

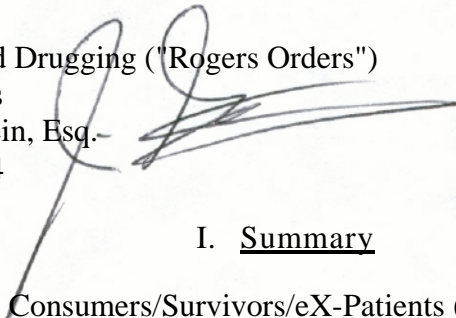
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MEMORANDUM

SUBJECT: Opposing Forced Drugging ("Rogers Orders")  
in Massachusetts  
FROM: James B. Gottstein, Esq.   
DATE: February 1, 2004

I. Summary

A group of psychiatric Consumers/Survivors/eX-Patients (C/S/X) at the Freedom Center in Northampton Mass are protesting the forced psychiatric drugging in their community.<sup>1</sup> There is no outpatient commitment statute in Massachusetts and the authorities instead rely on the 1983 Massachusetts Supreme Judicial Court's decision in the Rogers case, 458 N.E. 2d 308, to obtain guardianships and force people to take drugs against their will. The Rogers case was intended by the Massachusetts Supreme Judicial Court to set a very high bar before forced medication could take place. However, due to the lack of adequate representation for people faced with proceedings against them, the Rogers case has been turned on its head and become a vehicle for assembly-line involuntary psychiatric drugging orders. The purpose of this memo is to assemble a serious legal effort against these forced drugging orders in Northampton, Massachusetts and hopefully mitigate them around the state as well.

II. Discussion

A. The Guardianship of Roe and Rogers Cases

In Guardianship of Roe, 421 N.E.2d 40 (Mass 1981), the Massachusetts Supreme Judicial Court ruled that a guardian could not constitutionally consent to the forcible psychiatric medication of an non-institutionalized incompetent to refuse ward, requiring instead a judicial "substituted judgment" determination as to what the person would decide if competent. In doing so the court said:

We have recently identified the factors to be taken into account in deciding when there must be a court order with respect to medical treatment of an incompetent patient. "Among them are at least the following: the extent of impairment of the patient's mental faculties, whether the patient is in the custody of a State institution, the prognosis without the proposed treatment, the prognosis with the proposed treatment, the complexity, risk and novelty of the proposed treatment, its possible side effects, the patient's level of understanding and probable reaction, the urgency of decision, the consent of the patient, spouse, or guardian, the good faith of those who participate in the decision, the clarity of professional opinion as to what is good medical practice, the interests of third persons, and the administrative requirements of any institution involved." . . . Without intending to indicate the relative importance of these and other factors in all cases, it is appropriate to identify some of those factors which are weighty considerations in

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<sup>1</sup> Two local newspaper stories about this are appended to this memo.

this particular case. They are: (1) the intrusiveness of the proposed treatment, (2) the possibility of adverse side effects, (3) the absence of an emergency, (4) the nature and extent of prior judicial involvement, and (5) the likelihood of conflicting interests.

(1) The intrusiveness of the purposed treatment. We can identify few legitimate medical procedures which are more intrusive than the forcible injection of antipsychotic medication. "In general, the drugs influence chemical transmissions to the brain, affecting both activatory and inhibitory functions. Because the drugs' purpose is to reduce the level of psychotic thinking, it is virtually undisputed that they are mind-altering." A single injection of Haldol, one of the antipsychotic drugs proposed in this case, can be effective for ten to fourteen days. The drugs are powerful enough to immobilize mind and body. Because of both the profound effect that these drugs have on the thought processes of an individual and the well-established likelihood of severe and irreversible adverse side effects, see Part II A(2) *infra*, we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy.

421 N.E.2d, at 52-3, footnotes and citations omitted.

In Rogers, 458 N.E. 2d 308 (Mass 1983), the Massachusetts Supreme Judicial Court responded to nine questions certified by the United States Court of Appeals for the First Circuit which focus on the right of involuntarily committed mental patients to refuse treatment, and the standards and procedures which must be followed to treat those patients with antipsychotic medication.<sup>2</sup> The Massachusetts Supreme Court ruled the same requirements attach to someone who is institutionalized and a patient adjudicated as incompetent can not be medicated against his or her will except by a court made Substituted Judgment Decision that includes the following factors:

1. The patient's expressed preferences regarding treatment.
2. The strength of the incompetent patient's religious convictions, to the extent that they may contribute to his refusal of treatment.
3. The impact of the decision on the ward's family -- this factor being primarily relevant when the patient is part of a closely knit family.
4. The probability of adverse side effects.
5. The prognosis without treatment.
6. The prognosis with treatment.
7. Any other factors which appear relevant.

The Rogers court specifically re-affirmed Guardianship of Roe's holding that "No medical expertise is required [for making the substituted judgment decision], although medical advice and opinion is to be used for the same purposes and sought to the same extent that the incompetent

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<sup>2</sup> In Mills v. Rogers, 457 U.S. 291, 102 S.Ct. 2442, 73 L.Ed.2d 16 (1982), the United States Supreme Court held that U.S. Constitutional due process rights in this area under the 14th Amendment "may depend in part on the substantive liberty interests created by state as well as federal law," and remanded the case to determine what the state law rights might be. The First Circuit then certified the nine question to the Massachusetts Supreme Judicial Court, which was addressed in this 1983 case.

individual would, if he were competent." The Massachusetts Supreme Court also held because of the inherent conflicts in interest, the doctors should not be allowed to make this decision.

### B. Rogers Orders in Practice

The mental health system regularly obtains what is called "Rogers Orders" to force people in the community to take psychiatric drugs against their wishes. This seems ironic since the Rogers case was specifically about institutionalized people, while the Guardianship of Roe case was specifically about non-institutionalized people. It is also ironic in that the Rogers case which was a great legal victory for patients' right to refuse medication has been turned into an instrument for just the opposite.

Regardless, it seems quite clear that the courts are regularly issuing these "Rogers Orders" against people who are not institutionalized. I contacted Karen Talley a staff attorney for the Massachusetts Protection and Advocacy agency, Disability Law Center, about this situation and her response is appended to this memo.<sup>3</sup> Will Hall, Freedom Center co-founder, said that he and other Freedom Center advocates have spoken with many people on Rogers orders and is clear that the protections provided for in law are widely disregarded.<sup>4</sup> Mr. Hall says that because of clients' lack of knowledge about their legal rights and the general negative associations with the courts, Rogers orders are also used as a threat against clients where their enforcement or legal validity would be questionable. At this juncture, what noted scholar Professor Michael Perlin writes about the system's disingenuous legal proceedings is probably helpful to understand what is likely going on:

[C]ourts accept . . . testimonial dishonesty, . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." . . .

Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment . . .

This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" social end is met . . . . In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.

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<sup>3</sup> The Center for Public Representation has published a guide to psychiatric medicating in Massachusetts, which is appended to this memo. There is a brief discussion of "Rogers Orders," in it.

<sup>4</sup> Mr. Hall indicates that the "danger to self or others" and "deterioration of condition" criteria for involuntary commitment are similarly abused in practice. This is consistent with practice around the country. It can be noted here that the "deterioration of condition" criteria may very well be unconstitutional under Kansas v. Crane, 534 U.S. 407, 409, 122 S.Ct. 867, 869 (2002).

The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone? by Michael L. Perlin, *Journal of Law and Health*, 1993/1994, 8 JLHEALTH 15, 33-34.

One of the problems is that all of the participants except the patients -- the providers, judges and even the patients' attorneys -- essentially believe "if this person wasn't crazy, she would know this is good for her" -- and then "wink and nod" at the actual legal requirements. These legal requirements are ignored, in Prof. Perlin's wording, in favor of the "therapeutically correct" end. Of course, it is improper for the patient's lawyer to do anything except zealously represent her client, but that tends not to be the case because of the feeling that "it is in her own good."

The underlying assumption about the beneficial nature of the medications needs to be attacked directly because it turns out that this common view about the medications being beneficial is totally incorrect.<sup>5</sup>

These circumstances suggest a number of areas to address.

### C. Needs

#### 1. Mount A Serious Legal Effort

A serious legal effort needs to be mounted for a systems change case. This includes substantial legal work and good expert witnesses.

#### 2. Challenge the Assumptions on the Science

The underlying assumption about the benefits of the drugs needs to be directly challenged through a serious expert witness presentation. PsychRights has pulled this evidence together (to a large extent directly from the sources cited in *Mad in America*) and will provide whatever assistance it can to "make the case." This has already been done in the Alaska case of Myers v. Alaska Psychiatric Hospital, which is now on appeal in the Alaska Supreme Court.<sup>6</sup> This evidence includes:

- "An Approach to the Effect of Ataraxic Drugs on Hospital Release Rates." *American Journal of Psychiatry*, 119 (1962), 36-47 (Release Rates Study), which found that "drug treated patients tend to have longer periods of hospitalization."
- "Relapse in Chronic Schizophrenics Following Abrupt Withdrawal of Tranquillizing Medication." *British Journal of Psychiatry*, 115 (1968), 679-86 (Relapse Study). This National Institute of Mental Health study found relapse rates rose in direct relation to neuroleptic dosage--the higher the dosage patients were on before the drugs were withdrawn, the greater the relapse rates.

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<sup>5</sup> The extraordinary book, *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill*, by Robert Whitaker is must reading for people to understand this.

<sup>6</sup> Oral argument in the Myers case is scheduled for February 11, 2004.

- "Comparison of Two Five-Year Follow-Up Studies: 1947 to 1952 and 1967 to 1972," American Journal of Psychiatry, 132 (1975), 796-801 (Comparison Study). The Comparison Study "unexpectedly" found that psychotropic drugs did not appear indispensable and the data suggests neuroleptics prolong social dependency."
- "Dopaminergic Supersensitivity after Neuroleptics: Time-Course and Specificity, Psychopharmacology 60 (1978), 1-11 (Supersensitivity I). Supersensitivity I reports that prolonged use of the neuroleptics studied, except clozapine, cause an increase in dopamine receptors in the brain) which results in a supersensitivity.
- "Neuroleptic-induced supersensitivity psychosis," American Journal of Psychiatry, 135 (1978), 1409-1410 (Supersensitivity II). Supersensitivity II found that the "tendency toward psychotic relapse" is caused by the medication itself and that this and other deleterious effects could be permanent.
- "Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics," American Journal of Psychiatry, 137 (1980), 16-20 (Supersensitivity III). Supersensitivity III confirmed that neuroleptic use leads to psychotic relapse when it is discontinued.
- "The International Pilot Study of Schizophrenia: five-year follow-up findings," Psychological Medicine, 22 (1992), 131-145 conducted by the World Health Organization (WHO I). WHO I compared outcomes between patients with schizophrenia in developed and poor countries and found that that patients in the poor countries (where neuroleptic use was uncommon) "had a considerably better course and outcome than [patients] in . . . developed countries. This remained true whether clinical outcomes, social outcomes, or a combination of the two was considered."
- "Schizophrenia: manifestations, incidence and course in different cultures, A World Health Organization ten-country study," Psychological Medicine, suppl. 20 (1992), 1-95 (WHO II) confirmed WHO I's finding and concluded "being in a developed country was a strong predictor of not attaining a complete remission." [Exc. 84].
- "Empirical Correction of Seven Myths About Schizophrenia with Implications for Treatment," ACTA Psychiatrica Scandinava, 1994: 90 (suppl 384): 140-146 (Schizophrenia Myths) states in its abstract:

This paper presents empirical evidence accumulated across the last two decades to challenge seven long-held myths in psychiatry about schizophrenia which impinge upon the perception and thus the treatment of patients. Such myths have been perpetuated across generations of trainees in each of the mental health disciplines. These myths limit the scope and effectiveness of

treatment offered. These myths maintain the pessimism about outcome for these patients thus significantly reducing their opportunities for improvement and/or recovery. Counter evidence is provided with implications for new treatment strategies.

\* \* \*

Myth Number One in Schizophrenia Myths is "Once a schizophrenic always a schizophrenic:"

Evidence: Recent worldwide studies have . . . consistently found that half to two thirds of patients significantly improved or recovered, including some cohorts of very chronic cases. The universal criteria for recovery have been defined as no current signs and symptoms of any mental illness, no current medications, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not being able to detect having ever been hospitalized for any kind of psychiatric problems.

\* \* \*

Myth Number 5 in Schizophrenia Myths is "Patients must be on medication all their lives. Reality: It may be a small percentage who need medication indefinitely . . . Evidence: There are no data existing which support this myth. " [Exc. 91].

- "A Critique of the Use of Neuroleptic Drugs" by David Cohen, Ph.D., in From Placebo to Panacea, Putting Psychiatric Drugs to the Test, edited by Seymour Fisher and Roger Greenburg, John Wiley and Sons, 1997, a comprehensive review of the scientific evidence regarding the safety and efficacy of neuroleptics (Cohen Critique). The Cohen Critique's summary of the scientific efficacy evidence included:
  - The ability of neuroleptics (NLPs)<sup>7</sup> to reduce "relapse" in schizophrenia affects only one in three medicated patients.
  - The overall usefulness of NLPs in the treatment of schizophrenia is far from established.
- The Cohen Critique also discusses an analysis of 1,300 published studies which found neuroleptics were no more effective than sedatives.
- The side effects of these drugs are also addressed:

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<sup>7</sup> This class of drugs is commonly known by a number of names, including "neuroleptics" and "anti-psychotics."

[T]he negative parts [the side effects] are perceived as quite often worse than the illness itself. . . . even the most deluded person is often extraordinarily articulate and lucid on the subject of their medication. . . . their senses are numbed, their willpower drained and their lives meaningless.

- Concluding, Dr. Cohen states:

Forty-five years of NLP use and evaluation have not produced a treatment scene suggesting the steady march of scientific or clinical progress. . . . Unquestionably, NLPs frequently exert a tranquillizing and subduing action on persons episodically manifesting agitated, aggressive, or disturbed behavior. This unique capacity to swiftly dampen patients' emotional reactivity should once and for all be recognized to account for NLPs' impact on acute psychosis. Yet only a modestly critical look at the evidence on short-term response to NLPs will suggest that this often does not produce an abatement of psychosis. And in the long-run, this outstanding NLP effect probably does little to help people diagnosed with schizophrenia remain stable enough to be rated as "improved" -- whereas it is amply sufficient to produce disabling toxicity.

A probable response to this line of argument is that despite the obvious drawbacks, NLPs remain the most effective of all available alternatives in preventing relapse in schizophrenia. However, existing data on the effectiveness of psychotherapy or intensive interpersonal treatment in structured residential settings contradicts this. Systematic disregard for patients' own accounts of the benefits and disadvantages of NLP treatment also denigrates much scientific justification for continued drug-treatment, given patients' near-unanimous dislike for NLPs. Finally, when social and interpersonal functioning are included as important outcome variables, the limitations of NLPs become even more evident . . .

The positive consensus about NLPs cannot resist a critical, scientific appraisal.

The evidence is also now showing that the so-called "atypicals" are really no more efficacious, nor less dangerous than the older neuroleptics.

- Effectiveness and Cost of Olanzapine and Haloperidol in the Treatment of Schizophrenia: A Randomized Controlled Trial, by Robert Rosenheck, MD; Deborah Perlick, PhD; Stephen Bingham, PhD; Wen Liu-Mares, PhD; Joseph Collins, ScD; Stuart Warren, JD, PharmD; Douglas Leslie, PhD; Edward Allan, MD; E. Cabrina Campbell, MD; Stanley Caroff, MD; June Corwin, PhD; Lori Davis, MD; Richard Douyon, MD; Lawrence Dunn, MD; Denise Evans, MD; Ede Frecska, MD; John Grabowski, MD; David

Graeber, MD; Lawrence Herz, MD; Kong Kwon, MD; William Lawson, MD; Felicitas Mena, MD; Javaid Sheikh, MD; David Smelson, PhD; Valerie Smith-Gamble, MD; for the Department of Veterans Affairs Cooperative Study Group on the Cost-Effectiveness of Olanzapine, JAMA. 2003;290:2693-2702. Conclusion Olanzapine does not demonstrate advantages compared with haloperidol (in combination with prophylactic benztropine) in compliance, symptoms, extrapyramidal symptoms, or overall quality of life, and its benefits in reducing akathisia and improving cognition must be balanced with the problems of weight gain and higher cost.

- Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis by Geddes J, Freemantle N, Harrison P, Bebbington P., BMJ (British Medical Journal) 2000 Dec 2;321(7273):1371-6 After a systematic and rigorous statistical analysis it was found that "There is no clear evidence that atypical antipsychotics are more effective or are better tolerated than conventional antipsychotics."
- Happy birthday neuroleptics! 50 year later: la folie du doute, by Emmanuel Stip, European Psychiatry 2002 ; 17 : 1-5. In this paper, Dr. Stip asks the following questions: "After 50 year of neuroleptic drugs, are we able to answer the following simple questions: Are neuroleptics effective in treating schizophrenia? Is there a difference between atypical and conventional neuroleptics? How do the efficacy and safety of newer antipsychotic drugs compare with that of clozapine?" There are a lot of interesting comments Dr. Stip makes about the lack of answers to these and other questions, but perhaps the most interesting is: "At this point in time, responsibility and honesty suggest we accept that a large number of our therapeutic tools have yet to be proven effective in treating patients with schizophrenia." He also notes: "One thing is certain: if we wish to base psychiatry on EBM [Evidence Based Medicine], we run the genuine risk of taking a closer look at what has long been considered fact."

This evidence is critical to challenging a Rogers Order in my view because as set forth above, the prognosis with and without the medication is a key factor to consider.

### 3. Level of Representation

It also seems a direct challenge that the level of representation provided by the system now does not comport with the requirements of due process. The recent case of In the matter of the Mental Health of K.G.F., 29 P.2d 485 (Mont. 2001) laid out the minimum representation requirements in similar circumstances in Montana, addressing the following criteria.

1. Appointment of competent counsel
2. The initial investigation
3. The client interview
4. The right to remain silent
5. Counsel as an advocate and adversary



#### 4. Other Issues

If Massachusetts is like every place else I know about, Professor Perlin is exactly on the mark about the dishonest nature of the legal process. Thus one can assume the competency determinations are not fair.<sup>8</sup> The same probably goes for the substituted judgment decision itself.

Similarly, are the "Rogers Monitors" neutral or really just another part of the stacked deck against the patient? It seems likely the latter is more the case.

### III. Conclusion

The Freedom Center folks have undertaken a very brave effort against the established authority at not inconsiderable personal risk. They deserve to have a serious legal effort to achieve their legitimate goals of vindicating their rights to be free of these debilitating and dangerous drugs. Such an effort would be a systems change lawsuit that could help many residents of Massachusetts get out from under the thumb of oppressive and essentially illegally obtained forced drugging orders. The Law Project for Psychiatric Rights will provide whatever resources it can in support of such an effort, including help in assembling the evidence and experts, but one or more Massachusetts litigators are needed who are willing to make the type of effort the situation requires.

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<sup>8</sup> In most places a person who agrees to take the medications is automatically deemed competent to agree and everyone who refuses is almost just as automatically deemed incompetent to refuse.

# Group opposes forced drugging

11/23/2003

By FRED CONTRADA Staff writer  
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NORTHAMPTON - As James Bower tells it, when he refuses to take his psychotropic medication, an ambulance and some police officers show up at the door of the group home in Easthampton where he lives.

"I may be handcuffed or not," Bower said. "I'm taken to the hospital and confined."

If Bower still doesn't agree to take the drugs, he said, "they'll hold you down, strap you to a cot, and give you a shot."

Bower, 25, a client of ServiceNet Inc., is being treated for schizophrenia and depression, a diagnoses he insists is wrong. His case has become a rallying point for The Freedom Center, a locally-based group that opposes the forced drugging of people with mental illness.

Thanks to a Freedom Center campaign, ServiceNet and the Department of Mental Health have been bombarded with e-mails protesting Bower's treatment, as described by the group. More generally, the Freedom Center opposes the involuntary administration of psychotropic drugs and is trying to force the debate on the nature of mental illness and its supposed remedies.

"We believe in self-determination," said Wilton E. Hall, one of the group's founders. "It's all a very individual thing."

Hall, 37, was diagnosed with schizophrenia 10 years ago and says he was coerced into taking medication.

"It added a whole level of trauma to my experience and made recovery much more difficult," he said.

Hall said he eventually went on to recover without the use of drugs. In 2001, he got together with some other people who had similar experiences and formed The Freedom Center. The group is affiliated with the MindFreedom Support Coalition, an organization started by those who identify themselves as "psychiatric survivors" to advocate for the rights of the mentally ill. Hall said that 10-20 people attend the Freedom Center's weekly meetings and another 20 or so are involved in other ways.

According to Hall, the Freedom Center does not absolutely oppose the use of medications but simply believes patients should have the right to refuse them. However, its members disagree with those in the mental health community who believe that mental illness is a biologically based condition that can be rectified by drugs.

To many mental health advocates, this position threatens to set back years of medical advances. Jane Moser, president of the National Alliance for Mentally Ill of Western Massachusetts, said the Freedom Center's actions are "harmful to people with serious mental illness because of their underlying message that you don't need medication, you don't need your caregivers, and your psychiatrists are somehow oppressing, you which undermines trust in the very people that are helping."

Moser said she knows of some people who have gotten involved with the Freedom Center, gone off their medication, and had to be hospitalized. In a couple of cases people committed suicide, she said.

Speaking from personal experience, John W. Shepard of Westfield, who is bipolar, said stopping medication is dangerous.

"When people go off their medication they are not thinking clearly," he said.

Susan Stubbs, the director of ServiceNet, said she could not comment on individual cases because of client confidentiality, but insisted that no one in her agency's care is held down and administered drugs against their will. According to Stubbs, some people with mental illness are subject to a "Rodgers Order," under which a court-appointed guardian may make decisions about the person's medication. Stubbs described this situation as rare, however, noting that only 15 of the 1,700 people in ServiceNet's care are under a Rodgers Order." Even in those cases, she said, ServiceNet does not force-medicate.

"If someone refuses to follow a Rodgers Order, we do absolutely nothing," Stubbs said. "We just watch them more closely."

Bower said he has never experienced hallucinations and was originally hospitalized nine years ago after hitting someone with a lacrosse stick. He is under a Rodgers Order, he said, because "people didn't like the way I was acting and wanted to blame it on mental illness."

Staff writer Patricia Norris contributed to this report.

# The Republican.

## Advocates at odds over mentally ill

12/05/2003

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NORTHAMPTON - They are both working on behalf of the mentally ill, but the differences that separate two advocacy groups point to a larger question with nationwide repercussions.

Is drug treatment the best option for mental illness?

The Freedom Center thinks not, while the National Alliance for the Mentally Ill cites research showing that many illnesses are biologically based and respond best to drug treatment.

The divide between the groups widened this week when the Freedom Center called on an alliance official to resign after she said she knows of people involved with the Freedom Center and other groups who have harmed themselves - including committing suicide - after halting their medication.

"The information regarding suicide is totally not true," said Wilton E. Hall, one of the group's founders. "It's a fabrication."

Jane E. Moser, president of the alliance's Western Massachusetts chapter, said she never intended to specify the Freedom Center when she spoke with reporter Patricia Norris about the dangers of withdrawal from drugs for a Nov. 23 story.

"What I was talking about is that our concern that untreated mental illness resulting in suicide is a huge problem in our society," she said.

Moser's own paranoid schizophrenic son was jailed for attacking his parents and refused to take his medication until he was ordered to do so following an attack on another man after his release. Moser said Tuesday she does not know of any specific individual associated with the Freedom Center who committed suicide and only has anecdotal information about people who killed themselves after halting medication.

The issue arose as the Freedom Center campaigned on behalf of James Bower of Easthampton, a 25-year-old client of ServiceNet Inc. who is under a court order to take medication for schizophrenia and depression. A so-called "Rogers Order" is imposed when a judge decides that someone would be a danger to himself or others without the help of drugs.

Bower told The Republican that police and an ambulance have sometimes been summoned to the Easthampton half-way house where he resides when he refuses his medications. He is then taken to Cooley Dickinson Hospital where the drugs are sometimes forcefully administered, he said.

Easthampton police say they have taken Bower to court on a summons but could not confirm that they had escorted him to the hospital. Bower said he was put into a psychiatric facility at the age of 16 after hitting his brother with a lacrosse stick. He maintained that he is not mentally ill and has been misdiagnosed.

Although Susan Stubbs, director of ServiceNet, said she could not comment on individual cases because of client confidentiality, she said it is rare that a court-appointed guardian is asked to make decisions about a person's medication. Of 1,700 people in ServiceNet's care, she said, only 15 are under a Rogers Order.

Moser is not the only alliance member drawn into the fray.

Earlier this month, Janice White, the vice president of the local Alliance for the Mentally Ill of Western Massachusetts, wrote a letter to Mount Holyoke College psychology professor Gail A. Hornstein blasting a film series called "Experiencing Madness" that Hornstein had organized. In the letter, which was provided to The Republican by Hornstein, White argued that the series downplays the biological aspects of mental illness.

"Serious mental illnesses are not romantic psychic episodes, spiritual crises, or part of an alternative life style, nor are they a result of homophobia, racism, or sexism," White wrote. "It is very sad to think that a Department of Psychology and Education at such a prestigious college as Mount Holyoke would engage in such dangerous propaganda!"

Hornstein, who teaches a course on madness, said she was "absolutely astonished to receive a letter attacking me." She questioned whether White attended any of the films and said that no one from the alliance participated in the discussions that were part of the series.

"This is part of a pattern by (the alliance) to make strong and sweeping allegations without any corroboration," she said.

White could not be reached Tuesday for comment, but Moser said that denying the biological causes of mental illness flies in the face of accepted research.

"Where we are coming from is that we accept the scientific findings in the last couple of decades that fully and without dispute are telling us that these are brain disorders," she said. "The people who are going against science are not in the majority."

Hall, who has been off medication for a decade after being diagnosed with schizophrenia, said mental health consumers are hungry for alternative treatments and blames groups like the alliance for standing in their way. He also says the Freedom Center is not absolutely opposed to medication and never recommends that patients go "cold turkey."

"Going off medication abruptly can be damaging," he said.

Hall also accused the alliance of lobbying to cut funding for consumer initiatives in Massachusetts. State Rep. Ellen Story, D-Amherst, said she sponsored a budget amendment to eliminate Department of Mental Health funding for such groups after talking with constituents who had concerns about their philosophical positions.

The alliance never lobbied for the cuts as an organization, however, Story said. She added that she hoped the amendment would spark discussion of the issues and lead to better oversight of consumer groups. Although the measure failed to pass, the Legislature did cut some of the funding.

Dr. Benjamin Liptzin, who heads the psychiatry department at Baystate Health Systems, said mental illness is the leading cause of more than 30,000 known suicides in the U.S. each year. Although he believes drugs are often beneficial, Liptzin said there are often environmental and personal factors that can be treated by other methods.

"They're both right," Liptzin said of the opposing groups. "Instead of fighting with each other, we should be encouraging people to get help."



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December 9, 2003

Jim Gottstein  
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Via e-mail: [jim@psychrights.org](mailto:jim@psychrights.org)

Dear Jim,

Michael Perlin forwarded your e-mail to me, and I also read the article you sent him. The Disability Law Center is the Protection and Advocacy agency in Massachusetts. One of DLC's priorities for this year is informed consent, and we'd be interested in hearing from people experiencing coerced treatment in group homes. We have heard from consumer/survivor advocates that this is an issue, but have not gotten many calls from people who are experiencing it. I'm copying this letter to Oryx Cohen so he can refer people to us.

In the meantime, I thought I'd answer some of your questions about the state of the law in Massachusetts. We have no outpatient commitment law. Instead we have what are called Rogers orders, which get their name from the Massachusetts Supreme Court decision *Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489; 458 N.E. 2d 308 (1983). The order is issued by either a District Court or a Probate Court, after a hearing at which the individual is represented by appointed counsel. The petitioner is usually a hospital or other service provider. If the court finds that the individual is incompetent to make treatment decisions, it then makes a "substituted judgment" determination, balancing a number of factors set out in the Rogers decision. The court is supposed to render its decision based on what it believes the individual would do if he or she were competent.

Rogers order includes a court approved treatment plan which lists the medications that may be administered (over the individual's objection if that is the case) and the allowed dosages. If the Rogers order is issued by the District Court, it must accompany a civil commitment, and it automatically expires when the commitment does. The type of Rogers order people in Northampton are probably referring to is issued by the Probate Court, and it indeed "follows the person into the community." (In fact, our former Commissioner of Mental Health was able to fight off legislative efforts to pass an outpatient commitment law in part by arguing that we already have the Probate Rogers orders.)

Although in the Probate Court context the term "guardian with authority to administer antipsychotic medication" is used, no person or entity other than the court has any authority to decide what treatment is allowed. The medication and dosage is either in the court order or not. If it is not in the court order, no one can consent to it. If the treater wants to administer something that is not in the order, he or she must return to court.

The person under a Rogers order does have, in addition to appointed counsel, a "Rogers monitor." This person is supposed to monitor the implementation of the order, and regularly report to the court about

things like side effects, efficacy, the continued need for the medication, whether the person has regained competency, etc.

The Probate Rogers orders should have expiration dates and a timeline for periodic reviews. See *In re Guardianship of Weedon*, 409 Mass. 196 (1991). There is no clear rule, but most courts set them to expire in twelve months. If the court is not in the practice of doing this, or has previously issued an open-ended order, the person's appointed counsel should seek an expiration date. Where the judges have concerns, or where the person is a juvenile for instance, the order will often expire sooner than twelve months, and the provider will have to return to court if it is seeking renewal. For orders that have a longer duration, periodic reviews should take place. In addition to being scheduled by the court, an intermediate review can also be granted upon request by one of the parties. Even if there is no review scheduled, the monitor and/or the attorney for the individual can and should bring the matter back before the court if issues arise, or if the person has become competent.

If a person has a Probate Rogers that has followed him into the community, my opinion is that refusal to take the medication does not in and of itself allow the person to be involuntarily hospitalized. The law in Massachusetts allows for a four day emergency hospitalization on the basis that the person presents a risk of harm to self or others or is at risk of not being able to survive in the community due to inability to care for self (this latter basis is less commonly invoked and is supposed to involve a higher evidentiary burden.) This law is found at M.G.L. c. 123, §12.

Under section 12, certain designated persons can order the individual's transport to a facility based on the alleged risk of harm. The person must then be evaluated by a designated physician before he or she can be admitted. If admitted, the person is supposed to be given a notice of rights and can request appointment of counsel for the purpose of determining whether there is a basis to challenge the admission. The person him or herself can also seek to challenge the Section 12 admission by requesting a hearing in District Court. The hearing is to be held within 24 hours.

This ability to request counsel upon admission and to challenge the admission as an abuse of process is the result of a relatively recent amendment to the law (November of 2000.) It is envisioned primarily as a remedy for procedural errors, as opposed to a forum in which to argue about whether the evidence relied upon was sufficient to justify the admission. I don't believe there have been many cases where it has been successfully invoked. However, in an instance where, for example, someone was taken to the hospital for simply refusing medication and was not otherwise evaluated for a risk of harm, the request for counsel and an emergency hearing might be an option.

This analysis applies to an "ordinary" Rogers order. It is my understanding that there is at least one case in which the Probate Court was asked to amend a Rogers order to include a provision allowing the person to be picked up by the police and brought to a location where he could be injected with medication. On appeal, a single justice of the Massachusetts Appeals Court directed the Probate Court to hold an adversarial hearing at which the individual was present and was represented by counsel. The Court was instructed to determine whether the person would choose this type of enforcement if competent, and to determine a less restrictive alternative was a section 12 hospitalization. The Probate Court was also directed to consider whether the enforcement order was necessary to prevent harm to self or others.

If these types of enforcement orders are being entered in Western Massachusetts, or if this authority is being implied, our office and the Committee for Public Counsel Services would be interested in hearing about it.

What I've said above describes the way the law is supposed to work and the various protections that exist. However, we know that people are sometimes medicated pursuant to stale Probate Rogers orders. I'm also sure that the threat of hospitalization is regularly invoked, despite the fact that the person arguably cannot be hospitalized solely for refusing to take the medication.

Again, consumer/survivors in Massachusetts should be aware that informed consent is one of DLC's main priorities. We are very interested in hearing from people who are being denied their right to informed consent, or who are otherwise being coerced around treatment. If a Rogers order has become stale or the person has become competent, our office might work together with the Committee for Public Counsel

Services in order to get the person back into court. If people have issues around wanting to disengage from PACT team services, we're interested in hearing about that as well. Starting this week, DLC is participating in statewide trainings of human rights officers for all community programs. Together with a DMH attorney, I will be doing a piece on informed consent. It is our hope that this will increase awareness about treatment rights in the community.

The Freedom Center should feel free to refer people to us. Individuals can call 1-800-872-9992 and should ask to speak to one of our intake paralegals. Callers might mention that the issue is informed consent or forced treatment in the community. While we obviously are not able to take all cases for individual representation, we encourage people to call.

I hope this information is helpful

Sincerely,

Karen O. Talley  
Staff Attorney

cc: Oryx Cohen (via e-mail: [oryxc@hotmail.com](mailto:oryxc@hotmail.com))  
Michael Perlin (via e-mail)  
Stan Goldman, Committee for Public Counsel Services (via e-mail)  
Maggie Lunevitz, Committee for Public Counsel Services (via e-mail)  
Bettina Toner, DLC Attorney



# YOUR RIGHTS REGARDING MEDICATION

Massachusetts law protects your right to decide your course of treatment and, more specifically, to refuse medication. You have this right whether you are receiving inpatient or outpatient treatment, voluntarily or involuntarily hospitalized, in a public or private setting, or in a mental health or mental retardation facility.

## I. INFORMED CONSENT

Before administering *any* type of treatment, including medication, your physician must obtain your **informed consent**.

In order to exercise informed consent, you must be told in terms you can understand:

- the **nature and extent** of your **illness**;
- what **medication** the doctor wants to prescribe for you and why;
- the **benefits** the doctor believes will result from taking the medication;
- the nature and probability of the **risks** associated with the medication generally, and any special risks which the medication may pose for you specifically (for example, if you are pregnant or have a heart problem, some medications may be particularly dangerous);
- **alternative treatments**, including not having treatment; and
- the **prognosis** with and without treatment.

Further, if you are in a facility that is operated or funded by the Department of Mental Health, your doctor must:

- respond to your questions about the medication;
- provide you with medical information written in "everyday language" about the benefits, risks and side-effects of the medication prescribed to you;
- explain that you have the right to freely refuse the treatment without coercion, retaliation, or punishment; and
- explain that you have the right to withdraw your consent to treatment, either orally or in writing, at any time.

The fact that you have been admitted or committed to a mental health or retardation facility *does not* mean that you are incompetent to give or withhold consent. To the contrary, in Massachusetts, an adult is presumed competent to make his or her own decisions regarding antipsychotic medication until he or she is proven incompetent to do so in court.

Neither your doctor nor the staff may threaten or punish you for refusing to consent to treatment. The hospital *may not* deny you privileges because you refuse to take medication.

## II. EXCEPTIONS TO INFORMED CONSENT

The law recognizes only two situations in which your informed consent to treatment is not required: incompetency and emergency.

### **Incompetency**

- When your physician believes that you do not understand the nature of your illness or the proposed treatment, she may conclude that you are not competent to make your own treatment decisions, and, therefore, that she may not legally treat you on the basis of your consent. The only consideration for competency should be whether or not you are able to make or communicate informed decisions. The physician's opinion must not be based upon her belief that you made a "bad" treatment decision.

### ***Rogers Hearings***

When a doctor believes you are incompetent, she may initiate a guardianship proceeding, popularly called a *Rogers* hearing.

At this court proceeding you have the right to be represented by an attorney, and, if you cannot afford an attorney, the court will appoint one for you. The court shall authorize treatment with antipsychotic medication only if:

- it finds you *not capable of making informed decisions* regarding medication;
- by applying a *substituted judgment* test, it finds that you would accept the treatment if competent; and
- it approves and authorizes a *written antipsychotic treatment plan*.

### **Probate Court *Rogers* and District Court *Rogers***

**Probate Court *Rogers*** hearings are commenced in probate court. The statute governing probate court *Rogers* guardianships does not establish a time period for the duration of the guardianship. The Supreme Judicial Court, however, has ruled that all probate court *Rogers* orders must provide for periodic review and include a termination date. You may file a petition with the Probate Court at *any* time for termination of the guardianship.

**District Court *Rogers*** hearings are commenced in district court. They may be initiated only when you are hospitalized *and* the subject of a petition for commitment. The petition for guardianship with authority to administer antipsychotic drugs is separate from the commitment proceeding and the court may consider it only after the judge issues an order for your commitment. A district court guardianship expires at the end of your commitment. You may petition the court at *any* time for termination of the medical treatment authorization.

## Emergency

Absent a court-ordered *Rogers* guardianship you may be medicated against your will in only two emergency situations: to prevent violence against yourself or others or to prevent irreversible medical damage to yourself.

### Chemical Restraint

A physician may authorize the use of chemical restraint to prevent violence in an emergency situation "such as the *occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide.*"

### Emergency Psychiatric Treatment

If your doctor believes that you have a serious mental illness, you are incompetent, and an "*immediate, substantial, and irreversible deterioration*" of your medical condition will occur unless you receive the medication, she may administer a **single** treatment of medication without your consent. However, this emergency treatment cannot continue without a judge's authorization.

## III. HEALTH CARE PROXY

In 1990, Massachusetts enacted the Health Care Proxy law. The proxy allows you to choose, while competent, a trusted relative or friend to make medical treatment decisions for you if, and when, you are no longer competent to do so. The proxy only takes effect after your doctor determines that you lack the capacity to make decisions about your course of treatment. A health care proxy may negate the need for future substituted judgment determinations by a court.

## IV. WHAT TO DO IF YOU HAVE BEEN ILLEGALLY MEDICATED

If you believe that you have been illegally medicated while at a program or facility operated by DMH, contracted for by DMH, or licensed by DMH, ask to speak with the Human Rights Officer. You may also file a written **complaint** with the Person in Charge of the program or facility. You may give your complaint to any facility employee; he or she must forward it to the Person in Charge. If you are dissatisfied with the response of the Person in Charge and believe that additional fact-finding should occur, you have 10 days to request **reconsideration**. You also may file an **appeal** to a higher level up to 10 days after receiving a decision. In most cases, you have the right to a **further appeal**, which must be filed within 10 days of receiving the *appeal* decision. If you have questions about the complaint process, contact the Human Rights Officer or the Mental Health Legal Advisors Committee.