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The Implementation of Act 114 in Vermont:

Report to the General Assembly

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VERMONT

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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 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. When the statute was passed in 1998, it permitted the administration of involuntary psychiatric medication in non-emergency situations to patients committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in the community in addition to the Vermont State Hospital (VSH). Until August 29, 2011, when Tropical Storm Irene forced the evacuation of the State Hospital, non-emergency involuntary psychiatric medications were given only at VSH. With the development of a decentralized inpatient system of care for adults post-Irene, designated hospitals are now pursuing non-emergency involuntary psychiatric medication orders. The adult inpatient system of care is comprised of the following hospitals:

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

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

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

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

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

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). The state filed eighty-eight petitions for involuntary medication under Act 114 between December 1, 2014, and November 30, 2015. Thirteen of those petitions were withdrawn or dismissed before a court hearing. Seven other petitions were denied throughout the year and two were pending at the end of November 2015. The courts granted the state's requests in the remaining sixty-six petitions and issued orders for involuntary medication of those individuals.

Through December 15, 2015, DMH received responses to the Commissioner's questionnaire about their experiences from ten people who were involuntarily medicated under the Act 114 process. These responses included four from individuals who were involuntarily medicated in 2014 but whose responses arrived too late to be included in the report that was filed in January 2015. The other fifty-six people who were under orders for involuntary psychiatric medications from December 1, 2014, through the end of November 2015 did not respond to the Commissioner's questionnaire this year (but it must be noted that court orders for fourteen individuals were issued in October and November; it is unlikely that any of them would have become well enough to respond so soon).

Among the stakeholders who receive annual requests to respond to the Commissioner's questionnaire about their perspectives on Act 114, the Office of the Chief Superior Judge, Vermont Legal Aid, and the National Alliance on Mental Illness of Vermont (NAMI—VT), the state chapter of the national organization for families of adults with diagnoses of severe mental illness, sent responses for this year's report. Please see the section on "Input from Individuals and Organizations as Required by Act 114," which begins on page 5.

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

PROBLEMS WITH IMPLEMENTATION

The implementation of Act 114 procedures for administering involuntary psychiatric medication in five different hospitals around the state is considerably more involved than carrying them out in a single location, as had been the case before the Vermont State Hospital closed in August 2011. DMH has provided extensive training to the staff of all of the hospitals where Act 114 medications are now administered: the Brattleboro

Retreat, the UVM Medical Center, Rutland Regional Medical Center (RRMC), Central Vermont Medical Center, and the Vermont Psychiatric Care Hospital, which opened in Berlin in July 2014. Additional thoughts on problems with Act 114 from the perspective of hospital staff are collected under the section on "Input from Organizations and Individuals as Required by Act 114."

In 2014 the General Assembly passed Act 192 with the intent of improving the process for treating individuals who, because of their mental illness, were not accepting psychiatric medications voluntarily. Among other objectives, Act 192 was passed with the intent to reduce the length of time between involuntary treatment (hospitalization) and involuntary medication hearings. Its implementation has not had a significant impact on the time it takes for a patient who is refusing psychiatric medications to receive adequate and appropriate treatment. DMH's Legal Unit has identified problems that DMH and designated hospitals continue to experience under Vermont's current law on involuntary psychiatric medications in non-emergency situations.

One of the statutory changes intended to advance the processes for hospitalization and for medication was allowing the Commissioner of Mental Health to request expedited hospitalization hearings. Under this provision, once a hospitalization hearing is expedited, the Commissioner may also file an application for involuntary psychiatric medication, a court process that is separate from that for hospitalization. The motion to expedite hospitalization must be granted when the court finds that the person demonstrates a significant risk of causing the person or others serious bodily injury, even while hospitalized and receiving other clinical interventions. 18 V.S.A. §7615 (a) (2) (A) (i). The expectation is that an expedited hospitalization hearing will make it possible to hold a medication hearing earlier, thus speeding up the times for both processes to unfold.

The standard for requesting an expedited hospitalization is admittedly high. From DMH's perspective, the courts' interpretation of the language has set the bar for ordering expedited hearings too high. In one case, the state presented evidence that a floridly psychotic male patient of significant size had been menacing and making threatening statements toward hospital staff and patients. The patient's behavior, which had continued for days, included intruding into the physical space of a female patient, posturing aggressively toward her with a clinched fist, and propositioning her to perform oral sex on him. Additionally, the patient made threats to multiple staff, including a detailed threat to sneak up on an identified staff member from behind and to assault him.

Despite this uncontested evidence, the Vermont Superior Court, Rutland Family Division, denied the request for an expedited hospitalization hearing, having concluded there was insufficient evidence to show that the patient posed a substantial risk of bodily injury to others. See *In Re: DN*, Dkt. No. 8-1-15 Rdmh (February 10, 2015). As interpreted by the court in *In Re DN*, which in essence requires treatment providers to wait until the patient actually causes serious bodily injury, the standard for requesting expedited hospitalization hearings can only rarely be met.

In order to prevail on an application for involuntary hospitalization, the state must demonstrate by clear and convincing evidence that a person posed a danger of harm to

self or others at the time of admission or application. 18 V.S.A. § 7617(b). No such finding is required before a court can order that a patient be involuntarily medicated. Despite that, the Vermont Superior Court, Washington Family Division, denied an application for involuntary medication on those grounds. *See In re CC*, Dkt. No. F 126-11-14 Wnmh-im (December 16, 2015). The court's denial of involuntary medication for the patient resulted in an unnecessarily prolonged period of hospitalization.

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 2015

It should be noted that the number of petitions for involuntary medication for psychiatric treatment in the twelve months between December 1, 2014, and November 30, 2015, was almost triple the number in 2010, the last full year that the Vermont State Hospital was in operation. Petitions in all of 2010 numbered only thirty-one as compared with eighty-eight for the most recent twelve-month period covered by this report. Thirteen petitions were withdrawn in 2015, seven were denied, and two were pending as of November 30, the end of the period covered by this report.

COPIES OF ANY TRIAL COURT OR SUPREME COURT DECISIONS, ORDERS, OR ADMINISTRATIVE RULES INTERPRETING §4 OF ACT 114 IN 2014

Citations appear on pages 4-5.

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 has solicited input in writing from:

- Vermont Psychiatric Survivors (VPS), a statewide organization of adults with experience of severe mental illness
- the National Alliance on Mental Illness of Vermont (NAMI—VT), the state chapter of the national organization of families of adults with severe mental illness

- the Office of the Administrative Judge for Trial Courts
- Vermont Legal Aid (VLA), Mental Health Law Project, which offers legal counsel to Vermonters with low incomes, who are elderly or who have disabilities, and
- Disability Rights Vermont (DRVT), the federally authorized disability protection and advocacy system in Vermont pursuant to 42 U.S.C. 10801 et seq., and the Mental Health Care Ombudsman for the State of Vermont pursuant to 18 V.S.A. §7259.

Additionally, the statute requires input from individuals who received psychiatric medication involuntarily under Act 114 at the state's designated hospitals. DMH received six responses to the Commissioner's questionnaire from patients who were involuntarily medicated at those hospitals December 1, 2014-November 30, 2015, in addition to responses from four patients who received involuntary psychiatric medication in 2014 and sent responses that arrived too late for inclusion in the report that was submitted in January 2015.

Finally, DMH central office staff held telephone interviews to solicit input from physicians, nurses, and other hospital staff during the weeks of December 14, 2015, and January 4, 2016.

INPUT FROM ORGANIZATIONS

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?

The first response given below is a verbatim transcript of a letter to the Department of Mental Health from a parent of an adult with severe mental illness. She identified herself as a "Vermont Mother." She sent her replies to the Commissioner's questions in response to the solicitation from DMH to NAMI—VT. Vermont Legal Aid's response follows the Vermont Mother's response, while the letter from the Office of the Chief Superior Judge completes the responses received for this 2016 report. Disability Rights Vermont and Vermont Psychiatric Survivors did not respond to the Commissioner's questionnaire this year.

Letter from a Vermont Mother

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

Yes. My son with early-onset schizophrenia was involuntarily hospitalized for something like the 18th time.

(Summary of history[,] which is necessary to put latest episode in perspective:
Symptoms of mental illness by preschool and probably before. Taken to first child psychiatrist at age 12. Made no clear diagnosis and refused to see him again when I tried to make a second apt about a year later. Said sis not need to see a psychiatrist and if it was "that bad" to take him to a psychologist. I did and psychol was very concerned, thought maybe an autism spectrum and needed to see psychiatrist again, but she still refused. Tried to see Dr. Hudziak, but he said he was doing research only and no waiting list. With help of pediatrician saw second child psychiatrist who agreed with me had ODD and thought the bizarreness which I feared was the early stages or prodrome of a psychotic illness was due to a personality disorder, but can't call that in a child. No treatment recommended. Many problems continued and at exactly age 18, after flunking out of college, had a clear psychotic break. Pediatrician saw him and agreed was psychotic. Consulted with 3 psychiatrists and dx of schizophrenia for years made. Pt would not see DA or any psychiatrist as has always had anosognosia and psychiatrist denied my pleas for a house call. Said I could get no involuntary care unless he became imminent danger.

Assaulted a roommate and went to court hearing. I involved AG[']s office and got psychiatric eval, but it had to be a certain forensic psychiatrist and he refused to receive info from me before seeing pt, though I did finally provide a letter with info. Determined not seriously mentally ill and thus no treatment indicated. At age 20 went totally psychotic (in excited phase of catatonic state) and committed several felonies, and sustained lacerations. Taken to UVM Med Center and went into catatonic stupor. Though I made it clear he had sz, was in a catatonic stupor and in need of treatment and hospitalization he was sent to jail with no treatment. Jail sent to VSH [Vermont State Hospital] after 3 days. 10 month hospitalization with recurrent trips to Burl to criminal court. Charges not dropped due to insanity until I found the right criminal lawyer. Long wait for medication. (Full attempt to persuade him to take voluntarily unsuccessful due to anosognosia.) Tremendous suffering. Better on bezno [sic] for catatonic features and antipsychotic once finally court ordered.

Here's where it becomes too much to detail. By now he has been hospitalized something like 18 times, depending on what you call a hospitalization. (One technically 1.5 years long, but was at [two different community recovery residences] for 2 weeks each during that time, so seemed like discharged. During most long waits for the two separate hearings. He was dragged into court in mental handcuffs [sic; the writer probably meant metal handcuffs] and shackles and then had to hear others talking about his alarming and dangerous behaviors and how insane he was. Pure torture. (Being involuntarily treated without these court torture sessions would have been more humane in

his case.) Had to wait almost 3 months one time for medication that relieved the worst of the signs and symptoms. Once on an ONH and monthly Haldol injections for 6 months—did the best he has before and since—even got a job. But ran away and ended up hospitalized out of state twice. Treated within a few days in those states and so improved much more rapidly and I could take him home in a couple [of] weeks. Been in malignant catatonia 3 more times and almost died once.

Finally he was able to perceive how benzos prevent him from going back into severe catatonic states and enable him to move and speak some so takes those voluntarily, though during some admissions has done so to avoid the court tortures and get out sooner. Then stops them. (Only on an ONH the one time.)

We built a beautiful apartment for him on our land 1.5 years ago. Everything was optimized. Pathways visited twice a week, psychiatrist drove 25 miles to see him, our DA tried to do Open Dialogue with him. We provided all food, meals, love, etc. He declined OD, so I became the "patient" and was helped considerably for the first time, but he continued to become progressively disabled. He did accept increasing doses of benzo, but that did not seem to help anymore. All psychiatrists and a psychopharmacologist agreed an antipsychotic was the only hope for improvement. Extreme movement disorders or stereotypies[sic]/catatonic mannerisms (from the sz, not prior meds) extremely disabling. Often could not move or speak. No real self-care. Started many fires in apartment and caused severe damage to it. Ordered weapons such as machetes online until no more bank account. Threatening to us and visitors.

With the help of our two OD people and in conjunction with Pathways we enlisted help at the state level to formulate a plan. Final group decision. Must be hospitalized again. (Avoiding this has been a primary goal and he did go for 14 months which was a record.) Tried to arrange for a direct admit to VPCH (experiences at B. Retreat had been terrible and Rutland once so-so.) This involved a court hearing as outpatient. Once the paperwork was filed with the court system they sent it to our son, which caused him to become totally paranoid about us, thus destroying our fragile relationship and decreasing our ability to care for him at home. (Protection of the "civil liberties" of a gravely mentally ill person gone way awry yet again.)

This caused huge damage to him and led to an episode of such danger that we initiated the EE system with the help of our DA providers, who were poised for this Plan B. Removed to nearest ER by state police, who were excellent, warehoused there for a week and then transferred to VPCH.

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

He was EEd and taken to an ER on [date]. Held there for a week until a bed opened VPCH and then transferred. Hearing for Involuntary Commitment on [date], 9.5 weeks later. Not sure of exact dates of Hearing for Involuntary Medication, as we (his father and I) were not there, but it was around 1 week after the [date] hearing. There-

for[e] he was hospitalized for around 10.5 weeks before starting psychiatrist-recommended medication while extremely ill, but he had been that way as an outpatient for about two years, which changes the perspective considerably from back in 20__ to 20__ when he languished at VSH for around two months to 88 days without treatment. This time I think his attending psychiatrist figured it wouldn't hurt to give him longer to decide to take medication voluntarily and see how he did with approaches other than antipsychotics. (This approach did not work and thus her hand was forced as he was direly disabled by the illness in multiple ways.)

What worked well regarding the process?

I'm not as well informed about what went on as in the past since my son refuses all contact with me because of the increased paranoia caused by the court system sending him all the reports for the direct admit process. (Needless to say this means he has not given his psychiatrist consent to discuss his situation with me.) Also we hae not been legal guardians for about ___ years now, since he would have nothing to do with us unless we gave it up.

This time his (2) Mental Health Law Project Lawyers (MHLP) were actually helpful and did not do things that could harm him further. They talked to us like the loving caring parents who have done everything to help our son that we are. Unlike some of their predecessors, they seemed to have an understanding of SMI [severe mental illness] and were willing to learn about their client's illness. They were not only professional, but compassionate. This was a huge positive change and made the ordeal much less traumatic and distressful than in the past. (In the past the MHLP has rubbed salt into very raw wounds.) In the past I have told MHLP people that it is my understanding that in some states the patient's lawyer(s) work with the "state" and providers to truly help the patient instead of trying to win another round. For the first time I saw them assuming a helping rather than a win-the-game stance by individualizing their approach.

One thing that worked well with the judicial court aspect this time was that the hearing was held in the hospital . . ., so he was not dragged elsewhere in metal handcuffs and shackles. Actually this time he declined to attend the torture session even though it was held at the hospital, so he suffered less. Without even leaving the room after the proceeding ended, the judge reviewed the evidence and allowed him to be officially committed for 90 days. In the past it has taken judges up to 2 weeks to make the same type of decision. (Except for the one who discharged him onto the streets in the middle of winter with no outerwear after he [judge] left the room and allowed the metals to be removed. He stated to our son that he was clearly severely mentally ill, but could go because he was not an imminent danger.) A good judge who understands serious mental illness, the value of the attending psychiatrist's evaluation and the urgency of the situation makes a huge difference. We've seen the gamut by now and lucked out on that this time.

What did not work well regarding the process?

The worst thing this time was the long wait for an outpatient hearing so that he could be a direct admit and thus not warehoused in an ER for a week (so long that it did not come to pass)[.] Not only did he become too dangerous before the hearing occurred, his receipt of the reports from the court system, which included info provided by us, made him more paranoid about us and now our relationship is gone. Despite this failure, he did end up back in the hospital without serious injury or death to himself or others, so it could have been worse. He suffered more than he would have with a direct admit, but the schizophrenia makes him suffer terribly constantly no matter what anyone does.

As usual, despite Act 192 the court proceedings took too long [to obtain an involuntary medication order] IMO, but I'm not sure how much difference that makes by now. The window of opportunity to prevent additional brain damage likely closed years ago. But it still does make a difference for other patients, as it did for him for the first few years of revolving doors.

In your opinion, was the outcome beneficial?

Yes. Based on what little information I'm privy to, since taking the antipsychotic he has started to improve and is able to function somewhat better already. (Of course if he's discharged without an ONH again and again goes off the med that is helping all will be lost once again.)

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

I continue to recommend that the judicial proceedings occur more rapidly [bold font in original] as proposed in several failed bills over the past 10 years. Finally S. 287 passed, but the final version was so watered-down that I'm not sure that these wait times are shortened much or not. For one thing I think the attending psychiatrist, with a second opinion from another psychiatrist, should be able to have a combined hearing (for "commitment" and medication) if they think that is in the best interest of the patient. The final legislation greatly reduced the ability of physicians to do this for direly ill patients such as our son. (Had to be actively violent, responded to invol med within two years, etc.) Mere severe suffering was not enough in the final version.

IMO for patients such as my family member waits of 2 to 3 months are unacceptable and should be more like 1 week as is the case in other states. (However, unlike when he became clearly psychotic at age 18 when early treatment could have made a difference, but I could not get it until he became an imminent danger at age 20 and was first sent to jail, by now so much damage has been done to his brain that I'm not sure if waiting a couple additional months for medication yet again makes such a difference as long as he's in a [now] nice environment and all are safe. Even though it took over 2

months for the first of the two hearings in 20__, he was hospitalized in an excellent hospital so whether or not he was "committed" didn't really matter. In terms of medication, I think his psychiatrist was trying to "work with him" for a long period of time before going the involuntary route and I do not second[-]guess [the psychiatrist's] judgement. It's a very different situation than it was 12 and then 10 years ago when the disease made him so dangerous he committed felonies, but when there was some hope that a shorter duration of untreated psychosis would lead to a better outcome.)

At this point it's so hopeless I'm not sure any additional changes will help him, but they could help others. **One thing would be enough beds so that patients still don't have long ER waits**. [Bold font in original] Of course that's not part of what Act 114 is about and I know I'm getting off topic. The care is better now too, but it's probably too late for him.

We need so much more than just involuntary treatment for the sickest with anosognosia, even though I think we do need that. I think treatment youth and all people who manifest psychosis early is critical and there are many ways in which that should have happened for my son. It should be happening now—for the most part in the outpatient arena. (I think it is happening now more than it was __ years ago when I first sought psychiatric care. The Early Episode Psychosis study and project by the VT Coop[erative] for Practice Improvement and Innovation should help eventually.

Parents who seek help for a child they fear is in the early stages or prodrome of a psychotic illness should be respected and taken seriously. Even parents who don't voice such extreme concerns should be taken seriously. Their children should be monitored carefully and receive various modalities of treatment if disease manifests. Treatment should be directed by caring **competent** psychiatrists and **individualized** with input from parents like us when available. [Bold font in original] (But I don't see how the state can mandate this. Child and all psychiatrists need to be better trained, especially about the value of parents.)

There cannot be a law for every patient and judges are no substitute for physicians, human and thus flawed and sub-optimally trained as they are. The concept that judges should be the deciders because doctors make some mistakes is not medically sound. Some psychiatrists have made horrible mistakes about my son, but that doesn't mean I think a judge should make the most major decisions about his medical care. **Paraphrased: I think the law should change so that two psychiatrists make the decisions about treatment now required of judges.** [Bold font in original]

What a dreamer I am!!!

Sorry this is so off-topic. I am obsessed by what the schizophrenia has done to my son and how badly he and we have been failed. The help we received from our DA [designated agency for mental health services] this past year was fantastic, but too late. We could not get that type of help when he was 18. VPCH is also excellent, but VSH and then The Retreat were not. FACH [sic] [Fanny Allen Health Care, now the UVM Medical Center] always refused him care because he was too sick for there.

That's another thing I think should change, but doubt it will in my lifetime: **Our tertiary care teaching hospital should not refuse to care for the sickest of psychiatric patients** any more than they should for other direly ill patients. [Bold font in original]

Bottom line about what's relevant [bold font in original]**:** Some of the most severely ill psychotic patients still need to be treated involuntarily. This is a very tiny percentage of people with mental illnesses, but the ones who need care the most. It is inhumane to not teat them and to make them wait weeks or months for treatment recommended by their physicians, who[,] contrary to popular opinion in some circles, do try very hard to go the voluntary route first.

I absolutely think that involuntary treatment should be used as a last resort, but with my son we have been down to the last resort for years. By the time he actually received psychiatric care, despite my seeking it at age 12, all else had failed. He has anosognosia and thus cannot perceive the need for an antipsychotic, despite heroic attempts on the part of many. Leaving him to suffer indefinitely or for protracted periods without even trying the last resort is cruel and irrational. Yes, involuntary is a terrible thing for a sick person, but for patients such as my son the alternative is even worse.

The process still takes too long for patients who need the last resort, who are the ones this legislation is about. I don't know for certain if passage of S. 287 (Act 192) has helped, but think it has some, but not enough. The attitude of judges and lawyers from the MHLP seems improved compared to a few years ago.

Letter from Vermont Legal Aid, Inc.

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

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

As of today's date [date of letter is December 31, 2015] our records show that the Department of Mental Health has filed seventy-nine involuntary medication cases in

calendar year 2015, exceeding the all-time record of seventy-seven filed in 2014. This continues the pattern of continuous increases in involuntary medication since 2008, as this table demonstrates. Since 2008 the number of involuntary medication cases filed by the State has more than tripled, and it has more than doubled since 2011, the year the State Hospital closed.

YEAR	INVOLUNTARY MEDICATION CASES FILED
2008	23
2009	30
2010	31
2011	39
2012	45
2013	64
2014	77
2015	79

Were you directly involved with any individuals involuntarily medicated under Act 114 in 2015?

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

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

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

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

What worked well regarding the process?

Act 114, and the availability of court-appointed counsel to represent the patients in the State's custody, is the only mechanism available to either prevent unjustified use of involuntary medication or to restrict the State's psychiatrists from administering medications or doses that would likely be h armful to the patients. In 2015 approximately 25% of the involuntary medication cases filed resulted in a denial by the court, a dismissal by the State, or an order from the court limiting the medications sought or the method of administration; in other cases, the State, after hearing from the independent psychiatrist, agrees [sic] to exclude a requested medication or reduce the requested dose.

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

In your opinion, was the outcome beneficial?

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

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

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

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

ability Rights Vermont for a study of the long-term outcomes of people who are subjected to forced medication.

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

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

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

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

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

Very truly yours,

[signature]

John. J. McCullough III
Project Director

INPUT FROM VERMONT JUDICIARY

Chief Superior Judge Brian J. Grearson passed along responses from Hon. Katherine Hayes, who, Judge Grearson explained, presided over "a significant number" of requests for involuntary medication.

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

Yes, between January 1, 2015[,] and the end of August 2015, I was involved in 16 IM cases. Of these, four were dismissed by the State, and the remainder required hearings, and IM orders were issued.

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

In general the process went very smoothly. Changes to the involuntary medication were small; the most significant change (I think) made by the Act was the requirement of probable cause review on the papers by the judge within 72 hours of filing of all involuntary hospitalization cases.

What worked well regarding the process?
What did not work well regarding the process?

As stated above, for practical purposes the Act made few changes to procedures that were already in place.
*We had NO cases in which there were applications for IM under 7624(a)(6) (delay more than 26 days without hearing).
*We did have a few requests for expedited hearings, but I don't think they actually resulted in speedier hearings.
*However we did have a number of cases in which the IM hearing and the hearing on the petition for involuntary treatment were combined under Section 7624(b)(2)(B).
*In general, all of the changes, and much closer oversight by the Administrative Judge and others in the judiciary, resulted in somewhat earlier resolution of IM petitions, and therefore earlier appropriate treatment appropriate treatment being offered. It's possible that it also created an obstacle, in a few cases, to agreed withdrawals of the involuntary treatment petition, and therefore resulted in some more contested hearings than would otherwise have been required. However, the number of IM filings in 2014 and 2015 are comparable. If anything, the IM filings for our court are down a little this year—there may be many reasons for that though, including the expansion of bed space in other parts of the state.
*Consolidated hearings on both issues do require more time than hearings that address only involuntary treatment, often nearly twice as much time (two hours instead of one hour).

In your opinion, was the outcome beneficial?

I think that more people received speedier hearings on both issues in part as a result of the Act (as noted above—I think the judiciary's attention to timelines speeded hearing time up, and would have done so without any statutory change) (Average time for IM hearings from time of IM petition filing in our county from January 2015 to September 2015 was less than 10 days for cases that required hearings, and during the same period of the preceding calendar year, which included a few months under the revised statute, the average time was a little over 14 days). Some of those hearings would probably never have been necessary under the old procedures (because over time patients would have developed trust for providers, benefited from treatment offered, accepted medication voluntarily, if needed, and been either discharged or released on involuntary non-hospitalization orders). I have non way of knowing how many of these cases there might have been. Contested hearings are not good for patients, in general—they are traumatic, painful, and erode the medical provider-patient relationship, A system that results in more contested hearings is not necessarily in the patients' interests. On the other hand, it is important that patients be provided hearings as speedily as possible if it is clear that they want and need one.

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

I wonder if there is any place in this process for an alternative dispute resolution approach—in occasional cases I can imagine that using mediation (with skilled and knowledgeable mediators) might be productive and much more humane.

After the responses from Judge Hayes to the Commissioner's questionnaire, Judge Grearson observed that "responses [from other judges in the state] were narrative in form and did not correlate with the specific questions asked but in general the judges believed the process was working well." He added that data kept by the courts show "virtually no change in the total number of Applications for Involuntary Medication [78 in Fiscal Year 2014, and 79 in Fiscal Year 2015] but notably, the distribution of venues has changed consistent with the opening of the Psychiatric Hospital in Berlin and the closing of the Lamoille facility [in July 2014]. The numbers of cases for the last two years continues [sic] to be almost double that of the preceding three years. Finally, as noted by Judge [Amy] Davenport in her response last year, these cases are marked by very few settlements and very short timelines to disposition."

INPUT FROM INDIVIDUALS INVOLUNTARILY MEDICATED UNDER ACT 114

Four patients who were involuntarily medicated under Act 114 from January 1-November 30, 2014, and six who were involuntarily medicated from December 1, 2014, through November 30, 2015, responded to the Commissioner's questionnaire about their experiences during their hospitalization for psychiatric care.

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: 5
   No: 6

One of the respondents answered both yes and no to this question, yes about the experience in court but no about the experience in one of Vermont's designated hospitals. None of the respondents who answered yes to this question offered additional information.

One of the respondents who answered no to the question said, "I felt honored and then dishonored in at [sic] the court. The process was grueling and difficult because there are times I felt I was not listened to, and that cost me in the courtroom. I feel that because I am being judged, by the psychiatrists who don't know me, they had no right to interfere with a truthful process in the courtroom. There have been lies, and non-fact[s?] and I felt I had to defend myself by speaking out."

An additional two of the respondents who answered no to the question had the following to say about their experiences in one of Vermont's designated hospitals for administration of involuntary psychiatric medications under Act 114:

"No [I was not treated fairly] because of engagements that were not necessary. I felt that I was provoked a lot. I mainly kept my cool. I was told right off the start by all staff I would only be there a few days. That 'I seemed like the guy that fit that role'."

Another respondent said that a physician "took me off Risperdol [sic] in the first place."

Finally, another respondent said, "I decided at [the] last minute not to go to court." And, about his/her experience in the hospital, the same respondent said, "Many things that were said about me and my behavior was [sic] falsified in order to get me hospitalized and then to keep me hospitalized."

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: 4
   No: 6 (one of the respondents who checked no added a question mark also)

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

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

- "I started taking an antidepressant, Zoloft, at 27 years old. I did not need the meds for the 1st 26 years and the Zoloft, after 4 months[,] shot me into my first major mania."
- "Bad trauma in past. Bad side-effects. I have plenty of knowledge about pharmac[e]uticals and their purpose and industry."
- "Because I am a vergan [vegan? virgin?] and want to keep away from drugs and medication. [Also] religion [and] addictions to medication"
- "Fear of health"
- "I liked the way I was feeling without taking them before I was hospitalized."
- "[Names of two people] stopped my meds and then Dr. McGee stopped everything here."
- One respondent simply put a big question mark in the space for answering this question.

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: 8
No: 2

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

- "able to think better[,] heart hurts"
- "Kind of"
- "not hearing vocise [sic][,] being paranoid or having hallucinations sence [sic] being on my meds"
- "I am in more control of my Self"
- "Calm and tired"
- "I am more psychotic—meaning, I can't calm my body[,] the side-effects are terrible, so I have to take more drugs. I feel I am losing freedom of speech and have not been included as a countryman."
- "I feel like the medications alter who I am. They sedate me."

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.**

Seven respondents to the Commissioner's questionnaire answered yes to this question, but only six named or mentioned individuals who had been helpful. Most of the individuals are identifiable as probably on the hospital staff, while one seems to have been a friend. Others were not named but identified as hospital staff, a doctor and a social worker.

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

- "They listen to me"
- "[Person's name] helped me get out of this hospital. [Another person's name] helped me with [illegible][and] she was not forcefull [sic] on telling me to take medication."
- "By telling me to take my meds and not to stop taking them because they help me"
- "Acted as counselor"
- "They were comfortable with me and listened. [Names of two people] were very sweet young kids, now growing into young women. [Another person] helped with computer printouts and mailings.
- "They paid attention to me when I needed it"
- "She brought unconditional love—and chocolates"

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

Yes:	5
No:	4

One of the respondents who checked "no" to this question about changes in the Act 114 law added that "I would like to see everyone in prison. The five respondents who answered yes to this question said:

- "Give them a choice and maybe they would want to take medication instead of force"
- "Wish I could be put on other meds than what I'm taking currently"
- "having with [illegible] that don't work in doctor['']s favor"
- "If this is the law that involuntary medicine is made for then it needs to change and you need to listen to the country of Finland. There is no 'spiritual acceptance' here for not taking meds, and the right not to."
- "Yes. I don't know what Act 114 is but I was flabergasted [sic] by how the whole situation was handled."

INPUT FROM PSYCHIATRISTS, NURSES, AND OTHER HOSPITAL STAFF

During the weeks of December 14, 2015, and January 4, 2016, central office staff of the Department of Mental Health conducted telephone interviews with hospital staff at Vermont's designated hospitals for involuntary patients where Act 114 medications are administered. Most of the staff respondents at the Vermont Psychiatric Care Hospital in Berlin offered their comments in writing, although one staff member came for an interview at the scheduled time at VPCH.

Hospital staff answered the following eight questions:

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

Only two staff members from one of Vermont's designated hospitals went so far as to say that the Act 114 process works very well, and she praised her treatment team for being very careful to adhere to the requirement of a twenty-four-hour delay after a court order is issued. She also praised her staff for being meticulous and respectful explaining the process to patients and offering them the option of taking oral medication if they would agree to it. Another staff member of the same hospital noted that the process "works well when there is variability in dosages and adequate time of order. 60 days in insufficient [but] 6 months to a year helps people." One staff respondent answered "average" to this question.

The rest of the answers from other respondents clustered in the range of "not well at all" to "poorly." Complaints about the length of time after admission of an individual to the hospital to a court hearing and court-ordered psychiatric medication were numerous and varied. Complaints that physicians are not allowed to treat patients based on their own judgment were frequent as well. Additional comments on Vermont's statutorily mandated process included the following:

- The changes in the law that went into effect in 2014 have done little if anything to decrease the time that elapses between admission of an individual in need of treatment and court-ordered psychiatric medication for those who are refusing it
- Some patients remain manic or psychotic for months without medications, increasing their suffering and the risk of harm to themselves and/or others
- "The protocol puts patients and staff at risk. I have seen patients go in front of the judge and court[-]order meds were denied. Court[-]order[ed] meds weren't started until an assault occured [sic] usually multiple ones and [patients had to go] back in front of the judge[.]"
- Sometimes court orders specify medications that do not work for patients (for example, Clozaril is often effective but cannot be ordered by the court)
- The time required for completion of documentation is excessive, especially the required weekly reassessments to determine continuing need for medications

- "It is not unusual to have a very limited period of time when the [medication] order remains in effect . . . [challenges] by advocates and judges when we [medical staff] finally receive an order . . . [result] in longer stays in acute-care beds in a locked facility while acutely ill patients wait for beds in [e]mergency rooms and Corrections."
- Court hearings are too long, including even expedited hearings
- The time from an assault to a court hearing is often too long; physicians should be able to begin medication when the assault occurs and explain in court later

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

Hospital staff offered the following ideas in answer to this question:

- "It would be good if the courts used the new process of commitment and medication in one hearing." The process generally goes faster this way.
- Notification twenty-four hours ahead of time "because patients need to be reminded what is going to happen"
- "When the patient has had meds over a period of time, the changes are so evident."
- " . . . the State of VT is very respectful of patient's rights."
- "Having an advocate [illegible] with them gives the patient a voice"
- Act 114 provides a "structure to minimize coercion in the least-restrictive fashion."
- It is valuable to have legal steps to prevent violations of individual autonomy. Judicial oversight is good. Eventually people get treated and they get better, but it takes a long time.

3. Which steps pose problems?

Many hospital staff repeated their objections to what they consider the excessive length of time that passes from hospital admission to medication. Other factors that add to difficulties and delays throughout the process include:

- Continuances on the part of defense lawyers
- How is it possible for a person to be incompetent to make decisions and at the same time be regarded as competent to refuse medical advice?
- Having a lawyer meet with patients, who often become hostile during and after the meeting
- In court, judges end up making medical decisions which should be left to doctors to make
- There is no clinical rationale for the requirement of a weekly reassessment of continuing need for medication; this step is unnecessary, repetitive, and time-consuming
- The process for combining medication and commitment hearings is not used often enough
- The judiciary's medical activism

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?

Hospital staff mentioned numerous kinds of approaches, including:

- Working with patients "motivationally to try to get them to find personal benefits to taking medications including getting back to the community sooner, avoiding any involuntary emergency procedures, advancing privileges, building relationships with them."
- "Offer medications consistently. Talk about helpful potential effects of the meds consistently."
- Discussion of medication benefits and side-effects
- "Educated pts about the importance [of the medication]. Encouraged them. Re-approached multiple times."
- Talking to patients about what got them into the hospital in the first place and "the fact [that] the meds could help control their emotions."
- Having discussions of psychiatrist's recommendations for treatment with individuals and providing printouts with additional information.
- Nursing staff spend a lot of time going over questions with patients—discussions in detail about the side-effects and efficacy of particular medications.
- The individual's past history of medication problems or effectiveness is always taken into account and respected.
- People are offered low doses to begin with.
- Respect individual preference, even where to take the medication.
- Try to have staff with whom patient feels comfortable present for administration of the medication
- Offer therapeutic options that are available
- Offer to engage families and others in treatment if the patient wishes.
- Since denial of mental illness is often a factor in medication refusals, try to explore all reasonable alternatives.
- Medical staff really try to understand patients' objections to medications

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

The length of time can vary considerably from individual to individual depending on any number of circumstances—acuteness of illness, past experiences of hospitalization, legal status, whether or not a person is deteriorating rapidly, possibly becoming threatening and/or aggressive, and whether a person's general medical condition becomes compromised by the symptoms of mental illness, to name a few. For a patient known to the hospital and known to have responded well to medication in the past, the length of time could be only a few days. For others, it can require weeks or months. The process becomes more complicated with patients who may take medication sporadically, or take inadequate doses. Court time lines and legal defense introduce complications of their own that may lengthen the amount of time required to obtain a court order for involuntary psychiatric medication.

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

One respondent observed that "not taking prescribed medications is the #1 reason for people getting admitted to acute[-]care hospital beds." Hospital staff are unanimous in their opinion that medication almost invariably helps patients get better, with discharge often becoming possible within a month to six weeks. Another respondent said that "medications make all the difference" for people who are so ill that they have to be hospitalized. After medications, aggression decreases dramatically, and patients can cooperate with staff in their own treatment. They can get more organized, become independent and regain their autonomy, and they need less help getting on with their lives. The use of seclusion and restraint declines significantly or is eliminated once a person starts taking psychiatric medications.

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

Responses to this question ranged from the general to the specific, such as:

- Many would remain in the hospital untreated with a worsening prognosis
- Remain in hospital in state of fear and intense vulnerability for much longer
- Longer hospitalization
- Poor recovery
- They would have remained agitated/aggressive/dangerous.
- More seclusions and increased risk of injuries to patients and staff
- Some people might die if they don't receive medications; they could dehydrate and starve to death
- When people are psychotic, they are more likely to damage relationships with family, community, employers, authorities, et alia, and situations only get worse without medications
- Many people wouldn't be able to resume independent life in the community.
- Trouble with the law, resulting in prison or jail
- Higher risk of hurting themselves or others/suicide/homicide
- For many people, lack of medications prolongs torment
- Families become strained, heartbroken
- Decline in overall medical health
- Overall quality of life without medications is tragic

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

- Expedite the legal process.
- "Make provisions for medicating a specific group of individuals who routinely discontinue medication [upon discharge from the hospital] eligible for Assertive Outpatient Treatment (AOT), as is done in many other states."

- "Court[-]ordered meds should go with competency. Not competent = Court ordered meds."
- "I have never worked in a state/facility that takes so long to medicate dangerous, dysregulated patients. It is completely ridiculous that patients are hospitalized involuntarily but not medicated. This makes for a hostile environment that leads to many staff/patient assaults. In other states, where the pt is hospitalized at a state level and involuntarily, medications are not optional. This promotes a safer environment with less [that is, fewer] EIPs [emergency involuntary procedures] and APS reports. When the ptclears after they are medicated, then it may be appropriate to offer them choices. I think it is irresponsible and negligent how the court-order med process is implemented currently."
- "The process should be streamlined for patients who are involuntarily commit[t]ed. Medication is a tool to help with their recovery. The process used now denies the use of this tool up to and over 90 days. If we look at mental illness as a disease like any other disease, we don't wait 90 days to give patients with blood clots blood thinners."
- Have test cases for implementing Act 114 in the community outside a hospital setting (to include Corrections inmates)
- Put more money into community resources to keep people well outside the hospital
- Remove all barriers to combined commitment and medication hearings.
- When a patient becomes violent or aggressive, hospital staff should be able to administer medication immediately and explain later to the court.

CONCLUSIONS

What Is Working Well

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

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

Positive Effects of Medications. Hospital staff—usually doctors, nurses, and social workers—who participated in the interviews for this report were unanimous in seeing positive outcomes for individuals after medication. That has been the case every year that this report has been written for the General Assembly. The Act 114 patients were not unanimous, however. Eight of the respondents said that they discerned a difference in their condition before and after medication but noted effects both positive and negative. Positive comments included being "able to think better," not hearing voices anymore, not being paranoid or having hallucinations, and being "in more control" of oneself. See the next section for negative effects noted.

Hospital Staff. Six of the Act 114 patient respondents saw hospital staff in a positive light after going through the Act 114 process. They even mentioned some particularly helpful staff members by name and described how they were helpful—for example, by:

- ✓ Listening
- ✓ Helping "me get out of this hospital"
- ✓ Telling a patient to take medications and not stop them because they are helpful
- ✓ Acting as a counselor
- ✓ Paying attention when the patient "needed it"

What Is Not Working Well

The Act 114 Process. Five of the Act 114 patient respondents answered yes to the Commissioner's question about fairness but offered no additional information or details about their experiences. The rest of the respondents had a variety of complaints:

- Being dishonored in a court process that was "grueling and difficult"
- Not being listened to in court
- Being judged in court by "psychiatrists who don't know me"
- Perception of unfair treatment while hospitalized "because of engagements that were not necessary" (no further details were offered)

Length of the Process. Hospital staff who administer psychiatric medications under the provisions of Act 114 are unanimous in their perceptions that the process is too long. On the other hand, Vermont Legal Aid adamantly asserts that the process is too short. Neither medical staff nor Vermont Legal Aid see the changes in the law that were made in 2014 as having had a beneficial effect on the time involved to obtain an order for involuntary medication.

Education About Side Effects of Psychiatric Medications. Only four of the ten Act 114 patient respondents thought that the advantages and disadvantages of taking medications had been explained clearly enough to help them make a decision about whether or not to take them. On the other hand, hospital staff at designated hospitals all talked about how much time they take to explain the benefits of psychiatric medications and their side-effects to patients going through the Act 114 process.

Negative Effects of Medications. Among the eight respondents who said that they perceived a difference in themselves before and after starting psychiatric medications, two noted the following negative effects:

- "I am more psychotic—meaning, I can't calm my body[,] the side-effects are terrible, so I have to take more drugs. I feel I am losing freedom of speech and have not been included as a countryman."
- "I feel like the medications alter who I am. They sedate me."

A third described being "calm" but "tired," while a fourth described being "able to think better" but also having a "heart [that] hurts."

Perceived Fairness of the Act 114 Process. Excluding the one respondent who answered both yes and no to the question about fairness, only five respondents saw themselves as having been treated fairly even though an involuntary procedure was involved.

Opportunities for Improvement

Focus on Recovery

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

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

- Health
- Home
- Purpose
- Community

The ten guiding principles of recovery are:

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

Maximizing Individual Preference

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

- Expanded mobile crisis capacities all over the state,
- Hospital diversion and step-down,
- Peer-supported alternatives such as Alyssum and Soteria House

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

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

- The new Vermont Psychiatric Care Hospital in Berlin
- Continued emphasis on least-restricted transport
- Support for training in the Six Core Strategies for reducing seclusion and restraint
- Efforts to identify the most effective ways to support individuals experiencing early-episode psychosis

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

In Closing

The Department of Mental Health acknowledges that the outcome of medical care by court-mandated involuntary treatment, including the use of non-emergency involuntary medication, is not a preferred course of an ideal plan of care. DMH continues to take the position that use of medication for some persons with a mental illness is an effective component of a treatment plan to bring about mental health stability and continued recovery in their community. Patients should receive information regarding medication options and side-effects from a practitioner who is working to build a trusting therapeutic relationship, but, at the same time, we recognize that this relationship does not always result in agreement to take medication. DMH will continue to encourage efforts to broaden the choice of services to support earlier intervention for persons who might benefit from care or other treatment alternatives if they were more accessible sooner, and also to encourage options for services inclusive of the preferences and values of each individual patient.

DMH supports revisiting the statutes to make potential changes to Titles 13 and 18 that would be intended:

- To reduce the delay in court-ordered medications for patients who are refusing psychiatric medications but could likely benefit from timely treatment
- To encourage the use of court-ordered medications for individuals on orders of non-hospitalization if they present a significant risk of decompensation and potential trauma from stopping their medications
- To secure a departmental mandate to restore competency whenever possible through the use of court-ordered medication to improve outcomes for individuals

Finally, DMH reiterates its recommendation from the beginning of this report that the General Assembly strongly consider the current redundant content of these two reports on Act 114, eliminate the annual report from the department, and rely upon the independent report that efficiently captures both departmental actions and individual experiences in this area together with recommendations for changes in the law.