TESTIMONY FOR PUBLIC HEALTH COMMITTEE NOVEMBER 2017
(**BOLD=oral testimony)**

My name is Martha Healy and I live in the city of Hartford. I am a registered voter who stays informed, involved and votes. I am the mother of three daughters the eldest of whom, Karen, has many problems including mental health, orthopedic, neurologic, et cetera and who was institutionalized at Cedarcrest and then CVH. I am also Karen's conservator and have been for many years. I attended EVERY meeting about Karen, every treatment team session (and there is no "team" at CVH), every case management meeting, visiting every week for her entire stay at Cedarcrest and then CVH.

As I started to think about what I would say **I realized I needed the answer to two questions. First, how are you defining "abuse" and second, what are you, this committee, this legislature, trying to do**. I also realized I couldn't say what I wanted to say in three minutes and I was told I could WRITE it all, but then only speak for three minutes. So here is the whole brain dump…the highlighted portions will be part of my oral testimony.

I will speak to only those things I have first-hand knowledge of; I will NOT include things my daughter told me that I did not see or have confirmed by others.

My definition of abuse. I include as abuse: verbal yelling, threats, horrific "jokes" – the staff at Cedarcrest thought it was funny to constantly talk about how they were "hanging around" after the death of a patient by hanging. It is 8-9 years later and that was still the first thing that came to my mind.

Abuse—incorrect medication (given medications she had bad reactions to even though it was marked all over her chart not to give her the medication).

Abuse—giving higher and higher doses of narcotics to which Karen became addicted. I became her conservator to try to get some control on this problem but CVH felt they could change her medications without notification and/or approval from me whenever they wanted to. They also gave her or had her receive treatment at local hospitals without informing me or getting my permission as her conservator. Of course **for CVH staff this also served the purpose of "chemical restraint."**

Abuse—"punishing" her by putting her in isolation without anything, let alone any comfort mechanisms, in Karen's case a pillow or stuffed animal, etc. (Her apartment now is FILLED with stuffed animals and pillows!)

Abuse—being inconsistent in requirements and using "we'll see" as the answer of choice to her (or my) questions.

Abuse—inadequate, generic treatment and/or discharge plans. They had a template for everyone, every time.

Abuse—sitting in a chair, or in later years a wheelchair, in a large, drab room from morning to bed, interrupted only by meals and "incidents." There was a television (in a "cage") that was turned on, sometimes.

Abuse—being at the mercy of other patients, some of whom were violent and who were not well monitored. In fact, just a few days ago Karen underwent extensive surgery where the surgeon found "Her bone spurs were large" and he says they "were more likely the result of several falls and poorly healed fractures." Karen and I can tell you where these injuries occurred—when she was thrown against the wall by a violent patient after which Karen fell to the floor, complained of pain, but was not treated.

Abuse—having to listen to STAFF screaming down the halls to each other even though patients were admonished and punished for doing the same thing.

Abuse—staff sleeping through third shift and not being responsive when needed.

Abuse—keeping her from the physical therapy she required for the aseptic necrosis she developed in her hip. EVERY orthopedist prescribed aquatic therapy as a requirement which CVH treatment team required her to "earn." It was the pain from this progressive, degenerative condition which led to higher and higher doses of narcotics. She was not allowed by the state to have the hip replacement surgery that was recommended.

Abuse—incorrect treatment. A CVH neuropsychiatrist had diagnosed Karen with frontal lobe dysfunction with deficits in what is called executive reasoning. The treatment Karen was given was DBT, the common treatment for Borderline Personality—her major diagnosis. However, her cognitive deficits made this form of therapy totally useless. While she could memorize and parrot back what she was taught, she could never functionally use it. I would sit there in treatment team meetings uselessly repeating this.

So those are some of the things I call abuse.

Now to define the GOALS of this committee. Are you just trying to find a way to prevent the kinds of physical and emotional abuse we have heard about at Whiting? If all you want to do is keep people from being physically abused even that is probably impossible. A culture that does not recognize each person as an individual will never take care of them, they are just "things" to be housed and kept away from "normal" people. I sincerely hope that is not the goal you are looking for.

I would hope that what you really want to do is work towards a system that attempts to have each patient achieve their potential—whatever that may be. Frankly Karen would be the poster child for such a plan. This is the rest of her story.

She FINALLY had a group of CVH professionals who worked with me (and against others at CVH/DMHAS) who saw her problem as I would hope. A dedicated Behavioral Psychologist, **Dr. Tracy Sondik wrote a behavior plan based on Karen's abilities and needs** and with input from other professionals but also from me. Sean Keene at that time the social worker involved with Karen was a major positive player as was Claude Fields from Capital Region. (There were of course others including people in the commissioner's office, other professionals, and mental health aides on the floor who supported Karen through these years—just as there were those from physicians to other aides who were abusive as described above.)

It took YEARS, literally years, **to get that plan written and adopted**. We met with community agencies and Karen and I chose Goodwill's plan for community living.

At the last DMHAS Case Management meeting with then Medical Director Dr. Ezra Griffith (5 lawyers—2 from the commissioner's office, 2 from CLRP and my private attorney) before Karen's discharge, a kindly CVH employee put her arm around my shoulders and said: "She'll be back in two weeks, don't feel bad."

It will be three years December 4th, 2017. Karen had her hip replacement, has lost about 60 pounds, has had a volunteer job at Hughes Rehabilitation for over a year and a 6-hour/week paying job at the YMCA. This successful outcome COSTS LESS than sitting drugged and abused at CVH. According to a recent article in the *Hartford Courant*, "**it costs the public $567,000 to treat one patient for one year at Connecticut Valley Hospital**." **I believe the cost of the contract between the State of Connecticut and Goodwill is $300,000/year—and that cost has nowhere to go but down as Karen continues to become a functional, participating, member of her community.**

I would like to see a search of positive outcomes from other patients, other states. Speak to the "success" stories, people in recovery. Find the commonality, build a program around success and also avoid the pitfalls of programs that have failed.