VERMONT 2017

The Implementation of Act 114:

December 1, 2015-September 30, 2016

Report from the Commissioner of Mental Health
to the General Assembly

January 20, 2017

Department of Mental Health
AGENCY OF HUMAN SERVICES
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VERMONT'S ACT 114 (18 V.S.A. §7624 et seq.)

Vermont's Act 114 addresses three areas of mental-health law:

- The administration of nonemergency involuntary psychiatric medication in inpatient settings for people on orders of hospitalization
- The administration of nonemergency involuntary psychiatric medication for adults on orders of nonhospitalization (community commitments), and
- Continuation of ninety-day orders of nonhospitalization

The statute allows for orders of nonhospitalization, whether ninety-day or one-year orders, to be renewed following a hearing. Prior to implementation of Act 114, ninety-day orders could not be renewed.

Among other things, the Act replaced administrative hearings on applications for nonemergency involuntary medication with judicial hearings in family court. When the statute was passed in 1998, it permitted the administration of involuntary psychiatric medication in nonemergency situations to patients committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in the community in addition to the Vermont State Hospital (VSH). Until August 29, 2011, when Tropical Storm Irene forced the evacuation of the State Hospital, nonemergency involuntary psychiatric medications were given only at VSH. Now that the new Waterbury State Office Complex has replaced some of the buildings where VSH and other departments of state government were located, Vermont has six designated hospitals where involuntary psychiatric medications in nonemergency situations might be administered:

- The University of Vermont Medical Center (UVMC), in Burlington
- Rutland Regional Medical Center (RRMC)
- The Brattleboro Retreat (BR)
- Central Vermont Medical Center (CVMC), in Berlin
- The Windham Center (WC), in Bellows Falls
- The Vermont Psychiatric Care Hospital (VPCH), the state-run facility in Berlin

Section 5 of Act 114 requires an annual report from the Commissioner of Mental Health on the implementation of the provisions of the act to the House Judiciary and Human Services Committees and to the Senate Committees on Judiciary, and Health and Welfare. The statute specifies four sections for the Commissioner's report to set forth:

I. Any problems that the department, the courts, and the attorneys for the state and patient have encountered in implementing the provisions of the statute
II. Number of petitions for involuntary medication filed by the state pursuant to 18 V.S.A. §7624 and the outcome in each case
III. Copies of any trial court or supreme court decisions, orders, or administrative rules interpreting Section 4 of this act, and
IV. Any recommended changes in the law.

In addition, the statute requires the Commissioner of Mental Health to solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct-care providers, persons who have been subject to proceedings under 18 V.S.A. §7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

Act 114 requires two annual reports on the implementation of Act 114, one from the Commissioner of Mental Health and one from an independent research entity. Over the years, it has become abundantly clear that much of the material in these reports is duplicative and, therefore, redundant, inefficient, and a questionable use of taxpayers' money. DMH recommends, again, that only one comprehensive, independent report be required in the future.

INTRODUCTION

This annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health (DMH). The time period covered by this report is different from earlier reports because of recent changes in data collection and reporting for Act 114 patients. This report covers December 1, 2015-September 30, 2016.

The state filed sixty-nine petitions for involuntary medication under Act 114 during that ten-month time period. Fourteen of those petitions were withdrawn or dismissed before a court hearing. Five other petitions were denied throughout those ten months; none were pending at the end of September 2016. The courts granted the state's requests in the remaining fifty petitions and issued orders for involuntary medication of those individuals.

Through October 19, 2015, DMH received nine responses to the Commissioner's questionnaire about their experiences from nine people who were involuntarily medicated under the Act 114 process. These responses included three from individuals who were involuntarily medicated in 2015 but whose responses arrived too late to be included in the report that was filed in January 2016. The remaining individuals who were under orders for involuntary psychiatric medications from December 1, 2015, through the end of September 2016 did not respond to the Commissioner's questionnaire this year (but it must be noted that court orders for nine individuals were issued in August and September 2016; it is unlikely that any of them would have become well enough to respond so soon).

Among the stakeholders who receive annual requests to respond to the Commissioner's questionnaire about their perspectives on Act 114, the Office of the Chief Superior Judge, Vermont Legal Aid, and Disability Rights—Vermont (DRVT) sent written responses to the Department of Mental Health for this 2017 report. Please see the section on "Input from Individuals and Organizations as Required by Act 114," which begins on page 5.

Readers of this document will find a broad range of perspectives about the Act 114 process and the use of involuntary psychiatric medication as part of the course of treatment for adults with the most refractory mental illnesses. All of these views are included in this report to illustrate the varieties of opinions held and the complexities of the issues that must be addressed. DMH hopes that this information will inform and elevate discussions of the use of medication as an intervention for mental illness as care providers continue to strive for optimal outcomes for the individuals they serve.

PROBLEMS WITH IMPLEMENTATION

Stays Pending Appeal

DMH's Legal Unit has had two important cases in which patients moved for an order staying the effect of a medication order pending appeal.

In re I.G., Dkt. No. 69-4-16 Wnmh (Entry Order dated May 31, 2016); Supreme Court Dkt. No. 2016-163 (Entry Order dated May 18, 2016). The legislature eliminated automatic stays of appealed orders of involuntary medication in 2014 (Act 192); V.R.F.P. 12(d)(2)(ii)(I). In this case, the trial court, which had granted a stay on the patient's motion, applied the same logic, legal support and generalized policy grounds stated in prior court decisions that supported automatic stays pending appeal (or determinations not to lift automatic stays), and without any reference to the patient's particular circumstances or his condition. The decision is concerning, in that when there is a motion for a stay pending appeal in the future it seems likely to be granted without any reference to the change in law that eliminated automatic stays. The decision was made in the case as if there were no change in the policies supporting or undermining stays, just a simple change to the procedural hurdles a patient would encounter before obtaining a stay.

In re G.G., Dkt. No. 69-4-16 Wnmh (Entry Order dated May 31, 2016). This was a case in which a patient filed his own motion for a stay pending appeal long after the medication order had been made, and far beyond the time specified for such a motion. The motion was denied both because it was late and because it was not filed by the attorney assigned to represent the patient.

Competency Standard

In re I.G., Dkt. No. 101-7-16 Wnmh (Opinion and Order dated October 31, 2016) was a decision based on the reversal of *In re I.G.*, Dkt. No. 69-4-16 Wnmh (Findings, Conclusions, and Judgment dated May 6, 2016). In this case, the court altered its earlier determination that the patient was incompetent based on the patient's appreciation and understanding of potential risks of the proposed treatment. The court held that because there was a basis in reality for the patient's concerns about the risks of treatment, and because the patient accepted the idea that without medication he would remain hospitalized indefinitely, these factors prevented the state from demonstrating that he was incompetent to make a decision to accept or refuse medications. Unlike typical competency decisions in medication cases, this court entirely disregarded the patient's lack of insight into his illness and his rejection of any potential benefit from the medication. The decision is concerning since almost all other courts have found that the State can demonstrate incompetence whenever a patient's mental illness makes the patient unable to understand fully the risks as well as the benefits of medication.

Authorization of Clozaril with Court-Ordered Blood Draws

There were two cases in which DMH sought authority to treat a patient involuntarily with the antipsychotic medication Clozaril and, because this medication cannot be provided

without regular blood draws, the applications sought both authority to provide Clozaril and court-ordered blood draws. This is an expansion of treatment authority usually sought, as DMH ordinarily requests authority only to administer antipsychotic medications and side-effect medications. In one of the cases cited, the court granted the authority (which DMH believes was the correct result), while in the other it was denied. DMH highlights these two cases to illustrate the disparities that sometimes exist amongst the various courts, as well as to raise the potential need for legislation to address this issue.

In re M.W., Dkt. No. 75-3-16 (April 4, 2016) was a decision granting authority to administer Clozaril along with the blood draws needed to sustain that treatment. The court found that ordering the blood draws as an ancillary treatment was necessary to effectuate an order authorizing treatment with Clozaril and that the ancillary treatment was not so painful or invasive as to be one the statutory scheme would impliedly [sic] prohibit.

In re D.H, Dkt. No. F71-4-16 Wnmh-IM (May 19, 2016) was a decision denying authority to administer Clozaril along with the blood draws needed to sustain that treatment. The court found that while ancillary treatments are permitted, other laws authorizing blood draws from intoxicated motorists or for AIDS testing of convicted sex offenders demonstrated that the legislature knows it can authorize blood draws and that its failure to include a similar provision in the medication law meant the State had failed to show the ancillary treatment with blood draws could be authorized.

Motions to Expedite AIT Hearings

DMH sought expedited hearings under 18 V.S.A. § 7615(2)(A) for nine applications for involuntary treatment for the purpose of requesting involuntary medication orders pursuant to 18 V.S.A. § 7624(a)(4). In all nine instances, the applications were granted.

COPIES OF ANY TRIAL COURT OR SUPREME COURT DECISIONS, ORDERS, OR ADMINISTRATIVE RULES INTERPRETING §4 OF ACT 114 IN 2016

See citations under "Problems with Implementation."

INPUT FROM ORGANIZATIONS AND INDIVIDUALS AS REQUIRED BY ACT 114

Act 114 requires DMH to solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct-care providers, persons who have been subject to proceedings under 18 V.S.A. §7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

To meet the statutory mandate for input from organizations, DMH solicited input in writing from:

- Vermont Psychiatric Survivors (VPS), a statewide organization of adults with experience of severe mental illness
- the National Alliance on Mental Illness of Vermont (NAMI—VT), the state chapter of the national organization of families of adults with severe mental illness
- the Office of the Administrative Judge for Trial Courts
- Vermont Legal Aid (VLA), Mental Health Law Project, which offers legal counsel to Vermonters with low incomes, who are elderly or who have disabilities, and
- Disability Rights Vermont (DRVT), the federally authorized disability protection and advocacy system in Vermont pursuant to 42 U.S.C. 10801 et seq., and the Mental Health Care Ombudsman for the State of Vermont pursuant to 18 V.S.A. §7259.

Additionally, the statute requires input from individuals who received psychiatric medication involuntarily under Act 114 at the state's designated hospitals. DMH received six responses to the Commissioner's questionnaire from patients who were involuntarily medicated at those hospitals December 1, 2015-September 30, 2016, in addition to responses from three patients who received involuntary psychiatric medication in 2015 and sent responses that arrived too late for inclusion in the report that was submitted in January 2016.

DMH solicited input from physicians, nurses, social workers, and mental health and recovery specialists at hospitals around the state in three different ways:

- ❖ In writing
- ❖ Through telephone interviews
- ❖ Through onsite interviews

With the permission of Paul Capcara, RN, BSN, MPH, Director of Inpatient Psychiatry for the University of Vermont Health Network, Central Vermont Medical Center (CVMC), this report includes his written replies to the Commissioner's questionnaire in addition to "Joe's Story," an account he wrote some years ago about the experience of an individual caught up in the complexities of the legal and medical processes and procedures that attend psychiatric care and involuntary medications in Vermont. "Joe's Story" previously appeared in *The Commons Online*, Issue #242 (Wednesday, February 19, 2014), p. C1. Mr. Capcara emphasizes that both his replies to the Commissioner's questionnaire this year and "Joe's Story" are based on his extensive experience with involuntary medication applications and implementation before he accepted his current position at Central Vermont Medical Center, which does not use involuntary psychiatric medication in nonemergency situations.

INPUT FROM PSYCHIATRISTS, NURSES, AND OTHER HOSPITAL STAFF IN VERMONT

Paul Capcara: Responses to Commissioner's Questionnaire

1. How well overall do you think the protocol for involuntary psychiatric medication works?

It does not work very well for a fundamental structural reason–the process is too slow. In the dozens of cases I have participated in, many of which took many months to move from the application phase to implementation of medication, not a single patient improved without medication (over periods as long as six months to a year), and all but one patient ended up eventually being medicated via court order. And all of the patients improved dramatically following receiving medication and were able to be released from the hospital in a relatively short time frame (1-4 weeks). In essence, in our zealousness to protect patients from the possibility of being medicated against their will, we are depriving a large number of patients of their liberty by keeping them on locked psychiatric units (also against their will) and vastly delaying their ability to resume their lives in the community, all to prevent an outcome which proves to be inevitable in almost all cases anyway.

Keeping someone "safe" from effective and inevitable treatment which will allow them to regain their liberty and return home, especially when they will almost always eventually receive the treatment anyway, and doing so by depriving them of their liberty by forcibly locking them on a psychiatric unit for months on end in the name of protecting their rights, is truly bizarre. It also helps deprive other patients in need of acute psychiatric care of a bed in a system that is short of capacity (somebody is stuck in an ED [Emergency Department] awaiting a Level One bed being occupied by another patient waiting months for the treatment that will allow them to leave the hospital).

2. Which of the steps are particularly good? Why?

Because of the history of abuses in the psychiatric field, it is good to require TWO professionals to verify the need for medication and to have it reviewed by an independent party (a judge). It should all just happen in 72 hours, like in most states.

3. Which steps pose problems? Why?

[No response to this question]

4. What did you do to try to get these patients to take psychiatric medications voluntarily before deciding to go the involuntary route through the courts?

Inpatient psychiatric staff are all experienced and skilled at educating patients about the benefits and risks of psychiatric medications. Everyone would prefer that patients actively engage in treatment and make informed decisions based on dialogue with their physician and nurses—some patients are unable to do so due to the severity and nature

of their illness. Not all patients need medication, and even some who would benefit from it make an informed choice not to receive it because they can still function in the community without it and they believe the side-effects will outweigh the benefits. However, for the patients who clearly can't function safely in the community without it and refuse to take it because they are too ill to understand the consequences or make an informed decision, it makes no sense to delay [the] process.

5. How long did you work with them before deciding to go through the courts?

It depends on the patient. In patients who are highly psychotic, paranoid, or who have active delusions about medication, and who may be acting in ways that are harmful to themselves and others, it is difficult to engage in an extended dialogue on the topic because they often become highly agitated and aggressive.

6. How helpful or unhelpful was it to be able to give the medications when you did? In what ways?

See above [answer to question 1].

7. What do you think the outcome(s) for the patients who were medicated would have been if they had not received these medications?

They would have remained locked in the hospital indefinitely. In one famous and highly illustrative recent example, a well known VT woman spent over 20 years in the hospital untreated without any signs of improvement.

8. Do you have any recommendations for changes in Act 114? If so, what are they?

Speed it up—72 hours from application to administration [of medication] with court approval. Don't continue to lock patients up unnecessarily while denying them effective treatment.

Paul Capcara: "Joe's Story"
From The Commons *Online*, February 19, 2014, Commonsnews.org.

Vermonters have been watching in recent weeks [that is, at the beginning of 2014] as members of the state legislature consider proposed statutory changes related to timely access to judicial review for the small number of psychiatric inpatients being considered for court-ordered treatment. It's a difficult but necessary discussion that I think Vermonters are ready to have.

I hope we don't lose sight of the actual patients whose lives are at the center of this discussion. With that in mind, I offer a true story. I have been careful to alter or eliminate any identifying details that could compromise patient confidentiality.

Joe was admitted to our unit by court order after spending weeks in the Department of Corrections waiting for a bed in a mental health facility. With a history of schizophrenia, he had been successfully holding down a job and living independently with support from a community outpatient mental-health facility.

Then Joe stopped taking his medication. He quickly developed extreme paranoia and delusions. He became involved in an altercation with a neighbor who he believed was conspiring against him with help from the police.

When Joe arrived on the unit, the staff made sure to constantly reassure him that he was safe and that we were here to care for him and support him in his recovery. However, he would often become very agitated, pacing up and down the hallways and engaging in loud, angry conversations, mostly with himself and the voices he was hearing, about perceived wrongs. A fairly large man, Joe was frightening to other patients and staff when in this state, especially as his thinking grew increasingly disorganized and erratic.

Staff did their best to help him and others remain safe without resorting to the use of involuntary emergency procedures or restricting his movements. Joe clearly needed as much room as we could afford him to be able to work off some of his considerable energy.

After many weeks of watching Joe steadily deteriorate into heightened paranoia and distress, we were still unable to convince him of the benefit of resuming the medication that had helped him so much in the past.

One evening, he unexpectedly walked up to a nurse and punched him in the head. The nurse collapsed. In an attempt to prevent him from kicking the fallen nurse, another staff member put herself between him and Joe. She was badly kicked in the arm and neck.

Although Joe had been involuntarily hospitalized, he continued to worsen for several more weeks while an application for involuntary medication slowly worked its way through the courts. During this time, he would repeatedly call the police and the FBI, and frequently yell loudly at staff, accusing them of things like killing his baby, raping him, stealing his car, and violating his girlfriend.

It was obvious that Joe was suffering greatly, losing weight as he battled with the horrible ideas in his mind.

More than four months after Joe first fell ill, the Vermont courts finally authorized involuntary medications for him. Despite having repeatedly benefited from them in the past, he was reluctant at first.

But within a few days, a remarkable transition started to take place. The angry, tormented Joe transformed into an articulate, intelligent, caring young man.

A week later, he asked to meet with the nurse he had injured, and he apologized for his actions, explaining that he had not meant to hurt anyone, but that the voices in his head would just not give him peace.

Within two weeks, Joe was able to spend hours reading books, playing games with the staff, engaging in pleasant conversation, and planning for his future. We discovered, much to our delight, that he was a fan of Hemingway and jazz music and that he could engage in extensive and insightful discussions about a wide range of topics, including local and international politics.

As he prepared for his discharge, Joe's insight was restored to such a degree that he expressed a clear understanding of how early intervention would have spared him the horrible suffering he had endured by being allowed to refuse needed treatment for so long.

Indeed, it had been a long and arduous four months for everyone, and on the day he walked off our locked unit to return to independent living, there was not a dry eye in the house.

Additional Input from Staff at Other Hospitals Where Act 114 Medications Are Administered in Vermont

1. How well overall do you think the protocol for involuntary psychiatric medication works?

The most positive answer to this question from staff of one of the hospitals where Act 114 medication is administered in Vermont was "medium," while staff at another one offered only "mediocre to poor."

2. Which of the steps are particularly good? Why?

The length of time to allow judicial processes to unfold, ranging from weeks to months, from admissions to commitment hearings and thence to petitions for involuntary medications and the judge's decision, then, finally, to administration of medication(s) has both advantages and disadvantages. The advantages include:

- Staff have extra time to get to know patients better, to gain their trust, to try to find ways to help patients understand the need for medications and their benefits
- Patients can continue to stay in structured environments where other supports are available
- The additional time respects a patient's right to refuse medications

Expedited hearings are helpful in certain situations, but only those in which the patients become violent and have responded well to psychiatric medications in the past. (Only nine of the fifty court orders for involuntary psychiatric medications that were granted in 2016 were expedited.)

3. Which steps pose problems? Why?

- Short answer from staff of one designated hospital: "All the rest of them" except for expedited hearings
- The bar for granting expedited hearings is too high.
- The major disadvantage of lengthened time until the administration of needed medication under Act 114 is that patients suffer longer.
- In addition, patients who have decompensated after a period of stability in the community may not be able to attain the higher functionality they enjoyed before they stopped taking their medication.
- Hospital staff think that locking patients up for an extended period of time during which they are not receiving psychiatric medications is an infringement of their right to be free.
- Hospital staff mentioned several problems with judges and judicial processes:
  - Judges who often seem to be practicing medicine from the bench in regard to numbers and types of medications prescribed and their dosages
  - A judiciary that is inconsistent from one court to another
  - The perception that judges rarely if ever know the outcomes of their decisions on psychiatric medications for people with mental illnesses
- The Ulysses clause is problematic. Why should the law respect a patient's decision to refuse medication when he/she is sick but not honor the same patient's expressed desire for medication when he/she was well?
- Becoming institutionalized robs people of the relationships they had in the community before their hospitalization.
- Hospital staff do not have a good understanding of why Vermont has not proceeded to administer psychiatric medications in the community as permissible under Act 114. (See recommendations under Question 8.)
- There are times when hospital staff do not receive court orders for medications until days after the hearings, which are usually held on Fridays.
- Patients are not getting the type of treatment that will speed their recovery when medication is a recommended intervention, and delays in treatment prevent people who need acute inpatient beds from having access to them.

4. What did you do to try to get these Act 114 patients to take psychiatric medications voluntarily before deciding to go the involuntary route through the courts?

- "Everything imaginable"
- Education about mental illness and the need for medications to treat it
- The efficacy of medications
- If patients have been taking medications previously and they have been successful, discussions with the patients about the importance of restarting their medications
- Conversations with providers on possible options for treatment
- Being flexible about when and where medications might be administered
- Engaging families and anyone else who could be helpful in persuading patients to start/restart psychiatric medications

- ✪ Describing for patients the differences between their behavior, appearance, and overall health when they are taking medications and when they are not
- ✪ Offering many other options for inpatient supports such as recovery staff, a sensory room, working on physical fitness, art therapy, and the like
- ✪ Introduction of Open Dialogue, a new and more inclusive, holistic approach to dealing with mental health/mental illness issues

5. How long did you work with these patients before deciding to go through the courts?

Several weeks to several months; the time really depends on the individual. Some hospital staff estimated three to six weeks, on average.

6. How helpful or unhelpful was it to be able to give the medications when you did? In what ways?

Hospital staff are fairly unanimous in viewing medications as helpful to individuals in need of treatment, although some of them can require more time to respond and others may be refractory to medications. Sometimes within a few days staff can see improvements in a patient's condition, such as:

- ✓ Reductions in symptoms
- ✓ Increased self-control
- ✓ Decrease in assaultiveness
- ✓ Increased safety
- ✓ Increased ability to take care of their own needs
- ✓ The big picture is that "people are able to move on with their lives"

7. What do you think the outcome(s) for the patients who were medicated would have been if they had not received these medications?

The worst possible outcome mentioned by hospital staff for individuals was death. Short of death, staff views of possible outcomes for individuals without medications were bleak, including:

- ❖ Worsening symptoms
- ❖ Reduced functionality
- ❖ Possible complications of medical/physical conditions in addition to their mental illness
- ❖ Continuing inpatient hospitalization
- ❖ Continuing alienation from families, friends, community
- ❖ Increased frustration and anger

Some hospital staff looked beyond individuals and saw the whole mental-health system as being quite different, characterized by the use of more physical restraints and indefinite retention of the sickest individuals in secure settings.

8. Do you have any recommendations for changes in Act 114? If so, what are they?

The recommendation repeated most often by hospital staff, this year and in previous years as well, was shortening the length of time between hospital admission and administration of psychiatric medications. Some hospital staff noted that Vermont's law on involuntary medication is different from similar laws in most other states, where administration of psychiatric medication can often take place more quickly.

Other recommendations for changes in Act 114 included:

- Having additional options for psychiatric medications
- Expand Act 114 to community settings so that medications can be continued after discharge from psychiatric hospitalization without the need for rehospitalization (or, at least, make it possible to administer involuntary medications in Emergency Rooms while patients continue to stay in the community)
- Continuation of the work begun at the Vermont Ethics Conference held in November 2016
- Lowering the bar for expedited medication orders
- Making it possible for all Act 114 patients to have expedited medication hearings
- Combining commitment and medication hearings
- Reducing the role of judges in determinations or approvals of the medications and dosages to be administered
- Establishment of a single statewide court for mental health that could meet in various locations around the state

It should be noted that some hospital staff were disheartened after so many years of providing input for the Commissioner's report without being able to see that much has changed in Vermont in regard to the implementation of Act 114. They feel that no one is listening to their concerns and patients continue to suffer unnecessarily because of the long delays for trials, hearings, and petitions.

INPUT FROM ADVOCACY ORGANIZATIONS AND JUDGES

The questionnaires for organizations and the courts all asked the same six questions:

1. Were you directly involved with any individuals involuntarily medicated under Act 114?
2. Are you aware of any problems encountered in the implementation of this process?
3. What worked well regarding the process?
4. What did not work well regarding the process?
5. In your opinion was the outcome beneficial?
6. Do you have any changes to recommend in the law or procedures? If so, what are they?

Letter from A.J. Ruben, Supervising Attorney
Disability Rights Vermont (DRVT)

DRVT's answers to the Commissioner's questionnaire were as follows:

1. **Were you directly involved with any individuals involuntarily medicated under Act 114 in 2016?**

During the last year DRVT staff have often come in contact with patients subject to the Act 114 process.

2. **Are you aware of any problems encountered in the implementation of this process?**

DRVT staff witnessed, or reviewed medical records of, many episodes of non-emergent forced medication injections on psychiatric units around Vermont in 2016. Often those episodes were accompanied by traumatic uses of force, and contrary to popular opinion, often the patients continued to struggle against these injections for days, weeks or even months. In addition, DRVT staff noted several instances where patients, and in some cases staff, were not aware of DMH regulations providing protections and preferences to patients subject to these forced medication orders. See

http://mentalhealth.vermont.gov/sites/dmh/files/misc/Rules-Regs/Rules%20Implementig%20the%Act%20Relating%20to%20Involuntary%20Medication%20f%20Mental%20Health%20Patients.pdf.

In those cases, DRVT staff intervened to inform all involved about these regulations and secured the patients' rights in these areas.

Overall, DRVT did not see significant progress towards the statutory goal of working toward a system that does not rely upon forced medication and coercion (18 V.S.A. §7629) in 2016. DRVT's experience has been that people who are subjected to forced medication orders sometimes do not improve quickly and stay on the unit for long periods of time even after the orders are implemented. We continue to hear that patients are genuinely afraid of being subjected to forced medication orders and the disruption that causes in their relationship with their treatment providers. People tell us that they do not seek voluntary treatment because of this fear. Unfortunately, there remains a perception in our community that patients receiving mental health inpatient care will be subjected to involuntary medication that they do not want, they believe causes them harm, and which they will discontinue at the earliest opportunity. This situation is at odds with the legislative mandate to move to a non-coercive mental health system.

Most troubling from DRVT's perspective is the failure for DMH to follow through on commencing a study to determine the outcome for patients forcibly medicated going out five years, a plan that has been universally accepted as appropriate and necessary in

order to have an effective and informed policy on this practice. DRVT urges DMH to follow up on this suggestion and promptly implement such a study.

3. What worked well regarding the process?

Again in 2016 DRVT staff worked collaboratively with MHLP [Mental Health Law Project] attorneys and believe that while MHLP is an effective and critical part of the process that does exemplary work, there are insufficient resources in terms of attorneys and expert witnesses and quality of representation is likely to decline if no additional funding is provided while the numbers of these cases increase.

4. What did not work well regarding the process?

As noted above, lack of alternatives to forced medication, in part due to overreliance on highly marketed medications, and in part due to lack of adequate capacity in the overall mental health system resulting in patients being held in inpatient units unnecessarily, remains a significant problem with our mental health system. In addition, the lack of a five[-]year study of outcomes for people subjected to these forced medications orders is an aspect of the process that has not worked well over the last year. Overall, the Department's fixation on increasing the use of coercion in the system, in terms of speeding up medication orders, increasing the number of locked, non-inpatient facilities, and relying more on ONH's [orders of nonhospitalization] requiring medication compliance, instead of putting more resources into peer supports, step[-]down facilities, one[-]on[-]one community supports, and alternatives to involuntary placements, appears [sic] to be a major cause for the problems DRVT staff and our clients have identified.

5. In your opinion, was the outcome beneficial?

DRVT continues, as we have for many, many years, to urge the Department to conduct a long-term study of the immediate, middle and long[-]term impacts of forced medications on Vermonters in order to determine statistically rather [than] anecdotally if the process is beneficial. As noted in prior submissions, DRVT staff continue to meet with patients for whom the forced medication episodes were very traumatic and not helpful in the long-term, as well as meeting clients for whom the experience was worth the benefit.

6. Do you have any changes to recommend in the law or procedures? If so, what are they?

DRVT recommends that the Department implement a robust outcome study of the impact of these orders on people. We also recommend that the Department make stronger efforts to limit the number, as opposed to the recent trend of large increases in the numbers, of the uses of these forced medication orders, at least until the above-recommended outcome study demonstrates that no more harm than good is resulting from these proceedings. DRVT also suggests that the Department advocate for more funding for MHLP to hire additional staff and expert witnesses in order to avoid the

appearance that, due to the increase in forced medication petitions and the lack of similar increases in MHLP funding, the ability of MHLP to adequately represent their clients is at risk of significant decline. DRVT suggests again that the goal of more prompt forced medication orders held by the Department and the Hospitals can be attained more reasonably by increasing the resources available to the attorneys and the courts, including the availability of independent expert review, rather than conflating hearings for commitment and forced medication into one hearing in an effort to speed up the process.

Letter from John J. McCullough III, Project Director Vermont Legal Aid, Inc.

Thank you for asking me to participate in this year's study of the State's use of involuntary psychiatric medications. Involuntary psychiatric medication is the most extreme invasion of personal liberty the State of Vermont can engage in, it is vital that the State honor the human rights of psychiatric patients and the policies established by law to protect those rights.

Ever since 1998 the law in the State of Vermont has been clear. "It is the policy of the General Assembly to work toward a mental health system that does not require coercion or the use of involuntary medication." 18 V.S.A. § 7629(c). Unfortunately, the State, and in particular the Department of Mental Health, has failed to follow this policy. This has resulted in a continuous increase in the use of involuntary medications precisely at a time when the routine and lifelong use of psychiatric medications, which is the ideology of Vermont's involuntary mental health system, has come under serious question. In my view, the State should be looking seriously at alternatives to involuntary medication and should be reducing its reflexive reliance on this extremely intrusive practice.

As of today's date [the date of Vermont Legal Aid's letter this year is November 18, 2016] our records show that the Department of Mental Health has filed seventy-five involuntary medication cases in calendar year 2016 to date, putting us on a pace to reach or exceed eighty-five, which would exceed the all-time record of seventy-nine filed in 2015. This continues the pattern of continuous increases in involuntary medication since 2008, as this table demonstrates. Since 2008 the number of involuntary medication cases filed by the State has more than tripled, and it has more than doubled since 2011, the year the State Hospital closed.

YEAR	INVOLUNTARY MEDICATION CASES FILED
2008	23
2009	30
2010	31
2011	39
2012	45
2013	64
2014	77
2015	79
2016	75 (to date)

1. **Were you directly involved with any individuals involuntarily medicated under Act 114 in 2016?**

The Mental Health Law Project was appointed by the Superior Court to represent the respondents in all of these cases. To my knowledge there were no cases in which the respondent was either represented by outside counsel or pro se.

2. **Are you aware of any problems encountered in the implementation of this process?**

We have encountered a number of problems in attempting to represent our clients in these proceedings, many of which arise out of the extremely short time frames in which these cases are scheduled. The court process, as set forth by statute, imposes scheduling limitations that interfere with the patients' ability to defend themselves. The courts have often scheduled hearings with as little as three or four days' notice, which makes it extremely difficult for respondents' counsel to review several hundred pages of records, obtain an independent psychiatric examination, and adequately prepare for trial.

While the statute allows for a continuance for good cause, the Department routinely opposes nearly every request for continuance filed by the MHLP in these cases, regardless of the grounds or merits for the continuance request. It is important to note that the Department has the advantage in this situation, since it has complete control over when it files these cases, and the decision to oppose almost all requested continuances evidences the Department's disregard for the patients' right to a vigorous and well-prepared defense.

3. **What worked well regarding the process?**

Act 114, and the availability of court-appointed counsel to represent the patients in the State's custody, is the only mechanism available to either prevent unjustified use of involuntary medication or to restrict the State's psychiatrists from administering medications or doses that would likely be harmful to the patients. Consistent with previous years, in 2016 approximately one third of the involuntary medication cases filed resulted in a denial by the court, a dismissal by the State, or an order from the court limiting the medications sought or the method of administration; in other cases, the State, after hearing from the independent psychiatrist, agrees [sic] to exclude a requested medication or reduce the requested dose.

In every one of these cases, if the hospital had had its way, free of judicial review and an effective defense, the patient would have been forcibly medicated, but the court process allowed the patient to successfully defend against what was determined to be an unwarranted or excessive intrusion.

4. **What did not work well regarding the process?**

Legal Aid did not include an answer to this question in its letter of November 18 to DMH central office staff, but it should be noted that a good bit of information on this topic appears in other sections of the letter.

5. **In your opinion, was the outcome beneficial?**

In the cases in which the court either denied or limited the involuntary medication order the outcome was decidedly beneficial because it supported the patients' right to direct their own treatment or to ensure that they will [sic] not be subjected to harmful treatment.

It is much more difficult to say that an order granting involuntary medication was beneficial. The entire process of involuntary medication undermines the opportunity for patients to develop mutually respectful relationships with their treatment providers: the message of the involuntary medication process is that the patient's wishes are of no concern to the mental health system, and that the system exists not to help patients but to do things to them. By so quickly moving to forced medication, by treating it as a first, rather than a last resort, the State has abandoned any effort to establish a trusting relationship with the patient in favor of simply overpowering them through the court process.

It is well established that the great majority of patients who receive antipsychotic medications eventually discontinue their use, either because of intolerable side effects or other unacceptable results. This means that every case of involuntary medication must be viewed as no more than a temporary resolution. Unless the State can demonstrate that there are significant and long-lasting benefits to involuntary medication, it is difficult to see how the temporary benefits that involuntary medication may provide outweigh the cost to patient self-determination and autonomy in any regime of forced treatment.

In addition, a growing body of evidence demonstrates that in the long run, keeping patients on psychotropic medications does not result in improved functional outcomes. Pursuing forced treatment is a choice by the mental health system to favor immediate convenience over the long-term good of the patient. We support the proposal by Disability Rights Vermont for a study of the long-term outcomes of people who are subjected to forced medication.

Finally, as I noted above, the State has chosen to rely more and more heavily on forced medication. While the policy of the State of Vermont is "to work towards a mental health system that does not require coercion or the use of involuntary medication" (18 V.S.A. § 7629(c)), this dramatic increase and the Department's successful advocacy for legislative proposals to even further expand and accelerate involuntary medication demonstrate that the Department has abandoned this policy and chosen to pursue forced medication as its predominant method of treatment. I would urge the Department to take the legislative policy seriously and work to reduce coercion in every component of the mental health system.

6. Do you have any changes to recommend in the law or procedures? If so, what are they?

Involuntary medication is an affront to the human dignity and natural autonomy of persons in the State's custody, and it should be used only as a last resort. As written and as applied, the current statute makes it unreasonably difficult for patients to present an effective defense, and eliminating the provision of 18 V.S.A. § 7625(a) that requires hearings to be held in seven days would be a positive change. The changes in the law adopted as a part of Act 192 have generally made the situation worse by forcing the courts to schedule both involuntary medication and initial commitment cases unreasonably quickly. These provisions should be repealed. In addition, the State should adopt restrictions on the use of long-acting involuntary medications as a standard and routine treatment modality.

Fundamentally, though, the most important change in the practices of Vermont's mental health system is that the Department, and the entire mental health system, should begin to take seriously the idea that people have rights, that the things the system does to people in the name of helping them are often painful and devastating, and do more harm than good, and that the people the Department is established to serve are human beings who deserve to have their rights and wishes respected.

Thank you for your attention to these comments. I hope that you take them seriously, and that they result in an improvement in patient care and respect for patients' rights.

INPUT FROM VERMONT JUDICIARY

For the 2017 Commissioner's Report to the General Assembly on Act 114, Chief Superior Judge Brian J. Grearson submitted responses from four Vermont judges "who regularly presided over the largest number [of] Involuntary Medication requests" in calendar year 2016. Those judges were:

- Judge Timothy Tomasi, Civil Division of the Washington Superior Court
- Judge Karen Carroll, Family Division of the Windham Superior Court
- Judge Nancy Corsones, Family Division of the Rutland Superior Court
- Judge Mary Miles Teachout, Civil Division of the Washington Superior Court

1. Were you directly involved with any individuals involuntarily medicated under Act 114 in 2016?

All four judges answered this question in the affirmative.

2. Are you aware of any problems encountered in the implementation of this process?

Judge Tomasi: I felt the process worked well. The attorneys and the GAL's [guardians ad litem] worked effectively together to ensure fair hearings were held. The remote court room provided an appropriate venue.

Judge Carroll: The only problem I have observed in the process is that, at times, we have a petition for involuntary treatment (IT) set for hearing and the AG [Attorney General] will file a petition for involuntary medication (IM) just before the IT hearing and ask that the hearings be consolidated. This often does not give the respondent's attorney enough time to prepare for the added IM aspects of the hearing, which are often more contested. I have had to continue IT hearings because of this. I often wonder, when I am doing an IT hearing and there is testimony from a psychiatrist that the patient is refusing medication, why an IM was not filed along with the IT application. It seems that we could do more consolidated hearings if both were filed together, in a more timely manner.

Judge Corsones: No. We always met hearing deadlines by moving other cases, or were slightly past deadlines with the agreement of both attorneys.

Judge Teachout: In Washington County, we schedule the hearings right away. We meet the statutory time frames for conducting the hearings. We have a very good clerk who is on top of immediately addressing and scheduling the hearings.

3. What worked well regarding the process?

Judge Tomasi: I felt the process worked well. The attorneys and the GAL's [guardians ad litem] worked effectively together to ensure fair hearings were held. The remote court room provided an appropriate venue.

Judge Carroll: The process works smoothly. These are sometimes very contested hearings but everyone seems to be prepared and ready to make their arguments.

Judge Corsones: Having experienced and knowledgeable attorneys is essential to the smooth functioning of the process.

Judge Teachout: It works well to consolidate the hearings with hearings on other relevant applications (AIT [applications for involuntary treatment], ACT [applications for continued treatment], revocation [of an order of nonhospitalization, or ONH]) when we can. There is one significant problem, illustrated by a recent case. The IM [involuntary medication] application was filed on a patient and we scheduled and conducted an immediate hearing. She was on an ONH so the court had jurisdiction, although I wondered why she was at VPCH on an ONH but thought she might be there voluntarily. The day of hearing, we received in the mail several new filings on her (AIT, ACT, and revocation) that had been filed in another county. In that other county, a motion to change venue had been granted 12 days earlier, but we didn't get the files in time to consolidate the hearings. If we had statewide control of the docket, that wouldn't have happened. We would have known of all pending cases and could have scheduled a timely consolidated hearing on them all. As it was, we had to have the IM

hearing one day and we will have the other involuntary treatment hearings a week or two later. It would have been much more efficient for the lawyers, hospital, and court to have a single hearing (better use of everyone's resources), and more importantly far better for the patient to have one hearing rather than two [hearings] a week or two apart.

4. What did not work well regarding the process?

Judge Tomasi: On occasion we had a problem with the sound system and the recording feature of the computer but we were able to obtain support and continue the hearings.

The procedure could be improved if judges could have the option of not holding a hearing in order to appoint a GAL under Family Rule 7.1. The request in such cases comes from the appointed counsel based on an inability to communicate. Trying to schedule a GAL hearing on the already tight time frame is difficult and sometimes results in a delay of the hearing.

There is a bit of tension, at least potentially, between the standard for advance directives and written preferences. Under 18 V.S.A. ss. 7627, written preferences are given priority if they are "competently expressed." Advance directives under 18 V.S.A. §9701(4) speak [to] having the "capacity" to enter an advance directive. It's not wholly clear the relationship between capacity and competency. Additional clarification could be beneficial in this area.

Judge Carroll: See her answer to the question about problems in the implementation of the Act 114 process.

Judge Corsones: Patients waited too long in ERs [Emergency Rooms] or in jail before a bed was available.

Judge Teachout: See answer to previous question. Additional input for this question: "What does not work well is the disconnect between filings that are made in a county with a hospital and filings concerning the same patient that are made in the county of their residence. We need to be able to coordinate these.

5. In your opinion, was the outcome beneficial?

Judge Tomasi: I thought the outcomes were beneficial.

Judge Carroll: I hope the outcomes are beneficial but we are not informed of the results of orders granting petitions for involuntary medication.

Judge Corsones: Yes, I hope that by listening carefully to the evidence and applying the facts to the law, the outcome was beneficial to the respondent.

Judge Teachout: The hearings have been timely. Whether they are beneficial to the patients I cannot say.

6. Do you have any changes to recommend in the law or procedures? If so, what are they?

Judge Tomasi: See his answer to the question about what did not work well regarding the process.

Judge Carroll: See her answer to the question about problems encountered in the implementation of the Act 114 process.

Judge Corsones: We need far more resources in terms of attorneys, judges and court staff to ensure a prompt resolution of all MH [mental health] cases. We can only hear cases on Fridays, unless the AIM deadlines mandate that we continue cases from our domestic docket (and attorneys are available.) AITs are being booked into mid-January. We are booking community cases into late January or early February. In my view, that is totally unacceptable.

Judge Teachout: See her answer to the question about what has worked well regarding the process.

INPUT FROM INDIVIDUALS INVOLUNTARILY MEDICATED UNDER ACT 114

Six patients who were involuntarily medicated between December 1, 2015, and September 30, 2016, responded to the Commissioner's questionnaire about their experiences during their hospitalization for psychiatric care. An additional three who received involuntary nonemergency psychiatric medications in 2015 responded too, but their answers arrived at the Department of Mental Health too late to be included in the report that was submitted to the General Assembly in January 2016. They are included in this report to be submitted in January 2017. Data on Act 114 medications from October 1 through December 31, 2016, will not be available until late January 2017.

The Commissioner's questions and the patients' answers are as follows:

1. Do you think you were fairly treated even though the process is involuntary?

Yes: 4
No: 4

One of the respondents to this year's questionnaire from the Commissioner did not answer either yes or no, but observed that "I came to the hospital voluntarily."

Two of the respondents who answered yes offered no additional comments. A third commented that the experience in court was "[b]oring[;] why did I need to go to court? How come I wasn't put on the stand?" The same respondent called his/her experience at the hospital "Boring!!" The fourth respondent who answered yes to this question entered "N/A" in the part of the questionnaire that asked people to tell about their experiences in court and in the hospital.

The four individuals who answered no to this question offered the following comments:

After checking "no" for an answer, one respondent added "Not always. It didn't seem to matter what I said in the beginning or how I tried to explain to the psychiatrist. I felt that he didn't always really listen." About being in court, this respondent wrote that "I felt that the psychiatrist['s] testimony was given more weight and credibility than mine." About the hospital, the respondent added that "I felt that the staff were respectful and almost always or most of the time tried to listen to me and give attention to my wishes, opinions, feelings, etc."

On being in court, the second respondent who answered no to her feeling about the fairness of the process wrote that "[the] Doctor lied." About her experience in the hospital, the respondent wrote, "[I was] attacked and thrown down and given [a] shot."

The third respondent added "No not at all" in the space for describing his experience in court and "later months later" about his hospital experience.

About her experiences at the hospital, the fourth respondent wrote at length: "The doctor should have told me why he was prescribing the meds he choose [sic] & should have told me why I was being involuntarily medicated. The possible side effects should have been explained to me so I would not have suffered as long as I did."

2. Do you think that the advantages and disadvantages of taking medications were explained clearly enough to help you make a decision about whether or not to take them?

Yes: 6
No: 3

Seven respondents checked yes or no without elaborating on their answers. Two other respondents offered the following comments:

"People should <u>calmly</u> & caringly talk to patients[,] <u>not threaten them</u>! An[d] tell the patients <u>why</u> they are doing things like forced meds or one[-]on[-]one[.]"

"No[.] But I know I need my meds and did not need force or a drug that hurt my mood[,] caused wait [sic] gain[,] and diabeetees [sic]."

Special Note: Three of the nine respondents to this year's questionnaire did not answer questions 3-6.

3. Why did you decide not to take psychiatric medications?

The six respondents to the Commissioner's questionnaire this year offered the following comments on their decisions not to take psychiatric medications:

- "Because i [sic] was mentally ill and unaware of what was going on around me."
- "I did not think I needed them . . . [four or five words are illegible at this point]." The last word of the sentence is "nightmare."
- "Because I figured I didn't need them, I guess. I really don't know why. I just thought that I didn't need them."
- "Social stigma"
- "I don't need them."
- "Because I am sober for over 1 yr & did not want to take any [triple underline under the word "any"] medications"

4. Now that you are on medication, do you notice any differences between the times you are taking your medications and the times you are not?

Yes: 5
No: 1

The five respondents who answered yes, they could notice differences between the times they are taking medications and the times they are not, added the following details:

- "Now that i'm [sic] taking the medication i do not hear voices and do not see things that aren't there. I had hallucination[s] that are no longer there."
- "I feel even[-]kiltered."
- "My new meds do not have a sedative effect."
- "I'm not thinking my soul will be taken or I'm being stalked by evil entities."
- "My thinking is clearer[.] I have a new doctor & I am very happy with her. [Previous doctor] did not have my best interests in mind."

5. Was anyone particularly helpful? Anyone could include staff at a designated hospital or a community mental health center, a family member or friend, a neighbor, an advocate, someone else who is in the same hospital you are/were—really, anyone.

All six of the respondents to this question gave the names of many others who were helpful to them in one way and another. Most of the individuals are identifiable as probably on the hospital staff, while one may have been a friend and another was identified as a sister. Others were not named but identified as hospital staff: technicians, nurses, doctors, social workers.

Answers to the question "In what ways was he/she helpful?" included the following:

- "If I [had been] given a new doctor when I asked for one in the beginning things would have gone much smoother[.] I have a new doctor now who I like very much. [All three people named as helpful] are natural leaders[.] [T]hey do their job[s] very well & they work the whole time they are at work[.] I have never seen them having personal conversation about non-work-related subjects for long periods of time the way many workers here do. [T]hey have the best interest of patients['] needs for most in time [illegible] & I have never seen any of them antagonize paitients [sic] the way about 20 percent of the staff does."
- "They [all the doctors and technicians] had to give me involuntary medication for my condition because i didn't think there was anything wrong with me. I have good experiences with everyone no[w] that I'm back down to Earth."
- "She chatted & gave me a hug when I left the med window to get meds."
- "Gave me a place to live, made me laugh when I needed to. Gave me support and a listening ear."

One of the answers was illegible. Two respondents did not describe how the hospital staff they named were helpful.

6. Do you have any suggestions for changes in the law called Act 114? Please describe the changes you would like to see.

Yes: 1
No: 3

Two of the six respondents did not answer the question. The one who answered yes suggested occasional hugging for long stays.

CONCLUSIONS

What Is Working Well

Vermont Supreme Court Interpretation of Refusal to Take Medication. In order for the state to file an application for involuntary medication a patient must be "refusing medication proposed by the physician." 18 V.S.A. § 7624(c)(3). Oftentimes a patient may be accepting some medication, but not enough to adequately treat his or her condition. Other times a patient may accept medications on an inconsistent basis, but again not enough to adequately treat his or her condition. DMH's position is that a patient who is refusing to take medications as prescribed (meaning the type, amount, and frequency required by the treating psychiatrist) are refusing medication for the purposes of § 7624(c)(3). The Vermont Superior Court, Rutland Family Division, in *In Re DN*, Dkt. No. 23-2-15 Rdmh-aim (March 2, 2015), held that a patient's acceptance of some medication, though not in the amount or frequency prescribed, constitutes a refusal under the law. This is a good step forward for the state judiciary, but it is still inconsistently applied by judges in different courts around the state.

Input from Act 114 Patients, Hospital Staff, Families, Advocates, Judiciary, and Others. For a number of years, DMH has asked for input about what is working well and what is not from a wide range of people involved in the Act 114 process and other stakeholders. This approach has provided valuable information in the past; DMH feels that it has continuing merit and will plan to use it going forward. It is important to note that one of the suggestions from the 2013 report, holding court hearings in the hospital setting, has been introduced at the UVM Medical Center, Rutland Regional Medical Center, and the Vermont Psychiatric Care Hospital in Berlin.

Positive Effects of Medications. Hospital staff—usually doctors, nurses, and social workers—who participated in the interviews for this report were unanimous in seeing positive outcomes for individuals after medication. That has been the case every year that this report has been written for the General Assembly. Five of the six respondents who answered this year's survey question about the effects of medication said that they discerned a positive difference in their condition after receiving medication. Their comments included:

- I "do not hear voices and do not see things that aren't there" anymore.
- "I feel even[-]kiltered."
- My new meds do not have a sedative effect."
- I'm not thinking my soul will be taken or I'm being stalked by evil entities."
- "My thinking is clearer . . . [and] I am very happy" with a new doctor.

It should also be noted here that only one of this year's nine respondents to the Commissioner's questionnaire mentioned negative side-effects of psychiatric medications. The medications hurt her mood, she wrote, and caused weight gain and diabetes.

Hospital Staff. Three respondents saw hospital staff in a positive light after going through the Act 114 process. They even mentioned some particularly helpful staff members by name and described how they were helpful. One respondent praised hospital staff for being "natural leaders" and placing priority on patients' best interests. Another wrote that "I have good experiences with everyone no[w] that I'm back down to Earth." The third praised a staff person for chatting with her and giving her hugs for taking her medications.

What Is Not Working Well

The Act 114 Process. Four of the Act 114 patient respondents answered yes to the Commissioner's question about fairness, and four answered no. Only one who answered yes still complained that the experience in court was "Boring!!" and wondered why she was not "put on the stand." The other three who answered yes offered no additional details.

Among respondents who answered no to the question about fairness, complaints included:

- ❖ "It didn't seem to matter what I said in the beginning [of hospitalization] or how I tried to explain to the psychiatrist. I felt that he didn't always really listen." As for the court experience, this respondent's feeling was that the court gave testimony from the psychiatrist more weight and credibility than the patient's.
- ❖ The "doctor lied" in court and, in the hospital, she was "attacked and thrown down and given [a] shot."
- ❖ "The doctor should have told me why he was prescribing the meds he [chose and] why I was being involuntarily medicated." In addition, "the possible side effects should have been explained to me so I would not have suffered as long as I did."

Length of the Process. Hospital staff who administer psychiatric medications under the provisions of Act 114 are unanimous in their perceptions that the process is too long. On the other hand, Vermont Legal Aid adamantly asserts that the process is too short. As parts of a decentralized system of care, acute-care hospitals participating in Level 1 care services remain obligated by accreditation or certification bodies to offer active treatment to their patients and to ameliorate the symptomatology of psychiatric distress. The time frame of the legal processes at present may place inpatient facilities at risk from a regulatory standpoint if they are unable to provide timely and effective treatment interventions.

Education About Side Effects of Psychiatric Medications. Although six of the nine respondents to the Commissioner's question about psychiatric medications checked yes, the pros and cons of the medications had been explained clearly enough to allow them to make decisions about whether or not to take the medications, one respondent had a very negative view. She wrote that "people should <u>calmly</u> & caringly talk to patients [and] <u>not threaten them</u>!" She also expressed a desire to know "<u>why</u> [hospital staff] are doing things" like involuntary medications and one-on-one supervision.

Two Reports on Implementation of the Act 114 Process. For a number of years both the Commissioner's Report and the Independent Report on the Implementation of Act 114 have recommended that one report should be considered sufficient for legislative review and oversight. The DMH Commissioner reiterates previous recommendations that the General Assembly strongly consider the current redundant content of these two reports on Act 114, eliminate the annual report from the department, and expect an independent report to capture both departmental actions and individual experiences in this area together with recommendations for changes in the law.

Opportunities for Improvement

Focus on Recovery

For many years Vermont's Department of Mental Health has emphasized the concept of recovery as invaluable both for providers and for recipients of mental-health services. Recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[1]

The four major dimensions that support a life in recovery are:

- Health
- Home
- Purpose
- Community

The ten guiding principles of recovery are:

- Recovery emerges from hope for a better future
- Recovery is person-driven, based on foundations of self-determination and self-direction
- Recovery occurs via many pathways that are highly personalized for each individual
- Recovery is holistic, encompassing an individual's whole life
- Recovery is supported by peers and allies
- Recovery is supported through relationships and social networks
- Recovery is culturally-based and -influenced
- Recovery is supported by addressing trauma
- Recovery involves individual, family, and community strengths and responsibility
- Recovery is based on respect[2]

The next challenge is to move the concepts of recovery into tools and strategies that can be implemented in areas of health and wellness education, illness self-management and self-awareness, and appreciation of the negative impact of inadequate care for self on family, significant others, and the greater community. Individual stability and self-sufficiency are also compromised when compensation strategies are not identified in the absence of timely treatment for an acute phase of mental illness.

[1]Substance Abuse and Mental health Services Administration, U.S. Department of Health and Human Services, *SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery* PEP12-RECDEF (Rockville, Maryland: 2012), p. 3.

[2]*Working Definition of Recovery*, pp. 4-6.

Maximizing Individual Preference and Systemic Resources

The Department of Mental Health's opportunities for improvement, specific to the implementation of Act 114, lie in continuing to explore ways of maximizing individual preference whenever possible. The new community capacities that have gone into place over the past five years include

- Expanded mobile crisis capacities all over the state,
- Hospital diversion and step-down,
- Peer-supported alternatives such as Alyssum and Soteria House
- The new Vermont Psychiatric Care Hospital in Berlin
- Continued emphasis on least-restrictive transport
- Support for training in the Six Core Strategies for reducing seclusion and restraint
- Efforts to identify the most effective ways to support individuals experiencing early-episode psychosis (for example, Open Dialogue and the new requirements of Mental Health Block Grant funding to use 10 percent of the state's allocation to explore approaches to first-episode psychosis)
- Team Two training for collaboration between mental health providers and law enforcement, looking toward more individualized responses to people in emergency situations
- Working toward making orders of nonhospitalization more effective as treatment tools in the community through technical assistance
- Potential opportunities to collaborate with the Vermont Ethics Network in facilitating stakeholder discussions regarding community-driven priorities for mental-health system change, treatment intervention, and individual engagement strategies, and accountability tools that would improve individual and system outcomes,

These are among the most important ways in which the redesign of public mental health care here in Vermont has emphasized individual preference among a range of options for treatment and support. In addition, hospital staff repeatedly noted their attempts to maximize patient choice even in an involuntary situation: choosing the place and timing of medication, for example, and numerous attempts to engage patients in their own treatment and enhance their understanding of the individual benefits of medications when they are components of their treatment plans.

In Closing

The Department of Mental Health acknowledges that the outcome of medical care by court-mandated involuntary treatment, including the use of nonemergency involuntary medication, is not a preferred course for an ideal plan of care. DMH continues to take the position that use of medication for some persons with a mental illness is an effective component of a treatment plan to bring about mental health stability and continued recovery in their community. Patients should receive information regarding medication options and side-effects from a practitioner who is working to build a trusting therapeutic

relationship, but, at the same time, we recognize that this relationship does not always result in agreement to take medication. DMH will continue to encourage efforts to broaden the choice of services to support earlier intervention for persons who might benefit from care or other treatment alternatives if they were more accessible sooner, and also to encourage options for services inclusive of the preferences and values of each individual patient.

DMH still believes that it will be necessary to revisit statutes, specifically Titles 13 and 18, in the future to seek changes that would:

- Better support best practices for active treatment of individuals experiencing mental illness in psychiatric inpatient care,
- Affirm expectations for restoration of capacity when possible during psychiatric hospitalization, and
- Endorse community-based treatment approaches and service models that proactively promote psychiatric stability and community participation