Vermont Legal Aid, Inc. **MEMORANDUM**
Montpelier, Vermont

TO: Senate Health and Welfare Committee

FROM: John McCullough III, Project Director

SUBJECT: S. 287

DATE: February 19, 2014

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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.

Since 1998 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.

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.

Sections 2 and 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 for virtually every involuntary patient, with a hearing to be held on as little as seven days' notice. As statistics already presented have demonstrated, the number of involuntary medication cases filed each year has more than doubled in four years and this trend shows no sign of abating. 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 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, Dr. Grace Jackson has 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:

(3) any proposed medication, including the method, dosage range, <u>which shall not exceed the maximum dosage recommended by the Food and Drug Administration,</u> 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, <u>which shall not exceed the maximum dosage recommended by the Food and Drug Administration,</u> length of administration, and method of administration for each. The order for involuntary medication shall not include <u>long-acting injections, nasogastric intubation,</u> electric convulsive therapy, surgery, or experimental medications. The order shall require the person's treatment provider to conduct ~~monthly~~ <u>weekly</u>

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.

There is no need or justification for Section 9.

There is no evidence to support the underlying assumption of Section 9, that inadequate availability of independent psychiatrists is a significant cause of delays in mental health proceedings. Review of court statistics demonstrates that requests for continuances are unusual, that they are filed by both sides in approximately equal numbers, and that they are rarely, if ever, caused by inadequate availability of independent psychiatric examiners. While there are questions as to whether additional psychiatrists would help and not hurt the current situation, MHLP is willing to examine, in consultation with the Department of Mental Health, whether it would be advisable to seek additional psychiatrists to perform this important function. We suggest that Section 9 be amended as follows:

Sec. 9. AVAILABILITY OF PSYCHIATRISTS FOR EXAMINATIONS

The Agency of Human Services shall ~~examine its contract~~ consult with Vermont Legal Aid's Mental Health Law Project to determine whether ~~continued State funding to the Mental Health Law Project may be made contingent upon the Mental Health Law Project contracting with a sufficient number of psychiatrists to conduct psychiatric examinations pursuant to 18 V.S.A. § 7614 in the time frame established by 18 V.S.A. § 7615.~~ existing and projected caseloads justify expanding the number of psychiatrists available to perform independent psychiatric examinations pursuant to 18 V.S.A. § 7614 and increasing the funding available for independent psychiatric examinations.