. BIALECKI: 16 and older typically.

THE CHAIR: 16 and older, okay. And you mentioned that there would be all genders?

DR. BIALECKI: Yes.

THE CHAIR: Okay. And in terms of the presenting problems with this group, how would you describe that?

DR. BIALECKI: The initial residential program that's being developed is targeted to be the substance abuse treatment specifically.

THE CHAIR: So what does that mean in terms of presentation.

DR. BIALECKI: That means that

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addictions would be the presenting problem, not detox, but someone who has need for that next step after detox would be in need of a residential program.

THE CHAIR: All right. In terms of presenting probable admission criteria, the admission criteria, is that where you're saying you're going to get the referrals, and is there a difference to you in terms of -- well, what are the admission criteria for that group?

DR. BIALECKI: They would need to be medically stable, they would have to have had a detox stay, because you couldn't bring someone in who needed to still detox from a drug and have them be medically stable to enter into a residential phase of treatment.

THE CHAIR: May I pause you there for a moment?

DR. BIALECKI: Yeah.

THE CHAIR: Is everybody able to hear her or would you like her to --

DR. BIALECKI: I can stand again if that's -- I don't know how to face the audience and you at the same time.

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THE CHAIR: I know, it's difficult.

MR. MacEWEN: They're all set.

THE CHAIR: They're all set? You guys are all set? Okay, thank you.

Go ahead. So we were talking about admission criteria.

DR. BIALECKI: Mm-hmm. So since the target of the very first residential unit developed for adults will be residential treatment of substance abuse and addiction, that would be the criteria for them being admitted.

There would need to be, you know, looking at any other medical complications they might have to make sure they're ready and capable of being in a residential program.

MR. MacEWEN: So in Phase I and Phase II, at that point, it's all going to be individuals, like you said, the primary thing is substance and addiction. Those are all going to be individuals that are coming out of a -- most likely out of another detox program because you haven't --

DR. BIALECKI: We won't have one, right. Right. Adcare, BHN, there's other

programs that are a little distance away from here.

MR. MacEWEN: Right. They would be referring in.

THE CHAIR: You said Adcare and what was the --

DR. BIALECKI: BHN is the one in Franklin County that's now building detox beds.

THE CHAIR: Paul, I see you had your hand raised.

MR. YOUD: Yes, because I was just a little confused as to the way those licenses are grouped, it's more mental health. But I think what I hear Rebecca saying is that the initial unit would be more like substance abuse. So is that like the Section 35?

DR. BIALECKI: It could be a Section 35. It would also most likely be people who had gone through a short-term detox stay --

MR. YOUD: Right.

DR. BIALECKI: -- at an Adcare possibly, who maybe are not ready to --

MR. YOUD: Right. So why are you saying that -- see, when I look at those

licenses, I think of mental health, I think of someone who may be severely depressed or may be a danger to others or may be suicidal or something, that's the grouping that I would see there.

But I guess you're seeing that as substance abuse and not those other issues. And I guess I would then wonder why you would be going after those licenses, the II, III, IV and limited VI.

DR. BIALECKI: Again, I think we're talking about two different pieces of what we're trying to design.

MR. YOUD: Okay. So you're not going to have an adult mental health locked unit there, you are going to have --

DR. BIALECKI: Yes, we are.

MR. YOUD: Oh, you are. Okay.

DR. BIALECKI: Ten beds in the final phase.

MR. YOUD: In the final phase.

DR. BIALECKI: Right.

MR. YOUD: Okay. So now what you're talking about is an additional unit for substance abuse.

DR. BIALECKI: Residential treatment, right. Not a locked unit, residential treatment is a different level of care.

MR. YOUD: So you're talking now about --

DR. BIALECKI: Residential is what I've been asked about first.

MR. YOUD: Okay, I'm sorry.

THE CHAIR: Let's -- okay. Ann? Stand up and please identify yourself.

MS. LEWIS: Ann Lewis, 19 North Street. This is the first meeting I've been to, so I don't understand all of your language yet, and let me just ask a simple clarification.

I'm looking at your life safety plans, and essentially it's describing the different uses in what I see is four buildings. And so the question I have is what's the -- I understand your detox unit, which is a locked unit, but in the first phase and the second phase as I understand it, you list building two as being inpatient behavioral health, and building three as being residential care.

Could you just tell me what the

difference is between inpatient and residential care briefly?

THE CHAIR: Well, I'm wondering if we're going to get to an answer if we just go through these questions that I have, which is sort of -- it's organized around the licenses that they have mentioned. If it's a quick answer, go ahead.

MR. FLICK: The slide -- there you go.

DR. BIALECKI: I think the one that you're looking at is from a previous presentation.

MS. LEWIS: Yeah.

DR. BIALECKI: So that's why some of this is not lining up.

MS. LEWIS: But I'm looking at what your -- the difference between purple and red or fuchsia or whatever.

DR. BIALECKI: In the purple includes the residential substance abuse unit for adults or older adolescents is included in that, as well as intensive outpatient treatment, so day treatment.

MS. LEWIS: Okay.

DR. BIALECKI: Over in the light blue is where the adolescent residential unit is intended to be located. See the light blue over on the far right?

MS. LEWIS: Okay, yeah.

DR. BIALECKI: And then the inpatient locked unit would be the piece that's in red.

MS. LEWIS: Okay. So what you're doing is separating adolescents into --

DR. BIALECKI: They're actually in the freestanding building. These other buildings are all connected really.

MS. LEWIS: Okay. And so everything in purple, not fuchsia, is residential substance abuse for adults, which means 16-year-olds --

DR. BIALECKI: If I changed the color from previous presentations, I apologize for that.

THE CHAIR: One person at a time.

MS. LEWIS: All right. I think that clarifies what I needed. Thank you.

THE CHAIR: Okay, good.

DR. BIALECKI: Length of stay in the residential unit is the next piece on here. And

residential, it would typically be a maximum of 30 days, but substance abuse in particular has had a stay of more like 14 days.

THE CHAIR: Okay. You've discussed about referrals and whether Heywood can refuse admission, and you've discussed about the type of licenses you believe are needed for that.

Ann, I think you've discussed about the setting advantaging treatment. What about Heywood's existing MHU, does it treat this type of -- provide this type of service?

DR. BIALECKI: No, right now on Heywood's campus, there are only two options. One is a locked inpatient unit, and one is an intensive outpatient program, so a day program, it does not have any residential programs available.

THE CHAIR: And how about Athol or any of the others that are --

DR. BIALECKI: No.

THE CHAIR: So this would be a brand-new offering?

DR. BIALECKI: Mm-hmm.

THE CHAIR: So then the next category

we had was DMH licensure VI, which was voluntary and involuntary minor mental health unit.

DR. BIALECKI: And this would be the adolescents, which the primary presenting problem would be targeted to substance abuse for adolescents.

THE CHAIR: And is this Phase I, Phase II, Phase --

DR. BIALECKI: Phase II.

THE CHAIR: Phase II. And this is the building Ann just discussed with you --

DR. BIALECKI: Yeah.

THE CHAIR: -- the one that was for the minors. So let's go to age range. What is the age range for them? Is it under 16 if the other one was 16 and older?

DR. BIALECKI: Again, it typically starts around 14.

THE CHAIR: Starts.

DR. BIALECKI: The youngest, right.

THE CHAIR: The youngest would be 14.

DR. BIALECKI: Right. And the age range can vary some, because it depends on the developmental age and needs of each child. There

might be some children at 18 who are functioning much younger who have a need for substance abuse treatment.

THE CHAIR: Okay. So let's say when you say qualify 14 as typically --

DR. BIALECKI: So I'm not talking about five or six-year-olds being mixed in with teenagers, this is going to be adolescents.

THE CHAIR: So what would be the youngest child you would admit, youngest aged child?

DR. BIALECKI: I can't say what the youngest age could be, because we've seen these ages drop younger and younger all the time as the substance abuse problem has grown. The ages have dropped to younger. Typically the youngest would be about 13. That would be a typical answer, but I can't guarantee that 13 would be the youngest.

THE CHAIR: But for purposes of qualifying for the license, the license itself doesn't --

DR. BIALECKI: No.

THE CHAIR: -- pertain to a particular age range --

DR. BIALECKI: No.
THE CHAIR: -- or minimum age? Okay. And does -- I think you've answered a number of the other questions in between. Do you currently at Heywood's existing MHU treat this type of patient?
DR. BIALECKI: No.
THE CHAIR: So this is also an additional service.
DR. BIALECKI: Mm-hmm.
THE CHAIR: Okay. The next grouping we had was DMH Licensure VII.
DR. BIALECKI: Right, which we've determined is not part of the plan. The IRTP license is not necessary for what we're proposing.
THE CHAIR: So you are not planning to do that?
DR. BIALECKI: Right.
THE CHAIR: The next grouping we had was under Mass. General Laws Chapter 123, Section 35, which was civil court commitments to an alcohol and substance abuse program. Is that Phase I, Phase II or Phase III?

DR. BIALECKI: Generally a Section 35 requires someone to go into a detox unit, which would be there at Phase III. Won't be there at first, but later will be. So someone could be remanded to custody of the locked inpatient detox unit or they might be remanded to a facility other than Heywood where they go in for their 72-hour detoxification, and then the court decides because this is their third detox and it hasn't been successful that they want them to continue on into a residential program, so they land here.
THE CHAIR: Well, sometimes people are stopped for OUI, operating under the influence, the court will order them to go into a program.
DR. BIALECKI: Right.
THE CHAIR: Is that type of a situation covered here?
DR. BIALECKI: Yeah.
THE CHAIR: Okay, so the age range -- the age range is what?
DR. BIALECKI: Adults.
THE CHAIR: Which you're defining as --

DR. BIALECKI: 16 and over.
THE CHAIR: And admission criteria?
DR. BIALECKI: Again would be if it's someone who's coming in by way of a civil commitment, that's because a court has ordered them into this type of treatment, so the criteria would basically be bound by what the court felt their need was. And, again, it would have to be an appropriate setting to accommodate the admission.
So if someone was convicted of an OUI, for example, and has not been successful in treatment previously or hasn't voluntarily taken advantage of these kind of programs, the court may commit them to have to complete three weeks of intensive outpatient.
THE CHAIR: Is it only for people who are actually convicted? What about people that don't get a conviction or are you considering CWOFs as part of a conviction?
DR. BIALECKI: Sometimes the courts do pretrial recommendations, so they could do that, too.
THE CHAIR: So if there's somebody

that wants to get into a program rather than go to jail.
DR. BIALECKI: Right.
THE CHAIR: This is the type of -- now, do you reserve beds, a certain number of beds for that type of a situation or is it --
DR. BIALECKI: No.
THE CHAIR: It's all first come first serve.
DR. BIALECKI: Right, and what's open at the time when someone has the need.
THE CHAIR: Okay. And the typical length of stay for this type of patient?
DR. BIALECKI: Again, it depends on the level of treatment they need. It could be three days for detox, it could be two weeks in residential, and it could be an additional three weeks as an outpatient, depending on what the court determined is their need.
THE CHAIR: I don't know if the court would actually determine their need, that's probably something that you would.
DR. BIALECKI: Right.
THE CHAIR: Okay. And do you --

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currently does MHU currently treat such patients?
DR. BIALECKI: Yes. People are committed by way of the civil process as well to the MHU currently.
THE CHAIR: And then we have the next category -- and, by the way, if anybody has any questions, we can go back, but let me just try to get -- we're almost at the bottom of the list. Substance abuse residential rehab program, is that voluntary only?
DR. BIALECKI: No.
THE CHAIR: So it's involuntary as well, which was covered earlier --
DR. BIALECKI: Right.
THE CHAIR: -- on one of your licenses. So to the extent that it's voluntary, is there a licensing body for that type of a program?
DR. BIALECKI: They still fall within the DMH licensure category.
THE CHAIR: So what is -- didn't you -- I think you mentioned this as a category.
DR. BIALECKI: There's some additional support sometimes from Department of Public

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Health or the Bureau of Substance Abuse Services, but it's not necessarily licensed by them alone. DMH typically overarches DPH licensure for facilities.
THE CHAIR: So you highlighted this as a category in your earlier presentation because it's DMH plus some other --
DR. BIALECKI: Mm-hmm.
THE CHAIR: -- agency that can be involved, DMH and --
DR. BIALECKI: Right. DPH.
THE CHAIR: DPH.
DR. BIALECKI: The Bureau of Substance Abuse Services is part of the Department of Public Health, and they often provide additional support to support substance abuse specifically.
THE CHAIR: Okay. And how long do people usually stay that's voluntary?
DR. BIALECKI: Again, it could range, depending on insurance funding, and it would depend on the level. It could be from 72 hours all the way up to three weeks.
THE CHAIR: And you currently in your MHU unit treat such patients.

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DR. BIALECKI: No.
THE CHAIR: So this is also a new program?
DR. BIALECKI: Right. Substance abuse is a new program, because we don't have the capacity for this currently anywhere in the region.
THE CHAIR: The next category we had was substance abuse partial hospitalization or day treatment program. Is that voluntary only?
DR. BIALECKI: No. Those can be court mandated as well. And this is where there would be the potential for substance abuse as well as other mental health treatment and not commingled necessarily. You might have one group of patients who's there specifically around substance abuse treatment, it's an intensive day program, which like the START program that I referenced earlier, that's a three-week 9:00 to 3:00 kind of a day, it's really intensive programming for all three weeks. They go every weekday or four days a week in some cases.
The mental health patients would be there for similar kind of a time, but with a

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little different treatment model. Again, it's intensive day treatment, but they all leave at the end of the day.
THE CHAIR: And is this Phase I, Phase II or Phase III?
DR. BIALECKI: This would be Phase I.
THE CHAIR: Phase I. And do currently at MHU Unit treat such patients?
DR. BIALECKI: Yes, but not the substance abuse. But the mental health patient, there is a 20-bed unit currently on the Heywood campus.
THE CHAIR: That was -- I had a couple more questions, but that was the end of sort of like the grouping of -- and I think the piece that I want to make sure I have the connection on is suicide.
You know, in your opening, that was one of the really startling facts was just like the high rate of suicide. And I'm having trouble understanding how -- where the suicide prevention map connects with these different categories. So is suicide prevention something that's involved at Phase I, II or III?

DR. BIALECKI: All three.
THE CHAIR: All three.
DR. BIALECKI: Yeah.
THE CHAIR: And is it -- what would you associate it most closely with in terms of the groupings that we just went through or is that possible to do?
DR. BIALECKI: It's pretty widespread across all the categories that we've talked about. Suicide rates are much higher in a population that is abusing substances as well as a mentally ill population. The rate is significantly higher than the general population because of the other struggles that people are dealing with.
THE CHAIR: So would it be correct to understand that -- actually I don't think I have that question right now. Do you have any questions?
MR. MacEWEN: You're on a roll. No, I don't have a question.
THE CHAIR: Does anybody here have any further questions? Nancy?
MS. ALLEN: Nancy Allen, 17 Common

Street. Rebecca, I'm going to try and frame this question, but I'm a lay person so I probably won't do a great job of it, but bear with me. It kind of touches on the very last section that you guys just talked about.
And I'm just trying to understand the differentiation for when, say, a straight-up psychiatric patient, say schizophrenic, gets introduced into the center who has no alcohol or -- excuse me, any drug addiction or abuse, it's just straight-up mental health problems, when that patient comes into the equation and -- and I guess I also wonder why, I understand that someone might be a drug addict and has underlying secondary issues that are obvious, but schizophrenics can become addicts. But I'm just trying to figure out why you're I think purposely melding the two. Unless it is a secondary issue, and if I'm wrong, that you won't be bringing in mental health patients who do not have any kind of addiction, just correct me. So hopefully that makes some sense to you.
DR. BIALECKI: I think mental health patients might be better suited on the Heywood

campus in that case.
MS. ALLEN: Right.
DR. BIALECKI: But what we have found is that the co-occurring disorders have risen to such levels of need that there isn't capacity to provide the treatment services that folks need locally professionally.
MS. ALLEN: So say is it pretty much going to be the case that someone who is, and we'll just -- to me it's easier to use an example, someone who is a schizophrenic who is admitted into the center is also an addict, will it always be combined?
DR. BIALECKI: It might not always be combined, no. Because there will be that locked mental health unit that will help with the capacity issue at Heywood's current site where they have --
MS. ALLEN: Go straight up trying to take care of the capacity --
DR. BIALECKI: Right.
MS. ALLEN: -- for mentally ill.
DR. BIALECKI: Right. By adding, not deleting. We need more. And the other piece

might be that a patient that you're describing might certainly benefit from a partial hospitalization, which is a day treatment program where they come for three weeks straight, they get involved with group activities, they get involved with individual counseling, and really build coping mechanisms to be able to cope with their mental health illness and come up with some strategies to get the life skills they need to function without perhaps going to land in the hospital again.
MS. ALLEN: Okay.
THE CHAIR: Paul?
MR. YOUD: Rebecca, based on everything that I'm hearing, would it be fair to say that most of what you're proposing is really a substance abuse service that would be primarily licensed through the Department of Public Health's substance abuse, as opposed to -- see, and you had all these listings of all these mental health licenses, right?
DR. BIALECKI: They're not necessarily mutually exclusive.
MR. YOUD: Well, from what you were

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saying is that you don't intend to be running a mental health unit, a minor mental health unit. You are going to have the adult, I understand that, you're going to have the adult mental health unit, that's clear. But then you also had -- and I understand the IRTP, you don't want to do that, but there still is a minor mental health unit which you said you probably wouldn't be doing. So that leaves us with -- with the substance abuse services.

DR. BIALECKI: Are the majority of -- are all of the residential services that we're proposing for this plan focused on substance abuse? Yes, they are. But one of the reasons why we don't want to just be a substance abuse only licensed to treat that is because then we become much more silo'd and less able to effectively deal with people with co-occurring disorders.

MR. YOUD: I can understand that.

DR. BIALECKI: Okay.

THE CHAIR: Okay. Ross?

MR. FRANCE: I just have a follow-up.

THE CHAIR: Ross, just please identify

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yourself.

MR. FRANCE: Ross France, 190 Hardwick Road. My experience is you have a facility, and then you respond to an RFR or either Department of Mental Health or Department of Public Health provides the funding for the service and the license to service.

DR. BIALECKI: We are looking at third-party billing rather than public funding for this.

MR. FRANCE: Just third-party.

DR. BIALECKI: Yes, because you're right, if you were applying for public funding, you would wait for an RFP, apply, and go that route.

MR. FRANCE: Now, and you would do that for the detox though, yes?

DR. BIALECKI: Not necessarily, no.

MR. FRANCE: Okay.

DR. BIALECKI: I mean if one came up? Possibly.

THE CHAIR: So could you for those of us who don't operate in your world explain --

MR. BROWN: I thought that was pretty

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good.

THE CHAIR: Explain, Rebecca, would you please explain, just summarize for us what that exchange just meant.

DR. BIALECKI: Translation.

THE CHAIR: Yes.

DR. BIALECKI: I'm trying to remember back to what Paul started, so I can catch the whole thing. The majority of services offered at the Petersham site would be focused on substance abuse treatment, especially the residential components that we're looking at, the people who live there but are not in a locked unit.

The reason why we are not looking to respond to a public funding request through DPH or DMH is because we intend to have people funded through insurance. And that's how the current mental health unit at Heywood and the partial hospitalization program is in fact funded.

We know that we have much more need that we have to turn away at this point, so that's why we want to increase capacity, and we know that one of the significant needs in this area is the substance abuse treatment, and that's

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really lacking, that even when people are successful in getting through detox through some other facility outside the area, they then do not have a lot of next step places to go, and that's where people are most at risk to overdose and to really get into big trouble, rather than having beds locally so that they could come, spend a few weeks, and really be healthy enough to transition back home.

THE CHAIR: Okay, thanks. In terms of relapse time periods, you provided a stat on a seven-day basis. Do you have some more statistics looking further out like say on a year basis or like two years out, are those types of statistics available for --

DR. BIALECKI: For the current MA2 stats, does the recidivism rate go up that far or can -- I think it's just what the state tracks is what we presented tonight.

MR. BROWN: Right, the state tracks.

DR. BIALECKI: There are adults with chronic mental illness that do cycle through medical facilities regularly. Some of what the outpatient intensive model offers is another way

so people don't have to spiral to the point where they require being hospitalized sometimes involuntarily that they can go in for these longer term intensive treatment options and not have to go to the more intensive intervention.

THE CHAIR: As part of your vision, do you invite your sort of graduates back at all? Like you mentioned that there's AA meetings, there's NA meetings, are those meetings open to anyone who wanted to attend an AA or an NA meeting or are they limited to the residents of the facility?

DR. BIALECKI: I think our initial plan is to have them be limited to the in-house folks because there's not public transit available for people to come in to meetings like that here. But if we found out that there was a community need, that Petersham doesn't in fact have an NA meeting, maybe we could open that up.

Those are generally very locally attended. I know the surrounding towns throughout the North Quabbin have a number of the meetings at all different times of the day.

THE CHAIR: It's my understanding that

often people who have gotten these kind of services, substance abuse services, need to touch base again in the future with the place where they got help. And I guess I'm really kind of trying to find out if the facility you would run there is that type of a place or if they go back to the referring party or --

DR. BIALECKI: They might continue on long-term as an outpatient client so that the clinician who helped them get better is the same person still seeing them, but instead of seeing them every day for three weeks, they now see them, you know, once a week and then eventually once every couple of weeks to the point where they're in a better place.

THE CHAIR: Okay. So if the person was a year or more out even and just was having some triggering event, they wouldn't necessarily be able to come back to the Quabbin Retreat and like attend one of the meetings perhaps or whatever, that they would need to go through the channels you describe where they have to get referred in.

DR. BIALECKI: Only if they were

coming in to be admitted for an inpatient or a residential kind of stay. They could connect back with their outpatient clinic or their primary care physician to get in to one of those less restrictive programs certainly and connect back in that way.

THE CHAIR: Okay. Let me, before I forget, I wanted to ask about the one million dollars that was earmarked by the Commonwealth. Can you just explain to us a little bit more about that. Like what was the understanding that the legislature had in earmarking that money for your purchase of the property in terms of the use that you would make?

DR. BIALECKI: That funding was really led by Senator Brewer and Senator Flanagan, along with a number of other pieces of the state budget that were targeted towards really building resources rich enough to be able to combat the addiction crisis that has riffed our part of the state, certainly state-wide, but here in particular.

And I believe that both of them felt very strongly committed that if people can have

services closer to home, they're going to be better able to transition back to their home and family, and having a site here seemed appropriate given the fact that both of them were familiar with the property that we were purchasing and the purpose of it.

So I don't know that there were specific documents supporting that legislation.

MR. BROWN: Really just re-acquisition and the development of the property.

DR. BIALECKI: There were no restrictions as far as the use of the dollars.

THE CHAIR: So it's like a line in the budget that says that and that's all you'd really find?

MR. BROWN: It's like a line. I think it's a single sentence actually.

DR. BIALECKI: So there aren't conditions for the receipt.

THE CHAIR: Let me also ask you, too, about the status of the pilot agreement. Where is that, what's the status of it?

MR. FLICK: With the tax exempt committee, we have not received any invitation

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from them to come and discuss the pilot agreement.

I am getting notices now of when their meetings are scheduled. I don't know when the next meeting -- I know it hasn't been scheduled, but regardless of the invitation, we will be at the next meeting, because we want to be discussing that.

MR. MacEWEN: No questions.

THE CHAIR: Any other questions? Ann?

MS. LEWIS: I had a quick one. So if we had a Petersham resident who had substance abuse issues with secondary mental health -- I'm not even sure it would be secondary or primary -- but who did not have health insurance, then they could not avail themselves of your facility; is that right? Because despite OmbmaCare, despite Massachusetts health laws, there are a lot of people who are still uninsured.

DR. BIALECKI: In a case like that, I think then it would be appropriate for the staff of the Athol and Heywood system to help them find a place that does take people who are uninsured, because the facilities do exist, but it might not

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be here.

MS. LEWIS: Okay. Thank you.

THE CHAIR: One of the things we need to cover tonight is the consultant, the status of the consultant. And so it is getting late, I thank you for making the presentation tonight. Should I mark this as an exhibit, hearing exhibit?

MR. FLICK: Yes, please. And I would also include one more as a sub-exhibit to that. I don't know what exhibit numbers you've marked. That's the copy of the articles of -- the amended Articles of Organization for Heywood Healthcare.

THE CHAIR: This is multiple copies of that?

MR. FLICK: Yes. Yes.

THE CHAIR: So we're going to mark tonight's PowerPoint presentation as hearing Exhibit No. 21.

(Document marked.)

THE CHAIR: And the copy of the Articles of Amendment as -- you want that to be referenced to the PowerPoint because it goes to the Dover Amendment presentation that you --

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MR. FLICK: Correct, 21.1, if I may make that recommendation, since it's referenced in the PowerPoint presentation.

THE CHAIR: That's not a bad one, but we're going to call it 21A just to keep the convention that we've done before.

MR. FLICK: Not a problem.

(Document marked.)

THE CHAIR: So on the consultant, sadly Rob Hubbard, who we had intended to hire, we recently learned has died. And so we are in the position of needing to address that loss, and we had previously voted that we would like to have a consultant. We received funds from the applicant for consultant work.

So, Brian, do you have any thoughts on what we might do as the next step?

MR. MacEWEN: Thanks to Nancy Allen being diligent today in trying to track down some names, we have some names. Unfortunately I haven't had an opportunity to pursue anything after notification of the death. So I think we need to decide how we want to move forward.

You know, contact a few of these

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individuals, see what type of fees they're looking to get for this type of work. And unfortunately I know we need to move this along fast, but it's not something that's going to happen immediately without getting some answers, getting some contacts and getting some idea of whether an individual that's listed would even fit in a budget that we have for the consultant. Much less availability coming into the holiday season. That's going to be another issue all together.

THE CHAIR: In terms of the pool of candidates, you mentioned that Nancy's given you some names. You also should have received two names from me.

MR. MacEWEN: Yeah.

THE CHAIR: So you have --

MR. MacEWEN: One of the ones that you supplied in your e-mail is coincidental with one of the names supplied by Nancy as well, and that's Glen Eaton, MRPC executive director.

THE CHAIR: And then --

MR. MacEWEN: Some of the other names from Nancy's list are out of the area, which I'm

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guessing probably might not be as easy to make contact and easy to coordinate with as dealing with someone out of, say, Fitchburg or Worcester so --

THE CHAIR: John, you had provided --

MR. FLICK: Glen Eaton.

THE CHAIR: All right.

MR. MacEWEN: Okay.

THE CHAIR: And there was another name that I had given you, but I'm not sure at the moment who that was.

MR. MacEWEN: Bill Scanlon from Sibley, he did the Sibley Farm project. I don't know what the Sibley Farm project is in Spencer, so I don't know.

THE CHAIR: So we have a pool of like five or six, maybe even more.

MR. MacEWEN: Some of the names on the list that you have here, Nancy basically noted that she thought that they'd probably be out of the price range for the consultant fee that we have on the table, so I don't know. I mean, try to make contact, Nancy's actually going to talk with the Central Mass. PC individual and find out

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what she can find out from her relative to her availability, what she might be willing to do the work for.

And I guess that's what we need to do with the other individuals is contact them and then go from there. But obviously it's not something we can have an answer overnight.

THE CHAIR: How long do you think you'd need to get back to who you might recommend?

MR. MacEWEN: We may find that we get answers from all of the individuals that they're not interested, too. So, I mean, that could happen in a week. But, again, I would say hopefully we'd have some answers over the course of the next week one way or the other, because then we're getting into the holiday weeks, which is going to be tough to pin anyone down on.

So I'm hoping for suggestions on how we want to tackle it, short of just getting calls out. Nancy's already called several and left messages, but obviously short notice, no return calls yet.

THE CHAIR: I think, you know, since

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you were kind enough to volunteer to take the lead on this, we should just do what you think can reasonably be done.

MR. MacEWEN: Okay. But the question is if you're looking to pin down a new date for an answer of whether or not we have a consultant, one; and, two, what kind of timeline we'd be talking about to have some type of results or report submitted for our review from the consultant, that's something that obviously can't be done at this point in time.

So I know where we're headed is trying to look ahead to where we want to continue to, knowing that we want to get some answers or get a report in front of us before we close the public hearing and then move forward from there.

THE CHAIR: So next Tuesday is the 16th, December 16th. Do you think you can touch base with them and get an initial level of response as to level of interest and meet again on the 16th to pick one? The Tuesday after that's the 23rd.

MR. MacEWEN: Right.

THE CHAIR: That I suppose would also

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be okay, but maybe better because we're trying to move it along. We don't have to meet on a Tuesday either, I suppose, but do you think we could meet next week?

MR. MacEWEN: We could do a follow-up schedule or continue to the 16th, and if in fact we have either negative responses, they'll have an answer, or if we don't have any answers, I don't know if we could postpone it via e-mail contact and posting.

I'd just hate to have everyone come in here if we have nothing to report at that time. It's still a very short time, one week away.

THE CHAIR: Well, if we were to pick another day next week, I can't do the Wednesday.

MR. FLICK: I'm unavailable Wednesday or Thursday next week. I have to be in another town for meetings.

MR. MacEWEN: So we schedule for Tuesday and if we have to postpone because we don't have any results from our contacts --

THE CHAIR: Well, we'll continue. Yeah, and what I can do is I can use the agenda feature of the posting and actually -- although I

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got to do that 48 hours in advance.
MR. MacEWEN: See, that cuts you down to --
THE CHAIR: No, I can update it. I'll do the posting and I'll update it, and if people want to log on and get the e-mails, you'll see, you know, and the updates will be specific people that -- we'll give detail to clue everyone in. Eric?
MR. MANDEL: Eric Mandel. I have a suggestion about the consultant, another way of thinking about it. There was a name that everybody seemed to like very much, but that person was too expensive it was decided. That person has written a report that was of interest, and partly of interest because Henry Heywood disputed the report.
And what I was wondering is whether you might want to call that person and ask them what we could get for our $3,600. It might not be necessary to get a report that's this long, but if we got, for example, two things, if we got her view of Heywood's evaluation of her report, that might be very interesting data for us.

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And if she were to quickly triage our situation and tell us what it is we should be looking for, that might be very interesting for us. And the reason I mention it is because she seemed to be a recognized expert in this area, and therefore already vetted.
So I think if you were to consider asking her what we can get for that amount of money, that might be --
MR. GRIMMER: She's a real estate agent.
THE CHAIR: Thank you. Do you want to add her to the list to contact her? I can get you her contact information.
MR. MacEWEN: I remember reading her report, but that was the company. I don't know if you have her direct contact.
THE CHAIR: I will give you her contact information.
MR. MacEWEN: Because she's out of New Hampshire. Her company is out of New Hampshire.
MR. FLICK: Arlington.
MR. MacEWEN: Okay. I thought it was New Hampshire.

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THE CHAIR: And then if you could for any of the ones that seem positive, be sure that we have their resume or their CV, something, so we get a sense of what their qualifications are as well as their interest, can you do that?
MR. MacEWEN: Mm-hmm.
THE CHAIR: Fabulous.
MR. GRIMMER: Good job, Brian.
MS. FLYNN: Marcia Flynn, 3 Hardwick Road. Out of curiosity, what report are you referencing and who wrote it?
THE CHAIR: Okay. It's in an earlier -- it's referenced in an earlier part of the meeting.
MS. FLYNN: Oh, okay.
THE CHAIR: I'll tell you. Okay.
MR. EATON: I just got a couple of questions here about we seem to be going pretty far afield of The Dover Amendment in our questioning. I just wondered if these are the only factors that we're allowed to determine?
I'm on the limitations. Could you just go over that quickly? And did this come about because the cases that you referenced

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exceeded this authority in their decision?
MR. FLICK: Yes. In many respects, they did. They were denying -- for instance, the Fitchburg case, the Zoning Board of Appeals denied the special permit to operate the group residential facility on the basis that it was a group residential facility, and that the court came in and said they couldn't do that, because they couldn't regulate that use because it was subject to The Dover Amendment, but they could regulate the other factors within the purview of the Dover Amendment, which was reasonable regulations concerning the building and the structures, yard size, lot areas, setbacks, open space, parking and building coverage requirements.
There are essentially two ways that entities address Dover with the community. One is --
UNIDENTIFIED SPEAKER: I can't hear.
MR. FLICK: I'm sorry. There are essentially two ways that entities will address Dover Amendment when they come into a community. One is they come in like a steamroller, basically

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saying Dover Amendment applies, you've got us, too bad, that's it, and they end there.

We've had that happen to us in Gardner. There's famous cases from Framingham that involve that regarding South Middlesex Opportunity Commission -- Council, excuse me.

The other way is for organizations to come in in more of a cooperative manner which is the tactic that we've elected to take to say that is who we are, this is what we're going to do, we're going to be open and honest and tell you what we're going to do, however, Dover Amendment applies.

That's similar to how the facility in Middleborough proceeded. They also presented letters and presentations to the Zoning Board of Appeals in Middleborough that The Dover Amendment applied to the facility as well, although a formal determination was not made, it was more of a cooperative discussion back and forth.

There were -- if you look at the special conditions in their special permit, there were some issues pertaining to use that were addressed within the special permit, such as no

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forensic psychiatric treatment, which is essentially the determination that a person's fit to stand trial, mentally fit to stand trial. That's something that if that were a condition that Petersham wanted to put on the special permit, we're perfectly open to it because that's not something we will be equipped to do or want to do.

So that's why I make that presentation tonight, simply as an informative piece, but at the same time saying we're willing to have those discussions to some extent over use, but it really cannot come down to a determinative factor in the ZBA's decision.

MR. MacEWEN: Okay. Thank you. Since you're being so open, can you give us an update on how things are going with DEP relative to the water source and the septic system issues?

MR. FLICK: Well, if I can. I asked if there were going to be questions for the engineers, and I think those would be questions that are more apt to be --

MR. MacEWEN: I'm not looking for a technical, I'm just -- do you know where it

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stands, has it moved forward, or how is it progressing?

MR. GRIMMER: Mike Grimmer, Heywood Healthcare, Chief Operating Officer at Athol Hospital. It's moving forward well. We've done percolation tests on site. However, we're looking at all the things we have to do.

You know, we got a determination on the well itself that the -- that was a big piece for us. The original well was going to be suitable based on I think we presented last week Bill Hannigan or last month Bill Hannigan presented that, you know, it was determined to be a use of a nursing home type thing, all of those things.

So it's working well, and they're putting their restrictions on and they're going to make sure they test the water quality going forward and all this, but no red flags at this point.

THE CHAIR: Do I understand the engineers are available to come back?

MR. GRIMMER: Absolutely.

THE CHAIR: We're actually thinking of

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having them back once they have more to report. Once they're --

MR. MacEWEN: That was my next question. Obviously the tree clearing when it's for the septic is going to be a key issue with the abutting property. So I was just thinking once they have a better feel for what the footprint might be based on, and they don't have to have a final design, but they'll have a good feel for what their limits of work will be, that's something that would be interesting to see on paper.

MR. FLICK: We're hoping that that will be available for January.

MR. MacEWEN: And getting back to the Dover law, so relative to special permits to Section 2, our Item D relative to limitation of size, number of occupants, method of operation, are you saying that The Dover Amendment trumps that --

MR. FLICK: Yes.

MR. MacEWEN: -- in our by-laws?

MR. FLICK: Method of operation, yes, it absolutely trumps that.

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MR. MacEWEN: Number of size and number of occupants?
MR. FLICK: Size, no, under determining -- reasonable regulations concerning bulk and height of structures, and occupants would be governed by the size of the structure, because you're going to have occupancy permit for a specific safe number.
MR. MacEWEN: Based on use.
MR. FLICK: Correct. So that's part and parcel with bulk of the structure.
MR. MacEWEN: Hours of operation?
MR. FLICK: Again, that really falls under the use issue and a facility of this nature really has to be 24-7 because it's residential.
MR. MacEWEN: No, I'm just trying to get it clarified. Because that's one item in our by-law that kind of contradicts everything you went over.
MR. FLICK: But if you look at that within the examples like the Fitchburg case and the Gardner Athol Area Mental Health Case, all of those dealt with residential facilities.
MR. MacEWEN: Citings.

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MR. FLICK: Citings. So by nature, they're 24-7.
THE CHAIR: But the ones in those cases weren't this type of a facility.
MR. FLICK: Similar. There's some very clear similarities.
THE CHAIR: And we're actually, everybody, we're going to be rapping this up for tonight really quickly, because we don't go past 10:00 O'clock, everybody has things to do, places to be in the morning. But, Ann, you had --
MS. LEWIS: I had two points of clarification. One is with The Dover Amendment. It's my understanding from reading what you presented, and there are a lot of ellipses in there, so I don't know what it really says, but that we could regulate the detox unit because that's not primarily an educational unit; is that true?
MR. FLICK: There's really not selective regulation.
MS. LEWIS: That's your interpretation.
MR. FLICK: Well, yes. But you look

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at the dominant purpose, and if the dominant purpose is education, then the use of the facility is exempt from zoning.
MS. LEWIS: Okay. And the other related to DEP. So you're saying that DEP has agreed to grandfather the buildings and the parking lots and all of the structures that are within Zone 1?
MR. FLICK: No.
THE CHAIR: Can I just take a time out there. Can you please hold that question, because we will have the engineers back, and the engineers are working directly with DEP and will be able to probably best address it, and then also give us the most up-to-date information. We do know from prior meeting that things are under assessment, under review.
MR. GRIMMER: That's fair.
THE CHAIR: Would that be okay, Ann?
MS. LEWIS: Sure.
THE CHAIR: Do you want to just state your question so in case you're not here, we'll be sure to ask it, but if you would please not answer it in interest of time.

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MS. LEWIS: Okay. It's a pretty easy question. The impression I got from what you said is that DEP is at least right now planning to grandfather the buildings and the parking lot within Zone 1, but not grandfather the leach field that's within Zone 2.
THE CHAIR: So you want some clarification on that.
MS. LEWIS: Yes.
THE CHAIR: Okay, we got it.
MS. LEWIS: Otherwise you'd have to move the well or the buildings.
THE CHAIR: Okay. For those of you that -- John has actually mentioned The Dover Amendment in an earlier meeting, this is not the first time we've heard of it, but you went into a lot more detail tonight than you had previously.
For those of you who are not familiar, The Dover Amendment is an area of the law that has some controversies associated with it, so if there's been some current cases as John has mentioned, it's been the lead story on the Massachusetts Lawyers Weekly publication that comes out when there's disagreement among lawyers

over what it means and how it applies.
So I think it's entirely appropriate that you're making it as part of your presentation, but it certainly is something that is not necessarily without a different interpretation or something that even if the interpretation or bottom line ended up being consistent, not something that I would think that we would want to leave without getting our own legal opinion on how it applies in this particular situation.
Okay. Anything else from the board for tonight? We need a motion to continue to our next meeting. And other than that, I think we --
MR. MacEWEN: What number is that?
MR. BROWN: 16.
THE CHAIR: We talked about the 16th I think at our usual time, which is 7:30, and here if the room's available. If it's not -- we would plan for it to be here, and we would move it.
MR. MacEWEN: I make a motion to continue to December 16th at 7:30 p.m.
MR. EATON: I second.
THE CHAIR: All in favor?

MR. MacEWEN: Aye.
MR. EATON: Aye.
THE CHAIR: Aye. John?
MR. FLICK: Quick question on that, do we need a court reporter on that or would it be similar to the meeting we had Tuesday before Thanksgiving?
THE CHAIR: I don't think that we would need a court reporter. Brian or Don, would you like --
MR. MacEWEN: Yeah, because we're not asking for you to bring your engineers, I think it's going to be a formality just to --
MR. FLICK: Really the three of you discussing.
MR. MacEWEN: Right.
THE CHAIR: And then we'll end that with continuing it to the next date.
MR. FLICK: Yes, okay.
THE CHAIR: Do I have a motion to adjourn?
MR. MacEWEN: Motion to adjourn.
MR. EATON: Second.
THE CHAIR: All in favor? Aye.

MR EATON: Aye.
MR. MacEWEN: Aye.
(The hearing then recessed.)

CERTIFICATION

I, CAROL A. JEFFREY, hereby certify the foregoing to be a true and complete transcript of the oral evidence presented at the subject hearing.

_____
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