My name is Howard D. Trachtman. I have had a long road to recovery and wanted to share with you how I went

from being an expensive patient to becoming a tax payer and helping others on their road to recovery.

In 1985, I was a patient at Metropolitan State Hospital in Waltham for 9 months. I started psychiatric medicine including lithium while I was a patient there.

When I came out, I needed to live in group homes for many years and was frequently re-hospitalized. I was made to go to a day treatment program.

Even though I wanted to work, my treatment team would not allow me to do so. For a long time, I considered myself a "professional mental patient."

I gained much weight due to the medications, I did what I was told but wasn't getting better

and wasn't able to live independently for a long time.

My recovery started in earnest in 1995 when I discovered M-POWER, a peer organization run by people with lived experience of mental health treatment) . I was mentored to do direct action, lobby and testify for bodies like your own, run support groups, do advocacy and serve on

non-profit boards of directors. I also got involved at the national level. I served on the DMH area board, was sent to my first Alternatives conference

and started my recovery. Today I am the co-founder of the National Alliance on Mental Illness Greater Boston Peer Support and Advocacy Network

and the DMH-funded Metro Boston and Southeast Recovery Learning Communities. We help other peers in their road to recovery. I was the co-chair of MassHealth's One Care Implementation Council for many years. I am now a

Certified Peer Specialist, a Certified Psychiatric Rehabilitation Practitioner and a Certified Older Adults Peer Specialist.

Peer-run programs tend to cost much less than traditional medical model services and may even have better outcomes. Peers who have

been damaged by involuntary treatment are much less likely to seek out help again but will accept help from a peer. The Metro Boston Recovery Learning

Community offers a peer support line that diverts people from costly crisis intervention services by providing a compassionate listening ear.

We currently only have funding to operate 4 hours a day 7 days a week but could do much more with adequate funding.

Peer-respites, a place a person can got to in crisis in lieu of a hospital at the fraction of the cost are needed across the state.

The Wildflower Alliance (formerly the Western Massachusetts Recovery Learning Community) operates Afiya house with much success.

Respites in general are less costly than hospitalization and promote quicker recovery. Two years ago I felt psychiatric symptoms coming on but instead of going to a costly hospital I was able to go to a respite program

called Marie's Place operated my insurance carrier. I only needed to stay a short time while my prior hospitalizations averaged several weeks

each time.

Alternative types of treatment should be offered as they work and cost less, have fewer risks and are less traumatic to the person served.

These alternatives include exercise programs, meditation, trans-cranial magnetic stimulation, pet therapy and, of course, peer support.

I choose to take medications today but the lithium damaged my kidneys. My creatinine has been low for years and my nephrologist recommeneded surgery so I could

get dialysis. When I applied to be listed for a kidney transplant I was turned down, in large part because of assumptions made based on my psychiatric diagnosis about my ability to comply with post-transplant orders This is an example of the stigma and implicit bias toward people with a history of mental health conditions that bar access to physical health care.. Because of this implicit bias and because of diagnostic overshadowing (attributing physical symptoms to mental health issues) , the Commission should require data reporting on the physical health care of persons with psychiatric diagnoses if physical

and mental health care are integrated. I encourage the Commission to include a recommendations that insurers collate data on the physical health care claims of persons with mental health care claims and of those without mental health care claims to explore the difference in care. In addition, the Commission should recommend insurance coverage and funding of alternative modes of mental health treatment.

As an advocate, I highly recommend that the Commission should include people like myself who openly identify as persons with lived experience of

mental health challenges. Our expertise is essential to helping determine what would actually promote recovery and thereby lower health care costs.

Thanks for allowing me to testify.

Howard D. Trachtman