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

TO: Committee on Human Services

FROM: John McCullough III, Project Director

SUBJECT: Involuntary Medication Proposal

DATE: February 18, 2016

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I am taking the opportunity to provide some reactions to the Department's proposal to amend Title 18 to accelerate commitment and involuntary medication proceedings, but there is one very important thing I must say first.

We should not be here. The Department of Mental Health convened a working group in 2013 that consumed months, hundreds of person-hours, and untold financial costs; the Legislature took up the Department's proposed legislation in 2014, spent months taking testimony, debating some very divisive issues, and essentially gave the Department everything it asked for in that legislation. We should not be here having this same conversation in 2016.

But the history doesn't start in 2014. It was almost twenty years ago that the Legislature adopted this principle:

> It is the policy of the General Assembly to work toward a mental health system that does not require coercion or the use of involuntary medication.

And in light of that principle, how can the Department of Mental Health, a component of the Agency of Human Services—Human Services—come to the Legislature year after year with plan after plan to increase involuntary medication and undermine the rights and protections the law provides for people in its care? Why has the Department embarked on a course in which, year after year, its primary legislative goal is to reduce the due process protections the law affords to persons diagnosed with mental illness?

Look at the recent history. As recently as 2005 the Mental Health Law Project saw 429 involuntary hospital admissions, 254 applications for involuntary treatment, and only 20 applications for involuntary medication. In 2010, out of 552 involuntary admissions we were appointed to represent 429 people in applications for involuntary treatment and 31 involuntary medication applications. By 2015, however, out of 552 involuntary admissions there were 492 applications for involuntary treatment and 80 applications for involuntary

medication, more than in any previous year. The history shows that not only is the state more likely to commence commitment proceedings against someone who is involuntarily hospitalized, but in ten years it has relied ever more heavily on force.

A review of the Department's public statements demonstrates just how unreliable their projected savings are. In the AHS Budget Book the state asserts that approximately 50 persons per year are the subject of involuntary medication petitions and that the median time from admission to a decision on an involuntary medication petition is 90 days. The actual record for calendar year 2015 was 80 involuntary medication petitions. The same week that AHS was proclaiming a median time of 90 days, the filing from DVHA alleged a median 60 day period for the exact same measure, and on February 8 Vermont Digger, presumably based on statements from the Department, was reporting an average of 128 days for involuntary medication decisions. Meanwhile, at a meeting convened by the Department of Mental Health last week, the medical director of the psychiatric unit at Rutland Regional Medical Center stated that it takes approximately thirty days for them to go through the involuntary medication process.

I can tell you that it is very difficult to analyze and present case processing times. In late 2013, when the Department of Mental Health was pursuing the legislative proposals that were enacted in 2014, I had many meetings with DMH staff to go over our respective datasets, analyze the timelines, and produce a relatively uncontested report on how long it takes to go through the admission, commitment, and involuntary medication process. The most reliable figure we could arrive at was a median of 56 days from involuntary admission to the court's decision on an application for involuntary medication, but there was considerable variation among counties. The fact that various components of AHS and its contractors are still producing widely varying figures demonstrates that the Legislature should not be making decisions of this magnitude without much better data than is now available.

Dr. Steingard's testimony yesterday was instructive and very important. She establishes, as a recognized expert in this field, that the most current research on the issues involved in this proposal seriously undermines the claim that the best medical practice is always to move to involuntary medication as fast as possible. Her testimony, and that of other experts, also shows how dangerous these medications are. A report by the Department of Mental Health in 2012 found that adults taking what are called atypical antipsychotics, the class of medications that has been marketed as being less likely to cause side effects, are almost 60% more likely to suffer from diabetes than those who do not take those medications. The client at the Brattleboro Retreat I represented in court on Friday has gained fifty pounds since he was started on court-ordered antipsychotics in November; he has also been diagnosed with diabetes and high cholesterol in that same time period.

In 2014, when S. 287 was under review, Dr. Grace Jackson testified that older neuroleptics create scarring and neuronal loss in the movement centers of the brain. These changes are an example of subcortical dementia, such as Parkinson's or Huntington's disease. She also testified that old and new neuroleptics contribute to the progressive shrinkage and/or loss of brain tissue. Atrophy is especially prominent in the frontal lobes which control decision making, intention, and judgment. These drugs are well established to be dangerous, and should only be used in the most pressing circumstances, when there is a high degree of confidence that these medications, and nothing else, will help the patient to recover a high degree of functional recovery.

With regard to specific provisions of this proposal, the public statements from the Department refer to providing an accelerated measure of due process for the clients in the system. It is clear, however, that the effect of these proposals is not to accelerate due process but to deny it. I will discuss a few of the worst defects in this proposal.

18 V.S.A. § 7612a, eliminating probable cause review. There have been a few occasions in which a patient has been discharged because a court has found that there was no probable cause, but these have been very few, probably no more than 5-10 since the law went into effect. There is no indication that probable cause review has either caused any delay or caused any problem for the mental health system. Therefore, it is difficult to discern any justification for removing this protection.

18 V.S.A. § 7615, accelerated trials for application for involuntary treatment. (AIT) As written this provision would establish a mandatory trial for all AIT filings within seven days of filing, with a maximum extension to twelve days. There are numerous problems with this. This proposal will cause a litigation explosion and deprive patients of vital procedural rights.

First, as things have stood for many years, the majority of AIT's do not go to trial. Generally, once the patient has been in the hospital for a while and started to form relationships with the treatment team it is possible for them to be discharged or to negotiate an agreed-upon resolution, such as a "best efforts" settlement that contemplates a discharge a few weeks into the future. For instance, in 2015 the Mental Health Law Project handled 492 applications for involuntary treatment, yet only fifty-three of those cases went to trial; from all of our caseload only 171 cases were concluded by court decision. If the absolute latest date a case can go to trial is twelve days after the AIT is filed many of the cases that are now settled will be going to trial. Thus, this change alone would create an explosion in the number of trials consuming court time. The Mental Health Law Project does not have the capacity to handle such an increase in trials and neither does the judiciary.

Second, and as a related matter, this will inevitably lead to an increase in the number of people suffering an order for involuntary treatment with the restrictions on their civil liberties that that would entail.

Third, it is not possible for the psychiatrists who conduct independent psychiatric exams, or any other psychiatrists I have heard of in private practice, to be prepared to drop everything, review the medical records, travel to the hospital where the client is being held, and be prepared to testify at a trial for every AIT, on short notice, week after week. Naturally, the increase in the number of cases that are forced to trial will also lead to a substantial increase in the number of independent psychiatric exams, at additional state expense.

Fourth, since this proposal is that the client would not receive an independent psychiatric exam if it would delay of the hearing, a substantial number of litigants in these cases will be deprived of any opportunity to obtain an independent examination, or to present any expert testimony to rebut the testimony of the state's witnesses.

18 V.S.A. § 7624, automatic consolidation of AIT and involuntary medication application. The claim is that this will avoid needless delays of medication hearings, but present law provides for expedited AIT trials and consolidation with involuntary medication hearings upon a motion filed by the state. Although the Department's Act 114 report, dated January 19, 2016, strongly implies that the courts ordinarily do not grant those motions, this appears to be false. My staff and I have been searching our files for the outcomes of expedited hearing motions and to date the only case we have found in which the state's motion was denied was *In re: D.N.*, the case referenced in the DMH report. As far as I can tell, every other such motion has been granted. The decision in *D.N.* is far from typical. If they have evidence that this is not correct, I encourage them to produce it. If they believe that the courts' failure to expedite hearings has led to unwarranted delays, perhaps they should discuss with the Attorney General's office why they have not taken advantage of the chance to move for expedited hearings in more cases.

18 V.S.A. § 7627(f)(1), protection against unwarranted long-acting medications. Long acting medications are a particularly intrusive form of involuntary treatment in which an injection of a time-release medication is administered and provides a constant stream of the medication for two weeks to thirty days, the interval between injections. In these cases, if the patient develops side effects it is impossible to withdraw the medication until it is fully metabolized. Moreover, the use of long-acting injections denies the patient the daily opportunity to choose a voluntary oral or injected dose. This protection was adopted in 2014 because it had become routine for the state psychiatrists to request long-acting injections without showing that the patient could not be adequately treated without them. Have there been cases in which long-acting medications have been denied? Yes, but there have also been cases in which it has been granted. If you consult with the DMH attorneys, though, has there been a single case in which long-acting medications have been denied and the state has requested an amended order because the doctor was able to show that treatment with daily dosing has not been effective? The answer is no.

We understand that the state wants to save money wherever possible. Nevertheless, I see no reason to believe that these proposals will save the $5 million that is claimed for them. If the budget is adopted with those illusory savings, one must wonder what the consequences will be when they do not materialize.

There are other expenses that would enable the Department to both save money, improve patient care, and reduce its reliance on force. First, in every hospital in the state there are patients being held involuntarily not because they require inpatient care, but because there are not sufficient housing and outpatient treatment resources to serve them. Those patients are merely waiting for an outpatient bed, and according to a comment at last week's DMH meeting, they can represent up to 20% of the patients at VPCH at any given time. If the state were to adequately fund these outpatient resources it could save the very expensive hospital costs that are at the heart of these legislative proposals. Second, how much is the Department paying hospitals, and particularly community hospitals, to keep people in emergency departments? How much is the Department paying sheriffs' departments to provide armed guards in emergency departments? How much has the Department paid community hospitals for capital modifications to their emergency departments, not to provide high quality psychiatric care, but for security?

How much would reduction of these expenditures contribute to the Department's $5 million savings target? All of these options should be fully explored and exhausted before any changes to the protections the law now affords patients in the involuntary mental health system.

In a decision last week denying involuntary medications, the Washington Superior Court stated that "The administration of forced medications is an exercise of awesome judicial power." The constant attacks on patient rights emanating from the Department of Mental Health are unconscionable. The attempt to balance the DMH budget on the backs of the most vulnerable people in our society is reprehensible. Instead of taking action to diminish due process and civil rights, the Department should be spending its time on carrying out its legislative mandate, and working toward a system in which coercion and forced medication are history.

I urge you to reject the unwise and financially unsound proposal before you and make no change in the procedures now in place in Title 18.