

TO: House Judiciary and Human Services Committees

FROM: John McCullough III, Project Director

SUBJECT: S. 287

DATE: April 9, 2014

The Mental Health Law Project opposes the adoption of S. 287. If enacted the bill would diminish the rights of people in the involuntary mental health system, increase forced medication, and impose unreasonable and unjustified burdens on the Judiciary, the Mental Health Law Project, and the office of the Attorney General. Furthermore, it will not provide the benefits promised by its proponents.

S. 287 will increase forced medication.

For decades State policy has been to favor voluntary over involuntary treatment. "It is the policy of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication." 18 V.S.A. § 7629(c). This recognition of patient autonomy and self-determination was a major advance in Vermont law, but the actions of the mental health system have not honored this policy.

The number of involuntary medication cases filed each year has more than doubled in four years and this trend indicates another record-breaking year for 2014. By pushing to expand and accelerate nonemergency involuntary medication, S. 287 is a major retreat from Vermont's important goal of encouraging voluntary treatment and avoiding coercion unless absolutely necessary.

Section 4 of the proposed legislation would allow the immediate filing of an application for involuntary medication for any involuntary patient in any psychiatric hospital. Furthermore, Section 3 will also allow for a motion for expedited hearing even for patients who pose **no** present risk of significant bodily injury to self or others, but who were subject to an involuntary medication order at some time in the past two years, with a hearing to be held on as little as seven days' notice. Together, these provisions will result in an explosion in the number of involuntary medication applications filed and pushed to a hearing on the merits.

The Committee should reject S. 287 because it will increase, and not decrease, involuntary medication.

S. 287 should be amended to limit accelerated hearings to patients for whom it is truly needed.

The proponents of S. 287 have repeatedly asserted that the cases in which expedited process will be needed are rare, yet the bill as it now stands will encourage the state to file early in every case. If early filing and accelerated process are truly justified in only a few cases, the bill should be amended to limit early filing to those few cases. We propose the following amendment to Section 7624 to ensure that early filing of involuntary medication does not become routine:

§ 7624. Petition for involuntary medication

(a) The commissioner may commence an action for the involuntary medication of a person who is refusing to accept psychiatric medication and meets any one of the following ~~three~~ four conditions:

(1) has been placed in the commissioner's care and custody pursuant to section 7619 of this title or subsection 7621(b) of this title;

(2) has previously received treatment under an order of hospitalization and is currently under an order of nonhospitalization, including a person on an order of nonhospitalization who resides in a secure residential recovery facility;
~~or~~

(3) has been committed to the custody of the commissioner of corrections as a convicted felon and is being held in a correctional facility which is a designated facility pursuant to section 7628 of this title and for whom the department of corrections and the department of mental health have jointly determined that involuntary medication would be appropriate pursuant to 28 V.S.A. § 907(4)(H)-; or

(4) is the subject of an application for involuntary treatment filed pursuant to 18 V.S.A. § 7508, is currently held in a designated hospital, has acted in such a way as to demonstrate a significant risk of causing the person or others serious bodily injury as defined in 13 V.S.A. § 1021 even while hospitalized and clinical interventions have failed to address the risk of harm to the person or others.

S. 287 demonstrates the shortcomings of Vermont's involuntary mental health system.

The proponents of S. 287 have argued that rapid resort to involuntary medication is necessary to protect the safety of patients and staff in Vermont's psychiatric units and to reestablish control of the hospital milieu. These arguments raise serious questions about the mental health system, including whether the designated hospitals are equipped to treat patients in psychiatric crises; whether the current design of the mental health system, which does not provide for a dedicated unit for the most dangerous or threatening patients, is adequate to meet Vermont's needs; and whether the current system, even supplemented with the additional beds under construction in Berlin, is sufficient to meet the treatment needs of Vermont's people. Before truncating the due process protections of psychiatric patients the Legislature should examine all components of the system and consider how to provide treatment to people in psychiatric crises.

S. 287 is based on unexamined and questionable assertions about the nature, benefits, and costs of involuntary medication.

The rush to involuntary medication embodied in S. 287 is based on the assumption that antipsychotics work in both the short and long term, that they are the only thing that works, and that the benefits of involuntary medication outweigh any potential harms that they cause. These assumptions have been increasingly shown to be unwarranted based on current scientific research.

The largest long-term study of antipsychotics, the CATIE study, demonstrated that in the course of eighteen months approximately three quarters of patients treated with antipsychotics discontinued medications due to either ineffectiveness or intolerable side effects. For instance, in the Senate Dr. Grace Jackson testified that antipsychotics are predictably neurotoxic and increase rates of mortality for people with serious mental illnesses, and Dr. Ronald Bassman testified that many recent studies show that delaying medications does no harm and that medications can have long and short term harmful consequences.

In addition, not only the expert testimony from Dr. Van Tuinen and Dr. Bassman, but also the personal testimony of many who have been involuntarily medicated demonstrates that involuntary medication has long-term negative effects on the willingness of people who have been involuntarily medicated to seek help even when help is needed. In addition, the falsity of the claim that involuntary medications are necessary for recovery is borne out by the many witnesses who testified that their recovery began when they stopped the medications.

As shown in the paper by Sandra L. Steingard, M.D., *Anosognosia: How Conjecture Becomes Medical "Fact"*, the assertion that involuntary psychiatric patients suffer from a neurological condition that prevents them from recognizing their mental illness is at best questionable. It should not be the basis for changes in the legislation or for assumptions that psychiatric patients lack the capacity to make medical decisions.

Vermont law fails to protect the rights of competent patients and the medical needs of patients who are involuntarily medicated.

18 V.S.A. § 7627(f) requires the patient's treatment provider "to conduct monthly reviews of the medication to assess the continued need for involuntary medication, the effectiveness of the medication, the existence of any side effects, and shall document this review in detail in the patient's chart." What is not required, though, is an assessment of whether the patient has regained the capacity to make a decision concerning the medication. If only incompetent patients may be involuntarily medicated, as soon as a patient regains competency the justification for involuntary medication ends and the patient must be released from the involuntary medication order. Section 7627 should be amended to require and document weekly review of the patient's ability to take in information and make a decision based on that information, and to require discontinuation of the order as soon as capacity has been regained.

Current law requires the involuntary medication order to set forth the "types of medication, the dosage range, length of administration, and method of administration for each." 18 V.S.A. § 7627(f). It has become common for the State to seek authorization for involuntary medication at rates far in excess of the FDA maximum recommended dose, sometimes double the recommended maximum. While a patient making such a decision for him or herself might choose, based on the risks and benefits that a treating doctor explains, to take doses above the FDA maximum, this should not be permitted when the court takes the decision making authority away from the patient. MHLP suggests that 18 V.S.A. § 7627 should be amended to prohibit the court from ordering involuntary medications at a level greater than the FDA recommended dose in an application for involuntary medication

It has also become routine for the State to seek authorization for long-acting injections of neuroleptic medications. Long-acting injections are a more intrusive method of administration than daily oral or injectable dosing for a number of reasons. First, because the long-acting medication stays in the patient's system for weeks or months, if the patient develops side effects it is impossible to withdraw the agent causing the adverse effect. Second, when the patient is offered the medication every day he or she is given the opportunity to consider voluntary acceptance and either accept or reject it. Even in the context of an involuntary medication order, giving the patient the chance to exercise a choice every day, coupled with the interaction with the treatment team that the choice entails, is preferable to removing all choice. Finally, while the argument for long-acting medications is typically that they are helpful to ensure compliance, they are never needed in an involuntary medication order because the hospital always has the ability to administer the medication by injection if voluntary compliance is not forthcoming. The statute should be amended to prohibit the court from ordering long-acting medications.

In a recent case the State requested the court's permission to administer medications by means of nasogastric intubation. Although the court denied the application, the statute should be amended to prohibit this gross invasion of any patient's bodily integrity.

The cumulative effect of these changes would be to amend Sections 7624(c) and 7627 as follows:

Section 7624(c)(3) any proposed medication, including the method, dosage range, which shall not exceed the maximum dosage recommended by the Food and Drug Administration, and length of administration for each specific medication;

...

7627(f). (f) If the court grants the petition, in whole or in part, the court shall enter an order authorizing the commissioner to administer involuntary medication to the person. The order shall specify the types of medication, the dosage range, which shall not exceed the maximum dosage recommended by the Food and Drug Administration, length of administration, and method of administration for each. The order for involuntary medication shall not include long-acting injections, nasogastric intubation, electric convulsive therapy, surgery, or experimental medications. The order shall require the person's treatment provider to conduct ~~monthly~~ weekly reviews of the medication to assess the continued need for involuntary medication, the effectiveness of the medication, the existence of any side effects, and whether the patient is able to make a decision and appreciate the consequences of that decision, and shall document this review in detail in the patient's chart and provide the patient's attorney with a copy of the documentation within five days of its creation.