

## On Specific Coercive Practices

In my time as a patient advocate in VT, two consistent and disturbing practices involving involuntary status have stood out to me as particularly problematic. The first is the possibility of involuntary status being used inappropriately as a threat to coerce patients into or out of behaviors. The second is the possibility of involuntary medication being used inappropriately as a threat in order to coerce patients into taking medications.

I think it's fair to say that any action taken under duress is not a truly voluntary action. If I'm told at gunpoint "get in the car or we'll force you into the car", most reasonable observers would perceive my subsequent entering of the car as involuntary, regardless of whether I'm being manhandled in.

This false choice is presented to patients in the psychiatric system every day. "If you don't take the medication they'll get a court order and make you", "If you don't go to X facility *voluntarily* you'll have to go *involuntarily*", etc. I think it's obvious that these practices violate Vermont's stated directive of having a mental health system free of coercion. This should be sufficient reason for us to be considering legislation restricting how patients can be spoken to.

In addition to the moral and legal problems associated with coercing patients with threats, these practices also shroud the realities of our mental health system in darkness. We have no idea how many patients in our state's hospitals are actually inpatient on a truly voluntary basis, and this lack of surety contaminates any conclusions we draw from data on patient vol/invol status. The same applies to conclusions we draw about medication practices.

On top of all of this, the confusion and terror reported to me by patients I've worked with has convinced me that these practices are traumatic and hindering recovery. Patients often feel that they are trapped in a capricious system that operates in a fashion inconsistent to its publicly stated rules and procedures. My first week on the job, a patient tearfully explained to me the difference between being actually voluntary and being technically voluntary. Her explanation of the logic of the threats and conditions she was presented with required circuitous and absurd language. Another patient told me he felt invisible, trapped between gears in a sealed machine. Were these not conversations that took place in real life they'd would be at home in a pitch-black political farce.

A few months into this job, I wrote a friendly set of guidelines that I proposed be used by med nurses at the Retreat when talking to patients. I wrote them under the mistaken

assumption that coercive threats result from a lack of training. The administration showed no interest in them. I have since realized that the misuse of invol status and forced medication orders as threats is seen by some as a feature (not a bug) in the current system of care. Regardless of whether this was intended to be allowed, it currently is and is widespread in its application.

I am not a legislator, and I don't know what specific course needs to be taken to rectify this, but I plead the committee to consider some measure that directly forbids threatening patients with invol status or forced medication orders. I believe is too convenient a tool for frustrated Nurses, MHWs, and Doctors for it to be eliminated in a less direct fashion.

Thank you for the opportunity to share my thoughts,

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