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

TO: House Committee on Health Care

FROM: Jack McCullough

SUBJECT: S. 133—Mental Health Care and Care Coordination

DATE: April 12, 2017

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I am pleased that the committee is interested in taking a serious look at the operations of the mental health system. We always support such scrutiny, and we believe that the bill as it passed the Senate includes many positive measures. Unfortunately, we are concerned that certain elements of the legislation, which started out as a neutral examination of the operation of the mental health system, will naturally tend toward an increase in the use of involuntary medication. We have some changes to propose to address this problem.

Section 5. **Involuntary Treatment and Medication**. We completely agree that extended periods of involuntary detentions in emergency departments has been at crisis levels for years. Perhaps the highest immediate priority for the mental health system is to resolve this crisis, and it is vital to engage in a full-ranging examination of the causes for this crisis. As originally drafted, this section enunciated an outcome-neutral review of involuntary medication and involuntary treatment. By adding language specifying the direction of proposed legislation to be developed by the Department of Mental Health, the new draft seems to assume that expansion of involuntary medication and restriction of patient rights in litigation is the appropriate approach.

The history of involuntary medication since the closure of the Vermont State Hospital has been appalling. While subject to a legislative mandate to move toward a system that does not require involuntary medication, the Department of Mental Health has set a new record for involuntary medication applications every year, increasing from 23 in 2008 to 82 in 2016. The Department's argument appears to be that since the ever-increasing rate of involuntary medication has not resolved the problems in the system, the only logical solution is to do more of the same. Some of the specific proposals covered in Section 5 are no more than a rehash of the policies that the Department sought, and largely obtained, in S. 287, adopted as Act 192 of the 2014 legislative session. After such a long and painful debate it is premature to revisit the identical issues so quickly simply because the Department is dissatisfied with the results of that legislation.

First, Section 5(a)(2) would allow indiscriminate consolidation of applications for involuntary treatment with applications for involuntary medication. The Vermont Supreme Court has held that involuntary psychiatric medication is an even greater intrusion on a patient's autonomy than involuntary commitment. This proposal would rush an ever-increasing number of patients to involuntary medication at the expense of the protection of patients' rights.

Second, the Department's proposal, as set forth in Section 5(a)(3), is to allow only one independent psychiatric exam even if the patient is subjected first to an application for involuntary treatment and subsequently to an application for involuntary medication, denying the patient the right to an independent psychiatric exam in an involuntary medication case. I realize that this is intended to accelerate the involuntary medication process, but this proposal would diminish patients' rights without increasing the efficiency of the process. First, once an application is filed it is almost always held within a week, so the need for an IPE on an involuntary medication application does not cause delays in med cases; second, even when we try to get a sense of the doctor's opinion in advance of the medication application we don't have an application, so the independent psychiatrist is not in a position to render an opinion of whether the requested meds are appropriate. Disallowing an independent psychiatric exam in these cases would deprive the patient of an important protection against inappropriate medications.

Third, the Department has set forth a proposal to allow psychologists to carry out independent psychiatric exams under Section 7614. I just don't understand what problem this is intended to solve or how it does it. From our perspective we would not be inclined to change our practice to use psychologists for this function. The training isn't the same as a psychiatrist's training, and in those cases when we do present an expert witness I do not believe that the testimony of a psychologist would be accorded the weight that we would be looking for to overcome the testimony of the state's psychiatrist. I would propose deleting that idea.

We also object to the direction to focus on restoration of competency for all forensic patients. This would require a significant change of Vermont law and would potentially be unconstitutional. At present, Vermont law does not provide for involuntary medication for the purpose of restoring a defendant to competency to stand trial. This is not a minor oversight, but a specific recognition that the purpose of involuntary treatment, including involuntary medication, is to serve the treatment needs of the individual. Allowing involuntary medication simply to increase the opportunity to proceed with criminal charges and imprison the defendant perverts the nature and goals of any medical treatment.

In addition, the United States Supreme Court held in *Sell v. United States,* 539 U.S. 166 (2003), that "[T]he Constitution permits the Government to administer

antipsychotic drugs to a mentally ill defendant **facing serious criminal charges** in order to render that defendant competent to stand trial . . .” Authorizing involuntary medication to all defendants to restore them to competency, even if their charges are minor or involve no threat to the public safety, would go beyond what the Supreme Court has found to be constitutional.

For these reasons, we recommend deletion of Section 5(a)(1) of the bill.

Rather than rehearse the debates of past years we propose language that would focus on the problem, excessive reliance on emergency department detention, and provide for the study of the true causes and solutions to this problem. Thus, we propose to replace the current language of Section 5 with this new proposal:

INVOLUNTARY TREATMENT AND MEDICATION

The Secretary of Human Services, in collaboration with the Commissioner of Mental Health and the Chief Administrative Judge of the Vermont Superior Courts, shall conduct an analysis of the causes of excessive stays in hospital emergency departments and wait times for inpatient beds on psychiatric units. The analysis shall examine gaps and shortcomings in the mental health system, including the adequacy of housing and other community resources available to divert patients from involuntary hospitalization and to accept patients ready for discharge from involuntary hospitalization; treatment modalities, including involuntary medication and non-medication alternatives available to address the needs of patients in psychiatric crises while protecting patients’ rights; and other characteristics of the mental health system that contribute to prolonged detention in hospital emergency departments and psychiatric units.

On or before November 15, 2017, the Commissioner shall submit an analysis with any legislative proposals to the Senate Committee on Health and Welfare and the House Committee on Health Care.

Overlooked opportunities for improvement. For nearly twenty years 18 V.S.A. § 7629(c) has established the policy to “work toward a mental health system that does not require coercion or the use of involuntary medication”. We recommend that the Department of Mental Health be mandated to identify the efforts it is engaged in to accomplish these goals, the individuals responsible for these efforts, its plans to further advance these goals, and its recommendations for further actions to be taken.

In addition, for as long as the Legislature has required annual review of the process and outcomes of Act 114 cases Disability Rights Vermont and the Mental Health Law Project have been arguing for a study to determine the long-term outcomes of involuntary medication. At a time when we are evaluating the entire mental health system a major component of the evaluation should be a scientific investigation of whether, in the long run, involuntary medication is more beneficial than harmful to the patients who are subjected to involuntary medication. Consequently, we propose a new section mandating such a study:

NEW SECTION. EFFECTIVENESS OF INVOLUNTARY MEDICATION.

The Department of Mental Health shall design and conduct a longitudinal study comparing the outcomes of patients subjected to involuntary medications and patients who have been involuntarily hospitalized and discharged without involuntary medications. The study shall include all patients subjected to involuntary medications from 1998 to the present and shall examine the following measures: length of involuntary hospitalization; time spent in inpatient and outpatient settings; number of hospital admissions, both voluntary and involuntary; residential placement; the patients' success in different types of residential settings; employment or other vocational and educational activities; criminal charges; quality of life, determined by both qualitative and quantitative measures; and other parameters determined in consultation with representatives of the inpatient and community treatment providers and advocates for the rights of psychiatric patients.