To: Senate Health & Welfare Committee
From: Anne Krauss, Hartland
Subject: Comments on S.287
Date: February 19, 2014

The lived experience I've related below is my own. The years I spent working on the locked wards of a state hospital for an organization under contract with the New York State Office of Mental Health convinced me that it is far from unique. When I moved to Vermont in 2007, I'd planned to leave this part of my identity behind. However, after listening to the first person accounts in public testimony on S.287, I've decided to share my own.

Twenty five years ago, a staff member roused me from my bed in the ICU of a locked ward, and gave me a choice. If I did not voluntarily take the medication, six big men would hold me down and give me an injection. Earlier, after being told the medication would make me feel better, I had taken it willingly. By doing so I learned that for me, the drug was much worse than the psychosis - worse indeed than any pain I had ever suffered in my life, either physical or psychological. I felt like I was dying. Lest you attribute this sensation to my psychosis rather than the drug, consider the words of the first human subject. In 1951, after voluntarily undergoing an experimental injection of chlorpromazine (later known as thorazine), psychiatrist Cornelia Quarti reported a "painful feeling of imminent death" as one of the subjective effects. [1]

I quickly realized that hiding my symptoms and complying was the likeliest path to freedom. Soon after achieving transfer to a voluntary hospital, I developed life threatening neuroleptic malignant syndrome, and the meds were discontinued. Not long after, I was discharged. As frightened and frightening as I had been at the time of admission, it was not until after this sudden medication withdrawal that I had thoughts of suicide or violence. This is consistent with reports that abrupt discontinuation of neuroleptics increases suicide risk. [2] However, fearing a return to the hospital and more drugs, I concealed my inner state. My forced treatment, based on the false presumption that all psychosis is dangerous, had simultaneously put me in genuine danger and precluded me from seeking help. No one should have to feel so alone.

Through reading about alternative treatments, I learned to view psychotic thought as a waking dream. This reduced my fear, which in itself was helpful. I learned to use my dream-like experiences and thoughts to better understand my emotions rather than to take them literally or mistake them for reality. Studies have confirmed the effectiveness, safety, and cost effectiveness of alternative treatments which do not rely on medication and which can start before the psychosis subsides. [3] Why doesn't Vermont also embrace these alternatives?

Instead, treatment without drug compliance is summarily dismissed as impossible. Needless suffering and prolonged hospitalization result.

Proponents of S.287 claim expediting involuntary medication is compassionate, but there is a different reality at the other end of the needle. Not only do the drugs have limited efficacy, but their adverse effects cause considerable suffering and can result in lasting harm.
Fortunately, unlike many patients, I recovered from the physical effects of neuroleptic malignant syndrome relatively rapidly. However, it was at least a decade after receiving forced medication before I regained my ability to trust people. Few things have such a lasting impact on one's mental well being.

In the former Soviet Union, dissidents reported that neuroleptic medication was used "to obtain their complete subjugation. Some political prisoners do recant their beliefs, acknowledge that they are mentally ill... in return for an end to this treatment." [4] When insight means agreeing with a diagnosis of mental illness, and acquiescence to authority is proof of capacity, what's going on is not treatment but subjugation.

Justice is not served by increasing the control of the powerful over the weak, as S.287 would do. Institutional psychiatry already has more than enough power. What it lacks, and what is needed, is humility and the ability to listen.

Legislative Recommendations:

My preference would be to address the problem of long stays on inpatient units by providing access to treatments and secure environments that do not rely on medication and by providing more resources to organizations which provide patients with legal representation. Never the less I make the following suggestions for ways in which S. 287l could be improved, listed in order of importance.

1. Given the complexity of preparation for involuntary medication hearings, it's not realistic to expect due process can occur when only seven to ten days are allowed for the patient's attorney to prepare the case. Just because some other states do it is not a sufficient reason for Vermont to deny people due process on such fundamental rights not only to bodily integrity, but to be free of state interference in one's subjective conscious experience. There is no more fundamental human right than this.

Therefore I suggest striking the following language in section 3 of the bill:

~~The Court may grant the motion if it finds that:~~

~~(i) the person has received involuntary medication pursuant to section 7624 of this title during the past two years and experienced significant clinical improvement in his or her mental state as a result of the treatment; or~~

~~(ii)(I) the person demonstrates a significant risk of causing the person or others serious bodily injury as defined in 13 V.S.A. § 1021 even while hospitalized; and~~

~~(II) clinical interventions have failed to address the risk of harm to the person or others.~~

Emergency involuntary procedures already exist for these situations. Court ordered involuntary medication should be based exclusively on an incompetent person's best interests, and no rushing of due process is warranted solely on the basis of safety concerns.

Current law allows for the filing of a motion for an expedited hearing. But the law should not permit a court to grant a motion to expedite the hearing solely because the person has received involuntary medication during the past two years and experienced significant clinical improvement in his or her mental state as a result. Not only does this not demonstrate urgency, it may not even be relevant to the person's present condition. Also, any clinical improvement that is not significant enough to make it possible for the person to complete an advance directive is not significant enough to justify involuntary medication. A person who improves enough to be competent to complete an advance directive should do so if he or she wishes to receive involuntary medication in the event of future incapacity.

Hospitals already have the option of short term involuntary medication when there is an imminent risk of physical injury. Ongoing, nonemergency involuntary medication is far more invasive. Under Vermont law, it is justified only when found to be in an incompetent person's own best interests. It is unethical as a substitute for adequate secure space or staffing, or for the purpose of ward management.

2. Do not make an exception excluding an order of involuntary medication from the automatic 30 day stay pending appeal. The court can otherwise order if the court finds that immediate execution is warranted. The inconvenience of requesting a court order overriding the automatic stay is very small when compared to the importance of protecting the human right

to be free of state intrusion into one's body and consciousness.

3. Do not permit the consolidation of a petition for involuntary medication and an application for involuntary treatment.

In 2011 there was a sudden shift in the location of patient care from Vermont State Hospital to community hospitals. During the past few years there has also been a disturbing increase in the number of applications for involuntary medication. In her January 22 memo "Filing Trends in Mental Health Proceedings," Judge Amy Davenport referred to a "154% increase in medication filings since 2008."

Consolidation of petition and application will result in even more involuntary medication orders, each of which is a failure in therapeutic alliance. After a patient has lost an involuntary treatment dispute he or she often will realize that his or her preference regarding medication may also be overridden. Consolidation precludes the possibility of negotiation, and of reconciling the relationship between the patient and his or her doctor in the event the patient's primary objection was to involuntary hospitalization. Only when the patient objects strongly enough to medication that he or she is willing to go to court a second time will a second hearing even be necessary. These are exactly the cases which should receive the greatest scrutiny and the patients who should be allowed more time to prepare their cases.

Also, the decision to medicate should be clearly separated from the decision to hospitalize. As I observed while following patients through the court process in New York State, which allowed consolidated hearings, holding the two sequentially trivializes the serious risks associated with medication, as the process becomes "double or nothing."

4. The capacity determination for the involuntary medication petition process would better be be made by an independent psychologist, rather than, as presently is the case, by the same psychiatrist who is certifying that the treatment which he or she recommends is the best or only treatment option. Psychiatrists often view disagreement with their opinion to be evidence of "lack of insight", which in turn is viewed as a symptom of mental illness and lack of capacity. Using a licensed psychologist to provide a professional judgement regarding the capacity to make a reasoned treatment decision could help to address this problem. Also, the question of capacity is more of a psychological than a psychiatric question, and would be more appropriately rendered by a psychologist.

5. Strike section 7612a Probable Cause Review

This strictly paper review diverts scarce judicial resources which could be better expended relieving bottlenecks in existing legal processes. In the event the court finds that further retention is warranted, it also has the potential for being misunderstood by patients to mean that they've missed their opportunity to be released by a court hearing. In the early days of my hospitalization, my hope for release through a hearing was one of my few comforts. I doubt I would have understood the nuances of the probable cause review process, and consequently would have been crushed by a probable cause finding.

Thank you for the opportunity to testify at the public hearing, and for giving your consideration to my comments.

Footnotes:

[1] Laborit, H. 1967. Naisssance des phenothiazines (Birth of the phenothiazines). *Les Concours medical*, 44, 7164-7169.
As cited by David Cohen in A Critique of the Use of Neuroleptic Drugs in Psychiatry, p. 180 in *From Placebo to Panacea: Putting Psychiatric Drugs to the Test*, Edited by Seymour Fisher and Roger Greenberg, John Wiley & Sons, 1997

[2] See Robert Whitaker, *Mad In America* (Perseus Publishing, 2002). 187 - 189.

[3] see Dr. Ronald Bassman's Feb. 6 written testimony:
http://www2.leg.state.vt.us/CommitteeDocs/Senate Health and Welfare/Bills/S.287/Witness Testimony/2-6-2014~Ronald Bassman~S.287~Written Testimony on S.287 .pdf
also Deikman, A.J., & Whitaker L.C. (1979). Humanizing a psychiatric ward: Changing from drugs to psychotherapy. *Psychotherapy: Theory, Research, and Practice*. 16(2), 204-214.
and Karon, B.P., & VandenBos, G.R.. *Psychotherapy of Schizophrenia: The Treatment of Choice.* Jason Aronson, 1981. 371 - 471.

[4] Harvey Fireside, *Soviet Psychoprisons* (George J. McLeod, 1979), 148.
As cited by Robert Whitaker, Mad In America (Perseus Publishing, 2002). p. 216.