Quick Takes
A PODCAST BY PHYSICIANS FOR PHYSICIANS
HOSTED BY DR. DAVID GRATZER

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The debate over coercive care in mental health with Anna Mehler Paperny

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[Intro music]

David Gratzer: The Alberta government has drafted legislation, though not released it, that would see people with substance use disorders pushed into involuntary care. Among its fans, the premier of British Columbia. In California, they now have CARE courts with a similar idea. And over in New York City, the mayor is talking up the idea of more involuntary hospitalisations and treatments for those with major mental illness. To quote the writer and journalist Anna Mehler Paperny, "coercive care is having a moment."

My name is Dr. David Gratzer. I'm a psychiatrist here at the Centre for Addiction and Mental Health. Welcome to *Quick Takes*. Today we're talking about this topic. What should we worry about? What should we do? And we're talking with Anna Mehler Paperny, who, as I've mentioned, is a journalist, a bestselling author, and someone who's written and spoken in a very forthright manner about her lived experience. Welcome, Anna.

Anna Mehler Paperny: Thank you so much for having me.

David Gratzer: Is coercive care having a moment and why?

Anna Mehler Paperny: I think it is. And the reason I say that is because we're seeing multiple jurisdictions either float the idea or roll out new policies, procedures, legislation that would facilitate increased use of coercive care.

The "why" is a little harder to figure it out. On the one hand, you could say, well, people are seeing a need and now if there is a need, is that because we're seeing greater acuity of illness? Or is that because we're seeing more people affected? Is that due to other forces making people more sick? Or, our failure to treat people early which is resulting in deterioration? But I think whether or not we're seeing a greater acuity, I think we're also seeing a renewed distaste for disorder. There's this real sort of desire, I think, on the part of governments fueled by pressure from members of the public and from organisations within the public, to address disorder, to address people on the streets, to address issues around substance use. There's a heightened need for concern because this is not motivated by even superficially the best interests of the people being coerced. It's moved by a desire, justified or not, to help the orderly public and their desire to deal with instances of "messiness" in the public eye. And I think that's cause for concern.

David Gratzer: That's a bold statement. Some of the people who support coercive care, though, are family members of those with persistent mental disorders. So, we'll set aside the question of whether or not the politicians might be guilty of political opportunism for a moment, but to your question, though, about disordered, what to make then of family members who are so supportive?

Anna Mehler Paperny: Oh, man. Some of the hardest conversations I've had have been with family members struggling to deal with really unwell relatives. And it's painful because you can tell they want so badly to help them. And there's a compelling case to be made that when somebody lacks insight and they are either harming themselves, or are at risk of harming themselves, or at risk of harming somebody else, or, as in many jurisdictions, they stand the risk of substantial deterioration as a result of their unwellness into which they do not have insight. There's a case to be made these people who are causing, inadvertently, their families so much pain should be for some period of time coercively treated or coercively hospitalised. I think there is justification for that. And certainly, where we have frameworks for coercion, those tend to be, broadly speaking, the guardrails, the criteria under which that happens.

Where I think I become more leery is in discussions around expanding those criteria. I mean, who isn't at risk of harming themselves in some way? You know? As justifiably worried as family members are, we have to weigh that against the agency and the rights of the people we're considering coercing. And that should happen every time, no matter how upset family members are. People disagree with their relatives a lot. Sometimes they disagree with them about their own care, and I think we have to keep in mind that, to a degree, and we can debate over where that degree ends, people have the right to make bad decisions and people sometimes do things their doctors don't agree with. And they do things that their family members don't agree with. So, we have to ask ourselves, where do we draw the line? At what point does your right to make bad decisions for yourself end and society's obligation to address your bad decisions, to address your unwellness, where does that kick in? And so that's really the question that we have before us.

David Gratzer: And it would seem in some jurisdictions and again, draft legislation is not real legislation, say, in Alberta or discussions like we have in British Columbia. But it would seem that in some jurisdictions there is an active debate about rebalancing some of our patient's most basic rights.

Anna Mehler Paperny: It's true. And I think what's interesting in Alberta and what's being floated in B.C. as well is that the discussion is around substance use specifically. And I mean, you know the research better than I do, the efficacy and helpfulness of coercion when it comes to substance use the evidence is just not as strong. I mean, and we can debate the evidence over coercion broadly, but when it comes to substance use, because of the nature of the unwellness and because of what a period of time involuntarily hospitalised and involuntarily treated, because of what that can do to you once you get out if you don't have the buy-in required to continue either the abstinence or the medication assisted treatment, there are very real risks around overdose and death.

David Gratzer: Now you speak as a bestselling author and a thinker on this topic. You're also somebody who has written very clearly and thoughtfully about your own experiences. How does that inform your views?

Anna Mehler Paperny: It probably does more than even I would admit. Just because being involuntarily hospitalised has a real effect on you. It changes the way you see yourself. It changes the way you see your care practitioners. It changes the way you regard treatment. It certainly changes the way that you see coercive care going forward. And while I understand why I was involuntarily hospitalised on multiple occasions, I can see the basis for it, I can see the justification for it, but it also could have really turned me off treatment. Because at the very least, it is an infantilizing exercise. It is an exercise that tells you: "You do not know what's best for you. You cannot make these decisions for yourself. We can and we will." And that's traumatising. That creates very real trauma. And that if that turns you off of care, even if it does provide short term benefit, can actually provide long term harm if a person does not seek treatment. If a person does not trust their care practitioners, that harm is long term and can actually cause really serious sequelae.

David Gratzer: I'm on the other side of the equation as a provider, not a patient and I can certainly see that perspective and I've had difficult conversations with patients over the years who've talked about the humiliation. They've also talked about how it stoked memories of past trauma. It's a heavy decision to make, but sometimes these decisions can be lifesaving. What are your thoughts on that?

Anna Mehler Paperny: I do believe that coercion is justified in certain circumstances, and it can definitely be lifesaving. If a person is about to kill themselves or is about to harm themselves in a serious way, if you prevent that, that's a benefit. I think we have to ask ourselves two questions. One of them is, is there a way to achieve that benefit without coercion? Is there a way to persuade a person to acquiesce, to care and to hospitalisation? And I think that is possible. Most people, even if they don't agree that they have a mental illness or that they have a disease, most people want to feel good. And if you can make them feel better, if you can say, look, we don't have to agree, you have schizophrenia, but you seem to be having some challenges, this is how we might want to address them. This is how that might work. This is what it could do for you. Would you be amenable to just trying and see what that's like? Obviously I'm glossing over things, but I think I think, you know, clinicians have a power to persuade in a lot of cases. And then if someone is acquiescing to care or to hospitalisation, that can make the intervention potentially more effective. It can make it more likely that they stick with it when, you know, over the medium to long term.

I think the second question to ask, is will the long-term risks associated with coercion and the harms associated with that, will those outweigh the short-term benefits? And that leads to, I think, a bit of a "so, now what?" Question. You've hospitalised them against their will, now what? And I believe honestly that the "now what?" question should start at the moment of admission, whether it's voluntary or involuntary. Like what are you going to do with this person in the next few days? Few weeks? What are you going to do with them when you discharge them? And I think this is a weakness in our health system broadly, but it certainly exists in mental health care, and it definitely exists in involuntary mental health care. I don't think we often enough ask ourselves: "What's the next step? What is going to happen when this acute intervention is over and how do we set ourselves up for success and set the patient up for success going forward?"

David Gratzer: What should we do differently?

Anna Mehler Paperny: Starting a discharge plan on admission is the first step. It's difficult for psychiatrists, I think, because you're faced with a patient, you could clearly see a problem and they do not see it the same way. And while I don't have data to back this up, I'm pretty sure that psychiatry is probably one of the fields of medicine with the most disagreement from patients about what's wrong. Because what's wrong has to do with your fundamental conception of yourself. I think what the answer to this needs to be a greater degree, and I hate to say this, but of humility on the part of psychiatrists. You know, saying, "listen, I may feel like I know what's wrong with you, but you don't have to agree with me. We can pursue interventions. We can work together. We can collaborate." I think recruiting the patient as a collaborator is one of the most valuable things that a clinician can do.

David Gratzer: There's a *JAMA Psychiatry* paper that got published a couple of years ago that asked for the priorities of physicians and then contrasted it with the families' priorities and the patients' priorities. And obviously there's some overlap, but as a general rule of thumb, physicians tend to focus on symptoms and symptom checklists, and families and patients tend to focus much more on disability paperwork and insurance paperwork, things that and I'll confess this as a doctor, and I only speak for myself, we hate. Well, what are your thoughts on that?

Anna Mehler Paperny: I think it speaks to the importance of asking on the part of the clinician saying: "What are your priorities here? What is most bothering you? What are you worried about?" and seeking to address that. Where there's a diversion, a divergence in priorities, ask ourselves: "Why is that? Is it because the patient or the family members don't appreciate the gravity of what's going on?" And if so, can I explain it to them in a respectful and engaging and accessible way? Or do I, as the clinician, not appreciate their challenges and what they're facing? And if so, do I need to educate myself about what they're going through?

David Gratzer: Now, let me push you a bit. We've got multiple jurisdictions talking about more coercion. And you've expressed your hesitation, and as is always the case, in a thoughtful way. So, there is a role for coercive care. You acknowledge it can be lifesaving, but you think rebalancing may be a mistake. What should we

be doing when we think about violence on the TTC [Toronto Transit Commission]? The growing numbers of people who are overdosing with opioids, and so on?

Anna Mehler Paperny: I think the first thing we need to ask ourselves is what is the problem we're trying to solve? And the second thing we need to ask is, is this tool something that is going to solve the problem? So, while it may seem like a beguiling option to effectively lock up drug users so that they don't use drugs and overdose, is this tool going to address that problem, or are we just going to see people discharged after involuntary treatment or hospitalisation discharged with a lower tolerance to overdose?

The issues of violence in public places is hard because there's, I mean obviously harm to the health system is a harm, but harm to other human beings is awful and something that we want to prevent. The question I think we need to ask ourselves is: "Were there opportunities for intervention or prevention preceding these events?" And if so, if we're seeing harms committed by people with identified mental illnesses, was the only available or potential solution coercion, or could a voluntary intervention have had an effect? Are we seeing people commit heinous crimes following a falling through the cracks? Following a system failure? I would argue that before we beef up coercion it's incumbent on us to beef up the voluntary system to ensure that everybody who wants and needs care is getting it in an evidence based, accessible, attractive way. If that's the case, and if we're still seeing people falling apart, falling through the cracks, engaging in violent behaviour, then the question should be, okay, we have all the voluntary care we need, are there instances where involuntary care should be expanded?

David Gratzer: Let's make you the Tsar of Canada for a day. What would be on your wish list in terms of expansion of voluntary care?

Anna Mehler Paperny: I don't want people to be walking into psych emerge trying to calibrate their crazy in a way that will let them be admitted but not committed. Because I talk to a lot of people who say I've been turned away from the psychiatric emerge at CAMH, at other places. So I want to address that. I want to make sure that everyone's seeking care, gets care.

I want outpatient care to be available and accessible and evidence based and attractive so people can get psychotherapy, so people can get pharmacotherapy, so people can be followed because these are chronic illnesses. These are not acute issues. I mean, they can become acute, but they're not going to go away after a few days in hospital, whether that's voluntary or involuntary.

And I would try to engage family members in care to the degree that people with capacity consent. And I would make sure that we have a really robust voluntary care system in those respects, outpatient prioritised because most people are outpatients, and all inpatients will become outpatients. But that would be my first step.

I would also add, I think one thing that we need to emphasize is the importance of treating people with respect. When we're caring for them, whether they're voluntary or not, there's been research that shows that even more so than their voluntary status. What affects the way people view the care they receive is how they were treated. And it's possible to respect people and respect their agency even when you're involuntarily treating them. So that, I think, is really vital.

David Gratzer: Well, let me push you on that point. And of course, you're not speaking for every patient, but you have had involuntary hospitalisations and you've written, including a very compelling piece for the *Globe and Mail* recently about dehumanising care. What's the opposite of that? What are things, even in an involuntary admission that you personally found useful, or patients you'd spoken to, or family members had found useful?

Anna Mehler Paperny: Talk to people like human beings. Explain what you're doing. Explain why you're doing it. Explain if you can't meet their immediate need, explain why and tell them what you can meet. What

needs you can meet. Like these aren't complicated. But I think it's hard because so many of these illnesses intersect with behavioural issues and we have a strained system whose resources are strained. We're working with nurses, working with doctors who are under a lot of pressures, who may not always have the, you know, perceived capacity to explain their decisions. That, I think, is so important, though again, you can recruit someone as a collaborator even when they're involuntary because they retain other rights. Even as you abrogate some of the rights, you abrogate their liberty rights, but they still maintain others. And I think keeping that in mind, I think just sort of talking to somebody as a person. You know, explaining what you're doing and why you're doing it can make a really big difference.

David Gratzer: Do you have a message to the doctors who are listening?

Anna Mehler Paperny: Yeah. I think psychiatry is incredibly important. I think mental health care is unbelievably important and it's inadequately addressed and inadequately respected. And so I want to say to any doctors listening how much I respect their work, how glad I am that they're in this field and that they care about this work. And I recognise that people with severe mental illness are often challenging to deal with. That's the nature of the illness, whatever the illness may be. That said, I think the imperative to treat someone as a human being with respect cannot be overstated. And I think that that becomes more important when you are engaging in coercion and not less so. And so that needs to be remembered. But I think at the same time, the imperative to persuade, to recruit as a collaborator, a patient, even one, especially one who may have a leery view of your suggested interventions, I think is so important and I think will set the physician clinician relationship up for success but will also set the individual up for success in the long run.

David Gratzer: Can you think of a conversation with a doctor that was done right that perhaps helped you? What was said?

Anna Mehler Paperny: Yeah, I've been lucky enough to have a really wonderful psychiatrist who's followed me for years. He was actually the first psychiatrist, not the first to form me, but the first to extend my form. So, the Ontario version of an involuntary hospitalisation. He extended it for two weeks, which I had just been hospitalised after a suicide attempt. I was a mess and I was furious at him. I thought I thought he was making a terrible decision. I thought it was going to hurt me. I thought I wouldn't be able to go back to work. I was so upset. But he treated me as a human being. He made sardonic jokes in our sessions (respectful ones), he treated me like somebody capable of comprehending what was going on. I will just say that I think by approaching our sessions from a point of mutual respect he made me a participant in my own care in a way that I had not experienced before in hospital. And it continues to this day. Like when he makes a recommendation for treatment or for an intervention of some sort, I respect it even when I don't always agree. And when I don't agree I tell him, and I tell him why. And so we hash that out. When he's suggesting a medication change, he'll name the medication, explain why he wants me to take it, and then he says, take a week, our next session is a week from now. Go out, research it, come back with questions. So, I feel empowered. So, by making me a collaborator, he's helped to ensure that I pay attention, that I make sure I take all my meds on the right day, which sounds like a minor thing, but like adherence is an issue in psychiatric medications. And he also has proven, perhaps to my chagrin, that it's possible to use coercion without losing trust. And that is so important because while I would argue that coercion has to be used as a last resort every time, when you do use it, it does not have to jeopardize the patient-doctor relationship. And I think that's really important.

David Gratzer: Anna. It is a *Quick Takes* tradition to close out an interview with one rapid-fire minute, a series of quick questions and quick answers. Are you game?

Anna Mehler Paperny: Sure!

David Gratzer: I'm going to put a minute on the clock. You ready? Here we go.

Anna, do you think we'll end up rebalancing patient rights?

Anna Mehler Paperny: I think we will. I think it depends on what you mean by rebalancing. I hope we rebalance them in a way that respects the patient.

David Gratzer: What keeps you up at night?

Anna Mehler Paperny: A million things. The fear of failure, the fear of inadvertently harming the people I interact with.

David Gratzer: What's one thing psychiatrists should do differently?

Anna Mehler Paperny: I think that I will say the recruitment as collaborator is probably the biggest thing.

David Gratzer: Is your psychiatrist on your Christmas card mailing list?

Anna Mehler Paperny: He should be. If I sent Christmas cards, he would be. Yes.

David Gratzer: You're a bestselling author, a lot of people have read your book in English and, I understand, other languages. Are you writing another book?

Anna Mehler Paperny: I am, actually. I'm very excited about it. It's in edits now. It's taking forever, but yes, I am.

David Gratzer: Well, we can't leave us hanging there at the buzzer. What's the book about?

Anna Mehler Paperny: It's about police interactions with people experiencing mental illness. I actually, full disclosure, interviewed you for it. This was a couple of years ago now because it's taken forever. But it is in edits. It's going to come out!

David Gratzer: I wish to be portrayed as tall and smart!

As always we appreciate your comments. You're an important voice in this debate. And on a personal note, it's very courageous the way you talk about not only these issues but talk about your own personal experiences.

Anna Mehler Paperny: Thank you so much. And thank you for having me. It means a lot.

David Gratzer: Thank you for making the time.

[Outro:] *Quick Takes* is a production of the Center for Addiction and Mental Health. You can find links to the relevant content mentioned in the show and accessible transcripts of all the episodes we produce online at porticonetwork.ca/web/podcasts. If you like what we're doing here, please subscribe.

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