2/8/21

Re: Middlesex TCR replacement facility

To Whom It May Concern:

I am a Vermont resident, psychiatric survivor, social worker, manager at a designated agency, and member of the Adult Mental Health Standing Committee. I am writing in opposition to the Governor's budget due to the inclusion of $11.6 million allocated for the construction of a "secure residential" to replace Middlesex Therapeutic Community Residence.

It is not too late to abandon this project which has somehow gone without the attention of advocates. The State should cut its losses on the proposed Middlesex replacement facility and instead invest in meeting people's basic needs like affordable housing and voluntary supports such as the White Paper submitted by Alyssum, Another Way Community Center, Pathways Vermont, and Vermont Psychiatric Survivors in 2019. Please take the time to seriously consider the concerns below.

In short:

- Having a Therapeutic Community Residence (TCR) that is locked and uses restraint, seclusion and forced drugging is an **unprecedented** expansion of coercive practices as no other TCRs, including the current Middlesex facility, uses restraint, seclusion or forced drugging.
- The proposed facility is functionally a hospital in its design, practices, staffing, and cost. Calling this facility a residential program is a misnomer and inappropriate. The proposed facility should be thought of as a **second state hospital** rather than as a residential program.
- Data from the existing state hospital (VPCH) shows that 15% of the people incarcerated there are "non-white" (people of color). This is consistent with research showing that people of color are over-represented in psychiatric incarceration while being underserved in the community. This is a **racial justice issue** as well as a disability justice issue.
- DMH, DAs, advocates, and people receiving services all agree that there is a desperate and chronic need for increased funding for community resources and hospital alternatives. The significant amount of money that would be required to build and operate this unnecessary facility would be **better spent** on meeting people's basic needs and expanding voluntary services.

The way that this issue has been discussed and framed so far is not quite honest and has involved co-opting and euphemistic language to glaze over the uncomfortable reality of what is proposed. To illustrate this I have transcribed and responded to some quotes from DMH's testimony to the House Committee on Corrections and Institutions on 2/5/21:

“In order for us to improve what we call “flow” in the system, it’s our ability to step folks down from those inpatient beds in a timely way that allows people waiting in those emergency departments to then access that bed”

A) The proposed “secure residential” is not a step down from inpatient- it is the same level of care being marketed as a lower level of care. When DMH was asked during a stakeholder meeting about how the new “secure residential” would be different than a hospital the only response was “it’s different in the intention.”
B) There is more involved in improving “flow” in the psychiatric incarceration system than having other institutions for people to be transferred to, and there are better ways to solve this problem than with more incarceration. There is a huge need for other resources in the community so that we don’t end up in the ER in the first place. This includes housing, spaces to go to that are tolerant and friendly toward people in extreme states and open 24/7, education for the community in how to support people in distress, peer respites (which would be more accessible to some people who would not voluntarily participate in clinical models), and more voluntary community supports. Many people end up psychiatrically incarcerated (“hospitalized”) because there are insufficient, unsafe, or non-existent community resources and they are delayed in leaving the hospital for the same reasons.

“Our goal is really to expand and build a secure recovery residence that has expanded clinical capacity that ensures the safety and wellbeing of residents in a setting that is recovery oriented and promotes rejoining and rebuilding a life in the community”

It is a gross co-optation and misapplication of the term “recovery oriented” to use it to describe a prison-like environment in which “care” involves seclusion, restraint (including strapping people to a restraint chair in a seclusion room), and forced drugging (which often involves holding someone down, partially undressing them, and injecting a tranquilizer/neuroleptic into their buttocks in response to non-compliance). It is hard to imagine what “rejoining and building a life in the community” looks like while living behind locked doors. This rhetoric is a misrepresentation of what is actually proposed.

“The target population is individuals with higher treatment acuity who are ready to discharge from hospitals but not yet ready for intermittent support and supervision in community-based settings or programs and may be unwilling to voluntarily reside at the facility”

The proposed facility is hospital level of care therefore the target population cannot be people who are ready to discharge from the hospital. “Intermittent support and supervision” is an inaccurate way to describe some of the other step-down options like Intensive Recovery Residences (IRRs). At IRRs such as Second Spring, Meadowview, and Hilltop, support is available 24/7 and supervision is constant, which is why such facilities are referred to as “staff secure.”

“We really want this to be a state of the art, trauma-informed recovery residence for Vermonters”

Facilities that involve practices which have been described by many survivors as torture and are widely acknowledged to be traumatizing are clearly not trauma-informed. It is not trauma-informed to detain someone in a locked space, let alone for 6-18 months. It is not trauma-informed to forcibly inject people with a psychoactive substance. It is not trauma-informed to isolate people in distress. It is not trauma-informed to hold someone down or tie them up. When informed about the dangers of using a restraint chair by a community member, DMH said, “prisons use restraint chairs all the time.” This demonstrates the synonymous and traumatizing nature of prisons and locked psychiatric facilities.

“We also wanted a site that would mitigate any IMD risks...We do want to be thoughtful about where we geographically locate the facility so it does not become considered part of VCPH as we go forward.”

The fact that the facility could be considered part of VCPH underscores the fact that this “secure residential” is in fact a hospital (which is a type of incarceration). Does Vermont, in 2021 as the general public is beginning to understand the harm of carceral systems, want to create a second prison-like state-run locked psychiatric facility? Is there confidence that the public is aware of and supports this expansion of psychiatric incarceration? Have advocates been involved in the process in a way where their concerns have been taken seriously? The answer is clearly no. I voiced opposition to this project years ago in a DMH standing committee and that information never reached the commissioner even though the purpose of the committee is for representation of the public and people served. When strong concerns were raised in stakeholder meetings last year those concerns were only dismissed. The legislature owes the public an opportunity to consider and give input on this issue in 2021.

“We at the department and at the state highly value voluntary treatment”
“Expanding peer services and peer programs is a top priority”

This voiced commitment to voluntary and peer supports has not been demonstrated by the state’s increased investment in incarceration. There will be new inpatient beds opening this year at the Brattleboro Retreat and there have been plans to add beds at Central Vermont Medical Center (CVMC), in addition to the 16 new inpatient beds that will be created by the Middlesex replacement facility. While the state is paying a huge amount for these carceral facilities, peer support is only being paid lip service.

“...By adding the levels of security here one part of that is the attempt at helping an individual maintain in treatment until they’re better able to have that self insight and ability to maintain connection with services that support them in the community. And so when we’re talking about fences and things of that sort, that’s a primary rationale for that work, to help individuals remain in treatment longer than they would in a voluntary unlocked setting to, again, to try to prevent

that kind of vicious cycle of hospitalization, discharge, decompensation, hospitalization, and, quite frequently in an involuntary manner."

> The argument that DMH is making is that they need to involuntarily incarcerate people in a locked facility continuously because if they don't then those people will be incarcerated periodically. The Olmstead Act says that people need to be supported in the least restrictive setting. People are only discharged from the hospital when they are assessed to no longer need hospital level of care. To keep them incarcerated in a hospital level of care (which includes the proposed "secure residential") beyond that timeframe would violate that principle of supporting people in the least restrictive setting.

"An argument that is frequent for me with attorneys and, you know, our own attorneys, is that , you know, someone who is on a court order, that clearly means it's involuntary because the court is ordering you to a place. The reality is though we work with individuals and folks who are going to Middlesex residence are individuals who have said they're willing to go and work with the court and understand they're on a court order and such like that."

> This is like saying that when someone takes a plea deal they are agreeing to go to prison. People who are psychiatrically incarcerated often cannot leave until they "agree" to what the system wants them to agree to. This should not be misconstrued as voluntary choice.

"For a small cohort of individuals, particularly those who have been receiving treatment and care in one of our level one facilites, a more secure residence is actually more in their clinical interests and needs so that we can stabilize them so that if someone who has a history of elopement doest find themselves in the middle of winter, you know, out in a dangerous situation."

> The likelihood of people experiencing harm in long term incarceration at a facility like the proposed "secure residential" is high while the likelihood of people dying of hypothermia in an IRR because the doors are unlocked is quite low. When I worked at an IRR, a resident did leave in the winter while it was snowing. I accompanied them and eventually they accepted a ride back to the house. Later, we made an agreement that if they felt cooped up they could let someone know and then go for a drive or a walk. While incarceration is thought to prevent harm, people are much more likely to die by suicide after psychiatric incarceration. A 2017 study found that, "In this meta-analysis of 100 studies of 183 patient samples, the postdischarge suicide rate was approximately 100 times the global suicide rate during the first 3 months after discharge and patients admitted with suicidal thoughts or behaviors had rates near 200 times the global rate. Even many years after discharge, previous psychiatric inpatients have suicide rates that are approximately 30 times higher than typical global rates."

"This step down is what we need otherwise we are going to continue to see people waiting."

Again, the proposed facility is NOT a step down from hospital level of care. There are other solutions to addressing the issue of ED wait times. Primary among them is giving people access to other places to go for support in the first place, such as the community centers and peer respites that were proposed in this 2019 White Paper, and ensuring that all Vermonters have the basic right of housing. DMH's stated plan is to increase psychiatric incarceration and then, theoretically, to increase funding for community supports. This is backwards. Psychiatrically disabled people have the right to be supported in the community, and this also happens to be more affordable and more effective than incarceration. If we build all these hospital beds before expanding services in the community there is no chance for reducing incarceration because those beds will demand to be filled. If they aren't filled then the state will have spent millions upon millions on something that is both unnecessary and harmful.

Respectfully,

Malaika Puffer