Testimony 04/12/17

My name is Isabelle Desjardins. I am Vice-Chair of Clinical Affairs with the Department of Psychiatry at the UVM Larner College of Medicine. I am a practicing psychiatrist specialized in inpatient care and geriatric psychiatry. I have direct oversight responsibility for the delivery of care on UVM Medical Center Inpatient Psychiatry Units and I am the Executive Medical Director of the Vermont Psychiatric Care Hospital in Berlin. Thank you for hearing my testimony.

I was asked to provide insights into the efforts my team and the organizations I work for have set forth to address the access to psychiatric care crisis:

In my role, I have to observe the system to identify barriers to quality care:

Increased Length of Stays
Non-adherence with medication treatment outside of the hospital
Need to maintaining trauma informed therapeutic milieu
are clear contributors to the problem.

Regarding Length of stay:

UVMMC is currently in the midst of conducting data extraction looking at all individuals treated on the inpatient psychiatry service for more than 30 days, in the past 2 years. We are looking at days that were spent in the hospital that were not necessary from a clinical standpoint. We are identifying the barriers to discharge, in order to inform future policy decisions regarding step down from hospitals and access to care in the community. This will enable us to calculate the human opportunity cost of those non-acute patient-days and further inform the impact of new policy decisions on wait times for admission.

Regarding non-adherence with medications outside the hospital:

There is a number of individuals who get stabilized in the hospital under court orders for involuntary medications, they get off their medications when they leave and get re-hospitalized with repeated court orders for involuntary medications (patient repeatedly admitted and getting involuntarily treated).

As an example my team and I have provided care to the same individual during 4 involuntary hospitalizations between 2014-2017 - All were directly precipitated by stopping of medication treatment. The individual received court ordered involuntary treatment with medications during <u>all</u> hospitalizations. This amounted to a Total Patient-Days spent in hospital: **286.** This is just one example and there are a number of them.

Regarding the need to maintain trauma informed therapeutic milieu:

Hosting individuals who are presenting with acute exacerbations of their illness and who have demonstrated risk of danger to others is particularly challenging, as it undeniably affects the therapeutic process of all others trying to receive care in a healing environment that is not traumatic.

That is where the importance of weighing an individuals' right to refuse treatment against the right of other patients to receive treatment in a healing, trauma-informed and safe environment of care.

The attention to maintaining a therapeutic milieu for all affects access to inpatient psychiatry beds, as we cannot ethically accept to provide care to someone on a unit knowing that they have a great change to be traumatized or re-traumatized because another patient on the unit is making threats, behaving in a scary fashion or harboring specific paranoid dangerous delusions while awaiting for a court hearing for involuntary treatment to take place.

Given my observations, I support the measures found in the current bill that will 1) encourage patient flow data analysis to inform future policy decisions and 2) streamline involuntary hospitalization and involuntary treatment process.