

April 23, 2009

Mr. Ray Cryan
99 Chauncy Street, 2nd Floor
Boston, MA 02111

Dear Mr. Cryan,

Thank you for the opportunity to comment on the proposals to eliminate the inpatient detoxification unit and to reduce the number of adult psychiatric beds in the Cambridge Health Alliance (CHA) system. I understand that these proposals have emerged from long negotiation between the Executive Office of Health and Human Services (EOHHS) and CHA to produce a leaner system, which EOHHS is willing to subsidize in its current fiscal situation. I am relieved that such an outcome has been achieved, and I credit both parties for negotiating in good faith, and to good effect.

That being said, it's important to acknowledge that in this reorganization, our community is suffering real losses: in institutions, in services, and in people providing these services. Some of these losses are in the realm of familiarity and convenience, which is bad enough. Loss of access to needed services, however are simply unacceptable.

After all the meetings and discussions, I've concluded that these cuts to mental health and substance abuse services are being driven, if not dictated, by EOHHS. CHA makes its decision – as it must – within the context of EOHHS policies; on reimbursement rates, Medicaid spending, and on “managed care” decisions. My testimony, therefore, is a message to DPH's parent secretariat, that, based on EOHHS' closed decision-making process, and invisible analysis of need and services, I expect the service reductions to CHA to exacerbate further the already unmet need for mental health and substance abuse services in our community.

I'll address substance abuse treatment first. I do understand that not all detox treatment needs to be the “medically managed,” level 4 variety. Yet despite CHA having over 1,700 detox admissions last year in its 26-bed unit, the state has determined that it needs only four to six level 4 beds in the CHA service area. What is the basis of that determination, and why should our community feel confidence in it?

With the funding cuts of 2003, Massachusetts lost about half of its detox beds – from almost a thousand, to under 500. The loss of the CHA beds will bring the statewide number down to about 470, at a time when it appears that demand for substance abuse services is increasing. Certainly these services cost money – but so do the crimes, incarcerations, inpatient mental health institutionalizations, foreclosures, neglected children, and other inevitable consequences if we fail to treat addictions aggressively.

I understand, too, that the use of the drug bupranorphine is altering the way that opiate addictions, a major segment of our substance abuse problem, is being treated. Yet the “take this pill and don't call me in the morning” method of treating addiction is fairly new, and has not been studied well; and bupranorphine, like methodone, can be abused. Is it the expectation of DPH/EOHS that most detox treatment will soon become ambulatory treatment?

CHA seems aware of the need for a middle path of addiction treatment, that combines some level of medical supervision – and even intervention – with counseling, peer support, and other programs. I would hope that EOHHS recognizes this need as well, and has perhaps considered quantifying the

magnitude of such need in our geographic region. I am deeply troubled that EOHHS has not initiated or invited any public process around assessing and filling this need.

The mental health arena presents a parallel case. In-patient beds at CHA are being reduced, even as training programs and clubhouses are being closed, and adult day services “re-procured” in a manner that strongly suggests diminution. Once again, pronouncements are being made about “need” based on invisible data, undisclosed assumptions, and a top-down “process” that has not allowed for dialogue with community members and service providers. Such a dialogue could help to vet numbers, challenge assumptions, re-make models, and optimize own resources in a time of economic crisis.

Finally, I have to mention that I have had to ask DPH repeatedly, in writing and by telephone, over several weeks, to ascertain the true location of this hearing, without consistent or timely responses. I have protested, and wish to protest on the record, the announced decision of DPH to take written comments only for the ten days following the March 31, 2009 posting of notice for this hearing – a notice containing inaccuracies, by the way. I raise these issues here because they are to me emblematic of a process which evades public input, and so undermines public trust.

Very Truly Yours,

Denise Provost

cc: JudyAnn Bigby, Secretary, Executive Office of Health and Human Services
John Auerbach, Commissioner, Department of Public Health
Tom Dehner, Director of Medicaid
Dennis Keefe, CEO, Cambridge Health Alliance