Yale Conferences and Events

RebPsych 2022

Mental Health, Captivity, and Liberation

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[Parallel session 2]

[2A: Insights on Power: A Panel Discussion on Involuntary Treatment and Informed Consent - Kathy Flaherty, Leah Harris, Leigh Nathan  
  
Sreeja Kodali: Welcome back. If you want to submit a question do so in the question panel. There is closed captioning. This session is being recorded.   
  
Welcome to another RebPsych. I use she/her pronouns. I am a south Asian woman with brown hair. Thank you to our closed captioning team. If you want to see closed captions, select CC.   
  
I am pleased to open our next session “Insights on Power: A Panel Discussion on Involuntary Treatment and Informed Consent.” It is featuring these three presenters.   
  
Kathy Flaherty is the Executive Director of Connecticut Legal Rights Project, Inc., a statewide non-profit agency that provides legal services to low income individuals with mental health conditions, who reside in hospitals or the community, on matters related to their treatment, recovery, and civil rights.  
  
Kathy combines her personal experience as a recipient of mental health services and her legal background to speak to issues affecting those living with mental health conditions.  
  
Kathy is on Twitter @ConnConnection. Kathy has written op-eds and guest blog posts on a variety of topics, including politics, law, mental health, adoptee rights, and soccer.  
  
Leah Harris (they/she) is a mad, queer, disabled writer, facilitator, and advocate of Eastern European Jewish heritage. Their work focuses on access, autonomy, and choice, surveillance/tech in the mental health/suicide prevention space, the history of carceral mental health, and psychiatric abolition.   
  
Their writing has appeared in *Rooted in Rights*, the *Disability Visibility Project*, and *Mad in America;*and in the anthologies *We've Been Too Patient: Voices from Radical Mental Health*, *Fat and Queer: An Anthology of Queer and Trans Bodies and Lives*, and the forthcoming *Mad Studies Reader*. They live on stolen Manahoac lands, also known as Northern Virginia, USA. Twitter: @LeahIda  
  
Dr. Leigh Nathan is a psychiatrist in private practice. She is a Clinical Instructor (volunteer) with the Yale Program for Recovery and Community Health (PRCH) and a Healthcare and Recovery Integration Coordinator with The Housing Collective, a non-profit that addresses homelessness and affordable housing in Western Connecticut. She is also an advocate of Person-Centered Process Improvement in healthcare and social service delivery.

Dr. Nathan received her M.D. from Temple University School of Medicine. She completed her psychiatry residency at the University of Colorado School of Medicine and completed fellowships in Consultation Liaison Psychiatry (previously known as Psychosomatic Medicine) and Public Psychiatry at Yale School of Medicine's Department of Psychiatry.

Before I give the stage, some friendly reminders for Q&A. Our speakers will speak and there will be opportunities for questions from the group. Use "I" statements, do not use statements that are retraumatizing. With that I am happy to yield our stage to the panelists.   
  
Kathy Flaherty: Thank you so much for the applause in person or virtual. When I was approached by the folks organizing this conference I said, sure, I would be happy to speak if I can bring more people with me. Those people sitting in the auditorium, house, or office, listen, you have had your mind blown as much as I have.   
  
That is one of the reasons I love this conference. We wanted this to be a conversation among the three of us and incorporate all of you. We have built in plenty of time for questions and answers. Please put them in the Q&A or those in the auditorium they will deal with those in person.   
  
We will talk about what is wrong with the system and what we want to change but tell you the process of this and our thinking. I know from listening to the presentations today that this is not how I viewed the system when I entered it. My views have changed over time.   
  
As an attorney we are stuck working in the system by certain rules. We will give more of an introduction of each of us and then various topics of conversations. I will start. I am a psychiatric survivor. My first year of law school I was committed. I showed up for an appointment at my psychiatrist’s office and her telling me she was putting me in a hospital.   
  
I had no idea that could happen in the U.S. much less anywhere in the world. I walked out of the building into the waiting arms of the police. Fortunately, that is as bad as the situation got. I had that experience of involuntary, being forced going into the hospital.   
  
A tiny bit of trigger warning here. There were forced medical and restraints and following that experience I engaged in the system in a voluntary basis for decades. I had periods of checking into the hospital, participating in treatment given, and it changed given the timeframe I was given.   
  
Despite being told these were medications I would have to be on the rest of my life because I had a chemical balance my brain had to correct, I found that not to be true. I tapered off the medication and for better or worse feel the feelings, feel the life, engage with the world around me and not numb it with medications.   
  
I have had the experience of representing people over a number of years, some of whom feel the same way about the system. But I also have the experience of knowing people who have looked to the system for help and have found it. So that is something I always struggle with, how some people are finding what they need from the system but others are not.   
  
I would like to introduce Leah and then Leigh.   
  
Leah Harris: Thank you. I am a second generation survivor of family policing and family separation. I talk later about how these are intertwined. A little content warning about what I will be sharing.   
  
The story begins in part with my mom forcibly hospitalized at least 20 times. I am still collecting the correct numbers. This was over the course of her brief life. I tracked the effects of forced antipsychotics and forced poverty for many mentally ill folks. She passed away at 26.   
  
I was 5 years old when our family was separated. I was raised by my material grandparents who positioned my mother for being at fault and responsible for the family separation. They thought she have been better at complying. I didn't have an alternative framework.   
  
It was this simplistic equation, that mental health care is good and if you resist it is a sign of your illness. I had my own surreal experiences as a teen in voluntary psych wards and institutions. It planted skepticism. I went on a quest to find out what happened to my mom and us.   
  
I ordered her psych records. It was a giant stack. This occurred in Milwaukie. This connected me with Mad Movement, survivors, and more. It continued the process of unlearning, as the previous panel discussed, unlearning everything I was taught about mental health.   
  
It was a complete world view shift that has continued to affect my advocacy to this day.   
  
Leigh Nathan: I will go ahead. Leigh Nathan, I practice here. I finished in Colorado my education. I have been on faculty and worked in several different settings including clinics and hoping to improve care of people who are interfacing with mental health and homeless system.   
  
Prior to my time in healthcare, I was a manufacturing engineer and have worked in areas with robust improvement cultures. I may explain a bit about that.   
  
Throughout my working history in psychiatry, I have unlearned a lot of what I was taught and understood what person centered practices are. I'm still learning those things.   
  
I can see that a lot of our laws, regulations, and practices do not align with person centeredness. I chose psychiatry because I was very curious about the human experience. I didn't really understand the statutes that guide our work when I entered this field as a medical student.

I use work to distinguish from our care. I don't think my care can often align with my work because of the ways the laws are set up and how people with my credentials are given power.   
  
I've come to understand that it is a conviction, not a thought or feeling. We shouldn't do coercive things to humans. Being coercive is wrong.   
  
We have had our experience in Connecticut. It's been wonderful to talk to Leah and get her views. I feel like I am growing into others space. I am emphasizing the importance of looking at our world history, world history, case law, etc. to guide our work.   
  
I am currently looking at returning as a liaison and working in responsiveness.   
  
Kathy Flaherty: To talk about our conversant, we will talk about power, involuntary treatment, and informed consent.   
  
I want to refer to something in your intro, Leigh. What is informed consent, as a psychologist, and what should it be? How is that informed your work, as you said, and not the care?   
  
Leigh Nathan: It's being able to consent to a medical definition. It's having the competence to make a decision, being adequately informed, and not coerced. If those things are intact, it's informed consent.   
  
Informed consent is supporting mutual understanding and that mutual experience of trying to be helpful and understand one another by offering assistance. We've sullied that with the different factors that go into modern healthcare.   
  
My work around decisional capacity is to understand how we assess, and when we assess, decisional capacity. It took me many years to figure out that the one place we're not doing this is in situation where we're concerned about psychiatric dangerousness. We have a different set of laws. It's a bewildering situation sometimes. [Laughing]   
  
If the person has a "medical brain" problem, we use one set of laws. If they have a "psychiatric brain" problem, they use a different set of laws. It's confusing for trainees. I'm trying to untangle this, especially since we are being told that psychiatric diseases are psycho neurologically based. When there's a concerned about dangerousness, many statutes across the country (which vary widely on criteria) have a dangerousness requirement as opposed to their ability to consent to that treatment and being able to have decisional capacity. Decisional capacity would include what they can expect and what would suggest that it will be a helpful experience. We leave these things out.   
  
People find themselves in hospital settings. My work on the outpatient side means that people are very bewildered by what experience. I'll stop there.   
  
Kathy Flaherty: From my side, as a patient, service user, and participant in this system, my recollection about what happened, especially in terms of involuntary hospitalization, seemed to go out the window.   
  
Having signed myself into the hospital "voluntarily," the first time I was hospitalized was because they were sending me there anyway. The really was not anything I would call a free choice.   
  
Speaker: I'm so sorry to interrupt. The fire alarm went off. Can I pause you for two minutes and revisit?   
  
Kathy Flaherty: Absolutely.   
  
Speaker: Thanks so much.   
  
Folks, the fire alarm went off. Why don't we leave the building? For the folks online, we will try to restart in a few minutes if everything is clear. Thank you for your patience.   
  
[Fire alarm on-site]  
  
Speaker: Hello our virtual and in person attendees. Thank you for your patience. The fire alarm has turned off. We will be able to resume the session in a few minutes. In person attendees are trickling back in. Thank you for your patience. We will be able to start again quite soon.   
  
Hello again folks, thank you for your patience. Carley, if you could resume the recording, that would be great. Thank you for the patience of our panelists. We will let you resume your talk.   
  
Kathy Flaherty: Thank you for your patience and welcome back. There's nothing like a break in the middle of a panel to get the excitement flowing for the rest of the conversation.   
  
I'll try to remember where we were. I think Leigh had talked about her ideas as a psychiatrist about what informed consent could and should be. I had talked about how I experienced that as a patient.   
  
Note that I will talk about inventory medication a bit. When you talk about forced psychiatry, whether being put in a hospital or when you are there and are told to show up at a window to get a cup of water and some pills, people are not usually giving you the printout of those medications.   
  
They are not talking to you about the risks and benefits of taking the medication or not. It becomes a power play. That's why we put the word power in the title. It's either that you comply, or you are told that you will be injected with medication. That can involve being told to be in a room. If necessary, you may be held down and injected with a medication. It's not even the normal medication they would give you in the pill. It's a sedative to knock you out and calm you down.   
  
We heard about that from Dr. Hatch this morning, about how these medications are used in a caracal setting to keep people calm.   
  
I want to turn things over to Leah to talk about informed consent issues.   
  
Leah Harris: Thank you so much. Like Dr. Jenn, I sometimes use humor as a bit of a coping mechanism. There is this term "free and informed consent." It feels increasingly like a rainbow unicorn that only appears in our dreams.   
  
There is the technological and analog dimension that I will talk about. This is a whole other panel, but I think it's important to look at the world of mental health apps. There's about 10,000 of them at this point in time. You are required to consent to a bunch of legalese that you will probably not read or understanding all of it if you do read it.   
  
If you don't opt in, you can't access it. That makes consent fuzzy.   
  
It also makes me think of the crisis text line, as some of you know the story with that. I wonder how many people would have freely and fully consented to use crisis text line services if they knew the company was handing over their data to an AI service bot that they used to train customer service people. They were using the data of suicidal people in that highly unethical way. Would they have consented to that? Maybe, but it blurs the line around consent.   
  
I also want to talk about how consent is blurred in all of the ways of old school force, under the guise of diversion. There are different sorts of diversion programs. There's no meaningful consent here. It's framed as a choice. When we think about the proliferation of treatment courts, problem solving courts, drug courts, etc. there are so many of them. There's also inventory outpatient commitment statutes. I see them as connected.   
  
Is it free and informed consent if you are given a choice between treatment choice, hospitalization, or caracal options? There's a quote from a fantastic website called BeyondCourts.org. It's from a report called "Problem Creating Courts." They say that coerced services under the threat of incarceration are ineffective, violent and inhumane."   
  
I wanted to talk about what was free and informed consent. There's so much more we could say about this.   
  
Kathy Flaherty: I wanted to talk more about how involuntary treatment may have changed over time. As I said, the first time it happened to me, it was something that I didn't know could exist and could possibly be legal.

In any other kind of medical treatment people talk about giving respect to people’s autonomy and choice and encourage you to seek another opinion. They don't do that in psychiatry, but it is gathered by the facility to get support to treat people against their will.   
  
You don't routinely see people offered the ability to consult someone else to see if a different professional has a different perspective on what could help somebody. For me, the ability of psychiatrists to force what is really a recommendation, that becomes through the power of the law a forced order, it taught me I could not be honest in my relationships with certain treatment providers.   
  
I learned certain people had legal authority to write orders that I be taken to a hospital and held against my will. I don't know why anybody thinks they will continue to be honest in those discussions. I would like to turn it over to Leigh to see what it is like from the psychiatrist's perspective.   
  
Leigh Nathan: Thank you, Kathy. I graduated in 2010 from medical school so that is 12 years practicing and I have to say I am still putting it together myself. It is very confusing. Like you mentioned, Kathy, I know people professionally and personally who got an involuntary course of treatment.   
  
Where I am today on this is that if we presume there is one right answer, we're getting it wrong. We have to make it so that there is something for everyone and ask ourselves how we can arrange this so that it so people could volunteer as they could. They do what they are inclined and drawn towards.   
  
It goes back to coercion and understanding. Looking at Maslow's Hierarchy of Needs that has belonging and time to contemplate and come back, it involves repairing parts of relationships with understanding and coming out to say let's repair it.   
  
That is essential to healthcare. When a person believes they have knowledge to alter a person’s life for the better, be it medical or psychiatric, and is in a conversation with someone we are talking about, it often needs to be lengthy conversations.   
  
The things I need to make sure I do is look at the task list from an employee/worker standpoint how to use as much time as I can to have the most deep possible conversations so I can't get around it. That is why I talk about person process improvement.   
  
We're saying "person first." To be person centered we have to look at worker centered as well with the final goal of making time for relationships. It is that understanding that can lead to agreeableness, but not to medicine but agreeing on what will happen next.   
  
It is sharing in that philosophy and practice.   
  
Kathy Flaherty: Leah, can you say how this played out for you and your mother and what you found out from her medical records?   
  
Leah Harris: Yes, absolutely. Thanks, Kathy. I think that is something not spoken of as much, the impact on not just the individual but the entire family of forced psychiatric care. She was a woman with one of the most difficult diagnosis, schizophrenia.   
  
Looking back now I realize she needed support. She was living in poverty. She needed additional resources and parental support. Instead, she found the family policing system coined by Dr. Dorothy Roberts. These involuntary incarcerations were these little operations like 0 to 5 years.   
  
Those who have experienced trauma know these are critical years. These were used as fodder against her in court when she fought for five years for custody for me that she ultimately lost. I am old, this happened in the late 70s. If their story was obsolete, I would sit down and be quiet.   
  
I would say almost nothing has changed since then. That might be hyperbolic, but it is how I feel. Research done by Dr. Mary Seaman says 50% of mothers diagnosed with schizophrenia will have their children taken away. That is at least 50% that the data says.   
  
I think it is important to say that involuntary care has this result. As a result of what I went through this has intergenerational impact. I think all the more reason to carefully consider when doing this the harm that can happen across an entire family.   
  
Kathy Flaherty: Thank you, Leah. I want to ask you quickly how you were talking about that it effects an entire family and social circle, but can you answer two questions? How does a psychiatrist feel about a patient with history of involuntary care? Is there anything in the system that perpetrates it?   
  
Leigh Nathan: Thank you, go one question at a time please [chuckles].  
  
Kathy Flaherty: What goes into the calculations a psychiatrist might make for someone with a history in care?   
  
Leigh Nathan: Psychiatrists, we are different people. We are humans that practice psychiatry so I can only speak for myself. When there is a long history of involuntary treatment my question is. At what point are we going to try something different and what healing does the person need?  
  
I don't want to presume but it starts with trauma. How do I support someone who experienced a traumatic or many traumatic experiences? I would say that in order to survive in medicine we often have to, you know, tunnel vision comes on, you just have to accept it.   
  
When we are surrounded by things, we can't change we start to look at what we can. We often exclude the things we are powerless over. That may seem like insensitivity and failure to recognize another person's suffering but really after repetitive exposure it becomes something we do to keep coming.   
  
I always have to remind myself that even if I am witnessing repetitive traumas that I have no power over changing, that is nothing like what they are experiencing. They are going through the trauma. I have to remind myself to step out of the self-protection place and move in-out the most supportive place.   
  
Also, where is the breakdown? Where do we put the wrench? What is wrong here? It may not be happening in the hospital but outside the hospital. Maybe it is a social service thing, who knows. But really trying to guide everyone involved to shift the focus onto something new. That is challenging sometimes.   
  
What was your second question, Kathy?   
  
Kathy Flaherty: You answered it in what you were saying, there is your impact and how you focus on what is in front of you at the moment. I think you answered both questions to be honest.   
  
What I would like to talk about is put your questions in the Q&A section. This will go until 3:05 and then we have time for Questions & Answers. We envisioned this as a conversation that included you as well.   
  
Talking about what needs to change, having an abbreviated conversation due to time, we can talk about how we got to where we are. We want to give people the sense of history.   
  
What do we think of the systems? We're not necessarily talking about the individuals, but the systems need to change. I'm going to start with Leah and then go to Leigh.   
  
Leah Harris: Thanks, Kathy. To touch on the historical stuff if we have time, is that alright? Great. How did we get here? I think Dr. Hatch gave us an excellent overview of that. I highly recommend *Decarcerating Disability.* I think we should view inventory treatment as part of this carceral care that we have sorted to, and I would say we've become addicted to in various ways.   
  
I would say this has been the case since the colonial US become a thing, or settlers arrived on these shores. I'm paraphrasing here, but Dr. Hatch said the prison and asylum have always be connected in this place. This came from Europe. We have people we don't know what to do with in our societal normals. This has parallels industrialization. These people didn't want to go places voluntarily, so we had to compel them to go.   
  
There's the big lie, that you'll hear all the time. It's that de-institutionalization has failed. It's not a complete process. It's not happened yet! That's a big difference, between something not occurring and something failing.   
  
This narrative had led to these causes. There's the asylum and to forced patient regimes. If we can't bring the asylum back, then we can bring it into the community. I'll leave it there for now.   
  
Leigh Nathan: Adding on to that, as I was sharing earlier, my exploration of my identity as a psychiatrist and my power in my credentials led me to look into case law. One of the most striking piece of history is where suicidal laws emerged from.   
  
We started to connect suicide with insanity. It wasn't by mental health experts, psychiatrists, or therapists. It was by King Edward the Peaceful of England. He decided suicide was an affront to the church and to his kingship since one of his subjects would decline to be a subject of the king.   
  
At that point, the person who died by suicide would forfeit their estate. It would be forfeited to the king. I believe horrible things would happen to their body at the time of their death. I don't want to get too graphic.   
  
The exclusion was if they were thought to be in the throes of madness. Prior to that time, people generally didn't consider suicide to be an act of madness. Suddenly, juries comprised of people’s neighbors would say, "maybe they were in the act of madness" so the family could keep the estate.   
  
The law goes way back. We go to an era of where colonial laws and practices of impacted our lives today. This is an example of one of those things. I wonder how much of psychiatry has been shaped by politics and religion.   
  
Should I go on? Was there an additional question, Kathy?   
  
Kathy Flaherty: I wondered if you wanted to talk about some of the things you think should change. Then I get into my thoughts. We'll finish it out with Leah's perspective on that.   
  
Leigh Nathan: Sure. The thing we should look at is the process. I can't help but go back to the process improvement mindset. When we map out how things go, if we look at how things happen, and we look at how people find themselves where they don't want to be by mental health statutes, let's map it out. A legal standard was part of that process. Let's look at where people felt understood. Let's ask where dignity was compromised and honored.   
  
We can use this process improvement science. It's out there. We can assess what we do and how we do it. We can do it in a humanistic way. I'm not recommending we do it in a sterile, scientific way. Look at how dignity was compromised and stop that. Then we can look at how dignity was maintained and keep that.   
  
This will require looking at the laws, statutes, allyship, mental health advocates, etc. We will have to come together and listen to each other. No one make a decision until we all come together and say how we think we should try it. We have to be willing to experiment.   
  
We have to recognize that our scientific data on these topics can't be counted on. It all takes place in the presence of statutes. We don't live in a society free of statutes. We can't do a randomized control trial to see how a truly non coercive process might look. If a state wants to try it, who knows what we might find? I'd be curious to see something like that.   
  
If we're trying to realistically stop involuntary, and especially lengthy, hospitalizations, let's start placing people from their preferred environment to another preferred environment. We see this hospital as being a point where people have to wait for that. I think, unfortunately, that this is very traumatizing for people.   
  
Kathy Flaherty: Thanks for bringing those things up. I think I want to take some of what you have said and build on it, especially since I'm here as a lawyer. I appreciate when people say, "we need to take a look at the laws." If you look at the laws, I think you will see that the law is a part of the problem.   
  
A few of us are from Connecticut. Leah is from out of state. She mentioned involuntary outpatient commitment. We do not have that in Connecticut because the advocacy community has fight it. It has been proposed multiple times. Each time, people with that first hand lived experience of inventory treatment were brave enough to share their stories to the Connecticut legislature. They said this did not work for me. This harmed me. This is a terrible idea.   
  
When the people in power actually take the time to listen to the perspectives of the community, the people who would be most impacted by change and would be most likely to have solutions to the problem, you will probably end up with better solutions. People attending this, whether virtually or in person, may or may not be aware that the average length of state of Connecticut Valley Hospital, our largest state facility, is longer than 3 years.   
  
Even the young adult unit has an average length of state that is more than 1.5 years. How can separating people from their community, their natural supports, for that length of time, be good? How is that healing for people?   
  
How does that represent a recovery oriented person centered system? That's what our system claims to be.   
  
For some people, they may actually experience that. I think for too many people, especially the people that Connecticut Legal Rights Project represents, that is not their experience of the system.   
  
I think all of us who are part of the system need to take a hard look at themselves and take a look at the role they play in this system. As lawyers, we are forced to work within this existing system of laws.   
  
Over time, we have spotted the various problems with the laws. That's why there's currently a case pending in Superior Court Connecticut challenging the constitutionality of our civil commitment statute. Connecticut is one of the rare states with no time limit on civil commitment. When I was involuntary committed in Massachusetts, the time limit was 6 months. I was discharged after 60 days, which happened to coincide with my health insurance being maxed out.   
  
Here, someone can spend years in a state institute. I will wrap this up so we can get to Leah and questions. There needs to be an affirmative legal right to voluntary services and supports. When people do want access to that treatment recovery, those services and supports, if they have no affirmative legal right to get it, and it's not being provided, they're stuck. Those are my ideas.   
  
Those are my ideas. I'll turn it over to Leah.   
  
Leah Harris: Everything you just said. [Laughing]   
  
I'll add a few things on. In our ideal unicorn world where free and informed consent is actually a thing that exists, I can imagine the United States adopting the convention on the rights of the person with disability. We've not done it and I missed it right? Okay, I was double checking that. We would adopt that and adopt a rights based mental health system.   
  
I totally understand the way you intend it, Leigh. I think people can be person centered right into the hospital. Who determines what is right for you? I can.   
  
It gets slippery. I like the idea of a rights based system. If there was a political will, you don't need to reinvent the wheel. Associated with the CRPD are all of these alternatives to force like supported decision making. There are great papers out there which I which I could drop in the chat. They look at what this looks like operationally and in practice. There's a fantastic one by Peter Statsney [sp?]. If you're interested, reach out to me.   
  
I would love to see a rights based system that works to eliminate all forms of coercion and involuntary treatment. I would also recommend that folks check out the work of Susan Stephan [sp?] There's a work called *Rational Suicide, Irrational Laws.* It's over $100 but maybe your library will carry it. It is full of humane, rights based work arounds to our system. It's a 500 page book so this is a super capsule version.   
  
She has an idea to limit the liability of outpatient service providers, so they didn't have to be so carceral to imminent risk. We're not including negligence. We're talking about someone who has done everything they reasonably can to support a person.   
  
To have that liability piece taken off the table means we could support suicidal people in the community.   
  
It is simple, but we lack will. Something that is phenomenal. On the Washington Post there was a story about a man held for two months, a horrific, horrific story. It made me think of Susan Stefan's story to give people support, Medicaid. It is not that we're trying to neglect people but not incarcerate, so things like in-home care and respite for families. That kind of thing.   
  
I will quickly quote something Susan Stefan said in the book,   
  
[Reading: Instead of coming up with predicting suicide . . .]  
  
Here is my aside, what do we do to identify people?   
  
[Reading: Pay for someone to have a personal connection that is floundering and desperate.]   
  
I will add, this narrative persisted, and I will agree with it. People are clearly saying they need and want this and can't access it. Voluntary treatment would decrease. We haven't accessed this scenario to find out. Even if we robustly were to find the community system, who would work in the settings?   
  
The worker shortage is getting worse every single day. There are lots of us, particularly those of us in abolition, say it won't get us out of the carceral circle we are addicted to in this country. At the same time, we're criminally neglecting people’s survival needs. That's happening!   
  
I recommend that there are a lot of policy suggestions in that problem creating court report created by abolitionist creators. Housing, guaranteed income so people don't live in poverty - that would have helped my mother so much! These are not considered "mental healthcare" but intrinsic to health.   
  
These are things I can't go into now. I know I am going on; I have two more points I want to briefly cover. This is a path in diversity of this, but I see these upgrades and rebrands and new facades. In Milwaukie where I am from and my mother was, they went through a decades long reform.   
  
We got a brand new crisis center and hospital. What I will say about the crisis center is there are different entrances for voluntary and involuntary. I am betting the involuntary entrance is hidden. It is ominous. Has it changed? When you get in an effort, is it strengthening the system or doing something to dismantle it?   
  
The last thing I will say is I am a psychiatric abolitionist. That doesn't mean people shouldn't receive care, but it should be different. By Stella and [Name] there is a [book named] that breaks down the argument more than I can now. I think everything needs to change but we have a problem with more than resources but also political will.   
  
The sanism piece that we are dangerous, incompetent and should be put places what you occupy would encourage people to educate about ableism and sanism and how it shows up in healthcare to rehumanize people with psycho-social issues in our society.   
  
Kathy Flaherty: Thank you Leah and Leigh.   
  
We would like to open up to questions. If you are on virtually put it in. The Q&A. If you are in the room, please let us know if you are directing a question to one in particular or if you want all of us to answer. Thanks!   
  
Speaker: We have one question in the audience. I will pass on the microphone.   
  
Speaker: Hello, everyone. This is Tony. Despite the fire alarm it is nice to have a good train of thought and the thoughts on involuntary medical care and more. This question is for Leigh, the psychiatrist.   
  
You describe a process of disillusionment of what you were taught when in training to a psychiatrist. I am curious what you think of the current education for psychiatrists - what are the reform that is needed to expand that particular training to kind of minimize the disillusionment and minimize the unlearning that has to happen, or has happening subsequently for you? If that question makes sense. Thank you.   
  
Leigh Nathan: Thank you that is an excellent question. That is one I don't have concrete bullets for but one I hope to develop over time. I think we need to make sure we make room for is making sure everybody feels comfortable doing this.   
  
Talking with residents about their responses to this, to the different aspects of the mental health system that seems aligned with their personal values, those that don't, and making sure people who are questioning have a space they can talk about it without feeling they are going to.   
  
I may not have any consequences talking about this as a resident. Maybe I should have. [Laughs.]

Maybe other people felt the same way, but I didn't know where those folks were. All I know is -- and I didn't do my resident in Connecticut. Where I did my residency, the laws were very different I want to make clear.   
  
But involuntary treatment was there. I am not as in touch as someone else who could answer this question more articulately. You think about whether it aligns with what you think is right and talking through it more. Sorry, I don't have anything more concrete to say [chuckles].  
  
No, actually I do. Fundamentally connecting people with people with lived experience, connecting people to advocacy community, making sure we know we are part of a larger society and that we're all able to change how we show up. And if we listen to each other we can learn about how we're showing up.   
  
That is the very beginning of knowing what to do next. We have to understand before we can act. Making residents feel mentally prepared to connect without diagnosing, act, or be the expert. Residents often have the sense of trying to get our confidence, have expertise under our belts.   
  
Pointing out that, we're trying to act in confidence, but have to have humility. I want to respond to Leah's comments about the book by Susan Stefan, *Rational Suicide/Irrational Laws.* I highly recommend that book. Read a lot about laws, what advocates and people with lived experience write.   
  
Read, read, read. You are spot on Leah about that. That book is spot on. Another book called *Committed* by two psychiatrists I recommend. You can see Dr. Miller wrestling with involuntary care. She reflects on how humility in training can be hard to master with confidence.   
  
I will stop there.   
  
Kathy Flaherty: We did get one virtual question from Melanie. How does child psychology enter into the conversation?   
  
We don't represent children. There are lawyers who do. I didn't enter the system until I was an adult. I don't know, Leah, did you have experience being treated as a minor? I think you mentioned that. You might have useful input.   
  
Leigh, after Leah goes if you have something to add, that would be great.   
  
Leah Harris: Yeah. I think recognizing the importance of keeping families together to the greatest extent possible, because that is not happening now. I don't know how child psychologists could be allies in that but that is a huge piece of that.   
  
I will briefly share, there was a psychologist who evaluated my mom and me. His recommendations were taken 100% over hers. Thinking about the power and the harms of the foster care system, child protective services, and police social services need to be dismantled and abolished.   
  
Speaker: We have one last question in the audience and then we will wrap up the session.   
  
Speaker: Thanks, I have a comment and a question. I'm a psychiatrist and hospital administrator. One could easily conclude that those in my position are all in the wrong side by looking at the system we have. I have to tell you that I agree with close to all of what you've said today. I know a lot of other hospital administrators that feel the same way.   
  
Then, we have this question. Can you envision a way where people like me can be engaged in this process? Some days it feels like, short of quitting our jobs, there's not a lot we can do to fix the system. If I quit my job, there will be somebody else. I know a lot of psychiatrists and administrators who don't want the system to be the way it is and are struggling to change it. I wonder how we can bring about change from the outside and inside.   
  
Kathy Flaherty: There are absolutely ways to work together. I see it every day. There are people on the inside of these systems who recognize that the system itself is problematic and needs to change. You're working within it. How much change can you do from that side? Recognize us as allies.   
  
I say this as an attorney who works for Connecticut Legal Rights Project. We're serving people, just in different roles. We're all there to serve the individual people.   
  
If we really focus on what they tell us they want, from all of us collectively, we are more likely to get there. I think there are lots of opportunities for us to work collaboratively on changing laws that need to be changed.   
  
There are a lot of times we talk past each other. Conferences like this are great because we're talking with each other and that makes a huge difference.   
  
Leah Harris: I think administrators can lead by example. You can show you value lived experience. I've been on rounds where if the lived experience person talks, everyone high tails it. You can use your leadership to change the mindset in a lot of these hospitals.   
  
Leigh Nathan: I want to echo that. Adding to my previous response, we need to train everyone. Model for residents, model for staff, etc. Center people with lived experience. You have to work together and get to know one another as people, and respect each other as people, as you said, who all want the same thing. We have to find the space and time to come together, connect, and change what has to be changed.   
  
Speaker: Thank you all for such a wonderful and thoughtful panel, if we could have a round of applause.   
  
[Applause]   
  
Speaker: We will now start our coffee break. For those of you in person, the next session will start at 3:30. Thank you for your patience. We ran over because of the fire alarm situation. For the folks online, we will be resuming at 3:30.   
  
[End of parallel session 2A]