



**MASSACHUSETTS PSYCHIATRIC SOCIETY
TESTIMONY TO THE DMH INPATIENT STUDY COMMISSION
JUNE 12, 2006**

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 as 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.