vermont psychiatric survivors

Equal Rights, Protection and Participation

January 15, 2018

State of Vermont Senate Chamber
Senate Committee on Health and Welfare
115 State Street, Room 17
Montpelier, VT 05633-5301

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State of Vermont House of Representatives
House Committee on Health Care
115 State Street, Room 45
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Re: *Addendum to Report to the Legislature on the Implementation of Act 82 – Section 5: Involuntary Treatment and Medication Review*

Dear Senate Committee on Health and Welfare and House Committee on Health Care:

Pursuant to Act 82, section 5, subdivision (b),[1] Vermont Psychiatric Survivors submits this addendum to the Secretary's report. The section headings used in this Addendum refer to the section headings in the *Report to the Legislature on the Implementation of Act 82 – Section 5: Involuntary Treatment and Medication Review*.

In Act 82, the Vermont legislature asked the Secretary of Human Services, in collaboration with the Commissioner of Mental Health and the Chief Judge, to analyze and submit a report regarding the role that involuntary treatment and psychiatric medication play in inpatient emergency department wait times, including any concerns arising from judicial timelines and processes.

Vermont Psychiatric Survivors has studied extensively the problem of prolonged waits in emergency departments for psychiatric departments. In 2017, we conducted a review of

[1] (b) On or before January 15, 2018, Vermont Legal Aid, Disability Rights Vermont, and Vermont Psychiatric Survivors shall have the opportunity to submit an addendum addressing the Secretary's report completed pursuant to subsection (a) of this section.

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peer-reviewed research articles that addressed the issue.[2] Our review revealed that prolonged waiting in emergency departments for patients with psychiatric complaints is widespread, and is seen across the United States and internationally.[3] It is a phenomenon in every state notwithstanding laws and timelines pertaining to involuntary treatment and forced drugging.

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]

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

Our review of peer-reviewed journal articles did not disclose a single instance where prolonged waits were attributable to policies regarding involuntary treatment or forced drugging, including any concerns arising from judicial timelines and processes.

Therefore, it seems reasonable to conclude that there is very little, if any, connection between prolonged waits in emergency department and laws and timelines pertaining to involuntary treatment and forced drugging.

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[2] *See* http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Literature_Review_of_ED_Waits_Presented_Aug_17_2017.pdf

[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] Chang G, Weiss AP, Orac EJ, et al. Bottlenecks in the Emergency Department: the psychiatric clinicians' perspective. Gen Hosp Psychiatry. 2012.

[7] 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)

1. Adequacy of housing and community resources available to divert patients from involuntary hospitalization

The lack of safe, affordable housing surely contributes to very full psychiatric hospitals and prolonged waits in emergency departments for both voluntary and involuntary patients.

VPS has sought to understand what is driving the demand for emergency department mental health care. We developed a survey that is intended to ascertain what brought people to the emergency department and what services had they been available in the community would have obviated the need to visit the emergency department. The survey results are not yet available.

We also conducted in-depth interviews with 25 individuals who visited Vermont emergency departments in the last two years, and with their permission, we reviewed their medical records. We wanted to review the records to determine if what individuals told VPS about their ED visit differed from what they told staff at the ED. We also wanted to review the medical records to help refine the survey. The people interviewed were not randomly selected. They were individuals known to VPS and whose records we already had for other purposes or whose records were easily obtainable.

The demographics broke down as follows:

Gender			Residence		Presenting Problem	
Male	Female	Avg Age	Housed	Homeless	Mania	S.I.[8]
42%	58%	49	25%	75%	16%	84%

The medical records review revealed that individuals experiencing homeless had more frequent emergency department visits over the two-year, study period compared to people adequately housed. Individuals experiencing homelessness averaged five visits per year; individuals adequately housed averaged one visit per year. The average length of hospital stay was also longer for individuals experiencing homelessness (21 days) than for individuals who were adequately housed (3 days). Individuals experiencing homelessness and individuals adequately housed had roughly the same breakdown of diagnoses (major depressive disorder, bipolar disorder, schizophrenia, and PTSD). The only difference was that individuals experiencing homelessness had a slightly higher incidence of both substance use issues and a mental health diagnosis.

Nearly all the individuals experiencing homelessness presented to the emergency department because they were homeless. While they reported suicidal ideation, they also reported feeling suicidal because they were experiencing homelessness. For example, an

[8] S.I. refers to Suicidal Ideation.

entry in one individual's medical record stated: "I overdosed on Prozac because I had nowhere to go." He made this comment after his second hospital admission. There had only been a three-day gap between his first and second admission.

For individuals who were not experiencing homeless, the precipitating event that led them to the emergency department included the pain of isolation, marital discord, and mania.

In none of the cases were the events that precipitated the trip to the emergency department addressed while the individuals were hospitalized.

When asked what would have made the trip to the emergency department unnecessary, the most frequent responses were housing (75%), friends, supportive family, physical affection, and someone to talk to.

It is unclear how generalizable are these results. However, we have seen the impact of providing housing. For those individuals for whom VPS has helped to obtain housing, and/or Supplemental Security Disability Income (SSDI), their trips to the emergency department ceased.

The lack of safe and affordable housing, it appears, both brings individuals to the emergency department and also keeps them stuck in psychiatric units[9].

2. Other Characteristics of the mental health system that contribute to prolonged stays in hospital emergency departments and inpatient psychiatric units

In our experience, the current practices surrounding Orders of Non-Hospitalization (ONH) more likely than not shorten hospital length of stays. Most ONHs are achieved through stipulation. The people we work with through Vermont Psychiatric Survivors tell us that they stipulate to ONHs to get out of the hospital faster. In reading many of these ONHs, I have come to the conclusion that many of the ONHs entered pursuant to stipulation would not survive judicial scrutiny because the individuals are competent to weigh the risks and benefits of the proposed treatment.

We have also seen applications for ONHs for people who voluntarily take medication and attend all their appointments. They are simply not getting better. That is, despite taking medication and making their appointments, they are still suicidal or make frequent trips to the emergency department. In these instances, the application for ONH feels like a punishment for being ill, and creates more trauma for the person affected.

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[9] *See* Inpatient Psychiatry Barrier Days Analysis (May 31, 2017) which can be found at http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Inpatient_Psychiatry_Barrier_Days_Analysis.pdf

Many have told us that it was not until an ONH was entered against them that they truly wanted to die. The loss of agency and the feelings of powerless were too much to bear. One woman said she stopped eating and stopped leaving the house for one year after she stipulated to an ONH to get out of the hospital. Another woman said that her trips to the emergency department increased after an ONH because she didn't want to live after losing her right to make her own decisions. Many say they regret that they stipulated to an ONH.

In short, in our experience, ONHs have increased visits to the emergency department and have increased distress.

We have also seen that a number of individuals on ONHs become more interested in getting off the ONH rather than taking charge of their wellbeing. Their focus becomes misplaced. They focus more on what the State is supposed to do for them rather than what they can do for themselves. We see them cycling through the system, from the emergency department to the psychiatric unit, to a step-down unit, to temporary housing, and back to the emergency department.

3. Interplay between the rights of staff and patients' rights and the use of involuntary treatment and medication

We think a question about the interplay between the rights of staff and the rights of patients and the use of involuntary treatment and medication is a question better directed to legal counsel rather than the Secretary of Human Services and the Commissioner of Mental Health.

We also believe that the place to look to determine the interplay between the rights of staff and patients is the law, and not "input directly from direct care staff members." (*Report to the Legislature on the Implementation of Act 82 – Section 5: Involuntary Treatment and Medication Review* at p. 10.)

The rights of patients can be found in the Vermont and United States Constitutions and the case law interpreting them. The Vermont Constitution explicitly states that people are born free and enjoy freedom from restraint as a natural, inherent and unalienable right. Vt. Const. ch. I, art. 1. The United States Supreme Court and the Vermont Supreme Court have repeatedly recognized that involuntary treatment and medication constitutes a massive curtailment of liberty, and requires due process protection. *Addington v Texas*, 441 U.S. 418, 428; *In re E.T.* 2004 VT 111, ¶7 (describing "the Vermont Constitution's presumption that freedom from restraint is a fundamental, inalienable right".)

The "liberty interest at stake in involuntary commitment proceeding is as valuable an interest as liberty interest at stake in criminal proceeding." *G.T. v. Stone*, 159 Vt. 607, 611 (1992). And where involuntary treatment is accompanied by compelled medication,

the concerns about liberty are heightened because "[a]mong the historic liberties protected by the Due Process Clause is the right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security." *Vivek v Jones*, 445 U.S. 480, 492 (1980).

"The loss of liberty produced by involuntary commitment is more than a loss of freedom from confinement. It is indisputable that commitment to a mental hospital can 'engender adverse social consequences to that individual' and that '[w]hether we label this phenomena 'stigma' or choose to call it something else … we recognize that it can occur and that it can have a very significant impact on the individual." *Addington v Texas*, 411 U.S. 418, 425 (1979).

It is constitutionally impermissible to lock a person up against his will simply because he has been found "mentally ill," or to drug a person against his will simply because he has been found "mentally ill" if he is dangerous to no one. *O'Connor v. Donaldson*, 422 US 563 (1975).

Direct care staff members have no constitutionally protected right to be free from "compassion fatigue." Direct care staff members have no constitutionally protected right to render the "accepted standard of care" to unwilling patients. Direct care staff members have no constitutionally protected right to have patients, in their opinion, not suffer needlessly.

In *O'Connor v Donaldson*, the court wrote:

> "May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well as ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty."

In other words, the State does not have the right to forcibly medicate a patient simply because direct care staff is uncomfortable with his suffering or believes medication would help or believes the medication is the accepted standard of care.

We are not insensitive to staff's concerns about violence towards staff from some patients. However, the accounts from direct care staff in the Act 82 report conflate violence and psychosis. These reports imply that psychosis and violence go hand in hand. That is simply not the case. I say this as someone who suffered a protracted, medication-induced psychotic episode. During this protracted episode, I was not involved in a single act of violence towards myself or others. In my position as Executive Director of Vermont Psychiatric Survivors, I meet people in the community almost daily who mental health workers would consider psychotic, and they too are non-violent.

Moreover, there are procedures already in place to address violence from patients. Rather than painting all patients with the same, broad, stereotypical brush of violence, patient violence must be viewed individually and addressed individually.

It is both unfortunate and remarkable that the Secretary of Human Services and the Commissioner of Mental Health did not see fit to include in their Act 82 Report the voice of a single person who lives with the threat of involuntary treatment and forced drugging, which includes anyone who has been labeled with a mental illness.

However, it is not surprising. On August 17, 2017, the Commissioner of Mental Health convened a public hearing on the topic of involuntary treatment and forced drugging. Neither the Commissioner nor Deputy Commissioner bothered to attend. Those that did attend to represent the Department of Mental Health (DMH) were there in body only. Below is a photograph of DMH staff at the meeting. The photograph was taken during the meeting. All three, including DMH's General Counsel (photo middle), are engrossed with their phones.

This level of inattention and indifference when such sacred liberties are stake is appalling, and should not be countenanced by this Legislature. No person in Vermont who has been labeled with a mental illness can feel safe or respected or valued as a human being in the face of this blatant disregard of our voices and concerns.

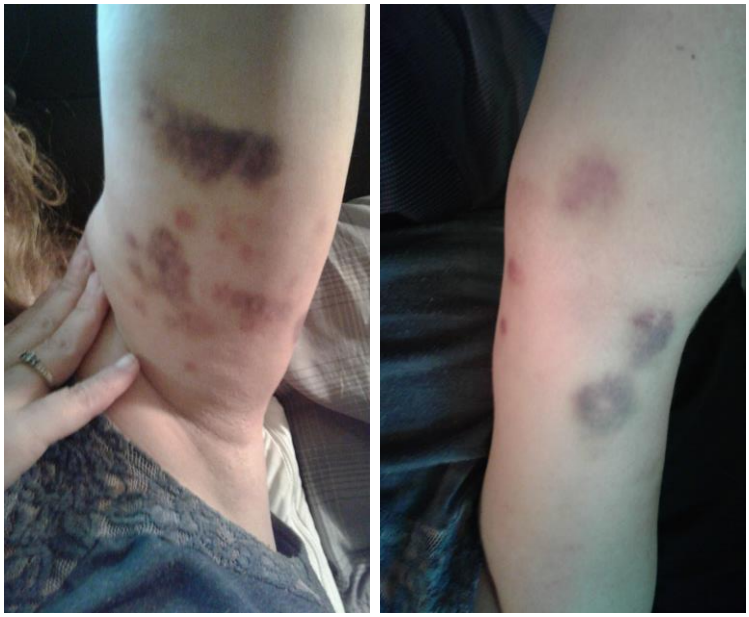
Involuntary treatment and forced drugging are traumatic not only for people subjected to it but also for people who might be. Again, this includes anyone who has been labeled with a mental illness. We live in fear that on very little evidence and with even less recourse, our agency and thus our humanity can be taken from us. The rush to drug us only exacerbates this fear.

The following is an account from a person who describes how she was traumatized simply by the loss of her rights, despite being treated well when she was hospitalized after a suicide attempt:

> After reading other people's accounts of their hospitalizations, I can appreciate just how well treated I was at my hospital. The nurses and techs were kind and respectful, medications were not forced on me – they were strongly recommended, but I was allowed to refuse them. I was not strip-searched or restrained in any way, and the facility itself was comfortable and well funded. There was even a swimming pool. I couldn't go in because of my stitches, but I could sit on the side and dangle my legs in.
>
> And it was still one of the most traumatic experiences of my life. Even though I wasn't mistreated, I was still locked up against my will. It was terrifying to suddenly have no voice, to be transformed from normal college student into someone who was "mentally ill" and therefore unable to determine what was best for myself. I knew that I did not belong in the hospital, but my thoughts and feelings meant nothing. It's hard to describe just how scary it is to be treated as if you are crazy, and know that there is nothing you can do to prove to the other person that you are not.
>
> After my 72-hour hold was up, I thought I would be released, but they told me they had filed papers to keep me indefinitely. I had been easy-going and pleasant up to that point. Even though I knew I didn't belong in the hospital, I could understand why they put me there, but hearing them say that was totally surreal and awful, and I stopped cooperating. I requested a lawyer, saw him the next day, and a few hours after our meeting I was released.
>
> Once I got out I had nightmares for years about being back in the hospital. I tried not to think about what happened, but the knowledge that my agency and voice could be taken from me at any time dominated my thoughts for years afterwards. I still managed to finish college, go to graduate school, and become successful in my career. I think the worst consequence of the hospitalization was that it scared me away from contact with mental health professionals for a long time afterwards. It is only in the last few years that I have started seeing a therapist again, and I feel sad that I went so many years of my life without help because of my experience at the hospital.

(Miller, Dinah, Hanson, Annette (2016). *Committed: The Battle Over Involuntary Psychiatric Care.* Baltimore: Johns Hopkins University Press at pp. 58-59.)

In July, a patient sent a dozen photos to VPS after she was forced drugged with Haldol. We include two of the photos here.



VPS Patient Representatives work in designated hospitals advising patients of their rights and assisting patients in working with their treatment teams. In the course of this work, VPS Patient Representatives have observed that many patients who the State has sought to force drug are not seeing a lawyer before the hearing, receive late notice of hearings, receive no notice of a combined hearing, and simply do not understand the legal process taking place around them.

Individuals subject to force drugging are routinely deprived of a support person in the courtroom. Individuals frequently ask VPS Peer Advocates to accompany them to court and to sit with them in the courtroom. However, after the Peer Advocate arrives, they are routinely not allowed in the courtroom, which seems to be a direct violation of Vermont law which states:

> The proposed patient may at his or her election attend the hearing, subject to reasonable rules of conduct, and the court may exclude all persons, ***except*** a peer or other support person designated by the proposed patient, not necessary for the conduct of the hearing. (emphasis supplied)

18 V.S.A. §7615 (e).

Rather than rushing to forcibly drug an individual, the Legislature should work to insure that individuals are accorded all the process that the Constitution demands

before they are subjected to this "massive curtailment of liberty." *Humphrey v. Cady*, 405 U.S. 504, 509.

Mandate to Treat

1. **Reduce timeline for applications for involuntary medications (AIM) in Forensic cases**

Vermont Psychiatric Survivors opposes the rush to forcibly drug individuals involved with the justice system based simply on their status.

Other ideas to explore

2. **Allow private guardians to consent to psychiatric medications**

Vermont Psychiatric Survivors opposes allowing private guardians to consent to psychiatric medications. For decades I served as the guardian of my brother and in that capacity I was permitted to consent to psychiatric medications. I did so, and today I live with immense guilt as I have watched my brother lose his thyroid, suffer kidney failure, move uncontrollably because of tardive dyskinesia, balloon in weight, lose his teeth, and endure daily injections to control diabetes, all side-effects of the medications I approved. I was never informed of the medications' side-effects.

Interestingly, as soon as I balked at consenting to psychiatric medications, his health care providers wished to have me removed as his guardian.

If a guardian cannot both consent to and refuse psychiatric medications, appointing a guardian is a farce and in all likelihood constitutionally impermissible.

3. **Amend current statutory language regarding expedited motions**

Vermont Psychiatric Survivors opposes amending the current statutory language regarding expedited motions.

4. Administrative Option

Vermont Psychiatric Survivors opposes the "Administrative Option." The liberty interests involved require an adversarial procedure overseen by a member of the judiciary, not another doctor, whose training and experience teach him to treat, and forcibly, if he deems necessary.

Very truly yours,

Wilda L. White