

VERMONT2013

The Implementation of Act 114 in Vermont in Calendar Year 2012

Report from the Commissioner of Mental Health
to the General Assembly
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VERMONT

**DEPARTMENT OF MENTAL HEALTH
AGENCY OF HUMAN SERVICES**

26 Terrace Street
Redstone Building
Montpelier VT 05609-1101
1.802.828.3824
mentalhealth.vermont.gov

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

The statute allows for orders of non-hospitalization, 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 non-emergency involuntary medication with judicial hearings in family court. The statute permits the administration of involuntary psychiatric medication in non-emergency situations to patients who have been committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in the community as well as at the Vermont State Hospital (VSH). Until August 29, 2011, when Tropical Storm Irene forced the evacuation of the State Hospital, non-emergency involuntary psychiatric medications were given only at VSH. When patients were relocated to other hospitals and facilities around the state, then-Commissioner Christine M. Oliver designated Fletcher Allen Health Care, Rutland Regional Medical Center, and the Brattleboro Retreat for involuntary medication procedures. On January 3, 2013, Acting Commissioner Mary D. Moulton wrote letters renewing those designations.

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.

INTRODUCTION

The annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health (DMH). You will find that under Act 114 the state filed 49 petitions for involuntary medication between January 1 and December 31, 2012. Fourteen of those petitions were withdrawn before a court hearing as the patients began taking medication voluntarily. One other petition was dismissed in court, and one petition was pending at the end of 2012. The courts granted the state's requests in the remaining 33 petitions and issued orders for involuntary medication of those individuals. Of that total, 26 had been discharged from inpatient treatment before the end of November 2012.

Six people who were involuntarily medicated under the Act 114 process in 2012 answered the Commissioner's questionnaire about their experience. The other twenty-six people who were under orders for involuntary psychiatric medications last year did not respond to the Commissioner's questionnaire.

It is worth repeating from previous reports that DMH does not consider the use of Act 114 a panacea for persons who are seriously ill and receiving inpatient psychiatric treatment. The medication is only a part of the treatments that can move individuals toward discharge. Additionally, recovery can be slow. Further, it is always possible that persons may stop the use of medication following discharge from the hospital, and many of them do. The situation is far from ideal, as the use of coercion to gain a patient's agreement to take medication that will address his/her symptomatology is the least-preferred avenue on which to move toward recovery. A trusting doctor/patient relationship may, in fact, be more effective in a person's decision to take medication as prescribed. Medication, whether voluntary or involuntary, is often a component of recovery and symptoms can be alleviated through its use.

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 those adults with the most refractory mental illnesses. All of these views are included 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 enrich discussions of the use of medication as an intervention for mental illness as care providers continue to struggle to improve outcomes for the individuals they serve.

PROBLEMS WITH IMPLEMENTATION

The implementation of Act 114 procedures for administering involuntary psychiatric medication in three different hospitals around the state is considerably more involved than carrying them out in a single location, as had been the case while the Vermont State Hospital was still in operation before Tropical Storm Irene forced its evacuation at the end of August 2011. DMH has provided extensive training to the staff of the three designated hospitals where Act 114 medications are now administered (the Brattleboro

Retreat, Fletcher Allen Health Care, and Rutland Regional Medical Center), and the information we have indicates that the hospitals are carrying out their responsibilities in a commendable manner. Additional thoughts on problems with Act 114 from the perspective of hospital staff are collected on pages 12-15, under the section on “Input from Organizations and Individuals as Required by Act 114.”

NUMBER OF PETITIONS FOR INVOLUNTARY MEDICATION FILED BY THE STATE PURSUANT TO 18 V.S.A. §7624 AND THE OUTCOME IN EACH CASE IN CALENDAR YEAR 2012

It should be noted that the number of petitions for involuntary medication for psychiatric treatment was much higher in 2012 than in 2010, the last full year that the Vermont State Hospital was in operation. Petitions in 2010 numbered only 31 as compared against 49 in 2012, an increase of 58 percent. The increased number of petitions was probably attributable to an upsurge of higher-acuity patients in these three designated hospitals, which were not used to that level of acuity. The process of learning about the filing process among a new cadre of doctors most likely resulted in this uptick in petitions as the hospitals adjusted to managing their treatment environment and timely treatment approaches for complex patients admitted to their unit.

The number of petitions granted in 2012 was also higher than the number granted in 2010, but the percentage of the petitions that had been filed was fairly similar: 33 petitions out of 49 in 2012, or 67 percent, and 22 petitions out of 31 in 2010, or 71 percent. In each year, one petition was denied by the court and one petition was left pending at year’s end. The rest of the petitions were withdrawn because patients had started taking psychiatric medications voluntarily before the court hearing (fourteen withdrawn in 2012, and seven in 2010).

The following table shows Act 114 petitions filed, granted, denied, and pending from January 1 through December 31, 2012, by hospital.

Hospital	#Granted	#Denied	#Withdrawn	#Pending	Total
Brattleboro R.	11	0	7	1	19
Fletcher Allen	9	1	3	0	13
Rutland Reg.	13	0	4	0	17
Total	33	1	14	1	49

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

None.

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
- the 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), a statewide organization offering information and support, referrals to other agencies, advocacy, an ombudsman through DMH, and legal representation for individuals with disabilities and/or mental-health issues

The only respondents for the 2012 report were VPS and Judge John P. Wesley, of the Family Division of the Vermont Superior Court for Windham County, located in Brattleboro.

Additionally, Act 114 seeks input from individuals who received psychiatric medication involuntarily under Act 114 at the Brattleboro Retreat, Rutland Regional Medical Center, and Fletcher Allen Health Care. Responses from six patients who were involuntarily medicated at those three hospitals in 2012 are included in this report.

Finally, DMH central office staff held telephone interviews to solicit input from physicians, nurses, and other hospital staff during the week of December 17, 2012. One additional response came in written form from an individual who could not participate in the telephone interviews.

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?

Response from Vermont Psychiatric Survivors:

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

At Vermont Psychiatric Survivors, the only role we play is providing peer support and advocacy. The staff here basically gets a call from the peer and then provides support through visits and phone calls. Generally any peer who wishes may also speak to the patient advocate while they are visiting. The first thing we do is to be sure that if the person chooses Protection and Advocacy [that is, Disability Rights Vermont] are aware.

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

The side effects of the medication can cause many health issues as well as death. Also if a [person is a] trauma survivor [the involuntary medication] often can be retraumatizing and cause them to be aggressive (fight or flight syndrome).

3. What worked well regarding the process?

For a few it helped them to start healing and working on their recovery.

4. What did not work well regarding the process?

For some the retraumatization and injuries to staff and patient.

5. In your opinion, was the outcome beneficial?

In some cases yes but many no. Whenever any one [sic] is forced to do something it often is not beneficial.

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

The only thing is keep the time constraint before one can be forced [sic] medicated. I understand there are cases where some are unpreventable. It needs to be decided on individual cases. Pre[-]Irene [administration of medication] was done by staff with years of experience. Dependent upon the circumstances this can be good or bad. Some staff had the history of the person so could determine when things might be getting out of hand and use preventive measures. Others would just go into crisis mode.

Post[-]Irene there was less opportunity to get forced [sic] medicated as many of the places weren't authorized to do the process. However many patients were held in hospital emergency rooms until beds were available. This is very disruptive for the patient as well as the hospital. Hopefully the new places being established will help this.

Response from Judge John P. Wesley, Windsor Family Court:

Judge Wesley presides over the Family Division of the Windham Unit of the Vermont Superior Court, located in Brattleboro. He began his letter of response to the Commissioner's questionnaire about the implementation of Act 114 by noting a significant increase in mental-health cases in Brattleboro since the closure of the Vermont State Hospital after Tropical Storm Irene at the end of August 2011. In the term from September 2011 until September 2012, the court dealt with 216 admissions for emergency examination at the Brattleboro Retreat and 26 applications for continued treatment. Eighteen applications for involuntary medication also came before the court. In contrast, over the year from September 2010 until September 2011, the court dealt with 142 admissions for emergency examinations, 14 applications for continued treatment, and no applications for involuntary medication. Judge Wesley has established a regular Friday calendar for mental-health cases.

Judge Wesley answered the Commissioner's questionnaire about Act 114 as follows:

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

I have been directly involved with each case seeking an order for involuntary medication since Sept. 2011. Of those, I estimate that less than 1/3 afforded direct contact with the individual patients, the majority of whom have elected against a personal appearance at the hearing. So long as the patient's attorney, and GAL [guardian ad litem], if one has been appointed, consents to non-appearance, the Court does not compel it in the interest of minimizing the possibility of adverse emotional response to the judicial proceedings. In most cases in which the patient chooses to appear, he or she has also chosen to testify. For the most part, the choice to testify has served to confirm the need for compelled treatment.

For a period of time during the last term, with the cooperation of the Retreat, the Attorney General's office, and the Mental Health Law Project, the Court participated

in a pilot program experimenting with holding hearings in a conference room at the Retreat. It was expected that such an approach might increase the likelihood of better patient participation in judicial proceedings. There was further hope that patients attending hearings might require less security and restraint. The project was discontinued when neither of those results materialized. In light of this experience, I concluded that continuation of the project could not be justified in light of the increased burden it placed on staff and security for coordinating the rest of the docket on days in which some hearings were scheduled to be held at the Retreat. My assessment also took into consideration the relatively close proximity of the courthouse to the Retreat. I am reasonably confident that the number of patients who choose to participate in hearings is not adversely affected by the difference between the logistics of getting to court, as compared to the logistics of moving across the Retreat campus from the residence hall to the conference room. As it developed that restraints were being used in either event, this factor was really not a consideration. However, I know that Windham County Sheriff Keith Clark consulted with Retreat staff and his court security personnel[,] and the use of softer restraints has been implemented, which allows for reasonably uncomplicated loosening for the freedom of at least one hand during court proceedings.

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

As with the entire mental health docket, the management of Act 114 proceedings depends heavily on the close collegial relations between the Ass't AGs [Attorneys General] assigned to mental health cases (typically Kristen [sic] Chandler, Esq.[,] in this region), and the attorneys for Mental Health Law Project (typically Bridget Lynch, Esq.[,] or, less frequently, John McCullough, III, Esq.). Many proceedings which begin as contested matters are resolved by stipulation. This tends to be less the case with Act 114 proceedings. Nevertheless, not infrequently a patient begins accepting treatment in a manner seemingly promising enough to prompt the advocates to seek a continuation of a scheduled hearing on the application for involuntary medication. Occasionally, the advocates have disagreed as to whether a continuation is justified by some movement toward voluntary compliance. In one instance, I denied the patient's request for a continuance at the commencement of the hearing, but concluded after consideration of the evidence that the soundest approach would be to delay any immediate ruling, and set the matter for a further conference in two weeks in order to assess the degree of continued voluntary compliance. No ruling was ever necessary in that case.

3. What worked well regarding the process?

It is difficult to generalize as to the circumstances associated with requests for involuntary medication, since they are very particular to each patient. However, as to the critical issue of whether the patient possesses the insight and willingness to accept a regimen of treatment without compulsion, I believe the records from contested proceedings would demonstrate careful inquiry of treating physicians as to their attempts to explain to their patients the basis for a recommended course of medication, and in particular, the expectation that a request for a judicial order will be made in the

absence of voluntary compliance. The responses to such inquiries have grown more particular, I believe, as the Court's expectations have become known. Further, there is some basis for inferring that careful attention to efforts to promote voluntary treatment, in coordination with the preparation of applications for involuntary medication, may result in a somewhat higher incidence of acceptance of such treatment without judicial compulsion.

4. What did not work well regarding the process?

I do not have any particular suggestions for amendments to the statutory Act 114 process, which appears to strike a careful balance between due process concerns and the humane objectives which sometimes require compulsory medication.

5. In your opinion, was the outcome beneficial?

As noted initially, proceedings for involuntary medication are a post-Irene phenomenon in Windham Family Division, since there were no applications in the year preceding the storm, when patients likely subject to such requests were housed at VSH for the most part. Considering that the physicians, staff and personnel at the Retreat have had to acquaint themselves with the discipline required by Act 114, at the same time that the court has been gaining experience incorporating such proceedings into its docket, I am reasonably satisfied that the concerns addressed by the statute have been handled sensitively and sensibly.

The request for my opinion as to whether outcomes are beneficial is perhaps the most difficult query you have posed. Except for the example I mentioned earlier in which a ruling was never made because the patient continued to accept treatment after I continued the hearing, following the presentation of evidence, I have granted the petitions which have reached an evidentiary hearing. I have every hope and expectation that my orders have resulted in improvement to the patients' conditions such that discharge from the hospital is eventually possible. I know that to be the case in some instances, but other cases resolve without direct monitoring or involvement by the court. While I can only hope that the Department has devised a means for evaluating the effectiveness of compulsory medication through outcomes[-]based assessments, such a process is not feasible within the court system based on the information available, or any methodology that might be developed to assess it.

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

Judge Wesley did not offer any recommendations for changes in the law or procedures.

**Individuals Involuntarily Medicated at Vermont’s Designated
Hospitals for Act 114 Psychiatric Medications**

Six patients who were involuntarily medicated under Act 114 in 2012 responded to the Commissioner’s questionnaire about their experiences during their hospitalization for psychiatric care. Five provided written answers, and one telephoned the Department of Mental Health and gave answers to the same questions over the telephone.

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: 3

One individual answered both yes and no to the question about fair treatment. About her experience in court, she said that the ruling was that she had to take psychiatric medication; if she had not taken it, then she would have had to have shots. She decided to take the pills because she wanted to get out of the hospital. About her experience in the hospital, she indicated that she did not believe she should have been kept for so long involuntarily before the court hearing, a period of time that she said was nine and a half weeks.

One of the other respondents who answered yes to this question added that the “court process was fair” and the “hospital process was fair.” The third respondent who answered yes to this question added the following:

In court: “unconstitutional legally for a ‘court’ to issue a chemical medicine. (See ‘unusual punishment’—thwarts the thinking processes.[.]”

In the hospital: “ ‘court’ = gossip sessions[,] backbiting and pretty flaws [flawed?] emphasis.”

The fourth respondent who answered yes to this question entered “None” in the spaces for comments about his/her experience in court and in the hospital.

Respondents who answered no to the question were asked to describe what they felt was unfair about the process (1) in court and (2) in the hospital. The comments from the respondent who answered both yes and no to the question about fairness are recorded above. The two who answered no had comments about both settings. They had the following to say about their experiences in court:

“violations [of?] civil rights”

1) “My lawyer never explained the reason I was in court[.] 2) I was not allowed to address the court[.] 3) Not being told I was going to be hospitalized for an

unknown time while judge should not have ordered verbally a 2[-]day inhouse [sic] evaluation.

In the hospital, they said:

“to[o] slow, doctor → violated civil rights”

“Never explained what changes [missing word here?] in my meds even though I have [a co-occurring medical condition].”

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: 3

No: 3

One of the three respondents who answered yes to this question had further commentary: “I felt comfortable talking about the medication[']s side effects[.] [I] still benefit from the med. I do better when I take [name of medication and dosage].”

One of the three respondents who answered no to this question offered the following commentary: “Med. was on a non[-]FDA clearance that involved lab work weekly and the med was there waiting for me to take with no doctor explaining how they obtained this med so quickly.”

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

The six respondents had various answers for this question:

“I thought the side effects were worse than not taking the medication at all. I did not know I can talk to my doctor to decrease the amount because it’s less side effect.”

One respondent felt that the medications would do more harm than not taking them. She thought that she would be less alert, experience more drowsiness, not coherent.

“I felt that medications were painful one time, maybe twice.”

“They are dangerous physically.”

Respondent told about an agreement with physician on medication modifications to meet respondent’s concerns.

“Took pills → speed of leaving hospital”

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: 4
No: 1
Did not answer question: 1

The respondent who did not answer the question wrote that “I feel fine.” The four respondents who answered yes, they could notice differences between the times they are taking medications and the times they are not, had the following things to say:

“I feel more rested and in self-controll [sic] without the medications (the chemicals).”

“Have not tried being ‘off’ any meds, or dose changes without Dr. agreement[.]”

Medications are helpful, respondent feels much better and can make decisions after starting medications.

“I’m getting well[.] I can still function and express myself[.] My thoughts are clear and I don’t complain much about taking meds because I know I have to.”

The respondent who answered no to this question did not elaborate on his answer.

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

All six respondents to the Commissioner’s questionnaire answered yes to this question. Their answers were variable.

Who was helpful?
In what ways was he/she helpful?

For one respondent, “Everyone was helpful,” and the list included a psychiatrist, social worker and nurses (all unnamed) at the Brattleboro Retreat. They were helpful by “always answering questions and giving me what I want.”

Another respondent offered the name of a social worker (hospital unnamed). He/she was “very helpful” in unspecified ways.

A third respondent listed the names of a physician and a patient advocate who “helped me by giving me support and explain[ing] things I don’t understand—like I have to agree to take medication . . .” They “helped me resolve problems I had when I went to the hospital and set goals to leave and go to an apartment, I [was]discharged from Brattleboro Hospital, [and] I live in my apartment now.”

A fourth respondent named a staff member who was very helpful at Rutland Regional Medical Center. The staff member “was tough sometimes” but made the respondent aware of the advantages of taking medications and explained things.

The fifth respondent mentioned an unnamed neighbor across the street, a staff member of one of Vermont’s designated agencies, and someone from the Brattleboro Retreat. The person from the Brattleboro Retreat was “always willing to talk [and] help clarify items.”

The sixth respondent said that “the group meetings for patients, held by staff, were excellent.” They helped by offering “new ideas without using pharmaceuticals.”

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

Yes:	0
No:	4
Did not answer the question:	2

Three of the four respondents who answered no to the question about making changes in Act 114 added the following comments:

“Do not know what exactly Act 114 law says/doesn’t say.”

It depends on the situation. If someone is going to be dangerous or hostile to others, then the law should stay the way it is. . . . Just keep it the way it is.

“I agree to taking medication now and it was involuntary.”

The fourth respondent who answered no to this question did not offer further commentary.

The two respondents who did not answer this question nevertheless commented as follows:

“illegal[l]y arrested[,] process to[o] slow after”

“Can not find it in the Supreme Ct. decisions books at the public library.”

Psychiatrists, Nurses, and Other Staff at Act 114-Designated Hospitals

Central office staff of the Department of Mental Health conducted telephone interviews with hospital staff at each of the designated hospitals for Act 114 medications during the week of December 17, 2012. Hospital staff answered the following eight questions:

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

Staff from all three hospitals noted that the legal process takes too long. They mentioned in particular the necessity of two different court proceedings, first to commit an individual to the care and custody of the Commissioner of Mental Health and then to determine the need for involuntary psychiatric medication in non-emergency situations. Thus, from admission to the administration of psychiatric medication can be a matter of weeks or months for many individuals. During the time that inpatients who are mentally ill and dangerous go without the medications they need, they suffer unnecessarily in the view of hospital staff, and the risk of harm to themselves or others increases. Unmedicated Act 114 patients also increase the suffering of other, less-acute patients in the same unit. As one physician observed,

Delays in effective treatment delay recovery, create health and safety risks for patients and staff, lead to dangerous and demeaning emergency involuntary procedures such as seclusion and restraint, and may even worsen the long-term course of illness. No other type of illness is addressed in this manner.

In addition, hospital staff observed, Act 114 patients occupy beds that other psychiatric patients who are seeking care voluntarily are denied for significant lengths of time. Unnecessary hospital costs mount by “hundreds of thousands of dollars per year” in Vermont. This is money “that could be better spent to increase access to treatment.”

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

From the moment a court order for medication comes down, the process improves because individuals can start receiving the treatment they need and “things smooth out after that.” Patients tend to respond relatively quickly once medications start.

3. Which steps pose problems?

The waiting, the delays that take up time before medication can begin, all were troubling to staff at all three hospitals. “It is simply wrong to delay treatment in the face of such illness,” said one of them. Continuing, he noted that “there really is no argument to tolerate these delays. . . . The current cumbersome process is dangerous and does not result in any benefit to the patient, either medically or legally.” In instances in which forensic evaluations are necessary, the delays are often lengthier and more problematic. Staff resources cannot be used efficiently in such circumstances.

The limitations on types and dosages of medication that can be given are also problematic. In this aspect, the legal process is often at odds with the clinical decisions that should be made by medical professionals, hospital staff felt, and not by courts. Sometimes, court-ordered medications are not effective and then the process has to start all over again for a different kind of medication. For hospital staff, the sooner

patients can be medicated, the sooner they can start getting better and the sooner they can be discharged—and that's the point of treatment.

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?

Staff mentioned numerous kinds of approaches:

- Offering treatment options according to individual preferences
- Offering medications more frequently or on different schedules
- Working with patients daily from day one of hospitalization through the whole process
- Gaining a patient's trust, establishing a therapeutic alliance
- In general, trying to give patients choices

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

The length of time really depends on individual patients. It could be a matter of weeks or months, according to circumstances and commitment hearings. Sometimes emergency situations arise, and then patients might begin to respond to emergency medications but the medications cannot be administered again because the emergency passes and everyone must await a court hearing (or hearings). It is difficult to watch patients decompensate during such a time.

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

Medications can generally reduce psychiatric symptoms, for some patients almost immediately and for others over time. Medications help to reduce risks to everyone involved.

It is not helpful to have to wait so long to begin medications. The longer someone who is mentally ill stays sick, the longer it may take to improve and the individual may not completely recover former functionality. Being held involuntarily on a psychiatric unit for long periods of time is also a violation of the patient's civil rights.

It is also unhelpful to have two separate hearings, one for commitment and one for medications. The two hearings should be combined to expedite treatment. A single hearing would benefit both the person refusing medications and other patients on the unit as well (for example, less violence, fewer emergencies and lessened risk of harm).

In addition, it is not helpful to have judges choosing medications and dosages. Those decisions should belong to treating physicians

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

Patients who go without the medications they need continue to suffer and present dangers to themselves, hospital staff, and other patients. The longer a patient is in the hospital, the greater the strain is for family members as well. Physical health can deteriorate along with mental health. Eating, daily hygiene, and other daily activities can be adversely affected. Individuals cannot return to their homes and communities. Others in need of psychiatric treatment are denied the beds they need in order to accommodate those refusing medications, at tremendous personal cost to those who go without medications for long periods of time in addition to great monetary cost to the state and federal governments.

8. Do you have any recommendations for changes in Act 114?

- ◆ Streamline the whole process
- ◆ Combine commitment and medication hearings
- ◆ Conduct hearings as scheduled
- ◆ Increase access to judiciary
- ◆ Have hearings at the hospitals rather than in outside courtrooms
- ◆ Create some kind of shortcut for repeat Act 114 patients
- ◆ Leave medication decisions up to physicians
- ◆ Increase the number of medications and the dosages that physicians can prescribe
- ◆ Compare Vermont's Act 114 to processes in other states

CONCLUSIONS

What Is Working Well

Input from Act 114 patients, hospital staff, families, advocates, 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.

Decrease in average wait time for psychiatric medications. The average wait time for the administration of psychiatric medications under Act 114 was reduced in 2012 from the average in 2010, the last full year the Vermont State Hospital was in operation. The average in 2012 was 53.8 days, whereas in 2010 it was around 68 days from time of admission to VSH to administration of involuntary psychiatric medications. This is an improvement in the process from the points of view of the Department of Mental Health and treating professionals.

Perceived fairness of the Act 114 process. Four of the six patients who answered the question about fairness saw themselves as having been treated fairly even though an involuntary procedure was involved. It is important to note, however, that one of the four answered both yes and no to that question.

Positive effects of medications. Two of the patients who discerned a difference in their condition before and after medication noted positive effects of the medication. One said that she felt much better and could make decisions for herself. The second said, "I'm getting well[.] I can still function and express myself[.] My thoughts are clear . . ." Moreover, the hospital staff who participated in the interviews for this report were unanimous in seeing positive outcomes for most individuals after medication.

Hospital staff. The six Act 114 patient respondents were unanimous in seeing hospital staff in a positive light after going through the Act 114 process.

What Is Not Working Well

Legal aspects of the process. Two of the patients who were involuntarily medicated under Act 114 considered their civil rights to have been violated. Hospital staff were also in agreement that holding someone involuntarily for a lengthy inpatient stay could be regarded as a violation of civil rights. A third patient complained that his/her lawyer did not explain why the patient was in court and that he/she was not allowed to address the court.

Length of the process. Hospital staff at all three designated hospitals were unanimous in their perceptions that the process is too long. Two separate hearings, one for commitment and another for medication, prolongs the time between admission and

medication, as do forensic evaluations for some patients and continuances or other delays in scheduled hearings for other patients. They do not see any benefits to the patients from these requirements.

Opportunities for Improvement

Focus on Recovery

Vermont's Department of Mental Health continues to emphasize the concept of recovery as invaluable both for providers and for recipients of mental-health services.

“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”¹

Here again, the process of seeking input from patients themselves about their experiences with involuntary medication may be seen as part of the healing process that leads to recovery.

The National Consensus Statement on Mental Health Recovery from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), which has appeared in these reports in previous years, still reminds us that we should keep our focus on recovery as the "single most important goal" for the mental-health services delivery system.² The ten components and concepts fundamental to recovery are:

- ✧ Self-direction
- ✧ Individualized and person-centered supports and services
- ✧ Empowerment
- ✧ A holistic approach to recovery
- ✧ A non-linear process in working toward recovery
- ✧ Strengths-based interactions
- ✧ Peer support/mutual support
- ✧ Respect
- ✧ Responsibility
- ✧ Hope

Maximizing Individual Choice

The Department of Mental Health's opportunities for improvement, specific to the implementation of Act 114, lie within exploring ways to maximize individual choice whenever possible. Since the evacuation of the Vermont State Hospital in Waterbury at the end of August 2011, after Tropical Storm Irene, the new community capacities

¹<http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>

²Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, DDHHS Pub. No. SMA-05-4060 (Rockville, Maryland: 2005), p. 4.

for crisis services, hospital diversion and step-down, introduced in many regions of the state, and plans for a new, state-of-the-art inpatient facility in Berlin next year are the most important ways in which the redesign of public mental health here in Vermont has emphasized individual choice among a range of options for treatment and support.

In 2012, one of these replacement programs maximizing individual choice is the Hilltop House in Westminster, Vermont. This is a residential recovery residence for young adults experiencing mental illness, which allows each of its eight residents to work primarily on interpersonal and social connections with little to no medication if that is their choice.

In Closing

In closing, the Department of Mental Health acknowledges that the outcome of medical care by court-mandated involuntary care, including the use of non-emergency involuntary medication, is not a preferred course of an ideal plan of care. As described in this report, DMH continues to take the position that use of medication for some persons with a mental illness is a very effective component, within a treatment plan, to cause recompensation of mental health stability and discharge from the hospital. Patients should receive information regarding medication options and side effects from a doctor who is working to build a trusting therapeutic relationship, but we recognize that this relationship does not always result in agreement to take medication.

When medication is deemed necessary, we believe it should occur in a significantly more rapid manner than the current process permits. DMH will be commencing an evaluation regarding wait times to determine the variables involved in these waits and work toward a system that will mitigate judicial system filings. Concurrently, we will continue to encourage efforts to broaden the choice of care services to support earlier intervention for persons who might benefit from care if it were more accessible sooner, and also to provide options for care services that are most inclusive of the patient's preferences and values.