My Turn: Myths of involuntary medication

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Involuntary medication for inpatient psychiatry patients is a treatment option not understood by many outside of the mental health field. However, the process for initiating involuntary treatment will become an intense issue in the coming months because the public mental health system is in crisis.

General hospitals are caring for aggressive patients admitted involuntarily because they pose a danger to themselves or others. But hospitals cannot treat them effectively because the required judicial review of involuntary medication petitions is very slow under current law. As a result, patients are detained for months without specific effective treatment or realistic hope of improvement.

The result? Psychiatry inpatient units are full; patients and staff are being injured. Patients wait for days in small emergency department rooms because there are no hospital beds in the state.

Why do we allow this to happen? One reason is that general hospitals were not designed to provide detention and asylum while effective treatment is delayed. Further, a number of misunderstandings exist about patient needs and treatment.

I would like to address three myths that have prevented a reform of our laws:

• We’re protecting civil rights — Not really. Under current law, we involuntarily hospitalize people who have a mental illness that poses a danger to themselves and others. No one seriously questions that this detention is needed and appropriate.

But in what way do we protect civil rights if we do not offer effective and timely treatments that allow a person to leave the hospital? Withholding effective treatment is medically inappropriate and undermines the individual’s self-determination and recovery.

In addition, when the courts review petitions for involuntary treatment, the petitions are almost always granted. These reviews are careful and appropriate, but delays in conducting reviews delay treatment needlessly.

• There are ways to treat patients without medication — Generally correct. But for a particular subset of people, those who are admitted involuntarily with psychosis and aggression, other treatments usually have not worked or do not work for the specific illness in question.

Some context: Petitions for involuntary medication treatment are filed for approximately 40 people each year. These people are very ill, meet legal criteria for being dangerous, and refuse the recommended treatment. About 40,000 adults in Vermont have a serious and persistent mental illness; over 39,000 of them manage their illnesses by one means or another. That is, the overwhelming majority of them find solutions, whether medical or non-medical, that they prefer.

Of the remaining individuals, there is a tiny fraction — perhaps 0.1 percent of all people with a serious mental illness — who require the most intensive services that we can offer. Their treatment does require medication, and they cannot leave the hospital without it.

• These are dangerous medications, and we must avoid using them — The medications used in psychiatry have side effects and risks that are similar to those of medication used for any serious illness. Sudden and serious harm is very rare.

On the other hand, the illnesses themselves are quite dangerous, leading to bad health outcomes and to shortened life spans.

The risks of medications — particularly when used short-term in a hospital setting — are usually far smaller than the risks posed by the illnesses themselves. Surely the timely resolution of mania or psychosis, the elimination of dangerous behavior, and the restoration of freedom are benefits that we all value.

We need changes in legislation that will establish a rapid review of petitions for involuntary medication by an objective third party. I do not suggest that we

change the protections that are now offered to patients, or that we change the criteria for involuntary hospitalization or treatment, or that we interfere with the ability of competent people to make health care decisions.

I am proposing a significant shortening of the current review process.

We should understand a very small group of people have extraordinary needs that are now not met — but could be met in a timely manner with resources that we already have. Their situations are true medical emergencies deserving of a rapid assessment and treatment. When medication treatment is critical to safety and recovery, we should ensure that both judicial review and treatment are provided without delay