GMCB Public Comment

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Topic: UVMMC's use of funds from 2017

Comment: The idea that just because there's an overload of patients in the ERs and they end up boarding overnight waiting for beds in hospitals, means there's a need for another psych hospital, is flawed and illogical. There are a lot of better ways to alleviate that problem, and adding another psychiatric hospital is unlikely to do much to alleviate that problem.

I have studied this problem extensively in Vermont and in general in conjunction with my role on the recent forensic mental health working group, and long term in my bachelor of science degree focused on mental health systems reform and in my other work in VT and NH in helping to improve the mental health systems. When a person is put into a psychiatric hospital, typically they don't get good nutrition, they don't get therapy, and they don't get consistent adequate access to the outdoors or to physical activity. The only thing they reliably get is psychiatric drugs, which don't work for everyone and make many people worse. (Read the books "Anatomy of an Epidemic" by Robert Whitaker, "Medication Madness" by Peter Breggin, "Drug Induced Dementia" by Grace Jackson, and "Brain Energy" by Christopher Palmer to get a better sense of that.) They typically get traumatized by their experience there, as well. Because there's woefully inadequate outpatient care, they are sometimes kept in inpatient care long after they should have been discharged, and sometimes they're discharged to a vacuum of care. I have witnessed several personal friends who have been discharged from a psych hospital in Vermont (suicidal ideation and rape ideation), and then could not find any follow-up mental health care after discharge. The one with rape ideation had been given a new antipsychotic medication. Without any psychiatrist follow-up after discharge, he became afraid because of heart palpitations he thought were caused by the medication, and since he didn't have any way to get advice about it, he went off it cold-turkey two days after discharge. This made him, seemed to me, psychotic, whereas he hadn't been psychotic at the time he went into the hospital. (The medication was the only thing he had gotten in the hospital- no therapy or other treatment.) He was afraid to go live where he had been living before, so he went and lived in the woods by himself for a while. He recovered by living in the woods and hiking a lot and staying away from other people until he was feeling better. (He had gone to the hospital because he was afraid he might actually rape someone.) The other friend went to the hospital because she wanted to kill herself. She was given a new medication and discharged. She was told that to see a psychiatrist, she had to see a therapist who was affiliated with the hospital. She couldn't find a therapist with any openings, at all. She really wanted therapy but could not find a therapist with openings at all. Within a few weeks, she was more suicidal than she ever had been before, but now she knew that going to a hospital was not going to help her, so she didn't go. I ended up going hiking with her regularly for a long time, listening to her, doing peer support. She gradually felt better and solved her problems by hiking and having someone to talk to. She stopped taking psych drugs and got TMS therapy as an outpatient, which helped. In Vermont, people are typically discharged from hospitals, to no outpatient care, or they are kept in hospitals way too long due to a shortage of outpatient care, or both.

Being discharged to no outpatient care is especially bad for suicidal patients. The number one reason why people become suicidal again right after discharge is because of lack of outpatient care. This has been demonstrated in many studies. Soon after discharge from a hospital, is the most common timing of

suicide. It's extremely common. The rate of suicide soon after discharge from a hospital is extremely high.

The reason is the lack of outpatient care after discharge. I can send you the full texts of lots of studies that clearly demonstrate this. Medication adherence doesn't help. Risk assessment doesn't help. The determining factor is access to outpatient care after discharge. Vermont fails at that. Hospitals primarily put patients on drugs. We have a shortage of outpatient psychiatrists, so patients usually don't get continuity or supervision with those drugs after discharge. And for most people, drugs aren't the most effective treatments. In many cases, they aren't even treatments at all, or are counterproductive. People need access to other treatments, especially psychotherapy and other psychosocial support, but also, metabolic treatments like sophisticated individualized approaches to nutrition and physical activity, and other treatments like TMS. Sending people to hospitals doesn't help them much. They end up just as bad, or worse, shortly after discharge, because there isn't adequate outpatient care. Or they end up stuck inpatient for an extremely long time due to inadequate outpatient care, clogging up the system so the next people don't have hospital openings. Why do we have so many people going to ERs with psych problems, to begin with? Because they aren't able to find outpatient mental health care, because we have such a shortage of outpatient mental health care. They aren't able to find a therapist or other outpatient care, so their problem gets worse and worse until they are suicidal or otherwise need to go to the ER. If we had more, more diverse, and better outpatient mental health care, much fewer people would go to the ER with psych problems, in the first place. And if we had more, more diverse, and better outpatient mental health care, when people went to the hospital, they would then be discharged in a timely manner and have good follow-up care, which would also greatly alleviate the load on the hospitals and ERs. Putting people in hospitals doesn't, and cannot, alleviate the ER overload. The patients end up languishing in the hospital for a long time, clogging it up so the next people don't have access, due to not being able to get outpatient care, or they will be discharged to no outpatient care and get worse again right away. It's like using a glass to solve a dripping faucet- the glass just fills up and then the spill-over is the same as the drippy faucet. And hospitalization isn't an experience that moves most people's mental health in a positive direction, anyway. It's the opposite, for most people.

Hospitalization isn't necessarily the best course of action when people go to the ER. There are other possible places they could go, that would serve some of them better. Peer-run crisis respites especially. There should be more peer-run crisis respites. People who are hearing voices or having suicidal ideation often do very well in peer-run crisis respites. They get connected with peer-run support groups and other services. They don't get put on a drug that they will subsequently have no outpatient psychiatrist to help make decisions about. They end up better off than they would by going to a hospital. Even if we had better outpatient mental health care, it would still be true that many patients are adequately and well served by going to a peer-run crisis respite, and don't need to go to a hospital, and it's a less-invasive and less-harmful intervention. Follow-up care should include copious access to peer support in the community after discharge. People go to the ER because there's nowhere else to go with a psych problem. Not all of them need hospital care. The number one thing we need is better, more, and more diverse outpatient mental health care. This would greatly reduce the number of people who get into such rough shape that they need to go to the ER, in the first place. People could go get therapy, peer support, metabolic care, and other outpatient services when they first start having a problem, and most people's problems wouldn't escalate to the level of needing to go to the ER. And when people do go to the ER for psych reasons and then go to whatever residential care is most appropriate (peer crisis respite or hospital), they could be discharged in a timely manner and have good care after discharge and be less likely to be in the ER again for the same reason. My proposal for a solution to the ER overload and boarding problem: 1. Invest heavily in outpatient mental health care in a wide variety of forms.

Psychotherapists, social workers, and case managers; peer support drop-in centers, support groups, and outreach; TMS accessible to people who haven't necessarily tried psych drugs; primary care; massage done by massage therapists with considerable training (to treat pain without taking pain meds in the first place, and to treat depression and anxiety); dieticians, personal trainers, and access to gyms, fitness centers, swimming pools, yoga classes, dance classes, and parks; community skills workers for people who have trouble doing day-to-day life activities; anything else that consumers pinpoint as a need. This will greatly reduce the number of people going to ERs with psych problems, in the first place, and will greatly reduce the revolving door problem of people being in terrible mental-health shape soon after discharge from hospitals. 2. Invest in peer-run crisis respites. Not everyone needs hospitalization. Peer-run crisis respites are better, for some patients. We have a shortage of them in Vermont. There need to be enough of them. 3. ERs could have separate Empath wings so that the people who are in the ER for psych problems start getting psychosocial care for their problem while they are in the ER, and so the ER doctor doesn't have distractions from dealing with urgent medical patients with heart attacks, strokes, massive bleeding, etc. On the other hand, the psych patients would be near the medical ER, which would be good in case they actually have a medical problem (such as a stroke). So I think we definitely need to let UVMMC spend their funds on a variety of things other than a psych hospital. I don't think building a psych hospital would make any meaningful dent in the ER overload problem, whereas spending the money on the priorities I outlined above, would. My opinion is grounded in valid scientific research. If you would like more research documentation of what I have said, I would be glad to provide it.

Post Comment: Yes