Stakeholder Comments for the EOHHS Hearings on DMH Inpatient Needs

1. My son who has autism will always need some level of care – unless he can get professional help to become gainfully employed.
2. He was progressing well at Westborough State Hospital until he was discharged to a "community" group home six and a half years ago (early in 2003).
3. In those six years, a cousin graduated from high school, attended four years of college, and obtained a Masters Degree.
4. During the same six years, my son has been sequestered in a locked-alarmed-door house.
5. Westborough State Hospital was a community with long-term professional staff.
6. Staff at the group home have minimal educational training or experience.
7. Staff turnover at group homes is high, as they seek better pay in other jobs.
8. My son has run away from his group home three times during the past year – most recently he was missing for 7 weeks and 2 days – a frightening experience for all concerned.
9. During my search for him during those 7 weeks, I saw how many severely impaired people are living in shelters, South Station, Logan Airport – and I was told to look for my son in places like laudromats – any warm refuge from cold nights in March and April.
10. My son has diabetes – most worrisome while he was out there without access to medical care.
11. Inpatient capacity has been grotesquely underestimated by DMH – how many of the swivel-chair wizards responsible for closing the state hospitals have seen what I have seen in the last 7 weeks?
12. Recovery should be possible for my son if he can get realistic help with socialization skills and preparation for remunerative employment – the primary need of anyone living in our capitalistic society.
13. Long-term care insurance should be mandatory for every child born, as an alternative to tax-funded care systems for people seriously impaired by mentally illnesses.

Eileen Nicole Simon, PhD, RN

June 7, 2009

Testimony of Walter Noons, Senior Staff Attorney, Disability Law Center 6/12/09

Recent Positive Changers at DMH Facilities

Tewksbury Hospital has demonstrated a commitment to Restraint and Seclusion and has made progress in that area;

Access to Fresh Air access has improved by the creation of an enclosed space at Tewksbury Hospital;

Increased Peer Involvement at all levels within the Department is a laudable goal.

Continuing Practices that keep Patient Census at State Hospitals Unnecessarily High

The diversion of NE Area clients through Taunton State Hospital seriously delays treatment, privileges, passes and discharge of patients. And negatively impacts both SE Area and NE Area clients;

The Mandatory Forensic Review program has resulted in extended stays of clients who are deemed discharge ready by staff but who are being subjected to impossible rigors by the forensic reviewer whose primary purpose is to protect the agencies risk rather than meeting the client's needs;

15b evaluation could be done in the community. 15b done in facilities often exceeding twenty days – Facilities routinely asks for extension;

There is dearth of suitable community placements. However, clients who are discharge ready are often "required" to go to group homes that are not available and remain in the facilities unnecessarily when their preference would be to return to their own home, or, to a shelter if necessary;

The unwillingness of staff to listen to client=s dc goals and instead demanding that they conform to staff=s expectations rather that adhering to the tenants of client-directed care;

The practice of encouraging otherwise discharge-ready clients to sign-in as 10/11 (Conditional Voluntary) primarily to wait until a Asuitable@ community bed is available;

The ongoing practice of vendors cherry picking clients;

The ongoing practice of the treatment teams in restricting privileges passes and discharge in order to coerce clients into accepting treatment or an undesired dc-plan.

I have been hospitalized eleven times, ranging from two weeks to a year and a half; my first in 1967 my last in 1980. I am partially rehabilitated, living in subsidized housing, and gainfully employed or five years at competitive employment in a library.

There was nothing magical about being put in hospital: Nothing healing about the overcrowded bedrooms. The wards served the poor. The food was indifferent at best. In the seclusion room, there was no comfort but a mattress. The only attractive rooms were used by the doctors. Even a normal mind would think the atmosphere in the hospital was poisonous. The teaching hospitals that my fellow patients said were the best, I found demeaning.

I have read that the illnesses goes into remission because of the hardness of hospital life. After beating your head against the wall, stopping it felt so good! But the process of stopping had to be repeated often, with diminishing returns. In the end, I had to go back to the hospital again and again.

I am against the segregation of people with mentally illness. I think the division into staff and patient bred feelings of superiority on the part of the staff and inferiority on the part of t he patients. The lack of support for their self esteem is not helpful to the patients. In my case, I turned to my religious faith for a feeling of self-worth, because I believe God sees us all on equal ground.

My hospitalizations aggravated my problems. Initially, when I was young, treatment helped. I liked the family-like atmosphere of the first psychiatric half way houses in the state, where the emphasis was on keeping a job, therapy, and medication. It was an exciting time at Berkeley House, a halfway house for McLean's ex-patients. Many members went on resume normal lives, graduating from college and pursuing careers. They returned much more in taxes than was ever spent on their treatment. Later, these halfway house programs lost their early idealism and became dead ends, just the cheapest and easiest way to shelter unwanted people.

For me, my work at recovery is largely done. Hospitals did not help me. What helped me was being with other patients I admired at Berkeley House, medication, faith, and work.

Peter Keller
reply to
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Testimony to the Department of Mental Health Study Commission

Presented by:

James Q. Purdy, Vice President, Inpatient Behavioral Health, Northeast Hospital Corp.

June 12, 2009

Testimony to the Department of Mental Health Study Commission
Presented by:
James Q. Purdy, Vice President, Inpatient Behavioral Health, Northeast Hospital Corp.

Thank you for this opportunity to present my thoughts regarding the Study of the future of the DMH Inpatient bed resources for the Commonwealth of Mass. I am, James Q. Purdy, Vice President, Northeast Hospital Corp. where we operate 92 psychiatric beds of acute inpatient care, emergency services, outpatient and partial hospital services, at our three campuses: BayRidge Hospital in Lynn, Beverly Hospital and the Addison Gilbert Hospital in Gloucester. I am also a former DMH Area Director for the Northeast area.

I will not repeat the policy issues as presented by David Matteodo of the Mass Association of Behavioral Health Systems nor that of Anuj Goel of the Mass Hospital Association. They have represented our thoughts and policy concerns quite clearly.

I would like, however, to express my thoughts as to a broad systemic approach as you consider and study this complex issue; at it is this:

> That the mental health system of care for the Commonwealth must continue to be a Balanced System of Care meaning that the core stakeholders and programs; or the philosophy that the stakeholders represent need to continue to be supported with both resources and policy consideration.

The primary stakeholders of consumers, families, community based providers, acute

inpatient care providers, and DMH services, needs to continue to be blended in such a manner that meets the range of challenging needs for our citizens.

The needs of consumers and families are broad and complex; I very much support the continued programming of an enhanced community system and the Community Based Flexible Support model of care recently developed by the Department. Consumer empowerment is central to recovery, rehabilitation and hope for the future for consumers. Contracted, community based providers require the resources to meet the new challenges of care provision to consumers who have persistent disabilities and have not been part of the community systems of care for sometime. And the acute care inpatient systems require the assurance that the Commonwealth has the adequate clinical services, community based programs and rehab level of inpatient care to provide for the consumer the continuum of care they need and deserve.

If one of these parts of the system is neglected, or not incorporated into the planning process, it can impact the whole of the service delivery system.

In addition, I would like to emphasize the need for the Commission to consider ways by which needs of the citizens of the Commonwealth can be addressed across Secretariats. Consumers of our acute inpatient services are also consumers of the Department of Public Health, the legal system, Public Safety and Corrections. I understand that services are currently provided across systems, yet I believe that planning for care for increasingly

complex and challenging individuals requires enhanced inter-agency planning and collaboration.

Thank you, for this opportunity to provide these comments to your Study.

Massachusetts Association of Behavioral Health Systems, Inc.

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Michele Gougeon
President
David Matteodo
Executive Director

Testimony to the Department of Mental Health Inpatient Study Commission
Presented by: David Matteodo, Executive Director
Massachusetts Association of Behavioral Health Systems
June 12, 2009

On behalf of the Massachusetts Association of Behavioral Health Systems (MABHS), I appreciate the opportunity to testify before the Department of Mental Health Inpatient Study Commission. The MABHS represents 47 inpatient mental health and substance abuse hospitals, units, and facilities in Massachusetts, which collectively admit over 45,000 patients annually. Our hospitals provide the overwhelming majority of acute inpatient mental health and substance abuse services in the Commonwealth.

The work of this Commission is very important to Behavioral Health hospitals across the Commonwealth. We understand that the State Budget and DMH are operating in an extremely difficult environment and acknowledge that there are no easy solutions to the issues confronting DMH. We offer these comments in the spirit of hoping to provide constructive and helpful information. We have researched this issue; solicited feedback from our membership; and held three Conference Call meetings to discuss common concerns from acute psychiatric facilities throughout Massachusetts. This testimony seeks to summarize the issues from the perspective of our members.

- In essence, the MABHS believes that it is a core responsibility of the Department of Mental Health to provide services to the seriously mentally ill. Historically, these services have included Continuing Care or long-term inpatient care. Our facilities can provide short-term, acute care which for most patients, is approximately eight days. However, there are some patients who need longer term care and that is where a robust Continuing Care system maintained by DMH is necessary. We are concerned that if the DMH Continuing Care system is not adequate to meet the needs of the serious mentally ill, there can be severe repercussions throughout the entire mental health system.

- According to DMH statistics, the DMH Continuing Care system has a 97% occupancy rate which essentially means it is full. Further, on a given day there are approximately 50 patients in our acute system either on State Hospital Wait Lists or in Application/Referral status. We get a weekly report from DMH Central Office which identifies the acute hospitals who have patients either on the Referral List or Wait List. Some of these patients can wait for weeks and months for a DMH bed. As this Commission is responsible for assessing DMH Inpatient Capacity, we strongly urge you to take these factors into consideration.

- It is essential that acute psychiatric hospitals have timely access to Continuing Care beds for the patients that need that care. Otherwise, the patients can remain on acute units beyond that which is medically necessary, which is not good for the patients or the units. Acute psychiatric units are under pressure from payers, including the Massachusetts Behavioral Health Partnership (MBHP) to provide

short-term acute care, even to the point of reducing payments when certain lengths of stay thresholds are exceeded. Also, Emergency Rooms can get backlogged with psychiatric patients if acute psychiatric units are unable to take patients because they are full. Thus, DMH Wait Lists and backlogs can be harmful both to patients and hospitals.

- The acute system should not be relied upon to serve Forensic patients. According to DMH statistics, on a given day there are about 167 Forensic patients in DMH facilities. The private psychiatric system currently has only four hospitals that are licensed to provide Forensic services, and they have very limited capacities to accommodate that population. Also, our acute hospitals have already seen increasing acuity on our units, especially for violent and assaultive patients, most of whom we can effectively treat. However, there is a certain population that requires more specialized services in the DMH Continuing Care system.

- There are significant concerns about the ability of the Community System to meet the needs of the serious mentally ill. The outpatient mental health system in Massachusetts has suffered severe budget cuts in Clubhouses and other settings. Right now, outpatient access is difficult. It is not clear what will happen given the current unprecedented State Budget issues as well as Community System Re-procurements and consolidations.

- It is important for the Commission to be aware that the acute psychiatric system is struggling under its own fiscal pressures as most facilities have significant gaps between their costs verses payments which have only been exacerbated by the recent 9c Budget cuts. Two independent studies commissioned by the MBHP since 2003 indicate gaps in excess of 20% between MBHP payments and hospitals' costs. Units throughout the state are increasingly concerned about their own viability: the acute psychiatric system is in a very precarious financial status at this time. We have already seen bed closures in our hospitals this year and we are hopeful that there aren't any more. Absent new resources it is difficult to see how the acute system can provide significant new services. It is imperative that the acute system be maintained as it essentially serves as a replacement system for nearly all of the acute care at one time provided by DMH.

Suggestions for the Commission to Consider would include:

- We would like the Commission to be aware that the acute system treats patients who cut across the EOHHS Secretariat, presenting multiple discharge issues. These patients need a viable state system and resources should follow patients whether they are discharged from the acute or Continuing Care system.

- The Commission may want to review the Medfield Hospital discharges to determine what happened with those patients and whether the Community system was able to meet their needs.

- The Commission could consider a review of the $19.8 million, 45 bed acute system that DMH currently operates to see whether that care could be met by the private sector. Perhaps the Commission could review whether any kinds of Replacement Units in the private sector could meet the needs of those patients now served by the DMH acute system.

- The Commission is no doubt aware that over the past few years, the DMH Continuing Care system has already closed many beds (over 100 beds). As a result of those closures, the MABHS had become concerned that the Legislature needed to be involved in this area, and language was inserted into the FY 08 Budget that required 60 days advance notice to the Legislature by DMH prior to any bed closures. This Language was included in both the House and Senate FY 10 Budget Recommendations.

- The Commission may want to review the length of stay for patients in the Continuing Care system. Perhaps there are ways the length of stay can be lowered, therefore improving the flow of patients as well as providing more appropriate care for certain individuals who could be served in the community. We would hope that the community system would be provided with adequate resources to assure continuity of care and support for the patients and providers.

In summary, we appreciate the opportunity to provide these comments to the Commission. We also understand and appreciate that we are serving many of the same patients as the DMH system and want to work cooperatively with DMH to better serve these patients. We are hopeful that you will seriously consider this testimony as you develop your recommendations.

Please do not hesitate to contact me should you need any further information.

MHA MASSACHUSETTS HOSPITAL ASSOCIATION

Department of Mental Health
Inpatient Study Commission
June 12, 2009

Provided by:
Anuj K. Goel, Senior Director, Regulations and Staff Counsel

The Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health systems, appreciates this opportunity to submit comments to the Department of Mental Health (DMH) Inpatient Study Commission. I know that several of our member hospitals and my colleague David Matteodo from the Massachusetts Association for Behavioral Health Systems also have testified on the issues and challenges currently facing the healthcare system, and I urge this Commission to seriously consider their comments along with MHA's as you discuss viable options for the future.

The purpose of the Commission as we understand it is to evaluate the Department's state-operated inpatient system and determine an appropriate level of state-operated inpatient capacity, while also balancing the need for the Department's Community First initiatives as well as the Department's operating budget. As we look at the current system and discuss ways to change it, it is very important to reiterate the specific challenges that the Commission has stated in its purpose and scope document -- challenges also faced by our members.

Namely, the current economic downturn has created a set of challenges for the Department and the provider community to care for our most at-risk patients, including:

1. An immediate structural deficit to the Department's operating budget of $24 million that will require significant service reductions;
2. An already significant reduction to DMH community services with the elimination of day and employment services and a reduced case management work force;
3. And, the fact that at any point in time, more than 200 of 788 adult patients in DMH continuing care facilities are ready for discharge but appropriate community services are not available.

Massachusetts hospitals provide critical mental health services to the Commonwealth, but these services are only viable if there is a corresponding state system that is able to support patient need through both community and inpatient capacity. In considering the appropriate bed capacity for state facilities, the Department must consider the collateral effects any decision to eliminate services will have on existing hospital and community providers and programs. From the hospital perspective, the Commission should recognize:

1. General and private psychiatric hospitals now form the safety net for mental health. Acute mental health care was primarily a state responsibility since the mid 1800s. In the early 1990s to the present, however, state hospitals shifted acute inpatient care to general and private psychiatric hospitals by using the 1115 Federal waiver for Medicaid to increase coverage for MassHealth Behavioral Health patients in acute care hospitals. As a result, the state was able to close or reduce state hospitals and build community services. The ability to make this change in the past was realized by getting the federal government to pay 50% of costs in the acute care sector, thereby offsetting the state funding that was used to support the community based services. Another result of this change was that state hospitals now focus on providing the majority of the continuing care and forensic admissions in the state. With the current acuity for DMH facilities at 97%, and with a significant waitlist of patients already seeking continuing care, closure of any state beds will further limit the ability of general and private hospitals to transfer patients needing these necessary resources. The lack of beds increases length of stay, backs up emergency rooms, limits options for discharge, and by default makes general and private psychiatric hospitals the **only** safety net for behavioral health patients needing continuing care. Closure of beds would be a further abrogation of the Department of Mental Health's responsibility to provide this necessary continuing care. The Commonwealth needs a robust continuing care system maintained by DMH to facilitate timely transfer of patients off of acute care units.

2. The Commission must keep in mind that Inpatient hospitalization is required for at-risk patients who are unable to participate in outpatient treatment or who have not responded to that treatment. Most patients can be stabilized fairly quickly (average stay is now 7-10 days) and transitioned to a less intensive level of care. However, there are many patients who take considerably longer (6 months or more) to stabilize so that they can be safely transitioned to another level of care. Unfortunately the acuity on inpatient psychiatric units is higher than ever and that presents challenges to provide a safe environment for patients and staff. The DMH system has historically been a critical resource for violent or assaultive patients, including those involved with the court system. Moving these patients to a DMH facility allows the acute care hospital to treat more patients that are able to be stabilized and transitioned to a community based setting.

3. The financial pressure on general and private psychiatric hospitals that provide acute mental health services will increase significantly with closure of more DMH beds. If continuing care beds are closed, the resulting increased length of stay at general and private psychiatric hospitals will further deteriorate their tenuous financial health. It is no secret that psychiatric services are loss leaders for many institutions. Previous studies demonstrate a 20% gap between cost and payment for mental health services, and further strain on these services will accentuate instability in the acute care system and produce gridlock. A recent survey of our member hospitals that provide mental health services indicated that these services generate a negative operating margin that is not sustainable. Recently one of our member hospitals in Western Massachusetts had a patient remain in their unit for more than 6 months. The patient exhausted coverage through MassHealth within 20 days; there was no available state bed, and the patient was not safe enough to be discharged to receive services through a community-based service. Despite efforts, from the Massachusetts Behavioral Health Partnership, MassHealth, and through discussion with other provides in the region, the patient remained in the facility with no insurance coverage options. The hospital assumed and maintained its duty to care for the patient until a bed in a forensic unit was finally available. As a result of this single case, the acute care hospital is now struggling to continue to provide

services to all other patients and must now reexamine the ability to maintain behavioral health services next fiscal year. This case is similar to several hospitals throughout the Commonwealth.

4. General and private hospitals already are at risk to cut back or close inpatient and other psychiatric services due to low reimbursement. Recent bed closures at Cambridge Health Alliance are but one example of the financial pressures general hospitals face. The few acute units that step up and try to mitigate these closures have suffered financial penalties. Examples of the cost drivers that acute care hospitals are dealing with include: a.) the pursuit of desperately needed guardianships incurs legal costs that are born by the institution; b.) pursuing transfer to a state hospital often results in the state and commercial insurers arbitrarily placing the patient on lower paid administrative days; c.) keeping a patient who is at risk of death with improper discharge means the unit will accrue a handful of so-called "outlier days" that will increase average length of stay and incur financial penalties for the institution. If the financial conditions or gridlock gets worse hospitals will make difficult decisions and close services. The Medicare system pays less under prospective payment than it previously covered, and the recent 9C cuts to MassHealth behavioral health services have further increased the gap in covering costs for behavioral health services, especially in general acute care hospitals. Psychiatry units admit far more Medicaid patients than medical surgical units admit and both Medicare and MassHealth are paying less for longer length of stay patients. Thus, these units and hospitals struggle under significant financial stress. The failure of DMH to meet the needs of continuing care may force more units to close.

5. The complex needs of seriously mentally ill persons require maintaining a robust, responsive state mental health system that provides high quality continuing care. While we laud the efforts to provide quality care in the least restrictive environment in a patient's community, we hope the Commission recognizes that some patients need additional resources and care that only can be found in a continuing care environment. Our facilities are designed to provide short-term, acute care. This model, however, is inadequate for those suffering from serious mental illness. These patients get "stuck" in our emergency rooms, waiting for transfer, and suffer needlessly. A recent study of our members also shows that behavioral health patients wait on average twice as long as medical patients in finding an inpatient level bed. The inability and impact to the system in providing timely transfer to more appropriate settings is clearly illustrated in the following examples:
    i. A 50 year old female was admitted to the hospital on 3/3/09 due to psychotic decompensation and a long history of schizoaffective disorder. The patient reported that Jesus told her to stop her medications and that Jesus had been whispering through her mouth, as she talked, since 1985 and telling her what not to do. A referral was sent to TSH for intermediate level of care on 4/6/09 but because of their long wait list, the patient was not transferred until 53 days later. The patient became increasing agitated throughout her stay because it was taking so long to be transferred. She refused to talk with her assigned social worker and spent most of her time isolated in her room.
    ii. A 30 year old male was admitted to the hospital due to his significant delusional and paranoid thought process and subsequent behavior. The patient presented with a longstanding history of schizoaffective disorder, bipolar type. The patient was very psychotic throughout his stay and became increasing angry that it was taking so long to be transferred to intermediate level of care at TSH. He eventually became quite depressed as well as psychotic. The patient was finally

transferred to TSH 103 days after his admission and still remained psychotic and depressed.

iii. A 43 year old male was admitted to the hospital on 4/7/09. He was brought into the ER by the police after holding his mother hostage, carrying a bat, turning off phones and not allowing any communication with the outside world. The patient's admitting diagnosis was psychotic disorder, NOS. The patient's mother was constantly fearful because he had two loaded guns under his bed at all times. The patient denied any psychiatric issues and was non compliant with all medications. The patient was committed by the judge for 6 months of treatment on 4/30/09. A referral for intermediate care was sent to TSH on 5/5/09 and the patient still awaits transfer to TSH 36 days later due to the long wait list at TSH.

6. It is important for the Commission to consider the effects that their recommendations will have on the entire spectrum of mental health care, from forensic capability, outpatient services, housing and homelessness, and community stability. As DMH discharges more long-term care patients, these patients may require acute care admission. Our hospitals are prepared to provide care in these cases. We are especially concerned about the potential for disposition barriers back to the new community-based system, resulting in protracted lengths of stay in acute care beds, reducing capacity and reducing reimbursements for these patients. We are concerned as well that services do not meet the patient's medical needs. DMH must be ready to coordinate with community based providers to more readily "step up" and help transition patients back to the community in a collaborative and timely manner. The community system must have enhanced training and support to respond to these patients' clinical needs and challenging behaviors.

7. Any decision to move services from an inpatient to a community-based process must be viewed with the current budgetary concerns and cannot be based on prior successful changes. Specifically, the closure of Medfield State Hospital is not a valid model for current studies. While the principles used in the closure of Medfield are goals that we want to attain now (significant individualized patient planning, identification of community resources, development of new support programs, dedicated financial resources), it cannot serve as a blueprint for any recommendations for reduction of current beds. First, the current economic conditions are significantly different. All sectors are hard-pressed by state budget cuts and elimination of programs. The community programs and dedicated funding that proved successful in the Medfield closure no longer exists. More than 200 of 788 adult patients in DMH continuing care facilities are ready for discharge but appropriate community services are not available. Second, the Medfield closure does not address the nearly 50 patients sitting on referral or waitlists each month. Even with adequate community services to facilitate discharges, the DMH beds would be quickly refilled with patients awaiting services.

Keep in mind that the goal of closing inpatient hospital beds was based on the fact that at the time adequate funding was available to cover the various innovative, recovery-based, non-hospital alternatives to inpatient care. While there have been some successful programs here and there, the options facing a person hospitalized for acute psychiatric care are incredibly limited. At the time that the Medfield closure was made, patients had access to residential services, group homes, DMH case management and step down services at discharge. Today, there is virtually no access to residential facilities at discharge, case management is inconsistent in its ability to connect with patients while in the hospital, and young adults with new onset psychotic disorders have almost no access to DMH aftercare. Given the current economic climate, the Medfield

closure serves as an example of ways to better manage throughput of bed use, but not as a blueprint for bed closure if the resources and funding for the community based services are not available.

In conclusion we recommend that the Commission consider the following proposals:

1. The Commission should be aware that the acute system treats patients who cut across the EOHHS Secretariat, presenting multiple discharge issues. There needs to be better coordination of resources and management of the patients whether they are discharged from the acute or Continuing Care system; those that were provided when Medfield hospital closed present a good example of what is needed.
2. Any focus on the Community First initiative must be viewed from the current financial crisis and the ability to provide long-term funding for these services without impacting the current forensic and continuing care beds that are at capacity.
3. The Commission should review appropriate areas for savings – such as the $19.8 million, 45-bed acute system that DMH currently operates – to see whether that care could be met by the private sector. Perhaps the Commission could review whether any kinds of Replacement Units in the private sector could meet the needs of those patients now served by the DMH acute system.
4. The Commission may want to review the length of stay for patients in the Continuing Care system. Perhaps there are ways that can be lowered, therefore improving the flow of patients as well as providing more appropriate care for certain individuals who could be served in the community.
5. While we understand that the Commission must complete its works by the end of June, many providers and advocates did not have enough time to thoroughly review the current system to provide adequate data as to transfers and discharge data points. We strongly feel that there needs to be a comprehensive DMH review of the current system prior to any proposed changes to ensure that the specific impact on the entire system, as well as on certain geographic locations, are understood.

We appreciate the opportunity to provide these comments to the Commission. We respectfully request that you will seriously consider them as you develop your recommendations. Please do not hesitate to contact us should you need any further information.

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TESTIMONY TO THE DMH INPATIENT STUDY COMMISSION

The Massachusetts Psychiatric Society, which represents over 1600 psychiatric physicians in the Commonwealth, thanks Commissioner Leadholm and the Commission for the opportunity to offer testimony on the subject of the future of inpatient services in the Commonwealth. I am Eugene Fierman, M.D., chair of the MPS Legislative Committee and past President of the Society.

As a professional society, advocating for the care of the psychiatrically ill citizens of the Commonwealth is a core part of our mission, one we share with other professional societies and advocacy groups such a NAMI, PPAL and M-Power. As a Society, we understand the unprecedented budgetary pressure that the Commonwealth and the Department are facing. I suspect we all find the cuts that we have sustained and the ones we are facing to be catastrophic. You have received a broad range of testimony from the professional and advocacy community, including data concerning that status of the hospital and community care systems. I would like to provide an overview, from the perspective of a psychiatrist who has practiced in the Commonwealth since residency, funded by the State, at the Massachusetts Mental Health Center in 1973-76.

For most of the past 2 centuries, state government has assumed the role of care of the seriously mentally ill. Until the advent of psychotropic medications and Federal support for community mental health services in the 1950's and 1960's, inpatient services were the cornerstone of the state mental health system. Beginning in the late 1960's, community services were expanded and a great many patients were placed in the community to their great benefit. As a result, resources were appropriately drawn from hospitals to the community and many hospitals were closed. Beginning in the 1980's, Federal community mental health funds were converted from categorical funding to block grants. My colleagues have testified to the results, positive and negative, of state hospital closure: establishment of replacement units and community programs on the one hand and an increase in shelters, homelessness and incarceration for mentally ill patients on the other. At this point in time, we must look carefully at the state of our mental health system, at the true effects of what has been done, positive and negative, and make a clear assessment of the consequences of past and future cuts.

We share the concerns of our colleagues at the Massachusetts Hospital Association and the Massachusetts Association of Behavioral Health Systems concerning the consequence of further cuts to the inpatient system of care. Before making further inpatient cuts, we urge you to examine more closely the effect of the closure of State Hospitals, such as Medfield, which were undertaken at times of greater budgetary flexibility. As we move more services into the community, we must insure that these services are adequately staffed with the appropriate level of professional services to match the needs of our patients. We see no conflict between

professional and peer services. We do feel, however that insufficient professional services would not be tolerated for any other type of illness. While we are asked to make difficult choices, we cannot accept the false choice between community, hospital and peer services. Our citizens deserve nothing less than a full range of high quality professional services. To do less would be tantamount to abdicating the Commonwealth's commitment to the care of our most seriously mentally ill patients.

As a former medical director of a community mental health center, I am aware of the benefits of this movement for many psychiatric patients and their families in the Commonwealth. However, I often think, however, of one unintended consequence of deinstitutionalization. With the closing of state hospital, hard resources, i.e. buildings and real estate, were lost to the psychiatrically ill citizens of the Commonwealth. While the majority of patients benefited from community placement, some patients are unable to live outside a hospital setting and many others became homeless or treated in forensic or prison settings. While I do not have nostalgia for the State Hospital as an institution, I do believe that we have missed an opportunity to use these hard resources more creatively to the benefit of the mentally ill. More diffused community resources are more vulnerable to cuts than buildings and land. It is a shame to see luxury condominiums on the site of State Hospitals while we contend with shelters and homelessness. We have seen in prior rounds of cuts just how vulnerable community based services are.

We appreciate and support efforts to create a system that is responsive to the needs of our patients and their families. All the members of this distinguished panel and those who have testified are dedicated to the care of our most vulnerable citizens. However, principled language cannot substitute for a full range of high quality service. Less is indeed less. At what point does the system become inoperable? And what will be the consequences for our patients and their families?

Thank you for your time and attention. We appreciate the opportunity to testify on these critical matters.