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

TO: Senate Committee on Health and Welfare

House Committee on Health Care

FROM: Jack McCullough, Ed Paquin, and A.J. Ruben

SUBJECT: Response to AHS Act 82 Report

DATE: January 16, 2018

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In the 2017 legislative session Act 82 directed the Agency of Human Services to:

> [S]ubmit a report to the Senate Committee on Health and Welfare and the House Committee on Health Care regarding the role that involuntary treatment and psychiatric medication play in inpatient emergency department wait times, including any concerns arising from judicial timelines and processes. The analysis shall examine gaps and shortcomings in the mental health system, including the adequacy of housing and community resources available to divert patients from involuntary hospitalization; treatment modalities, including involuntary medication and non-medication alternatives available to address the needs of patients in psychiatric crises; and other characteristics of the mental health system that contribute to prolonged stays in hospital emergency departments and inpatient psychiatric units. The analysis shall also examine the interplay between the rights of staff and patients' rights and the use of involuntary treatment and medication.

This response is being submitted on behalf of the Mental Health Law Project of Vermont Legal Aid and Disability Rights Vermont.

1. **THE PRIMARY CAUSE OF THE CURRENT CRISIS IN THE MENTAL HEALTH SYSTEM IS THE LACK OF COMMUNITY RESOURCES.**

In Act 82 the Legislature found that the mental health system is in crisis, with overcrowding, extended waits with minimal or no treatment in emergency departments, and worsening symptoms while patients who may legitimately need hospital treatment wait for days or even weeks in emergency departments. It is only with a clear understanding of the causes of this crisis that Vermont can hope to resolve this problem and begin to provide adequate services to those who need them. The AHS report fails to correctly identify or

adequately address the causes of Vermont's mental health crisis, and consequently hampers the Legislature in the search for a solution.

The primary driver of Vermont's mental health crisis is not a lack of involuntary treatment, or delays in the court system. Rather, people are stuck in Vermont's psychiatric hospitals because of inadequate housing resources in the community. Every psychiatric hospital in Vermont is housing patients not because they need inpatient psychiatric care but because, although their clinical condition would justify a discharge to a less restrictive setting, there is no available placement. When patients who don't need hospital care are stuck in a psychiatric unit the beds that they are occupying are not available for those who may be in psychiatric crisis, but continue to be detained in emergency departments.

In short, by failing to provide adequate outpatient resources, Vermont is choosing to confine psychiatric patients in the most restrictive and most expensive possible setting, thereby both needlessly depriving citizens of their liberty and wasting public funds.

In our opinion, the most important and effective thing the State of Vermont could do to reduce needless hospitalization would be to dramatically increase community treatment and residential resources. Pursuing other measures before completing this effort is certain to increase involuntary detention and reduce patient autonomy without improving long-term outcomes.

2. THE JUDICIAL SYSTEM IS ALREADY EFFECTIVE IN PROVIDING PROMPT HEARINGS AND DECISIONS IN CASES WHERE THEY ARE NECESSARY.

In order to consider the needs of the judicial system in mental health proceedings it is important to understand how the courts handle mental health cases. Since the closure of the Vermont State Hospital (VSH) the judiciary has developed a system to process mental health cases promptly and efficiently.

The great bulk of mental health proceedings are now conducted in the four counties in which a psychiatric hospital is located: Chittenden, Rutland, Washington, and Windham. Each of these courts has dedicated a day or half day per week for trials in mental health cases. When a new case is filed the court immediately schedules the case for a status conference, so that in each county the court will hold status conferences for all the mental health cases on one day, and hold trials either that same day or another day of the week.

The status conference is an opportunity for the attorneys in the case to discuss the status of the case with the court, talk about scheduling, and advise the court if the case appears likely to go to trial or has a chance of being resolved without trial. Whenever there is a case where either side indicates that a trial

will be needed, or that circumstances mandate expeditious handling, the status conference is a chance for the attorneys to let the court know that they consider the case a high priority for court time.

Special shortened time limits apply to involuntary medication cases, requiring a hearing within seven days of the filing of the application. When the state expects to file an application it is common for the attorneys for the state to consult with the court and the MHLP attorney assigned to the case regarding the timing of the application in order to ensure that the case will be set at a time when both attorneys are able to do the trial. In addition, if the patient has begun accepting medications it is not unusual for the parties to agree to a continuance to see if the trial will be needed at all.

The experience of the MHLP is that when cases are not held within the statutory time lines it is generally because both parties have agreed to a delay; there is some extraneous factor such as the unavailability of a witness or the court; or factors such as changes of venue when the patient has been moved from one county to another has caused a delay in case processing. Changing the statute on the timing of hearings will not change these factors.

3. THE AHS REPORT MISREPRESENTS THE TREATMENT OF MOTIONS TO EXPEDITE IN COMMITMENT PROCEEDINGS.

In 2014, as part of a major amendment to Title 18, the Legislature adopted a provision to allow the state to file a motion for expedited hearing in an application for involuntary treatment, and requires the court to grant the motion "if it finds that 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 clinical interventions have failed to address the risk of harm to the person or others." 18 V.S.A. § 7615(a)(2)(A)(i).

In its report the Agency of Human Services alleges that "this has been interpreted by courts to be an incredibly high standard needing an actual injury to meet the threshold." Report, p. 22. This claim is a misrepresentation. In fact, since this section was adopted there has been only one case in which a motion for expedited hearing has been denied, in the case of *In re: D.N.*, No. 8-1-15 Rdmh (February 10, 2015). The Department of Mental Health has admitted, both in conjunction with this report and when this was pointed out to them in 2016, that *D.N.* was the only case in which an expedited hearing was denied. Nevertheless, AHS continues to claim that the courts have required a standard that is not in truth applied to these cases.

The fact is that in almost every case when the state has filed a motion for expedited hearing it has been granted by the court without argument, and typically without opposition because the grounds for the motion are clear.

There is no reason to change the statutory language when it is creating no difficulty for the state in its current form.

4. THE AHS REPORT FAILS TO ADEQUATELY CONSIDER PATIENT RIGHTS, ALTHOUGH DIRECTED TO DO SO BY THE LEGISLATURE.

The mandate for the Act 82 study included a directive to the Agency of Human Services "to examine the interplay between the rights of staff and patients' rights", but the Agency report fails to do this.

The discussion titled "Interplay between the rights of staff and patients' rights and the use of involuntary treatment and medication" begins on page 9 of the AHS report and continues to page 20, consuming approximately ten pages of the twenty-six page report. Approximately three lines of this discussion consist of a passing acknowledgment of patient's rights. The entire remainder of the discussion consists of recitations by hospital administration and hospital staff of the reasons they favor curtailing patients' rights.

The Agency's omission of any consideration of patients' rights demonstrates that, rather than adhere to the Legislature's directive and conduct a balanced consideration of the issues involved in psychiatric treatment, the Agency entered into this effort determined to support only one course: increased and accelerated use of involuntary medications. To do so the Agency omitted from its report the notes of a public hearing held on August 17, attended by representatives of mental health agencies, advocacy organizations, patients, and family members. Many of the speakers opposed increased use of involuntary medications in eloquent and moving terms. The notes of that meeting, found at http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Act82_Working_Meeting_2017-07-25.pdf, are attached.

Comments from the public included "it is not just me who felt that going through the ordeal of involuntary medication is coercive and horrific, I have heard from a number of other people, confidently [sic, probably should be "confidentially"], who are in a state of terror and fear. How does Vermont move forward with treatment when treatment becomes coercive and terrifying? She is terrified of hospitals" and "I have taken a strong stance over the years against involuntary medication, having had received it in the past. I found it to be coercive, traumatic and frightening. The times I was not suicidal or homicidal, I was drugged so heavily in the past I lost my memories twice, woke up covered in bruises. The State needs to take a hard look at hospitals who are using those in a very coercive way."

5. THE ALTERNATIVE APPROACHES TO INVOLUNTARY MEDICATION PROPOSED BY THE AHS PROVIDE INADEQUATE PROTECTION FOR PATIENT RIGHTS.

In addition to the proposal to increase expedited hearings, discussed above, the Agency report urges the Legislature to consider allowing guardians to consent to involuntary medication, or to create an administrative process to review involuntary medication proposals. We oppose both of these suggestions.

The proposal to allow guardians to consent to involuntary medication would lead to needless fragmentation of mental health proceedings and deprive patients of vital protections of their Due Process rights.

Guardians in Vermont are appointed and overseen by the Probate Division of the Superior Court in proceedings established by Title 14. 14 V.S.A. § 3705 allows a guardian to seek court approval to consent to medical treatment for a person under guardianship. The authority is broad and covers all kinds of nonemergency treatment, although it specifically excludes psychiatric medications.

Transferring these cases to the Probate Division would have two consequences. First, it would reduce the procedural protections now afforded to patients in involuntary medication cases. Unlike the Family Division, where proceedings are governed by the Vermont Rules of Evidence, the Rules of Probate Procedure explicitly provide for a lesser standard of evidence:

> When necessary to ascertain facts not reasonably susceptible of proof under those rules, evidence not admissible thereunder may be admitted if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their affairs. When a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form.

Vermont Rules of Probate Procedure, Rule 43(a). We steadfastly oppose any legislative change that would reduce protections for Vermonters faced with the most extreme and intrusive involuntary procedures the state has at its disposal.

Second, it would add fragmentation and delay to the process. Under present law involuntary medication proceedings are often consolidated in court with other proceedings. Sometimes an application for involuntary treatment is filed and expedited, allowing for consolidation of the two proceedings; sometimes the application for involuntary treatment is not heard until twenty-six days after the application is filed, which automatically allows the state to file the involuntary medication application and have the two cases heard together; and sometimes an application for involuntary medication is consolidated either with

an application for continued treatment or a request to revoke an order of nonhospitalization.

When these events occur under current law a single court hears both cases at once, the same attorneys are involved, and most of the evidence presented in court is the same. The state's proposal would require separate hearings in separate courts, applying different rules of evidence. It would needlessly consume the time of courts, attorneys, psychiatrists, and other hospital staff on two different dates or times, and would leave open the possibility of inconsistent adjudications.

An alternative proposed by the state is referred to as the "Administrative Option". Report, page 22. It is worth noting that a process of administrative hearings to consider involuntary medication applications is precisely what existed in Vermont before the Department of Mental Health proposed and obtained a legislative change that transferred these proceedings to the Family Court. *J.L. v. Miller*, 174 Vt. 288 (2002). Nevertheless, the Agency's proposal seems to be to assign decision making authority to another state psychiatrist and eliminate any opportunity for a patient to challenge the proposed involuntary medication.

If this proposal were adopted it would be immediately subject to constitutional challenge. Ever since the consent decree in *J.L. v. Miller* in 1984 Vermont psychiatric patients have had a mechanism for due process before nonemergency involuntary medication, including a hearing before an impartial decision maker, a right to appointed counsel, and a right to an independent psychiatric examination. If any system were adopted that did not provide at least these rights it would deny patients the right to due process of law. Such a proposal would be absolutely intolerable.

6. WE OPPOSE REDUCING PROTECTIONS FOR CRIMINAL DEFENDANTS.

We also object to the proposal set forth in the Agency's report to reduce time lines and 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, 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.

Vermont law has long recognized the right of a legally competent person to refuse treatment. As the AHS report recognizes that this proposal would affect defendants whose competency has not yet been determined, this proposal runs counter to deeply ingrained Vermont values. In an appropriate case there is nothing preventing the Department of Corrections from commencing an application for involuntary treatment for a defendant who is in custody either after a conviction or during the pendency of a criminal charge. Any difficulties with the competency and sanity evaluation process should be addressed on its own terms, not used as an excuse to expand coercion in the mental health system.[1]

CONCLUSION

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.

We believe that the General Assembly has an opportunity to dramatically improve our mental health system by putting resources into community supports, supported housing, hiring and retaining peer and recovery staff, and ensuring that no one is held in an emergency department or inpatient psychiatric unit solely because of a lack of capacity at the appropriate level of care. We hope that the Legislature will not be misled by the unbalanced and inaccurate assertions that increased coercion is the key to meet the needs of Vermonters in crisis.

[1] We continue to believe, however, that the process would be improved by adoption of the language proposed last year in S. 61 to transfer jurisdiction for criminal court hospitalization hearings to the Family Division, with those proceedings handled by the specialized mental health attorneys who now handle all other mental health cases.