To: Members, Senate Health and Welfare Committee
From: Laura Ziegler
Re: S.287

Further below is a relevant excerpt from a report that was posted by the NYS Commission on Quality of Care. I wanted to flag this:

"When they studied 100 patients in psychiatric inpatient settings, Hall and colleagues (1981) found that 46% of patients had previously unrecognized medical illnesses that directly caused or exacerbated their psychiatric symptoms."

I can't access the cited Koranyi article, but from a (truncated) description in the preview of another article citing it:

"Koranyi's (1979) work was among the first to use large samples of patients. in a study of over 2,000 psychiatric patients, he found that 43 percent had at least one medical illness. Nearly 46 percent of these illnesses had previously gone unrecognized by the physicians who made the referral for psychiatric examination and treatment. Koranyi also noted that in 20 percent of the patients, the physical illness was the only identifiable cause of the psychiatric symptoms that formed the basis of the initial referral. He observed that the failure to recognize illness was highest (84 percent) when the patient was self-referred, second highest (83 percent) when the patient was referred by a social services agency, and third highest (48 percent) when the patient was referred by a psychiatrist. The lowest rate (32 percent) of failure to recognize existing illness ...

From a more recent article:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831667/

Medical Comorbidity in Women and Men with Schizophrenia:
Carney, C. et al, J Gen Int Med., 2006 November; 21:11; 1133-1137

Primary care and behavioral health providers dealing with apparent exacerbations of mental illness in their patients with schizophrenia may need to consider whether symptoms are being driven by undiagnosed medical conditions. Unfortunately, failure to treat medical conditions in persons with schizophrenia is a common problem,17–19,21 and these patients are more likely to report substantial barriers to care including economic barriers and delays in seeking care.10 Even among insured persons with mental disorders, risks for delaying care or not receiving needed care are substantial.22 Reasons include failure of psychiatric providers to ask about medical issues and patient inability to identify primary care provider by name.23

http://www.cqc.state.ny.us/sdmc/medicaldecisionmaking_Dr%20Schwartz.htm
[THIS IS NO LONGER A WORKING LINK]

Medical Decision-Making for People with Chronic Mental Impairments

by Charles E. Schwartz, M.D.

[Reprinted with author's permission from Choice & Responsibility: Legal and Ethical Dilemmas in Services for Persons with Mental Disabilities]

A Fundamental Problem: Poor Medical Care

Any discussion of issues relating to medical decision-making for people with chronic mental impairments must begin with the recognition that these individuals have traditionally received terrible medical care. Multiple studies have thoroughly documented the alarmingly high rate of undiagnosed medical problems in individuals with significant mental disabilities. In a review by Erwin Koranyi (1980) of a dozen studies conducted over a 40-year period involving some 4,000 mentally disabled persons, approximately half had major medical illnesses, and in one-half to three-quarters of these individuals, the major medical illnesses went unrecognized. Poor medical care occurs both in public institutions and in community-based residential and outpatient care settings.

Undertreatment

In psychiatric outpatient settings, Hall and colleagues (1978) found in their study of 658 patients that 9.1% had medical disorders that might be producing the patients' psychiatric symptoms and that three-fourths of these disorders had been unrecognized. Koranyi (1979) reviewed some 2,090 outpatients and found that 43% had one or more medical illnesses; referring psychiatrists had missed 50%; referring medical physicians had missed 33%. In self-referred and social agency-referred patients, where almost 100% had one or more illnesses, some 46% had gone unrecognized. Koranyi further found that 18% of the medical disorders were causing the psychiatric symptoms, 51% were exacerbating them, and 31% were serious but unrelated.

When they studied 100 patients in psychiatric inpatient settings, Hall and colleagues (1981) found that 46% of patients had previously unrecognized medical illnesses that directly caused or exacerbated their psychiatric symptoms. An additional 34% of patients had unrecognized serious co-existing medical problems. In fact, only 20% of the psychiatric inpatients were free of significant undetected medical problems.

Martin and colleagues (1985a, 1985b) demonstrate the unfortunate consequences of poor medical care. In their seven-year follow-up study of 500 individuals with chronic mental impairments, it was found that the mortality rate was twice that of matched individuals who were not significantly mentally disabled. And, in several investigations conducted by the New York State Commission on Quality of Care for the Mentally Disabled concerning the deaths of individuals residing in group homes for developmentally disabled persons, it was found that the individuals were exhibiting symptoms of diseases which claimed their lives, but the symptoms were mistakenly attributed to "behavioral problems" or emotional factors.

*** Example**

Ms. R., a 63-year-old woman with mild mental retardation was transferred from one group home to another. Soon after the transfer she began to complain of abdominal pains, and she refused to eat. Known to be a "picky eater," staff thought that she was just nervous over the recent move. Even when she experienced bouts of vomiting in the following days, administrative and nursing staff, without the benefit of ensuring a full physical examination, concluded she had a "nervous stomach" and was anxious over the recent transfer. On the fourth day after the move, she vomited what appeared to be black fluid and was taken to the hospital. She arrived unresponsive and died shortly thereafter. The cause of death was septic shock and gastro intestinal bleeding due to an abdominal catastrophe.

Overtreatment

At the other extreme, individuals with significant mental disabilities also run the risk of being inappropriately overdiagnosed and overtreated. For example, it is widely recognized that elderly patients with dementia who enter acute medical/surgical facilities may be subjected to an array of invasive diagnostic tests and therapeutic procedures, the risks and adverse consequences of which, including significant discomfort, are much clearer than the benefits.

*** Example**

A physician approached a surrogate medical decision-making panel in New York State on behalf of a 74-year-old profoundly retarded individual who lacked the capacity to consent to medical care and had no relatives. The physician sought permission to perform a cystogram, a biopsy of the prostate, a transurethral resection of the prostate, a craniotomy, and an insertion of a gastrostomy tube for feeding. The request for the procedures was denied by the panel as being medically futile; the patient was semicomatose with terminal brain cancer.

Contributing Factors

Why does this inappropriate under- and, at times, over-medicalization occur? Hoffman and Koran (1984) describe "disease-related, patient-related and physician-related factors."

By "disease-related factors," Hoffman explains that many medical disorders may first or most prominently present with changes in mental status. In addition, many symptoms can be associated with either medical or nonorganic mental disorders, e.g., weakness, fatigue, gastrointestinal complaints, anorexia, shortness of breath, anxiety, depression, and hallucinations.

*** Example**

Mr. J., an 80-year-old gentleman with dementia living at home with his wife, is brought to the hospital because he is up all night "ranting and raving and sitting by an open window, driving his wife crazy." On medical evaluation, however, he is discovered to have congestive heart failure with orthopnea and paroxysmal nocturnal dyspnea. What was initially mistaken for psychopathology was physiological in nature; due to fluid back-up in the lungs, Mr. J. could not lie flat and would periodically awaken and need to sit bolt upright at the window in the acute air hunger characteristic of severe congestive heart failure.

"Patient-related factors" include the off-putting appearance and behaviors of some individuals with mental disabilities, particularly those individuals who are not receiving appropriate assistance with these matters. As Hoffman puts it, "A malodorous, dirty, and obstreperous patient discourages close, prolonged, and careful scrutiny." In addition, persons with serious mental disabilities may be unable to provide good medical histories and may be uncooperative with examinations and tests. As Jonathan Borus (1987) points out, "Almost one-half of public sector mental health patients studied [in studies like those quoted above] did not participate due to lack of cooperation...."
"Physician-related factors" include an all-too-common aversion to individuals with mental disabilities. Physicians are often unsympathetic and sometimes frankly frightened by these patients. Physicians may have subconscious emotional biases that mentally impaired patients are subhuman and not really people, or may find those patients frightening reminders of the tenuousness of their own mental health. Physicians may even irrationally fear contagion. In consequence, physicians may too often perform inadequate evaluations like the classic hasty "medical clearance" of patients presenting for psychiatric care, and grossly underdiagnose and treat.

*** Example**

Ms. I., a young woman with a chronic mental illness, was admitted to the surgical service after swallowing glass. She was followed by the surgical house staff without any surgical intervention despite psychiatry's repeated misgivings. In retrospect, the director of the surgical service stated that this approach had been dangerous, and surgery ought to have been performed to remove the glass before it passed through narrow segments of the gastrointestinal tract.

Conversely, physicians may be overly zealous and aggressive out of reaction formation to their hidden distaste, out of a failure to see the patients as fully human, and out of the absence of a counterbalancing capable voice representing the patient and saying "No" where appropriate.
It is sometimes thought that all individuals who agree to medical treatment are capable of making that decision, and that only those who refuse need psychiatric evaluation. In fact, patients who accept medical intervention may be as incapable of making their own informed medical decisions as patients who refuse it, and we should always consider whether they are capable of making such decisions.

Need for Advocacy

What is clear is that individuals with chronic mental impairments need advocates to help them negotiate their successful passage into and through the medical care system. Such advocates must insure that patients are fully informed of their needs and options, given sound expert medical advice, and heeded when they are capable of making their own decisions. Advocates must insure that medical care is accessible and of high quality. And finally, when patients are incapable of making their own decisions, such advocates must see that appropriate surrogate decision-making is set into motion.

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FREDERICK T. ZUGIBE, M.D., Ph.D.
CHIEF MEDICAL EXAMINER

March 25, 1998

To: Laura Ziegler
Coalition for Disability Rights

In response to your query as to whether the most recent psychotrophic drugs on the market have a similar potential to cause serious side effects or even death as indicated in my article **"Death Due to Psychotrophic Drugs** (Legal Medicine 1980 edit. by Cyril Wecht , Saunders Publish.Co.), it is my opinion that they do. Moreover, many of the more recent drugs reported touting their safety characteristics have not yet stood the test of time and postmarketing assessment is yet to be fully evaluated. Moreover, drug interactions present a further hazard to their use. Even intensive drug monitoring may fail to protect the patient in some instances.

Frederick T. Zugibe, M.D, Ph.D.

[illegible]

I bring this matter before you out of sheer desperation and the realization that the last twenty years of my life have been destroyed by psychiatric drugs.

The philosophy of mental hospitals is anyone who comes through their doors is crazy whether they are or not and everyone gets drugged whether they like it or not. Innocent people are being victimized by psychiatry. Oh they'll try to justify their atrocities by saying that drugs have lowered the population of mental hospitals but thousands of people are being sent to mental hospitals for 90-day observation periods for merely speaking too loud or at the wrong time in court and as a result having their lives destroyed. I was one of them. I was committed in 1970, at the age of 20, shortly after I got back from Vietnam, because I objected about the pettiness of my crime which was hitchhiking on the wrong side of a sign. When I got to the hospital they told me to take a drug, I said no, and they pinned me to the floor and injected it. I say to you. I shout to the heavens. THERE IS SOMETHING DESPERATELY WRONG WITH THE MENTAL HEALTH SYSTEM AND IT'S GOT TO BE CORRECTED. God never meant for this tragedy to befall mankind. I'm telling you, mental hospitals are houses of horror.

I've been in the jaws of death (Vietnam, 3 bronze stars & purple heart), and death is one thing but psychiatric drugs are hell on Earth. The worst violations of human rights on Earth are happening in mental hospitals. Too many psychiatrists think drugs are the answer to everything. They are even taught that in school. There aren't very many psychiatric drugs that don't harm the brain and other organs in one way or the other. Some of them actually cause illnesses. Tardive dyskinesia is one. Psychiatrists admit to this yet still force patients to take the poison. I know God never meant for the human brain to be tampered with the way they are doing.

There strongest drugs, called phenothiazines, block a natural pain killer called endorphins, produced in everyone's brain and when this blocking action occurs, it causes the victim to go through utter hell and agony all over. Their tongues, throats and bowel movements dry up, speech becomes impaired, tongue swells, loss of control of different parts of the body, even the muscles that control facial expression, and fidgetiness caused by inability to find comfort in any position. It is not possible for you to imagine what kind of hell that is. The body has to have these endorphins in order to completely relax.

These drugs, I call them poison, were made in the early 1950's by some European scientists. Thorazine (also known as chloropromazine), the grandaddy of them all is still the most widely prescribed. They have many different names, made by different companies but all do basically the same thing as thorazine. And that is another part of the problem, all of the pharmaceutical companies that have to meet their quotas. This is like a runaway train and it's got to be stopped.

These people always love so much to say that people with mental problems have a disease. They love to use that word. I have always associated the word disease with an infection of physical matter. Most people that have mental problems just don't have their thinking right and they don't need any drugs that only cause more problems. They love to slap labels on everyone. Different personalities or a manic phase or a depressive phase, most of the time are only love and hate and everyone experiences love and hate.

Forcing people to take drugs against their will is insanity in itself. How can a doctor look a patient in the eye knowing that that patient knows he is forcing an unwanted drug into his body against his will? How can they call themselves doctors? A doctor is supposed to care how his patient feels. If a patient tells his doctor a drug makes him feel bad, then in God's name, what right does that doctor have to say take it anyway? I consider these people monsters- no less than Hitler.

Do you remember when Nancy Reagan used to tell everyone to say no to drugs? Well that should apply inside of institutions as well as on the streets. I like clean blood.

So I summarize by saying that it is obvious that a systematic poisoning of mental patients is taking place in this country, and two things make it obvious: Criminally committed mental patients are forced to take drugs while others are not. & If a mental patient is not psychotic, breaking windows or attacking people what's the need to force drugs into him.

Have you ever seen one of those movies where the victim is pleading for help while the tormentor is all smiles and making everything appear to be all right? That is the plight of the typical mental patient today. It is a silent scream. A horror. What I say is true. I implore you! I beg you to help me make them stop forcing drugs into my body.

God bless you,
Jerome Riche N-23
3102 E. Highland
Patton, CA 92369

P.S. They took a book from me called "Rights of Mental Patients" written by the A.C.L.U. If you can g a copy, can you please wrap a piece of plain brown and get a book store stamp on it. I was going to use it in court. They only let in books from publishers & book stores. If you can't get new looking copy, then please xerox the initial pages including all of the addresses at the back. Or anything you can get on the ill-effects of lithium (newspaper articles etc.). Psychotropic drugs should be abolished. It is time for the people to wake up to the fact that they were a mistake and should never have been invented. It has been ignorance [illegible].

Merry Christmas & Happy New Year

Testimony of Jenelle Johnson
Vermont Legislature
House Judiciary Committee

Re: S. 103 (Community Forced Drugging Bill)
January 28, 1998

Jenelle Johnson: Hello, this is Jenelle Johnson.

Rep [.]: Hello Jenelle, this is the House Judiciary committee in Vermont. We appreciate your taking the time to visit with us.

Jenelle Johnson: Well, thank you for taking the time to listen. I guess I'll just kind of start -- telling you my story. Basically the main thing I want people to know about this is that previously I had no psychiatric history and that this can happen to anyone, it doesn't just happen to the psychiatric population Your brother or you or anyone walking down the streets can get T.D. I didn't know that until about two and half years ago. I got food poisoning really bad. I was admitted to the hospital and given an injection of Reglan.

Immediately after my first injection I had symptoms but they didn't know what it was, and they didn't really diagnose it until I had three -- it was I.V., I believe -- I went into full dystonic posture. My back was arched off the bed and I couldn't breathe very well, it was really awful. They immediately began to try to reverse the reaction with Benadryl and Cogentin and other drugs that are used to reverse these types of reactions. It took my body about two hours to respond to what they're giving me to reverse it. Normal people--I say "normal" in quotes -- usually respond in five or ten minutes. I had been hospitalized for about eight days total that first time I was in. My food poisoning was gone in about three, but I had some major problems after the drug reactions and I was kept in the hospital.

After I was discharged I had all kinds of problems with movement. I had Parkinson's, I had akathesia, I had all kinds of cognitive problems, until about a week I tried to go back--I also should let you know that I am a pre-veterinary student. I was getting A's and B's everything was all good before this happened, but I tried to go back to school and I had -- now I know it's called akathesia. It's a nervous restlessness inside, I can't explain it to you specifically unless you've had it and you know what it's like. I could probably sit in class for about ten minutes, and then I would have to go out in the hallway and pace back and forth and tap. I tried to hide it from people because I didn't want people to see what was happening to me and I didn't understand what was going on.

I went back to the health center, where it was diagnosed as an anxiety disorder and I was given Xanex and I got worse when I was on that. I was probably on it only about four days, because I couldn't stand it. It made me worse, and eventually I was readmitted to the hospital. During that time there [were] a lot of different people that saw me and there [were] a lot of people that now I know diagnosed me correctly, but at that time I was misdiagnosed as psychiatric because of the movements. They said I was either faking or I must have a psychosis and that's why I was acting this way. There was a lot of -- they would threaten me. They came in and told me that if I didn't stop shaking they would take me to the psychiatric ward and drug me. There was a lot of that, that happened and I was terrified. I'd try to hide my hands under the covers when they came in so that they wouldn't take me away. I was very scared, and I knew that it was my body and there was nothing I could do about it. I knew there was nothing wrong with me in the psychiatric sense but at the time when all this is happening to you and -- you know -- you're shaking. I had ballismus, where your hands just -- your arms and legs just kind of throw. I didn't know if -- maybe I was, I started to second guess myself even though it was physical.

Anyway, at that time, because of the second diagnosis, I was given some injections of Thorazine and it made me worse. They still were saying that it was psychotic and -- there [were] just times when I couldn't breathe; my eyes, I had dystonia in my eyes where my eyes would shut really tight. There were all kinds of things that would happen to me. I had a lot of things going on then, but eventually I was discharged from that hospital stay and I'm lucky that I got out of there I think a lot of it had to do with my parents, and you know, that I had people there who helped me get through it, and helped them let me go I guess you might say that if I didn't have my family and my support group I probably would have been taken to the psychiatric unit of the hospital and sometimes now I wonder if I wouldn't still be there just because of the way that the drugs they gave you comatose you, and a lot of stuff that the drugs did to me made me seem like I was psychiatric.

It was very traumatic, but I got out and I went home to my hometown. I dropped out of school and when I got home I went to another doctor at home He knew that I had movement disorder, he didn't know what it was. He basically didn't worry about the records that I brought with me because he knew that most of it was not valid, it wasn't right, and so he tried to make his own diagnosis based on what he saw. He diagnosed me with Seidenham's chorea, which is a movement disorder, usually children get it when they have rheumatic fever But it was another misdiagnosis, and the treatment for Seidenham's chorea is neuroleptics.

I was put on Haldol, and within four days I was back in the hospital with my jaw almost dislocated from dystonia. I couldn't walk. I drooled. I couldn't speak. It got in my tongue and my throat. I had dystonia basically all over my body. A lot of my cognitive abilities were getting worse. I got so that I couldn't remember what people told me five minutes before. At this time he decided to put me on Artane with the Haldol, and I was on both of them for about 2-1/2 months. And during that time I had all kinds of awful things that I went through--hallucinations and seeing things, hearing things, all kinds of stuff that these drugs were doing to me, and knew that it was the drugs, but I thought that the drugs were going to help me get better. And so that's why I told him about it, told people what was going on and it didn't help. Nobody really knew what to do.

I actually ended up going off [the drugs], and this would have been December, so it was actually three or four months after this all had started and I enrolled for school. I had thought that no matter what I wanted to be back here at the university and doing what I loved to do best, and learning, and I knew that I had a lot of difficulties but I just wanted to get back with my life so I came back, and I had a lot of problems with school. It was probably the worst semester that I've done at the university, but it was because I didn't know what was wrong with me and I was having all these problems that no one could really tell me answers to.

About three months later--and I guess its what they call drug holiday, when you go off the drugs and then you kind of get better--so I could walk and things were more normal. I still had some problems with different things, but it wasn't near as severe. About three months later I started limping to class and I called the doctor back and at this time, I started getting akathesia, the nervousness. I started shaking, I had stereotypy , I had all kinds of things that started happening again. I called him up and he said that he thought it was a relapse and so he put me on Thorazine and after I started the drug this time--this time it seemed like I was getting better. It covered up my symptoms so it looked like I was getting better on the drug. I was on Thorazine for about -- and he put me on Artane with it so I wouldn't have to worry about dystonia--the dystonic reactions, anyway--I had some no matter what, but it got better

I was on that for about two and a half to three months, and then I got off of it At this time it was like--I probably felt better than I had in the previous year, jut because this time when I went off of it I really seemed to improve a lot more than I had before And so I enrolled for summer school. I was extremely athletic I have climbed a lot of mountains in the Rockies, in the Tetons, I skied, I swam, I did all kinds of things, and that summer I was jut excited that I could walk and do things again So every day I would go out and go swimming and run every morning on the track I just tried to get back to the way I was, and that probably lasted about three and a half months, maybe four months, and at that time everything came back again So I had a little drug holiday over the summer and then I started my nightmare again

This time it was probably the worst It's the worst it's every been I called my mother the second week of classes in the fall and I told my mother I couldn't walk to class any more at all and I needed to find someone to help me find out what was wrong with me We went to Mayo Clinic and they diagnosed me with a movement disorder--well I could have told them that, but it was all we got. I got a summary record from them that listed everything that they had tested me for and all the possibilities, and at that time I went home.

About this time I was probably pretty much a quadriplegic Within about a month or two I could not feed myself, dress myself, bathe myself. People had to--I had to have twenty-four hour care pretty much. But with my few fingers that worked for typing I sat at the desk and I typed things at the Internet. I matched my symptoms with different diseases and that's when I found tardive dyskinesia. It was sitting on this computer screen in front of me and I read it and I cried. I was basically enlightened as to everything that had happened to me in the past year just by typing a few words into the Internet I showed my parents and we all kind of cried and pondered it together and didn't know what to do rally because no doctors had told us this, we kind of figured it out for ourselves

At this time, I found Dr. Robert Sprague's name on the Internet, when I started searching different things about T.D. and I came here to see him and tell him my story. That's when I knew that that's what had happened to me. Since then I've gotten better. I can push my own wheelchair now, and I can walk but not significantly, when I came back. I do have some significant learning disabilities because of it and the rehab services here are really good to help me out with that. I learned how to compensate for it and ended up doing really good. I got a scholarship and did a lot of things to help myself get back on track in spite of what happened. But that's basically my story. So, if you want to ask questions...

Rep Lippert: Well, first let me thank you for sharing your story. Can I ask, jut to make sure I do understand correctly what initiated all your long series of medications was an incident of food poisoning and not an incident of (pause) mental illness as such?

Jenelle Johnson: Yes, I had campylobacter, which is usually caused by chicken or water. And I was treated with Reglan, which is a gastrointestinal drug that they use for abdominal pain and such.

Rep: I see. And is that initial drug -- I'm not familiar with that drug.

Jenelle Johnson: It's called Metoclopramide It's a neuroleptic and its used mainly for gastrointestinal illness. I think it's one of the highest--and I don't want to be quoted, but I think it's one of the highest incidences of dystonic reactions. It's just not known as well for T.D., because people aren't on it as long as they are on the well known--like anti psychotics, like Haldol and Thorazine

Rep: May I ask, have you taken any steps to protect yourself from future administration of these drugs?

Jenelle Johnson: I have a necklace I wear...(tape change, gap)...I don't go [to doctors] because I'm scared, but when I do go or when I have to get medicine, I tell them, no, I can't have any of these drugs and I list them as allergies because you know, that's what you usually are asked about is allergies and
so I list them so they can't give them to me.

Rep. Little: Does Dr. Sprague -- is he able to relate this T.D. back to a particular person or event or series of events so that he can tell you when the onset of that was in the history you've given to us?

Jenelle Johnson: Let me think here..When I had the reaction to Reglan this was after three injections--I had initial dyskinesia. So, I don't know if at that point its considered tardive dyskinesia, because it's not in the absence of drugs yet. And I don't know exactly how long you have to go without them before its considered tardive, but I was off the drugs, I was off Reglan for about 2-1/2 weeks with severe, severe symptoms. And then when I got back to hospital--and

I don't know how long that might have lasted -- before it might have went away or whatever, but it was pretty severe, so it would have been probably considered tardive if it lasted for very long but because I was given more neuroleptics after I went back that just exacerbated it. The first time--I'm trying to think--when I went off Haldol and Artane, I had a period of time when I looked like I was a lot better and that would have been considered a drug holiday. And so then, when it returned after that, that's definitely tardive dyskinesia and that would have been after only about two and a half months of minimal exposure. I was on maybe a milligram or two a day of Haldol, but the Reglan is what started it. And that was the worst of it and that was three I.V. injections.

Rep. Little: Anyone else? Just for your information, so you know who you're talking to here, this is the House Judiciary Committee with about a quorum, and a number of other people who are in the room as well, some of whom have testified, some of whom my testify, and we are trying to grapple with this piece of legislation and do the right thing with it over the course of the next four or five working days, and you've been very helpful. Does anyone have any questions here? If not then I guess we'll break for lunch. Thank you very much again.

I don't know how long the [illegible] I might have went away or what, but it was pretty severe, [illegible] completely confused [illegible] it lasted for very long because I was [illegible] something was [illegible] just [illegible] The [illegible] going to the [illegible] and [illegible] I had [illegible] word [illegible] considered a drug [illegible] determined they [illegible] that would [illegible] and that was the worse [illegible]

[illegible] work [illegible] questions [illegible]