Legislative Liaison as Critical Intervention*

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The ferment of rapid change now engulfs mental health legislation. The altering character of our psychiatric practice and research reflects the impact. Emerging issues include changing guidelines for civil commitment and for the use of certain somatic treatments like ECT. The Right to Treatment and the Right to Refuse Treatment find vocal legal champions who wish to implement good intentions with detailed, specific, and sometimes inappropriate directives. The AMA and state medical associations are now preoccupied with malpractice issues, development of PSRO guidelines, and falling memberships. Local APA District Branches must respond to the times and sponsor active spokespersons for laws consistent with good psychiatric practice. Forensic psychiatrists are ideally suited to make a meaningful contribution to such an effort. The need for involvement on a state and regional basis is more urgent now, since many of the developments that affect our daily practice are emerging in our state legislatures and through state court proceedings.[1]

Psychiatric legislative liaison can make a significant difference in the outcome of local legislative process. The term "legislative liaison" describes the active, informed, and relevant involvement of psychiatrists in the drafting, critiquing, and monitoring of all legislative proposals that affect our specialty. Myths abound about such efforts. Some of us feel that our legislators will respond only to powerful and well-financed special interest groups. Others recognize that, by and large, mentally ill persons are a disenfranchised group with few effective public spokespersons – unless funds are forthcoming for a special interest group project. Many of us feel that legislators are uninterested in psychiatric opinions and seldom appreciate or understand our recommendations. We have all read about the powerful professional lobbyists in Washington who allegedly shape our destinies. Most of us feel uncomfortable and out of place with such "hustlers" and show some disdain for our colleagues who get "mixed up" in political advocacy. Most of the time physicians are uninformed about developing legislation until it is too late to contribute meaningfully, and consequently our profession seems to replay the script of reacting defensively and objecting ineffectively. Too often, we physicians are interpreted as being interested only in our guild accoutrements.

This paper reports experiences involved with the development of a new mental health hospitalization act in Kentucky during 1975 and 1976. This involvement developed out of frustration with the restrictions of existing civil commitment legislation. Many of my colleagues shared my concern that some of our patients were being denied effective treatment of diagnosable illness, but expressed dismay about how to improve the situation. Most of the private psychiatrists in our state had withdrawn from treating patients needing involuntary hospitalization. The situation evolved not only because of existing guidelines written into the 1972 legislation but also because specific parts of the old law had been successfully challenged and found unconstitutional in January of 1975.[2] Only a skeleton of the former "model law" remained, and the ability of psychiatrists to respond to patient emergencies was excessively restricted by the District

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Court decision, *e.g.*, "dangerous to self or others" was interpreted as requiring that the patient have a plan and a means to commit personal violence in his possession before emergency detention could be used.

New legislation was obviously needed. An interested colleague and I decided to get involved. Neither of us had previous experience dealing with legislative bodies or law-making, but decided during the summer of 1975 to learn "how" as we went along. Since the legislative branch of Kentucky state government convenes for only sixty working days every two years, the solution to this serious dilemma could not be left to happenstance.

We set as our first task the identification of a few key people to whom we could get access. We learned through informal contacts in state government that a lawyer with special interest in mental health law had been retained by the Department of Human Resources, Bureau for Health Services, to develop new legislation for the governor to sponsor that would incorporate the latest developing national legal trends. We telephoned this lawyer and two other state government officials responsible for the developing legislation – the administrative psychiatrist responsible for the Kentucky State Hospital System and other mental health services, and a psychologist who was a special assistant to the Commissioner, Department of Human Resources, and specifically directed to see that a workable legislative proposal evolved. We decided to become positive advocates for change in our dealings with these people and to try to function in a "friendly consultant" role. We asked for a meeting with these three individuals at the University of Kentucky Medical Center and invited our colleagues within the Department of Psychiatry to attend. Much give and take occurred at this meeting in late August, 1975. We reviewed what we perceived as the major points of controversy between the physician's duty to provide effective medical care and the law's concern with individual liberty and civil rights. These representatives of state government who were writing the new legislation were able to explain why certain sections were included and elaborated on both the legal precedents and the national special interest group forces that were also molding the outcome. We physicians were able to highlight difficulties with hypothetical case examples which illustrated how some of the conditions in the evolving law would make our rendering of treatment more difficult. All participants found the interaction useful and informative. We agreed to meet again.

My colleague and I summarized our concerns about the existing civil commitment law in our state and our worries about the proposed new law to the fall meeting of the Kentucky Psychiatric Association in September, 1975. The President of the Kentucky Psychiatric Association appointed us to function officially in liaison with the 1976 Kentucky General Assembly as an Ad Hoc Committee on Civil Commitment. Two resolutions which expressed the sense of the membership were passed at this meeting and forwarded to the lawyer representative of the group drafting the legislation. The resolutions were: 1) That commitment to hospital and commitment for treatment be considered one and the same judgment; 2) that the concept of dangerousness to self or others as a basis for civil commitment be interpreted to include injury to property, finances, and community standing when that injury is due to a mental disorder.

In October of 1975 we contacted our local Kentucky state House and Senate representatives, who agreed to help us monitor all mental health legislation by asking their staffs to keep us informed. We also established contact with the Legislative Research Commission at the capitol and arranged to receive copies of all proposed House/Senate bills which might involve the practice of psychiatry, immediately after they were printed. Thus we had several resources to help us keep informed.

We were given a new draft of the legislation early in November, 1975, and we met again on December 3rd at the University of Kentucky Medical Center. Much give and take again occurred and we suggested further changes. One of the favorable outcomes of the second meeting was that some Right to Treatment and Right to Refuse Treatment

guidelines which had been proposed as details of the new law (*e.g.*, 15-minute exercise periods every two hours for patients in seclusion rooms) were changed to hospital directives. The representatives of state government were able to leave this second meeting feeling hopeful that organized psychiatry in Kentucky would support the legislation.

After we had our say in December, the legislation disappeared from public view as the governor's administration checked it out for all of its political implications. It did not surface again until March 1, 1976 – eighteen days before the end of the legislative session.

On March 4, 1976, we spoke before the Health and Welfare Committee of the Kentucky House of Representatives. This two-hour session was held in a jammed conference room. Fourteen bills were scheduled for review. It quickly became clear that the group had met to vote and not to discuss or debate. We were shocked, since this meeting was the first formal public hearing on the bill. Only now could citizens begin to express their opinions in a public forum. Unswayed by adversity, we gave our carefully prepared remarks. Although the bill contained much we approved of, we wanted still further changes. We expressed concern, *e.g.*, about what Right to Treatment and Right to Refuse Treatment directives might develop in our state hospital system and the process by which they would be drawn up and implemented. The legislation's identified sponsor – the majority party leader – only smiled, perhaps at our naivete and perhaps because he could not discuss the legislation, since he was only the "front man" for the governor's administration. We were gently advised to submit our proposed changes in written form. The Committee then moved on to discuss malpractice legislation and other pending bills.

We left the capitol discouraged and offended; we considered giving up the whole effort. Later that day, however, we did organize and submit our changes in a two-page single-spaced letter. Perhaps because we were angry and not hopeful, we were not thorough. We did not change the maximum allowable time interval between submission of a valid petition for commitment and the required formal court hearing from twenty-one to ten days in every paragraph in the proposed law. This suggestion (unscrutinized apparently) and the others we proposed were introduced as an amendment and passed in the House 79-0. The amended bill passed the Senate 38-0 and was signed by the governor. Our oversight was not picked up and we now have a logically inconsistent law: *i.e.*, if you petition for a 60-day commitment and your previously voluntarily hospitalized patient is detained on the ward with a 72-hour hold, the maximum allowable wait before the court hearing is ten days. If, however, your patient is in need of immediate care and your first contact is in the emergency room or the admitting office, the maximum allowable wait is 21 days after the petition has been filed. We were embarrassed. Our lawyer friends tell us, "It's o.k. – different rules for different sections" – "no problem," as they say.

My colleague and I authored a summary review article for the May issue of the state medical journal so that all of the physicians in our state had an opportunity to become informed about the new law.[3] We detailed how physicians should behave in order to be in compliance and explained some of the premises from which the new law evolved. This legislation became effective June 18, 1976.

We feel our rookie experience in legislative liaison has taught us several lessons: 1) Be sure you know from the beginning what it is that you want to accomplish; 2) Use facts and descriptive examples when you contribute your ideas; 3) Know what your legislative member (sponsor) has to deal with in terms of his political reality; 4) Do your homework and know all sides of the issue; 5) When drafting, double-check all details.

When we spoke before the House Health and Welfare Committee we were at a serious disadvantage. We had not identified a specific member of the Committee and spoken to him beforehand in order to inform him of our concerns and to obtain his support and suggestions. We should have provided typed copies of our proposed amendments to our sponsor before the meeting for distribution at the committee hearing.

Review of the two Kentucky Psychiatric Association resolutions passed in the fall of 1975 indicates that the thinking of the psychiatric membership was out of step with the legal *zeitgeist*. The reasoning for the first resolution, *i.e.*, "that commitment to hospital and commitment for treatment be considered one and the same judgment," seems a fitting example for that old Latin bromide, *"Res ipsa se loquitur est."* Linking treatment to hospitalization, it is reasoned, is only common sense. The average prudent person undoubtedly expects a person who is hospitalized for a mental disorder to be treated for that mental disorder. If it really turns out that the two do not go together, then the committed person should be confined to a less expensive place than a hospital pending authorization to render treatment. This resolution takes on the issue of sovereignty (who decides who does what to whom). The Right to Refuse Treatment seems to be the emerging answer which the law respects.

The second resolution, which suggested broadening the concept of dangerousness, did seem to strike a responsive chord. The new law does seem to have responded to the spirit of this recommendation with a definition of dangerousness which includes actions which would lead to the deprivation of self or others of the basic means of survival, including reasonable shelter, food, and clothing.

Two other points deserve mention. We were not able to mobilize our fellow psychiatrists to care much about what was happening. The great majority had withdrawn their involvement from such matters. No other special interest group, however, seemed really to care either. The local newspapers carried no stories or news releases about the mental health legislation. It seems that our two early meetings (while the legislation was still in draft stage) settled most of our association's concerns, and perhaps our organization just "let Bill and Dennis do it." Secondly, as former congressman William R. Roy, M.D., pointed out recently, good timing is a critical aspect of influencing legislative action.[4] We were able to get our ideas into the early drafts of the legislation. If we had waited until the legislation had come before the Kentucky General Assembly, we believe that we would have had no effect or else would have scuttled the whole proposal. With either outcome, both we and our patients would have suffered.

We were surprised at the impact we had on the legislative process. Inexperienced and unpaid, we sought involvement and tried to influence the legislation positively. There was really no opposition to most of our ideas. The state government seemed to be struggling to write an effective and fair law and seemed to welcome our willingness to contribute. We relearned what those in academic settings too often forget: *i.e.*, that legislators are "just folks" trying to do what they perceive to be in the best interest of their constituents. These people are not idealistic scholars but pragmatists who seemed to trust us. We were lucky to get on the governor's bandwagon. It is far easier to shift course a bit than to try to stop such a juggernaut. It is our conviction that if we had not personally mobilized ourselves, one more piece of legislation would have passed that we psychiatrists could have only grumbled about as we roasted our lawyer friends and condemned our law-makers.

We do not suggest that the scenario described here can be repeated in more populous states with large urban centers like New York or California. There, more sophisticated efforts by a more highly organized group of psychiatrists would seem necessary. Involvement such as that described here, however, will help avert surprises like the one the Assembly of California Branches received when it "overlooked" the significance of AB4481.[5] The restrictive ECT legislation included in the Vasconcellos bill was passed and signed in the fall of 1974 before effective and informed rebuttal developed. It is to the credit of the local California district branches that they have spearheaded the ultimate blockage of the implementation of the Vasconcellos bill[6] and have argued strenously in the Tarasoff case.[7]

Law-making is a continuous and dynamic process. Whatever is passed by legislatures can be vetoed by the governor, found unconstitutional by a court, or changed next

session. Every APA district branch must have at least one interested person (preferably a committee) to monitor local and regional legislative activity. Cooperation of local district branches with the APA's Commission of Judicial Action will help further to coordinate effectively the monitoring and shaping of evolving legislation.[8]

The American political process remains remarkably open.[9] Interested and active forensic psychiatrists can contribute much to the development of informed and humane mental health legislation. Our patients and our colleagues need our active participation.

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