

Act 82 Working Meeting (Involuntary Medication)
July 27, 2017
WSOC – Ash Conference Room
9:00 – 11:00

Comment: Has concerns about the definitions in Title 18: Health, Chapter 171, general provisions. What I found, there does not seem to be a way to operationalize 17 (B) ii, - if someone is in crisis, how do first responders assess the danger of harm to self here? How do they document risk of “serious mental deterioration” without treatment? This affected our family and I think someone needs to address this. There need to be procedures or guidelines for people who are screening so they know the law and have the tools to support individuals and families who meet this criteria of “danger of harm to self.”

Comment: Over the last couple of years, the numbers of involuntary med petitions have increased. If that is true, how do we square that with Legislative intent for a less coercive thing, concerned.

Comment: I would want that information in context. If there is an overall increase, we would want that data.

Comment: I have taken a strong stance over the years against involuntary medication, having had received it in the past. I found it to be coercive, traumatic and frightening. The times I was not suicidal or homicidal, I was drugged so heavily in the past I lost my memories twice, woke up covered in bruises. The State needs to take a hard look at hospitals who are using those in a very coercive way.

Comment: We know there has been a compression of times frames of patient rights over time. What is valuable is the time frames involved that we have now. 2-3 times in the past three months, I have been able to get people to avoid court hearings. The time frame can allow people to understand what is going on, sometimes it is too quick. Other concerns are routine overdosing of FDA of Neuroleptics and the routine prescribing of Klonopin – are we getting Klonopin addicts?

Comment: Came here today for his son who is mentally ill. He had ran away for six months and we finally heard from him and he was in Philly. Philadelphia has a very good outreach program. In Philly there is an Act 302 – if they see someone is a danger to themselves or others or can't take care of themselves, they allow the person to be reprimanded and they hold this person, and have a court hearing. Thank god that happened. He did get the help he needed. The problem I see is we want to be in control and involuntary medicate someone if they are out of control and need help, but me as a parent, I want to stay involved with that. That input is critical. Parents need to have access and feedback to what is happening. He was initially started off on the wrong drug, it was like play Russian roulette with medication. I think there is a better way, possibly look at genetic testing more. The Walsh Institute in Chicago does biochemistry testing.

Comment: Wanted to invite you to the Plainfield Firehouse at 169 main street, this evening at 8pm when Dr. Maire from Haiti will be there. There is less use of drugs in 3rd world countries in general and is in favor of that approach. Dr. Marie tries to get her medical school students to use these approaches.

Comment: I also wanted to add that it is not just me who felt that going through the ordeal of involuntary medication is coercive and horrific, I have heard from a number of other people, confidently, who are in a state of terror and fear. How does Vermont move forward with treatment when treatment becomes coercive and terrifying? She is terrified of hospitals.

Comment: Quality of care, what is optimal? When we focus on involuntary /coercion, we are really talking about the Neuroleptics. What worked for you in Pennsylvania, there are pros and cons. Yes, it is easier in some ways to get into a hospital, but those hearings, they have a slate of 20 people so in terms of due process, there is very little. As I am listening here, and have sat around the room for many years, would it be helpful for the people who are on the side that we should never force medicate, in what instances might you allow this? And the people who want coercions, if they could take about the downsides of that. Maybe that would be the place of coming together, where there is some overlap.

Comment: I am not the right person to respond to that, you said to get the option of someone that thinks that force medicating is never appropriate. That is not a position at DRVT. I think what people miss in the debate is that there is a dynamic that goes on, what is the right of society to protect itself and protect individuals from him /her self and what is that individuals right to determine their medical treatment? The standards that exist really embody society's right to protect themselves when they say that the initial standard for commitment for AIT is a diagnosis of mental illness and a danger to them self or others. The combination of medical/perception of danger, the criteria for involuntary medication is different. You have to have met those other standards and you have to be found to be incompetent to make that judgment yourself. That is why we have argued that these should be two separate hearings. There should be time, we believe to establish therapeutic relationship to find out if there is another way they can mitigate the issue of danger and get to an understanding with the individual.

Comment: A little bit of time initially so that a relationship that is real and constructive can be established instead of a forced relationship that is going to color how this person will look at hospitals and medical providers.

Comment: If we really believe we are trying to do two things really, one hopefully help someone through suffering and two trying to protect the public when someone's behavior is dangerous, and making those two things work has such a bearing on that individuals civil rights and I do think there are times there this is the best thing as you can quickly as workable get someone to stabilize. My personal opinion leans closer to what Dr. Steingard said but regardless of that I can't see any reason not to actually do what is in the statute, since 1999 they have been trying to work towards a system that is less reliant on force.

Q – The number of applications is considerably higher than it was when that law was passed. Who puts these in?

A – Medical doctors and representatives of the state.

Comment: I understand fully the concept of danger to self or others, I understand patient rights and so forth. In the summer of 2011 before hurricane Irene, I was a patient at VSH and one night I had a laughing attack, I was then tackled by about 7 staff members, with no communication whatsoever, got an induction of some medication, speculating that it might have been Haldol. You need to bring perspective

from a patient's point of view. It is used as a form of control, domination and subdue and used to terrorize the patient.

Comment: Wanting to speak on the behalf of the healthcare provider – they see a person in pain, they see a person they want to treat and help. They are trying to establish a relationship and can't, they have someone they are treating and can't do anything, they need treatment and there is nothing they can do. That is where they are coming from as the providers.

Comment: For many years she was a legal guardian for her brother who has Schizophrenic and for years I allowed them to force drug my brother. My brother is in his 60s and has no thyroid because of the medication, end stage kidney, obese, no teeth, has tardive dyskinesia. She was never informed of the side effects of these drugs and was never informed they largely don't work. He has never been free of these voices – even with the forced drugging. Late in my own life I suffered a psychotic episode and it has changed my views on forced drugging.

1. The father, you say your son is doing better. I thought my brother was doing better. His point of view should matter more than mine or yours. When you are force drugging someone, you say society is better off, he has to endure all these medial problems and no one is helping him. It is never appropriate to force drug somebody.
2. Hears many stories about the trauma that is involved in forced drugged. There is no therapeutic alliance when you start to force drug someone
3. The market perceptive on the medication and treatment for people who have been labeled with a mental illness will never improve as you are forcing them on. The pharmaceutical companies could improve the drugs but there is no incentive. We need to demand a higher level of drugs with less side effects.
4. Force drugging – never think involuntary medication is okay – they need to have been convicted of a crime, and ask the question is this cruel and unusual punishment?
5. Vermont's medication laws have heard that this can affect ED wait times. In all of the literature I have read, not once did anyone think that the forced drugging laws or inability to force drug people contributed to ED waits.
6. Perceptions increase in the number of psych patients presenting to the ED in distress, my hypothesis the use of antipsychotics is increasing the number in the ED's.

Comment: re: increase in medical applications – I think several people mentioned that and I read that in Act 114 report, I was under the impression that was partially a result from the state hospital doing medications and now two hospitals have the ability to do involuntary medication apps i.e. more petitions from a wider variety of physicians. I remember going around to both Rutland and BR with a psychiatrist and training the medical staff there about the use of involuntary medications and I have no idea if there is ongoing training for physicians in those hospitals about the idea of using involuntary medications.

Comment: I might have given the impression I am for medications, I am totally against meds for the reasons stated before. I formed a new opinion. My son speaks to the voices all of the time. He needs a line of separation from his voices (they don't; eat, need shelter) and my goal is to educate him, not using drugs but them learning to cope with the voices. I want him off these meds and it would be beneficial for him to get off these meds. We never coerced him to take drugs, it is always an alternative and available. In short term neuroleptics could be beneficial to cull the brain, but there might be a time to do that

short-term but long-term it is a terrible thing. Services need to take place long term that is the most important thing to make that connection. Your social network disappears. Finland is having great success without using drugs. You have to have trust – have mobile teams that visit you where you are more comfortable.

Comment: I would not want mobile teams coming in my home, bringing me to police station, absolutely not. My home is my haven. I have been taking medications 99% of the time since 1997. Therapeutic alliance comes from not the psychiatrist in the hospital but an alliance with the lower staff. If the patient is terrified of the treatment they are getting, they want to take their own life or their quality of life suffers – anyone who watched the old movie *Asylum*, knows that patients used to literally receive frontal lobotomies. I would surmise that in 10-20 years Vermont and the country will look back at force drugging as archaic. We need to embrace open dialogue, healthy and safe relationships in and outside of hospitals.

Comment: I think a lot of what we are trying to discuss are various definitions of freedom and rights. I also ask we keep our focus on who meets the criteria for people who have met the danger to self or others. As a psychiatrist, we have begrudgingly agreed to do non-emergency involuntary meds. It is quite difficult when we have people who have sought voluntary treatment, who are there with people who are not as willing to avail themselves to treatment, and may in fact pose a risk of dangerousness, that is a real challenge. I went back home to Wisconsin to practice for 5 years. The laws are quite different, probably cause within 72 hours in front of a judge and attorney. Justice was rapid. At that 72-hour hearing, unlike Vermont laws, criteria were fairly lax, asking the question were the meds going to mess with their future hearings. My perspective is that the therapeutic alliance started quiet quickly after medication started.

Comment: I ask people to keep in mind when we are waiting for a non-emergency order – what is the risk of emergency meds that needs to be used because medications are not being received quickly.

Comment: It is clear to me that there is the first impact of forced treatment and the trauma that occurs with that. I am looking at it and wondering if there are other unintended consequences with the decision for involuntary meds. Perhaps the public gets an unrealistic expectation of the effectiveness of the medication, and doesn't understand the side effects of the medications. What might be within society, an unintended consequence of forced medication? Is that why parents are medicating their children now? There is forced medication and there is uninformed medication. Patients don't fully understand the long-term consequences.

Comment: The philosophy of care at VPCH, we are enacting and changing there, I want to share. The environment was not the best at VSH, but now have a new beautiful hospital designed for the patients, it is an adversarial place to start with as it is. I take pride in the physicians who work with me on being patient centered, of a trauma informed approach recognizing that coercion and restraints are traumatic and we all appreciate that. Physicians take that very seriously and struggle with that. We see individuals suffering. We have very high standard when taking this away from people. We train our staff to be less restrictive. Open dialogue approaches, we are very invested in that and send the physicians to that training. We are trying to listen to the individual's perspective. Respectful, person centered, culture

change is happening, but might not be for many years, and I am proud to be part that of that. I think Vermont is cutting edge. VT has a high standard, we also have to balance their autonomy with safety for the staff members, other patients. Sometime the length of time they have to wait – it puts lots of people at risk when they can't get medication. For the patients, when the court order comes in 90% of the time, they are like the judge has ordered this and it is not so much of a struggle. We work through it. If the medication we ordered isn't the medication they would have preferred, we will work to get them on the medication they prefer, if possible. Collaborative work happens.

Comment: It is not always easy to go with involuntary medication, but sometimes when someone is psychotic, they lose track of who they are, it can become more cumbersome and something needs to be done and there is no joy in that.

Comment: I am thinking there is not ever a good time to force drug someone. It seems to me that when I am hearing justification for forcing drugs, I am getting that it comes from an assumption that drugs are helpful, that they do more good than they do harm. It feels punitive for the person being forced drugged in my perspective. It is a real human rights concern. Legislation in section 5 is asking for an analysis for involuntary treatment in the ED and inpatient admissions. I do see a direct link there in that folks who are court ordered to take drugs in the hospital and then discharged, a lot of folks are having a hard time with that, having terrible adverse effect, inhibiting them from their actual recovery. There is not a lot of support in the community to come off of the drugs, we are creating medical emergencies and crisis from the withdrawals.

Comment: There is not a lot of education and support outside of the advocacy community for people who want to titrate off of drugs. A lot of the definitions in DMS are derogatory in nature. If I get slapped with a label of mental illness, it almost puts me in a subhuman category. Most people who have been taking meds for a long time (psychotropics) die 25 years younger than other people in the population. The trauma aspect needs to be brought up – forced drugging is an adult trauma.

Comment: I think a lot of good excellent points have been made. I think we can all agree that we need to treat dealing with mental health issues just the same as we deal with physical issues and destigmatize mental health issues. I don't think levitative is trying to dramatically change the current system or dismantle it.

Q – Are there things to improve the process as it stands currently?

Comment – I have an observation, in talking about the place we come from, it strikes me the disconnect from what I hear the psychiatrists saying and what the patients are saying. I think that is part of the problem. The communication between psychiatrist and patients is not what it needs to be. I think it would be helpful for the DMH to bring psychiatrist and patients together to a place outside of the therapeutic setting. The description of psychiatrists with the person I work with is not the same from the people in this room.

Comment: I appreciate everyone's different perspectives. It seems that this legislation that we are looking at it as wanting to review the data, what are some best practices, also getting to the patients who have been involved in the process more recently. What has worked? What hasn't worked? Looking at

services that has helped their recovery. Medicine does have side effects and trying to find the least amount of medication to support peoples' recovery for any medical condition. How do we get to that point? How do we maintain our wellness? We need to look at the best practices moving forward. How do we maintain their wellness in the community?

Comments: lots of different perspectives – I struggle with being coercive, but there are times. You ask what would you do here in this setting, other things aren't working at the time. I think sometimes you are doing harm and some benefit at the same time, it is a hard thing to hold in.

Comment - 90% of the time, they come up with some sort of compliance – part of that is losing an argument vs. not having an argument at all. We do have involuntary commitment in the medication currently – the people that involved are in that statute are a subset in the population. There is no due diligence to getting people titrated off medications

Comment: Stepping out of roles, speaking purely for myself as an individual – I think one of the disconnects from perspective is when we remember and refresh ourselves in terms of the statute that involuntary medication is only in therapy approved to a person who is incompetent to make their own decisions. Why wouldn't we not treat it the same as other folks who can't make the decisions? Someone has to step in. We don't talk about that as being involuntary voluntary, there is a whole lot of disconnects and we can't ignore those

Comment: If they are objecting – you can be incompetent and not understand and not be able to give informed consent and yet your rights are not protected as someone else stepping in. Mental illness is different - lots of different paradigms. Lack of social consensus on what mental illness is, and what is competency to make one's own decisions with the context of mental illness, the fact that the use of psychotropic medication is effecting your mind/thinking.

Comment: Deeply involved with the revision to our existing statutes. I think it is important to understand that the people who were involved in those legislative changes, reached the conclusion that best practice, is establishing a therapeutic alliance in treatment. That can take a long time – you shorten a timeframe, you lose the ability. For legislatures at the time, there is a lot of change over, and are very distressed that this whole issue is brought up again, because we feel we worked hard to draw that balance.

Comment: Physical versus vs. psychological diagnosis– you wouldn't take someone with cancer and put them in four-pint restraints if they refused and shoot them up with drugs. When medication is forced upon someone, often times obesity is a result., risk of diabetes. Would like pharmaceuticals to tweak medication for the side effects. When involuntarily hospitalized, I was held a lot longer than needed.

Comment: I represent people in all the involuntary medication proceedings, involved in the civil system. I have been involved in discussions about accelerating and expanding involuntary medication for many years – it is very distressing to me that year, after year, what happens is that someone perceives there is a problem, the immediate response is to take people's rights to defend themselves away. That is not representative of the people's rights or values imbedded in the statutes. I think this discussion has been

driven in recent years by people who deep down, really don't believe that there should be judiciary should have a role in designating what treatment patients receive and those definitions should be made exclusively by psychiatrists. That is not what the 3 psychiatrists in this room think.

Advocates of speeding up medication and commitments, always bring up the patients who wished they had been medicated faster and what we are told and what legislative committees are told we have to listen to people who wish they had it done faster. Implicitly we are told to ignore the patient, after patient who comes to these and says I am person who was medicated involuntary, and I do not wish for this to happen any faster. Every single year that has been an increase in filings.

Comment: I think if we continue with our current approach, I would ask we make sure we have the space, the staff and the training of staff to allow the time to happen and we also don't squeeze out patients who are seeking treatment voluntarily. We also need to do a better job once someone has gone through the involuntary system, that they be afforded the appropriate stepdown after they discharge from the hospital.

Comment: What is working are the services provided from the Howard Center, paying people more money is huge and I still believe that the mobile units are great.