

# RESPONSE TO NATIONAL DISABILITY RIGHTS NETWORK “TALKING POINTS” MEMO CONCERNING THE BRUCE MURDER CASE IN MAINE

By Robert (Joe) Bruce

The National Disability Rights Network (“NDRN”) has published a misleading “Talking Points” memo as part of its lobbying campaign to oppose enactment of HR 3717, the bill that Congressman Tim Murphy has introduced to make important and needed reforms in the treatment of severely mentally ill Americans. As part of this campaign, NDRN has disavowed their member’s responsibility for actions that led to my wife’s death and my son’s incarceration, and has suggested that my testimony to Congress in May 2013 was misleading. This response sets forth the truth, and also shows why HR 3717 should be passed as proposed.

## Summary

My untreated, seriously mentally ill son William was dangerous and psychotic in 2006. After intense work, his mother and I were finally able to have him hospitalized in Maine’s Riverview Psychiatric Center. However, lawyers from the NDRN affiliate in Maine, Disability Rights Center of Maine (“DRC”) quickly stepped in to “free” him from the hospital. DRC’s general counsel, Helen Bailey, and a DRC patient advocate named Patricia Callahan caused him to be released prematurely and with no supervision. Their actions led directly to his subsequent hatchet killing of Amy, my beautiful and beloved wife and the 47-year-old mother of our three sons. NDRN concedes this was a “horrendous tragedy” and doesn’t deny DRC Maine’s responsibility outright; rather, it merely seeks to blur it with “Talking Points.”

After Will’s incarceration, I became Will’s legal guardian, despite efforts of DRC to prevent it. I obtained Will’s medical records. They reveal that DRC in fact *caused* the “horrendous tragedy” my family experienced, as I show below. First, however, I discuss why HR 3717 is such an important bill, and should be passed.

## HR 3717 Contains Important Fixes That Could Prevent What Happened to My Family From Happening to Others.

It is obvious that legislative action is needed. Once the advocates were empowered by PAIMI in 1986 to enter into the treatment system to prevent abuses of vulnerable mentally ill Americans, they used their position to take on “additional and legally impermissible responsibilities that Congress never envisioned or authorized.”<sup>1</sup> HR 3717 would restore the balance that Congress tried so carefully to strike in 1986, in several ways.

---

<sup>1</sup> Amanda Peters, *Lawyers Who Break the Law: What Congress Can Do to Prevent Mental Health Patient Advocates From Violating Federal Legislation*, 89 Ore. Law Rev. 133 (2010) (hereinafter, “*Lawyers Who Break the Law*”) available at <http://mentalillnesspolicy.org/myths/mental-health-bar.pdf>.

***Lobbying by PAIMI Organizations Prohibited.*** In the wake of Amy’s death I worked to reform the laws in Maine, including the passing of an Assisted Outpatient Treatment Law (AOT Law). AOT Laws like Kendra’s Law in New York give the treating doctors and hospitals another option in between commitment and release, and have worked well in the states where they are in force. To my shock and utter surprise, DRC *lobbied against the AOT Law* (and did so dishonestly)! Prof. Amanda Peters noted:

Maine’s P&A system, the Disability Rights Center, has lobbied against provisions that would allow families and law enforcement officers to petition a court to initiate civil commitment proceedings. It has also lobbied against laws in Maine that would loosen patient confidentiality restrictions for family members and allow patients to be medicated over their objections.<sup>2</sup>

The AOT Law passed in Maine, but NDRN’s affiliate members are consistently opposed to legislative reforms of the current system. HR 3717 would prohibit PAIMI funded organizations from lobbying altogether and is a much needed reform.

***Systemic Litigation by PAIMI Organizations Prohibited.*** When they can’t defeat legislation they sue to block it. HR 3717 would prevent PAIMI funded organizations from engaging in such “systemic litigation” and attempting to get from the courts what they failed to achieve in the legislature.

***Interfering With Doctor-Patient Relationship Prohibited.*** As is obvious from Will’s case (see examples below) advocates openly counsel patients contrary to their doctor’s advice. In Will’s case he was counseled that it was his “right” to refuse medication – as if a person lacking insight has any meaningful “rights” when it comes to refusing medication that will restore his insight. Will himself now knows that medication can do much good. Tragically, the actions of his “advocates” prevented him from experiencing the improvement and healing medication would have brought.

***HIPPA Privacy Restrictions Eased.*** Amy and I were excluded from Will’s treatment meetings and so she never knew what the advocates were saying about us (“a negative force in his life” – see below) or that he was being counseled not to take medications. Our presence in those meetings could have prevented a tragedy. HR 3717 would allow physicians to exercise good judgment and allow caregivers into the meetings.

***State AOT Laws Required as a Condition of Block Grants.*** As discussed, AOT Laws give treating doctors and hospitals a middle path between commitment and release, and have been successful in other states. Maine passed one over DRC Maine’s objections. HR 3717 would require states to enact AOT Laws. This is a much needed reform.

---

<sup>2</sup> *Lawyers Who Break the Law*, at 153-54.

## The Medical Records of William Bruce Show That DRC Maine Caused His Release.

By March 2006, Will had a well-documented history of dangerousness, paranoid thinking, and refusal to take medication. Amy and I repeatedly told his doctors of our fears for his safety and ours. We pleaded that he remain in an environment where he would be compelled to take the medications that were so effective in relieving his condition, because in an unmedicated state he lacked the insight to know he needed them. Unknown to us at the time, *because we were excluded from the meetings concerning his treatment*, the patient advocates from DRC were persistently and single-mindedly lobbying Will's doctors to release him from Riverview Psychiatric Hospital while simultaneously advising him he had the right to refuse medication. His mere *release*, not his successful treatment and our welfare as a family, was apparently their only goal. As a result of their interference in his treatment and their "advocacy" on his behalf, William was discharged from Riverview Psychiatric Center on April 20, 2006. Knowing DRC would defend his 'right' to refuse treatment, he did refuse it, and in a psychotic, unmedicated state he killed his mother on June 20, 2006.

NDRN's "Talking Points" memo is written to leave a deliberately false impression that DRC had nothing to do with Will's early and inappropriate release from commitment in April 2006. But as I show below, DRC persistently lobbied for his release, ignoring his doctor's dire warnings that he was "very dangerous indeed for release to the community."

In this memo I quote NDRN's assertions in the "Talking Points" memo verbatim, and respond with content from his medical records.

**NDRN Assertion:** *"There continue to be assertions that the Disability Rights Center (DRC) of Maine caused Mr. Bruce's release. However, because the hospital had taken no action to legally recommit him, he was due to be discharged."*

**Response:** Will's medical records show that DRC did indeed cause his release. His doctors were consistent in saying he needed treatment including medication, but DRC was consistent in insisting he did not need medication, there was no basis for holding him, and he should be released. Amy and I were excluded from the meetings where DRC Maine was making these assertions by rigid HIPAA privacy restrictions [*HR 3717 would ease those privacy barriers so families of the most seriously ill could get the information they need to help ensure their loved ones are cared for.*] Eventually DRC Maine's "advocates" wore down Will's doctors and the hospital, and he was released, unmedicated and unimproved. Amy's and my pleas were disregarded. The following are some excerpts from Will's medical records.

**February 6, 2006:** Will was admitted to Riverview Psychiatric Center for 90 days because of aberrant behavior. The initial nursing assessment states "poor impulse

control,” “delusions,” “agitation,” “noncompliance with meds,” “isolative,” “guarded,” “assaultive.”<sup>3</sup>

**February 14:** “Dangerous to others if discharged to a less restrictive setting at this time.”<sup>4</sup>

**February 23:** “[D]angerous to others without additional observation, and active attempts to treat him.”<sup>5</sup>

**March 1:** “[D]angerous to others without additional observation and treatment.”<sup>6</sup>

**March 7:** “[W]ithout such treatment [i.e., medication], he would remain dangerous to others if released to the community without treatment.” Diagnosis of paranoid schizophrenia.<sup>7</sup>

**March 14:** “[W]ith the patient’s poor insight into his mental illness and with a history of dangerousness in the context of his mental illness, the patient remains dangerous to others without treatment.”<sup>8</sup>

**March 17:** Will “refuses to take meds,” and he says, “There’s a law that says I don’t have to take meds.” *[HR 3717 would prohibit PAIMI-funded advocates from interfering with the doctor’s treatment recommendation, as they obviously did in Will’s case.]*<sup>9</sup>

**March 20:** Dr. Fliesser’s notes state that Will is “dangerous indeed for release to the community without pharmacotherapy and decrease in paranoid symptoms.”<sup>10</sup>

**March 23:** Treatment meeting. Amy and I were excluded, as usual, but two DRC employees attended, its General Counsel, Helen Bailey, and a patient advocate, Patricia Callahan. Will’s doctor’s notes recite that he “repeatedly emphasized to the disability rights advocate my clinical opinion that the patient’s paranoid psychosis is not likely to improve without pharmacotherapy.” DRC refused to hear it and instead strongly pressed for his release. Bailey, a lawyer, even asked if a second opinion could be obtained, and then “verbalized concern that she reviewed the record and saw no documentation to support William having to remain at Riverview.” Callahan actually suggested that

---

<sup>3</sup> Initial Nursing Assessment signed by RN Cecelia Garret [Tab1]. (References to “Tab \_\_” are to a compiled notebook of Will’s medical records on file with me.)

<sup>4</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 4].

<sup>5</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 5].

<sup>6</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 6].

<sup>7</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 7].

<sup>8</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 10].

<sup>9</sup> RN Note signed by RN Valerie Files [Tab 11].

<sup>10</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 14].

William was getting worse by remaining at Riverview because his behavior was deteriorating while at Riverview.<sup>11</sup>

Dr. Bailey pointed out that pt is refusing medication
+ is competent + is refusing to engage + therefore
should be discharged.
Callahan suggested that pt may actually be getting worse
by remaining here. (based on ↑ episodes of irritability,
accusations, paranoia)

**March 27:** Will “remains dangerous if released to the community without pharmacological treatment of these paranoid symptoms.” Will continues to refuse medications, having been advised by DRC that he had a right to do so.<sup>12</sup>

**March 30:** Dr. William Nelson, medical director of Riverview, gives the “second opinion” sought by Bailey, and states “I agree [with Dr. Fliesser] that he is at high risk of being released to the community if he does not receive pharmacotherapy to ameliorate his paranoid and other psychotic symptoms.”<sup>13</sup>

[Dr. Fliesser leaves Riverview at this point; Dr. Filene takes over Will’s treatment.]

**April 6:** Dr. Filene describes Will’s case as being “currently in a high state of contention.” He meant that DRC Maine was continuing its campaign to secure his release without further treatment. At a treatment meeting on this date DRC’s Callahan (1) told Will how to answer the doctor’s questions, (2) told Will to refuse to consent to the doctor speaking to Will’s prior treating professionals, and (3) told Will to refuse to consent to the doctor talking to Will’s mother, Amy. (Callahan said *in Will’s presence* that his parents – whom she had never met – were “a negative force in his life”! There is no knowing the extent to which the DRC’s reckless statements about Amy and me contributed to Will’s delusions that Amy had to be killed.) The doctor put in his notes the following:<sup>14</sup>

this meeting had a tone of legal antagonism

<sup>11</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 15]; Progress Notes (unsigned) [Tab 16].

<sup>12</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 19].

<sup>13</sup> Progress Note signed by Jeffrey M. Fliesser, MD [Tab 21].

<sup>14</sup> Psychiatrist Progress Note signed by Daniel R. Filene, MD [Tab 23].

**April 11:** Dr. Filene meets with Will, who demonstrates that he views DRCs advocates as being at least co-equal in credibility to his doctor. Will justifies refusing treatment because of their advice and “continues to feel there is no reason to consider that he has an illness.” The following excerpt from Dr. Filene’s notes contain this information and more:<sup>15</sup>

Mr. B has difficulty understanding the difference in roles and expertise between his physicians and his state-appointed Advocates. Mr. B notes that the Advocates are stating he is not ill, not a danger, and should be released. He feels these opinions have the same or more weight as those of mental health professionals, and therefore continues to feel there is no reason to consider that he has an illness. Mr. B continues adamant that he will not consider accepting medications under any circumstances. He still states that this is because his previous medications had made him drowsy. He stated he still would not consider medication even if it didn’t make him drowsy.

*[HR 3717 would prevent the advocates from interfering with the doctor’s treatment over the objections of parents in this way.]*

**NDRN Assertion:** *“DRC reviewed the medical record and alerted the facility that it had not taken action to obtain the necessary legal documentation to hold Mr. Bruce beyond his already scheduled discharge date.”*

**Response:** NDRN phrases this “talking point” to suggest that DRC was benignly alerting Riverview Psychiatric that it needed to do more in order to hold Will. The reality is that DRC was relentless in its determination to secure Will’s release regardless of his need for further treatment, as shown above. Amy and I knew nothing of their efforts and Amy paid the price of their reckless disregard of his condition and his need for treatment prior to release.

**NDRN Assertion:** *“When a psychiatric facility takes no such action to recommit, or when there does not seem to be sufficient evidence to support recommitment, mental health advocates work with hospital social work staff to develop and implement a quality discharge plan including housing, employment, case management, counseling and other support services.”*

**Response:** It would have been remarkable indeed were Riverview Psychiatric Hospital to have taken steps to commit Will in the face of DRC’s persistent and forceful lobbying for his release. The hospital yielded to DRC’s pressure to release Will.

NDRN claims they worked for a “quality discharge plan” but there is no evidence of that. NDRN implies that in Will’s case his release included provisions for “housing, employment, case management, counseling and other support services.” This is false.

- *“Employment”* – False. Will was released to “Jesse,” a supposed friend in Connecticut. Will had convinced DRC Maine and Riverview that Jesse had employment for him, but this was simply false – a creation of Will’s imagination

---

<sup>15</sup> Psychiatrist Progress Note signed by Daniel R. Filene, MD [Tab 24].

- “*Housing*” – False. Will’s friend Jesse in Connecticut, to whom Will was directed on release, was supposedly traveling but would return two weeks from Will’s discharge date, so Will was given enough money to stay in a hotel, by himself, for two weeks until “Jesse’s” return.
- “*Case management*” – False. Will was equipped with the phone number of Andy Davis and exhorted to check in. He didn’t.
- “*Counseling*” – False. Counseling was not part of Will’s “quality discharge plan.”
- “*Other support services*” – False. None were provided.

After DRC obtained Will’s release, he was put in a hotel in Skowhegan by himself, and then put on a bus to Connecticut with spending money so he could “get back on his feet,” in the memorable words of his Intensive Case Manager. Within a few weeks Will showed up at his grandmother’s home in Massachusetts appearing psychotic. Amy and I had to bring him home. Our pleas for treatment had been intentionally thwarted by DRC’s single-minded determination to enforce his “right” to be free, and untreated.

Notably, NDRN’s description of the “quality discharge plan” in Will’s case fails to mention medication. This is the only truthful aspect of that assertion, because there was no provision for meds, nor could there be any expectation that he would stay on his meds, given DRC’s counseling that he need not. Moreover, at the time, Maine had no Assisted Outpatient Treatment law (a/k/a Kendra’s Law) that would have required him to stay on his meds or face a return to the hospital. [*HR 3717 would fund pilot AOT programs in states.*]

In summary,

- DRC counseled Will he could refuse antipsychotic medications.
- In the treatment meetings from which Amy and I were excluded, DRC inserted themselves in between Will and his family and between Will and his treating psychiatrist, impeding the trust and open communication that is so essential to effective treatment.
- DRC counseled Will to refuse the doctor consent to talk to his family, whom they stated *in front of Will* was “a negative influence in his life.”

DRC pressed over and over for Will’s premature release from the hospital despite repeated warnings from three physicians that without the medication *the advocates were counseling him to resist* he would be a danger to himself and his community.

Once he was remanded to Riverview by the Criminal Court and treated, with medication and otherwise, Will regained insight into his condition. He now knows what his advocates were blind to in 2006. In a *Wall Street Journal* article published in 2008, Will himself said the

following: “There are times when people should be committed. Institutions can really help. Medicine can help. None of this would have happened if I had been medicated.”<sup>16</sup>

## Is the Bruce Case an Anomaly?

How would we ever know? It was lucky that in my son’s case DRC’s actions were well documented by Will’s treating doctors, so that when I was able to obtain his medical records, the truth emerged. But that is not the norm. NDRN and the patient advocates operate in the secrecy created by HIPAA. NDRN has a pattern of making extravagant public claims that it has investigated and helped thousands of cases of abuse, and it describes particular incidents in florid detail, *but HIPAA prevents its claims from ever being tested against the records*. So we can never know for sure, but I will say this:

From everything I have observed in the years since 2006, Helen Bailey and Patricia Callahan are products of the NDRN mindset and the PAIMI system.<sup>17</sup> The NDRN and patient advocates consistently express – and their actions display – an ideology that all care should be “self-directed.” But this means that people like Will, who lack the capacity to self-direct their own care, are left without care. The flaw in the NDRN philosophy is that it protects the right to remain psychotic and ignores policies that can free a person from its grip. According to a SAMHSA report, NDRN’s DRC affiliates are currently working to *prevent* AOT legislation.<sup>18</sup> Those activities are evident in New York, California, Tennessee, Kentucky, Connecticut and other states.

The advocates’ intervention in Will’s treatment stems from an overzealous belief that any diminution of the rights of a single mentally ill person creates a slippery slope that endangers the rights of the entire American population. Thus, patient advocates want to “win” their cases all the time, whether it’s in the best interests of the patient or not. To them, using intimidation to get a patient like Will released is cause for celebration, notwithstanding the wishes of the family members who know him best (and who are his primary caregiver) or the doctors who have professional expertise. When a patient gets released, to them it is a victory for “individual rights,” plain and simple. Civil liberties are of course important to all of us, but taking the defense of patients’ rights to these extremes doesn’t allow the doctors and mental health workers the room they need to actually treat their patients.

---

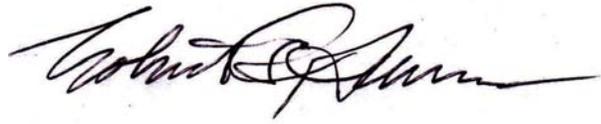
<sup>16</sup> “A Death in the Family,” WALL ST. JOURNAL, Aug. 16, 2008.

<sup>17</sup> This mindset, as well as illegal activities by Protection and Advocacy, was well documented in *Lawyers Who Break the Law*.

<sup>18</sup> *Evaluation of the Protection and Advocacy for Individuals With Mental Illness (PAIMI) Program, Phase III: Evaluation Report*, SAMHSA, 2011. Summary and link to full report at <http://mentalillnesspolicy.org/myths/paimifails2011samhsaevaluation.html>. Full report available at <http://store.samhsa.gov/shin/content/PEP12-EVALPAIMI/PEP12-EVALPAIMI.pdf>

Neither DRC nor NDRN has ever acknowledged any fault or even expressed remorse for what happened. HR 3717 cannot bring Amy back but if enacted it will cure many of the ills of the current system that contributed to her death. For the sake of severely mentally ill people and their families across the country, please support this excellent legislation.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Robert (Joe) Bruce". The signature is fluid and cursive, with a long horizontal stroke at the end.

Robert (Joe) Bruce