vermont psychiatric survivors

Equal Rights, Protection and Participation

April 7, 2017

Vermont General Assembly
House Committee on Health Care
c/o Loring Starr, lstarr@leg.state.vt.us

Re: S.133 Testimony
Wilda L. White, Executive Director, Vermont Psychiatric Survivors

Dear House Committee on Health Care:

Thank you for the opportunity to address the House Committee on Health Care this afternoon on S.133. Please accept this letter as a summary of my testimony, as well as an elaboration of some parts of my testimony.

As I testified, I am the Executive Director of Vermont Psychiatric Survivors, a statewide, mutual support and civil rights advocacy organization run by and for people marginalized because of mental health challenges or perceived mental health challenges. Our mission is to insure the equal rights, equal protection, and equal participation of psychiatric survivors. We are a membership organization and I submit this testimony on behalf of our members.

I am also a member of the ED Waits Work Group and the Mental Health Flow Work Group, work groups formed by the Department of Mental Health and Vermont Care Partners, and the Secretary of the Agency of Human Services, respectively, to address the long waits in emergency departments for people presenting with psychiatric complaints. My participation in those groups forms the basis of some my testimony about S.133.

1. **Sec. 1. Findings**

No. (2): The description of Vermont's mental health system as one that "fosters the movement of individuals with psychiatric conditions between appropriate levels of care as needed" strikes us as dehumanizing, as well as establishing a very low bar. When people seek care for mental health challenges, we are not looking for

movement between appropriate levels of care. We are seeking to feel better. We would hope that the goal of S.133 and Vermont's mental health system is to optimize the care that people receive so that they can flourish and live lives of their own design, rather than to optimize the flow through that system without regard to the quality of care delivered and the humanity of the people who rely on the system.

No. (3): Finding Number 3 asserts that Vermont's gradual increase in the number of individuals with psychiatric conditions waiting in emergency departments is due to "hospital flow and other system pressures." This is an unproven assumption and is therefore misleading, as the cause of long emergency department waits has yet to be determined.

No. (4): Finding Number 4 paints a very incomplete picture of the experience of patients with psychiatric conditions waiting in emergency departments. Such patients are subjected to degrading treatment, including removal of their clothing, being watched by custodians, and going days without bathing. One patient reported being assaulted by a staff member. Another patient reported being charged with assault when she resisted the forced removal of her clothing after declining to remove her clothing because of a history of sexual assault.[1]

While it is true that some patients' conditions worsen while waiting in the Emergency Department, it is also true that the treatment some patients receive in the Emergency Department itself becomes a source of trauma from which they must recover in addition to recovery from the condition that brought them to the Emergency Department in the first place.

No. (6): Finding number 6 uses the term "boarded" to describe people who are waiting in the Emergency Department. People who are waiting in emergency rooms for themselves, their children or a loved one, do not find the term "boarded" or "boarders" to be respectful or helpful. We ask that the term "boarded" be replaced with people waiting.

Suggested Additional Findings:

In Vermont, there is no consistent standard for measuring the length of time psychiatric patients wait in emergency departments. There is also no uniform definition of prolonged emergency department waiting, and there are no performance targets for emergency department throughput. There is also insufficient data to measure prolonged waits in emergency departments for patients with psychiatric complaints who go to the emergency department voluntarily.

[1] "A State of Emergency," *Counterpoint*, (Summer 2016, Vol. XXXI No. 1) at p. 1.

The number of psychiatric patients treated in United States emergency departments has been steadily rising. In 2007, 12.5 percent of adult emergency department visits in U.S. hospitals were mental health related, up from 5.4 percent in 2000.[2]

Prolonged waiting in emergency departments for patients with psychiatric complaints is widespread, and is seen across the United States and internationally. [3] Nationally, mental health patients wait more than three times longer for an inpatient bed than non-mental health admissions.[4] Mental health patients are routinely held in emergency departments for days or weeks without access to definitive psychiatric care.[5] Almost 41 percent of psychiatric visits to emergency departments lead to hospital admission –more than 2.5 times the rate of emergency department visits for other conditions.[6]

One study calculated that the financial impact of prolonged waits for psychiatric patients accounted for a direct loss to the emergency department of $1,198 per patient compared to non-psychiatric admissions. When you include opportunity costs, that is, the loss of bed turnover for waiting, non-psychiatric patients, prolonged waits for psychiatric patients cost the emergency department $2,264 per patient.[7]

National research has also shown that not all psychiatric patients wait for prolonged times. Factors associated with long waits include (1) homelessness; (2) inter-hospital transfer; (3) public insurance; (4) use of sitters or restraints; [8] (5) age (children wait longer than adults); (6) co-morbid medical condition; (7) alcohol and substance use; and (8) diagnoses of autism, mental retardation, developmental delay, and suicidal ideation.[9]

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[2] Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: Agency for Healthcare Research and Quality, 2010.
[3] Hoot R, Aronsky, D. Systematic review of emergency department crowding: causes, effects, and solutions. *Ann Emerg Med.* 52.2(2008): 126-136.
[4] Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int.* 2012; 2012:360308.
[5] Kutscher B. Bedding, not boarding. Psychiatric patients boarded in hospital EDs create crisis for patient care and hospital finances. *Mod Healthc*. 2013;43:15-17.
[6] Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: Agency for Healthcare Research and Quality, 2010.
[7] Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int*. 2012; 2012:360308.
[8] Chang G, Weiss AP, Orac EJ, et al. Bottlenecks in the Emergency Department: the psychiatric clinicians' perspective. Gen Hosp Psychiatry. 2012.
[9] Abid, Z et al. Psychiatric boarding in U.S. EDs: A multifactorial problem that requires multidisciplinary solutions. *Policy Brief* (2014); Burke, G and Paradise, J. Safety-Net Emergency Departments: A Look at Current Experiences and Challenges. *The Kaiser Commission on Medicaid and the Uninsured* (2014)

2. Sec. 2. Proposed Action Plan

The bill sets September 1, 2017, as the due date for a comprehensive series of reports analyzing the mental health system. Department of Mental Health Commissioner Melissa Bailey testified before this Committee on April 6, 2017, that by her count, the current version of the bill would require the production of 16 reports by September 1, 2017. In light of what is being requested, a due date of September 1, 2017 seems overly ambitious and impossible to meet if the analysis and action plan are to be useful.

It seems especially unreasonable when one considers the experience of other state legislatures that have also directed their respective departments of mental health to conduct studies on prolonged waits for psychiatric patients in emergency departments. For example, the 2015 Oregon Legislature directed the Oregon Health Authority to conduct such a study. The study started in fall 2015 and was completed in October 2016, with the assistance of Oregon State University's College of Public Health and Human Services serving as consultant.[10]

In 2012, the Massachusetts legislature directed its Department of Mental Health to conduct a study of the Commonwealth's mental health system, including the issue of prolonged emergency department waits for psychiatric patients. Even with the assistance of consultants, the study was not completed until June 2014.[11]

We suggest that the bill pare back the number of reports requested, prioritize the issue of prolonged emergency department waits, and stagger due dates for a significantly reduced number of reports.

3. Sec. 3. Operation of Mental Health System

Section 3 of the bill again focuses on optimizing movement through the system, rather than quality of care. We think this is misguided. In addition, section three seems to focus exclusively on increasing capacity. However, the problems facing the mental health system include issues of both capacity (i.e., supply) and demand.

We urge the House Committee on Health Care to insure that any analysis includes an analysis of the demand side of the equation; specifically an analysis of what is driving demand for emergency department care and how to reduce it. Ideally, we want patients to avoid the emergency department, and if care is necessary, to receive it in the community. We also want to avoid inpatient admissions. Research

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[10] Emergency Department Boarding of Psychiatric Patients in Oregon, Report Briefing. February 1, 2017 Oregon Health Authority Public Health Division.

[11] Massachusetts General Court Mental Health Advisory Committee Report Phase I and Phase II Final, June 30, 2014, submitted by Abt Associates in partnership with The Technical Assistance Collaborative.

has shown that psychiatric patients are at high risk for suicide following an inpatient admission. One study found that women were 246 times more likely than would be expected – and men were 102 times more likely – to die by suicide in that crucial week following discharge from inpatient hospitalization. Chances of suicide remain markedly high for at least a month following discharge from a psychiatric hospital.[12]

We also know anecdotally that psychiatric patients are habituated to seek care at emergency departments when in distress. In fact, hospital discharge papers for psychiatric patients often direct the patient to return to the emergency department if symptoms reoccur. Instead, patients should be directed to outpatient resources, including peer resources, such as warm lines, support groups, peer respites, and advocacy and education groups. Thus, an analysis of prolonged emergency department waits must include what is driving demand for emergency department care and how to reduce the demand.

To this end, Vermont Psychiatric Survivors is undertaking a survey of patients who treated at emergency departments in Vermont since January 1, 2016. A critical question the survey asks is what resources had they been available in the community would have made the emergency department visit unnecessary.

We also urge the House Committee on Health Care to include a provision in the bill that the analysis of Vermont's mental health system consider whether the State is delivering the right kind of care.

There is also an absence of data in Vermont about the scope and dimension of the problem of prolonged waits for psychiatric patients in emergency departments. Quantifying the extent of the prolonged waits is a necessary step in addressing the problem. While the Department of Mental Health has comprehensive data for involuntary patients, involuntary patients account for less than one-third of psychiatric visits to the emergency department and inpatient admissions.[13]

We urge the House Committee on Health Care to include a provision in the bill that mandates the collection of data necessary to quantify the problem and later, to measure the effectiveness of interventions adopted to address the problem.

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[12] Suicide Risk in Relation to Psychiatric Hospitalization Evidence Based on Longitudinal Registers Ping Qin, MD, PhD; Merete Nordentoft, MD, PhD; *Arch Gen Psychiatry.* 2005;62(4):427-432. doi:10.1001/archpsyc.62.4.427. http://archpsyc.jamanetwork.com/article.aspx?articleid=208501

[13] March 22, 2017 Memorandum Re: Update on Managing Data Needs for Flow Workgroup and Reducing ED Wait Times Workgroup

Research in other jurisdictions[14] has shown that the following data are necessary to analyze the problem of prolonged waits:

Prolonged Emergency Department Waits Data

- Age
- Race
- Sex/Gender
- Alcohol and substance use
- Medical problems
- History of aggressive behavior
- Recent mental health admission
- Prisoner status
- Homelessness
- Prearranged bed
- Hospital site
- Day of admission and departure
- Use of restraints/sitters
- Insurance status
- Chief complaint
- Diagnostic category
- Disposition (discharged, admitted, transferred)
- Mental Health Response Time (mental health request to consultant arrival)
- Mental Health Evaluation Response Time (arrival to completion of mental health evaluation)
- Waiting time (completion of mental health evaluation to patient departure from the emergency department)

We also urge the House Committee on Health Care to include in the bill a directive for the Department of Mental Health, in consultation with stakeholders, to create uniform definitions of emergency department waits and performance targets for emergency department wait times.

There is no national definition of prolonged emergency department waits. There is also no uniform definition in the research. However, multiple mental health studies have used emergency department length of stay and its component intervals (medical clearance, mental health response, mental health evaluation, and waiting time after clearance) as a measure of waiting. [15] The Centers for Medicare & Medicaid Services Hospital Compare Web site also uses these measures as a quality metric. [16]

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[14] Pearlmutter, Mark D, Dwyer, Kristin, Burke, Laura, et al. Analysis of Emergency Department Length of Stay for Mental Health Patients at Ten Massachusetts Emergency Departments; *Annals of Emergency Medicine*. 2016; http://dx.doi.org/10.1016/j.annemergmed.2016.10.005

[15] Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int.* 2012; 2012:360308; Chang G, Weiss AP, Orac EJ et al. Hospital variability in emergency department length of stay for admitted patients receiving psychiatric consultation: a prospective study. *Ann Emerg Med.* 2012;58:127-136; Weiss AP, Chang G, Rauch SL, et al. Patient and practice-related determinants of emergency department length of stay for patients with psychiatric illness. *Ann Emerg Med.* 2012;60:162-171.

[16] *See* https://medicare.gov/hospitalcompare/about/timely-effective-care.html.

In terms of performance targets, the Accreditation Council for Graduate Medical Education suggests maximum average emergency department throughput times of four hours for discharged patients and eight hours for admitted patients.[17] Some researchers have suggested six hours as a reasonable throughput time.[18]

VPS endorses a definition of a prolonged emergency department waits to include all patients with emergency department lengths of stay greater than six hours (from arrival to placement), including those ultimately discharged from the emergency department. We also endorse a performance target of no more than six hours as a reasonable throughput time.

4. Sec. 4. Care Coordination

We agree with the focus on designing a system that is easier to understand and to access, and a system with coordinated care. However, we think S.133 also needs to address directly issues of accountability among care providers, and particularly, the practice of cherry-picking of patients that may be driving prolonged waits for some patients.

5. Sec. 5. Involuntary Treatment and Medication

We urge the House Committee on Health Care to strike from S.133 an evaluation of forced treatment and forced drugging.

In the multitude of research studies on prolonged emergency department waits, not one has identified deficiencies in forced treatment laws and forced drugging laws as factors in prolonged emergency department stays.

Section 5 seems completely out of place in S.133, which purports to be an examination of aspects of the mental health system to improve access to care and care coordination throughout the system. None of the findings of S.133 even address the issue of forced treatment and drugging.

Furthermore, forced drugging was taken up by this Legislature three years ago. The Legislature has never addressed the issue of prolonged emergency department waits.

To allocate precious time and resources to forced drugging laws at this juncture would shortchange the analysis of and proposed solutions to the issue of prolonged

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[17] Nolan MN, Fee, D, Cooper, B et al. Psychiatric Boarding Incidence, Duration, and Associated Factors in United States Emergency Departments. *J Emerg Nurs* 2015;41:57-64.
[18] Pines JM, Localio AR, Hollander JR. Racial disparities in emergency department length of stay for admitted patients in the United States. *Acad Emerg Med.* 2009; 16(5):403-10.

emergency department waits, which is a more pressing issue. The people who are being forced to wait actually want treatment.

S.133 as passed by the Senate is unrealistic in the scope of the work requested and the timeline in which to do the work. A more realistic scope of work would exclude a review of forced drugging laws at this time, given the Legislature's review of those laws as recently as three years ago.

Moreover, given that the policy of Vermont is to "work toward a mental health system that does not require coercion or the use of involuntary medication,"[19] it would seem more appropriate to ask the Department of Mental Health at some point to report on the status of its efforts to achieve this goal.

6. Sec. 6. Psychiatric Access Parity

Vermont Psychiatric Survivors supports the spirit of this provision to achieve parity between the mental and physical health systems, however, we are of the view that separate but equal is inherently unequal. It is the fact that the systems are separate that is driving the inequality between the systems.

Nevertheless, we encourage a review of the policies and practices that perpetuate discrimination against people with mental health challenges and those perceived to have mental health challenges.

Examples of such policies and practices that require examination and repudiation include, but are not limited to (1) requiring mental health patients to strip out of their clothing; (2) using custodians as sitters; and (3) allowing ambulances to decline to transport mental health patients to waiting hospital beds after 7 p.m., purportedly so that those ambulances can be available for physical health emergencies.

7. Sec. 7. Geriatric and Forensic Psychiatric Skilled Nursing Unit or Facility

Vermont Psychiatric Survivors does not support the perpetuation of separate facilities for psychiatric patients. These separate facilities are invariably underfunded and under-resourced. While we agree that geriatric patients with mental health challenges are entitled to care that addresses all of their health care needs, we strongly oppose any further segregation of psychiatric patients, regardless of age, into inherently unequal systems of care.

[19] 18 V.S.A. § 7629(c).

8. Sec. 8. Units or Facilities for Use as Nursing or Residential Homes or Supportive Housing

Please see comments above, under number 7.

9. Sec. 9. 23-Hour Bed Evaluation

We urge the House Committee on Health Care to strike from S.133 an evaluation of a 23-Hour Bed facility. First, we are opposed to the perpetuation of separate and inherently unequal systems of care for mental health patients. Second, we already have enough information to know that a 23-Hour Bed facility is unworkable in Vermont. Such a facility would require additional psychiatrists, psychiatric nurses, and other mental health personnel. Those are the most constrained resources in our current system. It is unreasonable to believe that Vermont would be able to staff such a facility given the difficulty of staffing the mental health facilities that already exist.

In addition, given that based on national statistics, more than four of 10 people presenting to emergency departments with psychiatric complaints are hospitalized, those patients would have to be transferred to a psychiatric hospital. We know that transportation is another constrained resource in Vermont. As mentioned above, currently, there are ambulance companies in Vermont that refuse to transport psychiatric patients to waiting hospital beds after 7 p.m. Therefore, psychiatric patients would likely be stuck at a 23-Hour Bed facility until transportation could be arranged, thus further exacerbating the problem of prolonged waits for psychiatric patients.

Third, we are concerned that a 23-Hour Bed facility would simply re-locate the site of prolonged waits. While emergency department staff and non-psychiatric patients would no longer be affected, it would not necessarily reduce waits or improve the quality of care received by psychiatric patients because the constraints in the system would still exist and demand would not be affected.

We also believe that the reason the issue of prolonged emergency department waits for psychiatric patients is receiving any attention at all is because such waits affect hospital staff and non-psychiatric patients. Therefore, we are concerned that moving the problem to another location will result in the phenomenon of out-of-sight-out-of-mind.

We know of at least one jurisdiction that has eliminated waits in emergency departments by funneling psychiatric patients to an emergency psychiatric services facility. While the facility claims to have 69 beds, what this writer saw when she was admitted was patients relegated to yoga-type mats spread across the floor of a room that resembled a large gymnasium with staff seated in chairs around the

room's perimeter. Patients appeared to be chemically restrained. This so-called solution is hidden from the public's view. What the public sees and what it is told, is that the emergency psychiatric services facility has resolved the problem of prolonged emergency department waits for psychiatric patients.

Instead of a 23-Hour Bed evaluation, we urge the House Committee on Health Care to mandate an evaluation of the potential licensure of additional peer respites in Vermont.

Peer respites are voluntary, short-term, overnight programs. They provide community-based, trauma-informed, and person-centered crisis support and prevention 24 hours a day in a homelike environment. Peer respites are staffed and operated by people with lived experience of the mental health system.

In control-group, research studies, guests of peer respites were 70 percent less likely to use inpatient or emergency services. Respite days were associated with significantly fewer inpatient and emergency service hours.[20] Respite guests showed statistically significant improvements in healing, empowerment, and satisfaction. Average psychiatric hospital costs were $1,057 for respite users compared to $3,187 for non-users.[21]

Respite guests also experience greater improvements in self-esteem, self-rated mental health symptoms, and social activity functioning compared to individuals in inpatient facilities.[22]

10. Sec. 16. Pay Scale; Designated and Specialized Service Agency Employees

We support raising the salary of mental health workers to competitive levels.

We are concerned that the approach proposed by the Senate Committee on Appropriations is too little, too late.

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[20] Croft, B, & Isvan, N. (2015). Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services, *Psychiatric Services*, 66(6), 632-637.
[21] Greenfield, ., Stoneking, B, Humphreys, J, Sundby, E, & Bond, J. (2008). A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis. *American Journal of Community Psychology*, 42(1), 135-144.
[22] Dumont, J, & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook* (Vol. Spring 2002, pp. 4-6). Cambridge, MA: Evaluation Center @ HSRI and National Association of State Mental Health Program Directors (NASMHPD) Research Institute.

11. Other Issues

We urge the House Committee on Health Care to return to the bill a measure that would fully fund a 24-hour warm line as envisioned by Act 79.

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Thank you again for the opportunity to testify on S.133.

Very truly yours,

Wilda L. White