

VERMONT2011

*The Implementation of Act 114
(18 V.S.A.7624 et seq.) at the
Vermont State Hospital*

Report from the Commissioner of Mental Health
to the General Assembly
January 15, 2011

VERMONT

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VERMONT'S ACT 114 (18 V.S.A. 7624 et seq.)

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). At present, however, non-emergency involuntary psychiatric medications are given only at VSH.

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.

THE DEPARTMENTAL PERSPECTIVE ON ACT 114

This annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health (DMH). It is worth repeating (from past reports) that DMH does not consider the use of Act 114 a panacea for persons who are seriously ill at VSH. Further, it is always possible that persons may stop the use of medication following discharge from the hospital and many of them do, while some of those who received involuntary non-emergency medication in 2010 were still in the State Hospital at the end of the year.

Nine of the 31 petitions for involuntary medication in 2010 were granted in the last three months of the year. None of those patients answered the Commissioner's questionnaire before year's end. Recovery is sometimes slow. In addition, the medication is only a part of the treatment that can move individuals toward discharge. The situation is far from ideal, as the use of coercion to gain treatment progress is the least preferred avenue on which to move toward recovery. Nonetheless, it is also clear that medication, whether voluntary or involuntary, is often a key component of recovery and symptoms can be alleviated through its use.

Reviewing information from other states in regard to the administration of involuntary psychiatric medications in non-emergency situations for the Commissioner's report in 2009, DMH found that Vermont is among a few states where this involuntary medication process goes beyond a period of 20-30 days. The average in Vermont is now around 67 days. DMH has continued to pursue changes in the process so that people in need of treatment can get it without decreasing the legal protections that they have in place around their civil rights.

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.

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 2010

You will find that under Act 114 the state filed 31 petitions for involuntary medication between January 1 and December 31, 2010. Seven of those petitions were withdrawn before hearing as the patients began taking medication voluntarily. One petition was denied by the court, and one petition was pending at the end of 2010. The court granted the state's request in the remaining 22 petitions and issued orders for involun-

tary medication of those individuals. Of those 22 petitions, three were filed for persons who required extensions of their orders. Therefore, the number of persons who received medications involuntarily pursuant to Act 114 in 2010 was 19. Those 19 persons are 8 percent of the 237 unduplicated individuals who were served at VSH in 2010.

PROBLEMS WITH IMPLEMENTATION

As in previous years, the Department of Mental Health continues to regard the length of time from hospitalization to medication of individuals who are ill and dangerous as a particularly problematic aspect of Act 114. On average, patients are held in the Vermont State Hospital against their wishes for more than 60 days for the process to unfold—and this is an improvement over previous years. It is clear that Act 114 still has delays in care for persons who ultimately are found to lack capacity to make treatment decisions for themselves.

In addition, the treating physicians at Vermont State Hospital have sometimes been frustrated by the role the court plays in determining the prescribed course of treatment for individual patients. One example of the negative consequence of the current statute is that psychiatrists are generally unable to utilize two medications simultaneously because the court refuses to grant them that authority. This has been true with one exception, which was a unique circumstance.

Lastly, the automatic stay of the order for involuntary medication has again posed a delay to treatment for a patient who filed an appeal of the medication order. The statute calls for an automatic stay of the order pending an appeal to the Supreme Court. The attorneys for DMH have requested an expedited hearing by the Supreme Court in this matter, but they do not know how long it will take to get a decision authorizing treatment.

The incoming Commissioner is considering whether to propose legislative changes to address these issues of delay in treatment, prescriptive orders for medication, and the automatic stay of the order for involuntary medication pending an appeal to the Supreme Court.

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

In re N.K.

This petition for involuntary medication involved a request for two medications. The petition's main proposal was the use of Risperidone Consta as a first choice because of the patient's history of benefitting from that drug, and the use of Haldol as a second

choice if Risperidone was ineffective or otherwise had to be withdrawn. If Risperidone Consta was approved, then an additional proposal was made to provide the patient with potential daily injections of Haldol in the two to three weeks until the Risperidone Consta injection took effect. The court granted the petition's main proposed drug regimen, but denied the additional proposal to use Haldol on a daily basis until Risperidone Consta took effect. The court found that there would be risks in having two antipsychotics in the patient's system. The court then concluded that these risks, combined with Haldol's unknown effect on the patient, outweighed any benefit that might arise from a more effective treatment pending the effectiveness of the Risperidone Consta injection.

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 who have 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 Washington County Family Court, which hears applications for commitments and involuntary non-emergency medication
- 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 (DRV), a statewide organization offering information and support, referrals to other agencies, and advocacy and legal representation for individuals with disabilities and/or mental-health issues

Additionally, Act 114 seeks input from individuals who received psychiatric medication involuntarily under Act 114 at VSH. Fourteen such individuals responded to the Commissioner of Mental Health's questionnaire about their experiences with involuntary psychiatric medication: seven VSH patients who were involuntarily medicated late in 2009 but did not submit their questionnaires until 2010 and seven of the patients who went through the process for involuntary medication between January 1 and December 31, 2010.

All five of the parties from which DMH solicited written input responded to DMH's inquiry. In addition, DMH central office staff met with VSH physicians on December

16, 2010, to hear input from direct-care professionals for this report. A different meeting was scheduled on December 22, 2010, to interview VSH nurses and psychiatric technicians, but only one person came to that meeting and said that she did not have anything to add to the summary of responses from VSH staff in the report that was filed on January 15, 2010.

The questionnaires for organizations 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?

Unless otherwise noted, the responses are given as verbatim quotations. Changes of font, text in bold type, and other formatting details are as close as possible to the originals.

The responses, in alphabetical order, were:

Disability Rights Vermont (DRVT)

DRVT responded in a letter dated November 30, 2010.

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

Yes, DRVT staff regularly work with individuals subject to Act 114 procedures. In 2009 [sic] we documented that at least ten individuals requested our assistance regarding the impact of Act 114 procedures.

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

DRVT witnesses and/or was made aware of the trauma and stress experienced by several patients being restrained while the subject of forced medication orders. DRVT staff also spoke with several such patients who indicated that they were significantly emotionally harmed by the trauma of being force medicated. Patients have indicated to

our staff that working collaboratively with their psychiatrist and treatment team is made more difficult by the result of the Act 114 process. In many cases patients complain about the side effects of court[-]ordered medications and their inability to have alternative medications or treatments considered after such a court order.

3. What worked well regarding the process?

DRVT found that patients appreciated that they had competent legal counsel to defend them in this process and some felt that they had adequate time to try alternatives and exercise their right to contest the forced[-]medication order. Patients often are frustrated by the lack of legal assistance from their court[-]appointed attorneys *after* the medication Order is made, in terms of requests to amend the Order to have it withdrawn.

4. What did not work well regarding this process?

DRVT was told by some patients that they felt VSH failed to provide adequate reasonable alternatives to forced medication. Some patients felt that they would have become less acute without medications had alternative therapies been adequately provided.

5. In your opinion, was the outcome beneficial?

In 2009 DRVT was not advised by any such patient that they felt the forced medication was more beneficial than their choices to attempt using alternative treatments, activities and therapy to regain their balance and safety.

6. Do you have any changes to recommend in the law or procedures?

Yes, DRVT suggests that the law/procedure be amended to require non-pharmaceutical alternatives be carefully researched, considered and attempted prior to a court granting a request for forced medication. In addition some patients would benefit from knowledge that they will be given notice of impending forced medication and time to consider alternatives, such as pill or liquid form, prior to the use of force to accomplish the medication.

When Act 114 was passed the legislative intent was clearly stated in law at 18 V.S.A. §7629: “Legislative intent . . . (c) It is the policy of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication.” DRVT has been disappointed that, with new proposals every year, the Department of Mental health seems intent that speeding the administration of forced treatment outweighs the damage to a constructive therapeutic relationship that is often inherent when resorting to coercion.

Mental Health Law Project

Writing for the Mental Health Law Project, John J. McCullough III, Project Director, sent essentially the same letter in 2010 that he sent in 2009. Two paragraphs were new in 2010; they are shaded, below. Mr. McCullough did not answer individual questions but, rather, offered the following response to DMH's request for input. The letter, dated November 29, 2010, is quoted verbatim.

I am responding to Frank Reed's letter regarding the study of the Act 114 process. The letter poses a series of questions, and I will attempt to cover all of them in this response.

As an initial point, it is important to note that the Legislature has adopted as a matter of public policy the principle that Vermont should be moving toward a mental health system free of coercion. "It is the policy of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication." 18 V.S.A. § 7629(c). In the years since the adoption of this policy there has been little evidence of an effort to reduce coercion. In fact, legislative proposals from the Department, such as the proposal, which we expect to see again in the coming legislative session, to accelerate involuntary medication proceedings, are more consistent with a drive to increase the burdens of an already coercive system. I would urge the Department to take the legislative policy seriously and work to reduce coercion in every element of the mental health system.

As of today's date [that is, November 29, 2010] our records show that the Department has filed twenty-five involuntary medication cases in 2010. The Mental Health Law Project was appointed to represent the patient in all of them, but in one case outside counsel was retained because of a potential conflict of interest. Out of these twenty-five cases involuntary medications were ordered in eighteen cases (we do not have information on the outcome of the case handled by outside counsel), one case was denied by the court, three cases were dismissed, and two cases were pending on today's date. There may be a few more cases filed by the end of the year.

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 held. It is our impression that the hospital is rushing to file involuntary medication cases against its patients much more quickly than it has in the past. I don't know if this is a result of pressure from the federal government, or of budgetary constraints, but it has the effect of abandoning any effort at establishing a trusting relationship with the patient in favor of simply overpowering the patient through the court process. I question whether the long[-]term interests of the patient are served by a process that teaches them that the mental health system will not respect, or even listen to, their wishes, and that the doctors who claim to be working for their benefit cannot be trusted.

Similarly, we have observed that the Department is working with the designated hospitals to keep patients at the designated hospitals until they can be committed by the Family Court, whereupon the patient will be quickly transferred to VSH and an

involuntary medication case rapidly filed against the patient. Again, since the Department is favoring an approach in which forced drugging is the first, rather than the last, resort, it appears that the Department has chosen to abandon any commitment to the principle of voluntary treatment.

The court process also imposes scheduling limitations that interfere with the patients' ability to defend themselves. As you probably know, 18 V.S.A. § 7625(a) requires the hearing on these cases to be held within seven days of the filing of the case. The court has often scheduled hearings with as little as three or four days' notice, which makes it extremely difficult for respondents' counsel to review the records, obtain an independent psychiatric examination, and adequately prepare for trial. While the statute does allow for a continuance for good cause, the Department appears to have made the decision that it will oppose every request for continuance filed by MHLP in these cases, regardless of the grounds for continuance request. This decision has the effect of interfering with patients' ability to receive adequate representation and to defend themselves against this massively intrusive practice of involuntary medication, and places the patient at an even greater disadvantage in these proceedings than would otherwise be the case. Since the Department has complete control over when it files these cases, we are often in the position of defending against medication cases with a few days' notice that the Department has known about for weeks.

We are also concerned about the practice of obtaining consent to medications. The practice of the Vermont State Hospital appears to be to administer medications to every patient who does not object. I do not believe that VSH physicians perform any evaluation of the capacity of patients to consent to medication before administering medications to those who are willing to take them. Consequently, I believe that it is common that patients at VSH are medicated without giving informed consent to this treatment. Moreover, I question whether the information provided to patients at VSH regarding the proposed medications is adequate. For instance, there has been voluminous litigation recently regarding the use of Zyprexa, and the serious side effects that have been experienced. I do not know if the information provided by VSH regarding Zyprexa has been changed to make clear to the patients who receive it that they are assuming serious risks of extreme weight gain, hypertension, diabetes, and death when they accept Zyprexa. It is possible that some patients would accept it even knowing of these risks, but they are entitled to know what the risks are, including the extreme difficulty of losing any excess weight that may be the result of treatment with Zyprexa.

A further concern is that in recent years I am aware of at least one case, and possibly more, in which the hospital filed an application for involuntary medication even though the patient was voluntarily accepting medications, and continued to take medications right through the date of the hearing. The statute specifically requires a refusal before an application can be filed, so the practice of applying for involuntary medications for a patient who is accepting them not only violates the letter of the statute, it violates the core principle that voluntary treatment must in all cases be favored over involuntary treatment, and that no patient should be involuntarily medicated if they are willing to accept treatment voluntarily. I understand that the hospital

sometimes wishes a patient to take a higher dose than the patient is willing to take, and this may motivate the decision to seek forced treatment, but it does not appear that the Department and the hospital appreciate that the long-term effect of weakening or destroying a constructive doctor-patient relationship may be worse than the inconvenience incurred by the state while working with the patient to build that relationship and obtain consent to a higher dose.

A further practice that diminishes patient autonomy and increases coercion is the Department's practice of routinely requesting authorization for long-acting, depot medications. Although the forcible use of these medications is convenient for the hospital because it reduces the number of forcible injections and potentially hostile interactions that arise, the injection of long-acting medications creates the risk of irreversible side effects. Such injections, since they have a long-term effect on the patient and the patient's brain chemistry, are inherently more intrusive and less respecting of patient autonomy than daily administration of medications. Because the court order, if granted, will enable the hospital to be sure to get the patient medicated for the entire length of the involuntary medication order, there is no justification for the involuntary use of long-acting medications.

In the realm of VSH practices, I am aware of at least one case which occurred in a prior year, and there may be more, in which the VSH psychiatrist exceeded the authority granted by the Family Court. In the case I am referring to the court authorized administration of one of the drugs at a dose of 5 mg. p.o. or i.m. The patient began accepting the 5 mg dose orally and subsequently agreed to an increase to 7.5 mg. The psychiatrist then wrote a medication order that the patient was to receive 7.5 mg orally, and that if she refused the 7.5 mg oral dose she would be involuntarily injected with 5 mg of the same drug. This order exceeded the authority granted by the court, because the hospital had no authority to give an involuntary injection as long as the patient was willing to accept the court-ordered dose in oral form. I do not know how many other cases there may be in which this type of abuse has occurred, but we have pursued a change in the standard order issued by the court to prevent it from happening again.

I would say that in some cases the outcome of Act 114 procedures has been beneficial. Every year we handle at least one or two cases in which the involuntary medication application is denied. In each one of these cases, if the hospital had had its way, the patient would have been involuntarily medicated, but the court process allowed the patient to successfully defend against what was determined to be an unwarranted intrusion, or to come to the conclusion to accept medications voluntarily.

In addition to the one case in which involuntary medications were denied outright, we represented patients in at least three cases in which the court restricted the medications it authorized. In one case the independent psychiatrist testified that the patient should not be given olanzapine because of her physical condition, and the court agreed. In another case the state psychiatrist requested the authority to provide two antipsychotics, Haldol and Risperdal Consta, simultaneously on the theory that there

would be a delay before the Risperdal took effect. The patient's attorney argued that this approach was unsafe, in part because if the patient developed side effects it would not be possible to determine which of the two drugs had caused the side effects. The court refused authority to give Haldol and limited her order to Risperdal Consta. In each of these cases, without the judicial review the hospital would have gone forward with its plan to administer potentially dangerous drugs or drug combinations to the patients.

In further evaluating whether the involuntary medication procedure is beneficial, a number of issues must be considered. It is well established that the great majority of patients who receive antipsychotic medications 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 inherent in any regime of forced treatment. Second, as noted above, the reliance on involuntary medication has a deleterious impact both on patient autonomy and on the doctor-patient relationship. From handling many involuntary medication cases, I get the impression that the bulk of the doctor-patient interaction in many of these situations consists of the doctor insisting that the patient should accept medications and the patient refusing. If the system did not rely so heavily on forced treatment it is possible that all the care providers would work more openly and cooperatively with the patients, and that the relationship between the patients and the treatment team would be less adversarial.

The Mental Health Law Project opposes involuntary medications. If the law is to be kept in force, we would recommend deletion of the provision of 18 V.S.A. § 7625(a) that requires hearings to be held within seven days. This would put the scheduling of involuntary medication cases on the same footing as scheduling of other commitment cases, and would have two [sic] beneficial effects. First, it would allow for adequate time for the patient's counsel to prepare a defense. Second, it would avoid the situation we frequently see now in which commitment cases which have been scheduled for some time, and need to be heard, are displaced at the last minute by new medication cases. Third, this would have the effect of encouraging the State to view involuntary medication as a last, rather than a first, resort.

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

National Alliance on Mental Illness of Vermont (NAMI—VT)

Note: Bold or italic fonts and underlining, below, appeared in the original letter of December 2, 2010, from Katina Cummings, Executive Director of NAMI—Vermont, to the Department of Mental Health.

On behalf of the members and Board of Directors of NAMI—Vermont, we are pleased to respond to the October 12, 2010, letter from Frank Reed to me, as Executive Director of NAMI—Vermont, inviting comments for the annual legislative report on the Act 114 proceedings. As you are aware, NAMI—Vermont has provided answers and feedback on this issue to the Department during the last several years and will continue to offer knowledge and understanding based on our individual members' lived experiences and analysis of the impacts of these experiences as they inform public policy and current legal and medical practices.

This year, we did not receive direct feedback from our members and friends who were directly involved with individuals involuntarily medicated under Act 114 during 2010. Therefore, we will not be providing answers to questions one, two, three and 5 in this letter. However, please know that the feedback provided by our members in previous years and contained in the Department[']s reports in 2007-09 remains valid and pertinent to the current discussions for policymakers and others.

During the last five years, NAMI—Vermont has been a consistent and outspoken proponent for changes to Act 114. Our position on this issue and the reasons underlying it have been documented in our legislative agendas . . . while our members have provided pertinent personal testimony on the impacts of the statute on them and/or their family members.

We understand that the primary intent of Vermont's Act 114 was to foster non-coercive treatment for persons suffering from serious mental illness. However, the unintended consequences of this law have produced *serious medical and due process restrictions* to patients, staff who serve those individuals, and others. Act 114 seeks to protect the civil rights of persons with serious mental illness. Yet often persons with mental illness are involuntarily hospitalized for months at a time while determinations are made as to whether the person may receive treatment for the very affliction that caused them to be hospitalized in the first place. To make matters worse, the length of time it takes to work with Act 114 generally causes the person to be removed from communities of origin, as community hospitals cannot board a person for months at a time without providing them with treatment. This is an application of due process and treatment that is unique in the United States and is viewed with incredulity by clinicians and policy makers from around the country.

In Vermont, the median length of time it takes for this application of due process is just under three months. This prolonged period between commitment and treatment results in several important unintended consequences:

1. Pending the application of due process on the question of treatment, the person who is involuntarily hospitalized is deprived of their freedom for longer period[s] of time than are found elsewhere in the country.
2. While awaiting the application of due process, the involuntarily hospitalized person is generally moved from a hospital near their family and friends in their

community of origin to Vermont State Hospital in Waterbury, which often serves to make it more difficult to maintain connections to their individual, family and community support systems.

3. Protracted periods of untreated psychosis or a long duration of untreated psychosis (DUP), particularly during early presentation correlate with poorer outcomes over the course of the individual's illness. DUP is also associated with and/or often leads to:

- A decline in social and occupational functioning;
- Avoidable injuries to patients and staff from assaults;
- Unnecessarily long stays in an involuntary hospital setting combined with decline in ability to reintegrate into society post-hospitalization;
- Higher economic burden born[e] by the patient and by society.

Recommendation:

NAMI—Vermont is in favor of changes in the Vermont statute which would allow for **the simultaneous petitioning of the court** for both involuntary hospitalization and non-emergency involuntary psychotropic medications when necessary in either one hearing or two consecutive hearings on the same day. Moreover, we advocate that a specified timeline for the application and treatment process be established and incorporated in the new statute. This timeline should be short enough that the patient does not need to be moved outside of his/her community of origin so that he/she could receive necessary and appropriate treatment within his/her own community.

Vermont Psychiatric Survivors

For Vermont Psychiatric Survivors (VPS), Linda Corey, Executive Director, answered individual questions in an e-mail of October 29, 2010:

1. Were you directly involved with any individuals involuntarily medicated under Act 114 in 2009?

Yes.

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

Yes. It was traumatic for the peers and will always be as a peer is yielded to powerlessness and force to take medication that there is evidence that can reduce their life span and cause several physical problems.

3. What worked well regarding the process?

In [a] few cases the person was able to return back to some normalcy of life.

4. What did not work well regarding the process?

Those that will be forever living with trauma and issues caused by the side effects of medication.

5. In your opinion, was the outcome beneficial?

Only in cases where the treatment was shortermed [sic] and people had personal choice to decide to continue or discontinue the medication.

6. Do you have any changes to recommend in the law or procedures?

If so, what are they?

Looking for alternatives outside the established box to use rather than medication.

Vermont Superior Court: Office of the Administrative Judge for Trial Courts

In a letter dated December 22, 2010, Judge Amy M. Davenport, Administrative Judge for Trial Courts, stated that the Washington Family Court received twenty-nine involuntary medication petitions thus far in 2010. Five of those cases were dismissed, while twenty-three were heard and one case was denied after hearing. The court granted the petitions in the remaining twenty-two cases. Judge Davenport noted that the cases consumed 14.25 hours of hearing time, and she estimated an additional forty hours for written findings. Finally, she observed that the number of involuntary medication applications in 2010 was up slightly over 2009. (Commissioner's note: The court heard twenty-six applications for involuntary medication in 2009, dismissed two of them, and granted twenty-four. See Report of the Commissioner of Mental Health on the Implementation of Act 114, January 15, 2010, page 2.)

From Judge Davenport's perspective,

The process appears to be working well. It is occasionally difficult to hear applications on the merits within the seven day time frame because of holidays or because Legal Aid is unable to schedule an independent evaluation of the litigant. If we are unable to hold a hearing within the seven day time frame, we make every effort to get the case scheduled as quickly as possible thereafter.

Judge Davenport added that the court continues "to have prehearing conference calls . . . in order to determine which cases are likely to need contested hearing time."

Individuals Involuntarily Medicated at the Vermont State Hospital (VSH)

Questionnaires sought feedback in two ways from patients involuntarily medicated under the Act 114 process at VSH:

- Through either written answers or interviews with a social worker or nurse while still at VSH, and
- Through written answers to the questionnaire after leaving VSH

Fourteen patients answered the questionnaire in time for inclusion in DMH's legislative report for January 15, 2011. That number includes seven patients who went through the involuntary medication process in 2009 but who did not fill out a questionnaire until 2010 in addition to another seven patients who went through the process between January 1 and December 31, 2010.

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: 7

No: 7

None of the patients who answered yes to this question elaborated on their answer. Patients who answered no to the question were asked to describe what they felt was unfair about the process (1) in court and (2) at the Vermont State Hospital. All seven patients had something to say about their experience in court.

Experiences in Court

"I was not present. The court proceeding took place without my knowledge. Patients should be required to go to court after what will take place is explained to them thoroughly."

"I asked the nurse on duty . . . for 2 Haldol tablets & asked her to call the Dr. for them, but she would not. Therefore, I was asking for medication before they took the court order & I could have stood it quite well [illegible] the court order.

Nothing unfair in court, except I neglected to tell them that part, I couldn't remember it at the time."

"A lot of what was said @ the hearing were lies (from what I read from the court proceedings)."

"Corrupt judges, doctors, fake patients, staff all witches all corrupt. Did not go to court—sherif [sic] guard whomever someone dressed as one did witchcraft outside the door they held me in, also those dressed up in court costumes did witchcraft."

"Couldn't tell my side of story in court—Lawyer would [not] let me."

“It is not appropriate to shackle and handcuff a patient wen [sic] in court[;] it’s degrading”

“Putting me in shackles & chains—some of the documents @ the courthouse are wrong & they were used against me.”

Six of the seven patients who answered no had comments on VSH.

Experiences at VSH

“While I was a patient at VSH, the process of going to court in order to avoid being medicated was not thoroughly explained to me before any court proceeding took place. I was not sure what the court dates were for so I did not attend.”

“I think they kept me too long.”

“Got court order for medication administered by witches—all staff + fake patients did witchcraft on me—had to look at them every day and wondered where or how legally they could do this.”

“No[,] only at break time to other staff members and had fun too.”

“There was a towel over my face and I stopped breathing.”

“The doctor thought I was imagining things that I didn’t + now I’m being treated for that.”

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: 8

No: 5

The fourteenth respondent did not answer this question.

One of the eight respondents who answered yes to this question added “but I think I am overmedicated.”

Two of the five respondents who answered no to this question had additional comments. One said, “No choice[,] court order,” while the other one said, “No one told me about the weight gain.”

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

All fourteen patients answered this question. Three of them either felt better (or better off) without medications or felt uncomfortable taking them:

“I felt better off medications, more stable and no side effects of weight gain or acne.”

“Because I felt I would be better off without them. I felt like they were causing the symptom they were meant to take away.”

“Because they permanently cause involuntary movements + other upsets[.] They make me uncomfortable usually.”

A fourth patient “felt that my vital organs were becoming decayed. I felt I was taking too much.”

A fifth patient did not “feel that they add to my quality of life.”

A sixth said, simply, “I’m not sick[.] I’m not crazy[.]”

Two patients said that they did not take psychiatric medications because they were confused. The remaining six answers touched on other individual themes:

“I didn’t feel like it.”

“No choice[.] got court order.”

“Because the doctor was helping me get off my drugs; now he says I’ll never be well. Before he said I would be well at age 66.”

“I didn’t[;] the doctor (Dr.) told me not to for it was from my doctor [Name]. the medicine was from Dr. [Another name].”

“Did not know if the medication was for me.”

“I’m taking meds.”

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: 11

No: 2

One of the respondents who answered this question in the affirmative said, “I think I have explained myself quite well” without elaborating on the meaning of the statement. Another six respondents noticed positive differences after they began taking medication:

“I can think clearly when I’m on meds.”

“I am more sociable to the inside and outside world while being facilitated.”

“They help to heal me.”

“I have a roof over my head.”

“I am not angry now.”

Another respondent noticed both positive and negative differences: “I seem to be more lucid. My hands shake. I wish I didn’t have to take the Haldol but I know I do.”

Another respondent remarked on his/her behavior without medications: “I go off on a slight tangent when off my meds. I mouth off.”

Three respondents who answered yes to this question noticed negative differences:

“I’m fat and breaking out.”

“I’m very sleepy + I gained a lot of weight.”

“I’m uncomfortable & my physique is constantly being altered. It might affect my mood a little. It leaves me depressed.”

5. Was anyone particularly helpful? Anyone could include staff at VSH or a community mental health center, a family friend, a neighbor, an advocate, someone else who is in the Vermont State Hospital—really, anyone.

Yes: 13

No: 0

Who was helpful?

Various VSH staff, sometimes by name and sometimes not, in addition to other VSH patients were most often included in the answers to this question. Other support people—friends and relatives, perhaps neighbors or others outside the State Hospital—were mentioned (without, however, always identifying the relationship). God was another helpful presence.

In what ways was he/she helpful?

Help and support take many forms. The answers to this question were quite varied:

- ◆ “Numerous ways to[o] many to count”
- ◆ “Supportive”—no further details
- ◆ “Listening to me.”

- ◆ [VSH staff] gave me his time and was patient
- ◆ “They gave me things”
“Friends I could talk to who supported me emotionally”
- ◆ “Provided information”
- ◆ [Person, relationship to patient not given] “was a good advocate for aftercare/to obtain a placement for me in [hometown]”
“Staff—they always cared + listened”
[VSH physician]—he talked to me about calming down. He saved my life.
- ◆ [Names of VSH staff] “They tried”
- ◆ “a girl was buying me soda [;]
The doctor + social worker”
- ◆ [Name of VSH staff] “she helped me to take medications”
- ◆ [Name of unidentified person] “he always stands by me”
- ◆ [VSH staff] “They helped me to get to a real direction”
- ◆ [VSH staff] “Explaining the medications and explain[in]g how the systems work”

One respondent added a footnote to the answer to this question:

“On the average, I think the staff did an excellent job here. I think they need this hospital for delicate + serious cases where they can’t handle them anywhere else. There needs to be a home for us people—we don’t quite fit into jail, we don’t quite fit in the community—”

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

Yes: 6

No: 8

Each of the six patients who answered yes to this question addressed his or her own concerns and circumstances rather than offering concrete changes to be made in Act 114. Their comments were as follows:

“It should not be a law. I do not agree w/involuntary treatment.”

“try to explain to the pt [patient] the pros & the cons of the medications”

“In most cases the patients already know. If I had given up my drugs that the doctor gave me years ago and just taken care of my family I’d be much better off. I regret not having done that because I think I could have at the time. The law interfered with my [children].”

“I don’t think involuntary meds are fair, but I understand why.”

“Let us speak in court, so everyone has to speak and defend ourselves before the judge.”

“Like to see justice—those involved in imprison [imprisoning?] me did so illegally and used witchcraft, sounds torture [sic] skills, of course corrupt legal system.”

One of the respondents who answered no to this question on the Commissioner’s questionnaire added, “Do Not Force Medicate. Individuals will come to their own conclusions about medication in their own time.”

VSH Psychiatrists, Nurses, and Psychiatric Technicians

The Commissioner’s questionnaire for VSH staff was shortened this year because their answers for the past two years have been so similar. The three questions on this year’s survey were:

1. Would you like to offer any additional information or observations to your answers to the Commissioner’s questions for last year’s report? (That is, the report that was filed on January 15, 2010.)
2. Did you note any changes that occurred in the implementation of Act 114 at VSH—for example, staff behavior, patient responses, environmental or other factors for consideration in the administration of nonemergency psychiatric medications—in calendar year 2010? If so, what were they?
3. Do you have any new recommendations to make for changes in the law?

In discussing the first question, the VSH psychiatrists agreed that their concerns remained fairly similar to the ones that they have expressed over the past two years. They observed in general that results for patients would be much better if the Act 114 process were more efficient. As an example, they talked about times when more than one individual on a ward refuse medication. Their refusals add to volatility and violence on the unit, and the therapeutic atmosphere deteriorates rapidly.

For the summary of VSH medical staff responses from the Commissioner’s report filed on January 15, 2010, see the Appendix, page 23.

In response to the second question, the psychiatrists said that they had not really noted any changes over the past year. They added, however, that internal efficiencies have shortened the length of time from a patient’s admission to medication. They still regard Vermont as an outlier among states in regard to what they consider the long delays encountered before patients can receive the medication(s) they have refused.

As for changes to the Act 114 process, psychiatrists suggested two changes in practice that would not require changes in the present law:

- Having an order for involuntary medication follow patients upon their discharge from VSH so that:
- Involuntary psychiatric medications in nonemergency situations could be administered in other hospitals in the state. Procedures would need to be worked out for implementing the law elsewhere, they added.

If the psychiatrists could get just one idea across to make the Act 114 process more efficient, it would be this: Shorten the time from admission to medication.

CONCLUSIONS

What Is Working Well

For Act 114 Patients. Again this year, the individuals who answer the Commissioner’s questionnaires about their experience of involuntary psychiatric medication through the Act 114 process at the Vermont State Hospital do not typically have a great deal to say. Nevertheless, their responses can be quite revealing. Seven of the fourteen patients who answered the question about fairness saw themselves as having been treated fairly even though an involuntary procedure was involved. Eight of thirteen respondents who answered the question about the advantages and disadvantages of psychiatric medications believed that the explanations they received were adequate to aid their understanding of the medications. Six of the eleven patients who discerned differences in themselves when they are taking psychiatric medications described the benefits of medications in the following ways:

- “I can think clearly when I’m on meds.”
- “I am more sociable to the inside and outside world . . .”
- “They help to heal me.”
- “I have a roof over my head.”
- “I am not angry now.”
- “I seem to be more lucid” (but this respondent also observed that “my hands shake”)

VSH Staff. As in previous years, the staff of the Vermont State Hospital came in for a lot of praise in comments from most of the respondents telling about people who were helpful to them.

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

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 keeping 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

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 the best care that can be provided at this time. The new administration will continue to review this issue.

It is premature to make recommendations as to statutory changes at this time. DMH will include all stakeholders in future conversations as we make these decisions on recommendations for legislative changes.

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.

APPENDIX

**RESPONSES TO THE COMMISSIONER'S QUESTIONNAIRE
FROM VERMONT STATE HOSPITAL PSYCHIATRISTS,
NURSES, AND PSYCHIATRIC TECHNICIANS**

**EXCERPTS FROM THE REPORT OF
JANUARY 15, 2010**

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

VSH staff expressed the same concerns with the Act 114 protocol this year that they had in the 2009 report. The list includes:

- A general perception that the process as a whole is cumbersome and does not work well
- From the staff's point of view, the process is too long from admission of a patient to the point at which medication can begin
- The perception that Vermont is unique among the states in having a process that is so protracted
- The process denies treatment to individuals who need it, causing their condition to worsen and lengthening their stay in a restrictive inpatient setting
- It causes undue stress and mental anguish to both patients and staff over weeks and months when, ideally, treatment could be started much sooner
- 90-day medication orders are too short
- The policy making VSH the only hospital in the state where involuntary psychiatric medications in non-emergency situations can be given
- Heavy paperwork associated with documentation that the steps of the process have been followed

Staff added the following observations during their interview on December 17, 2009:

- The length of time involved for the process causes more involuntary procedures for patients because they often become violent when they are not getting the medication they need
- The emergency involuntary procedures that have to be used while the Act 114 process is unfolding are more traumatic to patients and staff than a short, court-ordered process to administer medication
- The long-term prognosis for patients and the course of their illness worsens with the passage of so much time

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

VSH staff said that a period of twenty-four hours for a patient to adjust to the idea of court-ordered psychiatric medication is good. Also, it is good for patients to have their day in court—only it should not have to take so long to get there. Finally, scheduling a medication hearing within five days of a commitment hearing is good—when it happens. Ideally, commitment hearings and medication hearings would be combined.

3. Which steps pose problems?

Many of the staff answers to this question were similar to their answers last year. Their continued concerns focus on:

- ◆ The excessive length of medication hearings, once they get started
- ◆ The court's interference, as staff see it, with the ability of doctors to prescribe medications and dosages according to their best judgment about the clinical needs of their patients
- ◆ A reluctance to see a role for courts in determining medical treatment in the first place (there is no such role for courts in other fields of medicine, according to the staff)
- ◆ Admitting expert testimony on behalf of patients from psychiatrists who are considered to be outside "accepted practice" (and judges, for the most part, do not know what is accepted practice and what is not, said the staff)
- ◆ Sometimes lengthy waits from a hearing to the judge's decision
- ◆ 30-day reviews of the continued necessity of medication once started
- ◆ Lack of certainty about when lawyers inform patients of medication orders

Additional concerns mentioned this year included:

- ◆ The necessity of presenting evidence twice, once at commitment and again at a medication hearing
- ◆ The neurological damage that occurs when individuals remain psychotic for long periods of time
- ◆ Multiple involuntary procedures required during an extended psychosis
- ◆ Court rules of evidence that restrict or disallow the testimony that family members could offer

VSH staff remain dissatisfied over the statutory requirement for annual reports from the Commissioner to the General Assembly. They have spoken up year after year, they said, and yet they see little or nothing to convince them that anyone is paying attention to their repeated concerns in regard to Act 114. Some staff observed that consumers, family members, and other advocates have been permitted to offer testimony about Act 114 to lawmakers and wondered if they could do the same to tell their side of the story.

Another concern, not directly with Act 114 itself, revolved around advance directives and the ways in which those legal instruments were seen as inhibiting options for effective treatment for some individuals.

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?

- “Just about everything you can that is clinically appropriate,” said one staff member
- Advocating around symptoms and symptom reduction
- Trying to gather information about a patient’s experience with medications and which ones have been effective in the past
- Meetings with treatment teams to try to explain the benefits of medication so that patients understand them better
- Groups in the Treatment Mall deal with medications, side effects, and related issues

- Education, education, education
- Encouragement and motivation to get well enough to leave VSH

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

The length of time involved is always dependent upon the individual patient. It can be days or weeks or longer, although the sooner medication is started, the sooner one can look for positive results. The process can be even longer for forensic patients, since a competency hearing must be added to the usual commitment and medication hearings for individuals admitted to VSH for emergency examinations.

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

VSH staff remained unanimous about the benefits of psychiatric medications for patients in any number of ways. Examples mentioned include:

- Reducing symptoms
- Improving the overall functioning of patients
- People who have not been able to take care of themselves regain insight, quit being assaultive, and become “perfectly OK”
- Making it possible for those with co-occurring physical conditions to get treatment for those as well as their psychiatric conditions
- Getting out of the hospital and resuming their lives in the community

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

Staff saw bleak outcomes for individuals who go unmedicated. Possibilities included:

- Patients would be stuck at VSH for a long time (some have been at VSH for years, staff added)
- Physical-health needs of patients would go untreated, leading to poorer outcomes and possibly death
- Poorer prognoses, especially for younger patients
- More serious illness, both physical and mental
- Frustration, possibly leading to assaultive or self-injurious behavior
- Lowered chances for recovery or even getting back to baseline functioning

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

VSH staff offered many ideas for changing Act 114. All were similar to the ideas offered in previous reports. They included:

- ✪ Expediting the Act 114 process so that the time between admission and medication is much shorter than it is now

- ✦ Extending the 90-day time frame for medication orders
- ✦ Permitting the administration of involuntary psychiatric medications in non-emergency situations in other hospitals in the state
- ✦ Look to other states for models that are shown to be effective

In addition, VSH staff recommended that legislators read this Act 114 report, visit VSH to talk to staff and gain insights from their point of view, and respond to the concerns that have been expressed about the risks of withholding treatment from patients who are as ill as so many are at the State Hospital. Finally, staff questioned whether psychiatric medication should be a legal issue at all. To them, clinical decisions should lie with professionals trained in the field and not with others without the specific training that medical professionals have had.