Dear committees working on the question of possibly building a psychiatric facility in Middlesex,

I did an individualized bachelor of science degree at Keene State College focusing on mental health care reform. I began as a sociogy major taking other courses in nutrition, exercise science, psychology, and so on. Then, after my advisor died, I reorganized it into a degree that went directly at my question. While I was working on my degree, I was on the board of a peer support agency in New Hampshire.

I have lived experience of psychiatry, all of it previous to 1995. I have had outpatient psychotherapy after that, but not any drugs or inpatient things. I have found that physical activity, good nutrition, massage, and outpatient psychotherapy are very helpful. I, like many people, found the drugs harmful. Drugs affect different people differently. They are only helpful to a minority of people who take them. They're not a panacea. Forcing drugs onto patients, and a primary mental health modality, is a faulty idea, because it will harm most people, even if a few feel helped by it. It doesn't work to cherry pick patients who feel helped. Most are harmed. That's statistically true from the data. Mental health care has to be individualized via a dialogue between care providers and patient. This process is undermined or prevented if there is coercion. Coercion really does not help with "compliance" because it alienates the patient from the dialogue with providers and it gives providers too easy a shortcut so they can avoid the real work of communicating with patients. It seems like an easy "out" but it's actually just a way of not doing the job while pretending to do the job.

Psychiatry is a for-profit industry, backed by pseudoscience that took root during the Holocaust (as arguments for mass killing of people deemed mentally ill) and still persist today (as arguments that support a for-profit psychiatric industry). A lot of what is believed in psychiatry does not stand solidly on valid scientific data, and a lot of practices in psychiatry are not grounded in reasonable ethics. When listening to people from the psychiatry industry, make sure you are thinking for yourself and adequately questioning what you are hearing. There is a lot of money to be made and a lot of profit motive.

Part of what I did was explore what types of treatments have what outccomes. I still pay attention to that. You need to look beyond what appears to solve immediate problems, and think about the probable long-term outcomes of proposed practices.

My understanding is that a new psychiatric hospital is proposed in Middlesex to decrease wait times of psych patients in emergency departments and to keep people in treatment longer. The new psychiatric hospital is being thinly disguised as some other kind of residental treatment program, but if you look at the details of the proposal, it's abundantly clear that it is a psychiatric hospital.

One thing you should know is that you won't fool CMS regarding the IMD exclusion. It's a psych hospital, and plenty of people will make sure CMS knows that. CMS won't pay. You won't fool them. Don't play that game. You won't win it. You can spend a lot of money on it and you will find that CMS won't give you a cent.

The long term outcomes of keeping people in psychiatric hospitals that use coercive and abusive practices like restraint, seclusion, and forced drugging, are dismal. Chronic, extreme trauma,

long-term distrust of and fear of mental health care, and a lack of valuing one's own life (leading to suicidal tendencies, drug addiction, and tendencies to get in horrible accidents and get sick) are among the long term outcomes. It does not lead to good treatment adherence. It leads to people hating and mistrusting mental health care, for the rest of their lives, and being against any mental health care at all, for the rest of their lives. Treating people as non-compliant is self-fulfilling- if you force them to participate in things they don't find helpful, they will be less willing to engage with you. It creates a negative cycle. The fact that the outcomes are horrible, is one reason why CMS doesn't pay for long term institutionalization in psych hospital settings. So don't do it. Don't just do it and use euphemism-filled rhetoric to try to get away with it. Don't try to get away with it. Don't do it.

The fact that an attempt is being made to circumvent longstanding rules of what is and is not funded by CMS is a demonstration of how very backward and archaic this proposal is. It is kind of ridiculous. It's not within the scope of normal modern standards of care. That's why CMS doesn't pay for things like it if they're decribed honestly. Let's not try to drag up a bad practice from the past and try to get it paid for by lying about what it is. We don't need to do that. Better practices exist. That's why things like this aren't allowed.

There are better ways to solve the problems. Too many psych patients waiting too long in emergency departments can be largely resolved via more other places for people to go in a mental health crisis. Maybe some people really need to go to the emergency department, but many would do as well or better going to a peer-run crisis respite, or giong to a service provided by a community mental health center, seeing a therapist, or turning to peer support. We know that those services are all extremely scarce in most or all Vermont communities. We have a wonderful peer crisis respite, but it's so over-booked all the time, it's almost never available for crises. It's too booked out. It ends up being more like a vacation timeshare, and isn't useable for its intended purpose, because the demand is so much higher than the supply. We desperately need more of them. The state of Vermont should be funding at least one more peer-run crisis respits. I think it would be better to fund two more of them, for now, and make a 10-year plan to have one in every county 10 years from now. They would take a massive load off of emergency departments, and would be more bemeficial than going to the emergency department, allowing people to keep their self-determination while weathering a crisis.

Another thing we desperately need ss more access to psychotherapy. One thing that would help a great deal with this is if there could be a law de-coupling services, saying that psychiatrists don't get to require their patients to see a certaion psychotherapist or a psychotherapist from a certain organization, in order to see them, and vice versa- psychotherapists aren't allowed to require people to see psychiatrists or to take pscyh drugs, in order to see them. This would allow more people to access psychotherapy. Another change that would help is to allow Medicaid to pay registered but not licensed psychotherapists. This would give people access to a greater number of and a greater variety of psychotherapists. There could be a requirement that the psychotherapists who are registered but not licensed, have regular supervision with a licensed psychotherapist. I personally know some people who went to the emergency room and then psych hospital just because they could not find psychotherapy in the community. Shortages of psychotherapy in the community defeinitely add to the emergency department problems.

Also, the legislature should de-couple group programs from individual services, by disallowing any requirements to participate in one in order to have access to the other. A person who sees a psychotherapist who is not affiliated with the community mental health agency in their county should still be able to participate in that agency's groups, in-shape program, etc, and vice versa. This would make sure that everyone has access to all the services. If a group service like In-Shape gets oversubscribed, hire and train more staff. Maybe some participants can even graduate to being trained to be staff.

I also see a need for more housing, supported housing, and maybe another staff-secure 24/7 support voluntary residential program that doesn't use forced drugging, restraints, or seclusion, so that people can leave the hospital and have enough housing and enough support. There should be lots of possible structures for housing and supported housing. Some people need to live alone, but might need help with cleaning and shopping and stuff. Some people need to live with a helper. Some people would do well in a "family" like environment, and some would find that too infantilizing and would be better off with a more adult-like shared 2-bedroom apartment with a helper who lives in the other bedroom, or even in an independent apartment with a helper living in a neighboring unit in the apartment building. With respite for the helpers.

Staff-secure 24/7 programs that don't use abusive and coercive practices are an important part of the mix. They allow people to develop trust in their treatment and develop relationships they feel good about with people they trust.

There can be better bridges into community life, as people leave hospitals and staff-secure non-coercive residential settings, including help getting housing and help getting outpatient psychotherapy. Right now, there tends to be no discharge planning, and people are left to do these things by themselves with no help at all. There could be social workers at the hospital or who visit the hospital, who talk with patients and help them organize and plan their transition and their post-hospital support system. The state could pay for training and salaries for these social workers. The state could especially recruit people with lived experience for these roles, paying them a good wage and paying for their tuition for social work school. Right now there's essentially no discharge planning at all and no help at all for patients trying to find housing and psychotherapy in the community when approaching a discharge from the hosptial or after having been discharged. Changing that, would make a big difference.

I also see a need for much more investment in peer support, including better governance and supervision. With Intentional Peer Support training. With boards, board trainings, and funding, so that peers can do substantial work in the community. With pay, but accountable to their own boards, not to the carcereal system. Peers could even go into hospitals and would have a right to, with the pay coming from the peer support agegncy via the board, not coming from the hospital. This is easy to do. Most of what I just wrote has been in place in New Hampshire for more than 10 years. You can learn what is happening in New Hampshire and largely copy it.

We need to expand the warmline to 24/7 and to remote workers so that peer workers from all areas of the state can contribute to it.

As for the fear of someone leaving an unlocked facility and being out in the cold, the answer to that is RELATIONSHIPS. I once rescued someone from that too- a very confused person who didn't fully understand that she was not being locked up (because she was traumatized by hospital experiences) and fled from a non-secure facility ("Alternatives" in Springfield) and was out in the snow in February. She had my phone number with her because I had previously developed a RELATIONSHIP with her (as a peer) and so I could talk some sense into her and I provided what basically amounted to supported housing, which was what she needed. (This was in 1998. There was no official peer support in VT back then, but I had taken the IPS training at Stepping Stone in Claremont NH and I was just a nice person.) I could have transitioned this situation immediately to supported housing, but the state didn't appear to have a structure in place for that. This possibility is not scary or difficult to handle, and can be handled by staff-secure facilities and/or by peers. The important thing is to develop good relationships, which too much forced stuff works against. Keeping people in forced situations for extended times for this reason, just postpones and amplifies the problem to whenever they are finally not in a forced situation anymore. The person who I dealt with, was so traumatized as a result of a long term stay in a coercive setting. Long term stays in coercive settings are what causes this. Also, it would keep many people captive when actually very few people would actually do this, sacrificing the quality of life of many more people than are actually at any risk.

About the idea of "non-compliance." It is very clear that the best outcomes happen when people have input into their treatment. This is one reason why Open Dialogue is so very successful. Instead of forcing people to accept treatment they don't find helpful, a better solution to keeping them in long term treatment is to let them help make decisions about what that treatment is. If they are involved in the decision making, the content of the treatment will better fit their needs, and they will be more likely to continue with the treatment. This is pretty basic and involves thinking in terms of psychaitric patients being human beings. It seems pretty obvious.

We could fund or get Medicaid to pay for some of the well-developed, evidence-based alternatives that people want. UVM recently did a study that showed that magnesium supplementation is more effective than antidepressant drugs at treating depression. Massage is also an evidence-based treatment for depression, and Omega-3 oils are evidence-based at reducing suicides. Exercise programs are evidence-based at treating depression, anxiety, and even psychosis. Nutrition has a huge effect on mental health. Let's put some funding into improving the nutrition at all existing and any new inpatient settings, and let's be helping people with nutrition in practical ways at all of our community mental health agencies. Let's put funding toward making these and other evidence-based modalities, available, instead of trying to force people into an artificially narrow range of high-profit treatments.

The system makes a huge profit off of forced drugs, and coercion tends to be a substitute for adequate staff, adequately trained staff, adequately empathic and caring staff, and adequate, up to date therapeutic practices. it's cheap and easy to coerce, and the reimbursement for inpatient drugs is far higher than the cost. This model is attractive to managers and some professionals because it's cheap, easy, and profitable, not because it has good outcomes or is needed- it doesn't and isn't.

Good care is hard work. It requires caring, time, good training, investment in learning and implementing good practices, good supervison, enough staff, and other things that are not cheap and not easy. But it's worth it because the outcomes are better, and in this case the outcomes are the quality of people's lives.

And if we are looking 5-10 years in the future to what the load will be on our emergency departments then, making the investment in the quality of people's lives, and making sure they have the professional and peer resrouces they need in the community, will greatly decrease that load on those EDs in the near and distant future. There are no shortcuts. If we try to get away with not really doing the job, the job will still be there waiting for us- in this case, in the form of broken lives and broken people. IF we focus on really doing the job- providing the resources that will facilitate people healing and having good quality lives, it will actually be a lot less work in the long term and our communities and our people will thrive. Which path do we want to take? What appears to be the shortcut? Or the real thing? Let's choose the real thig. Because it's peope's lives we are talking about. If we were talking about not realy doing the job of, say, fixing a car, it would just be expensive in the future. In this case, it's not a car. It's people. It's not our prerogative to take an apparent shortcut and leave the real work for later. Ethics-wise, we don't legitimately have that option, because that involves leaving people to languish in the meantime. It's not OK to try to take the easy way out when it invovles providing inferior mental health care that leaves people suffering unnecessariily. Let's do the real job.

Let's allocate money for more peer crisis respites, more and beter peer support, social workers and peer workers (whoever patients feel more comfortable working with) to help people make transitions from hospital to community life, more numerous and more diverse post-hospital housing optionss, more numerous and more diverse psychotherapy providerrs, in-shape or other exercise programs in every inpatient and outpatient setting, and perhaps another 24/7 staff-secure non-coercive residential program, perhaps one that is especially focused on getting patient input in treatment programs and offering the modalities that people want.

We need to invest in widely varied, large amounts of community supports and housing, including supported housing. We need to NOT add any more inhumane stuff. We need to NOT make it easier or more common to force-drug anyone in any situation, inpatient or in the community. We need to NOT increase the frequency or ease of using seclusion or restraint anywhere in any setting. And we need to NOT build any more settings in which these barbaric practices will be used in any way. Better forms of mental health care exist. Let's stop being greedy and lazy, and implement them, and stop implementing the barbaric and unnecessary practices of the past. The only reason they're still in use is because people haven't made the effort to learn and implement the cutting edge modalities. They should be on the decrease.

It seems we had a similar conversation in 2014. The reason the system keeps lobbying for expansion of coercion in one way or another, is PROFIT. Contrary to what they claim, it doesn't have some other benefit, such as outcomes or safety. That is just fallacy. It's all about greed. Every time the legislature falls for that, it's later regretted. Don't fall for it. Don't keep falling for different versions of it. It's greed. It's not expertise. (That should be obvious from the fact that if CMS knows what it

is, they won't pay for it.) Point the mental health system in the direction of doing the real, honost work that will move Vermonters' lives in a positive direction.

I would be glad to testify to any committee.