VERMONT2017

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 82

Section 5: Involuntary Treatment and Medication Review

December 15, 2017

VERMONT
Department of Mental Health
AGENCY OF HUMAN SERVICES
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Table of Contents

Summary of Report Expectations

On or before December 15, 2017, the Secretary of Human Services, in collaboration with the Commissioner of Mental Health and the Chief Superior Judge, shall analyze and submit a report to the Senate Committee on Health and Welfare and the House Committee on Health Care regarding the role that involuntary treatment and psychiatric medication play in inpatient emergency department wait times, including any concerns arising from judicial timelines and processes.

The analysis shall examine gaps and shortcomings in the mental health system, including:

1. Adequacy of housing and community resources available to divert patients from involuntary hospitalization;
2. Treatment modalities, including involuntary medication and non-medication alternatives available to address the needs of patients in psychiatric crises; and
3. Other characteristics of the mental health system that contribute to prolonged stays in hospital emergency departments and inpatient psychiatric units.

The analysis shall also examine the interplay between the rights of staff and patients' rights and the use of involuntary treatment and medication.

Involuntary Treatment and Medication Review

Gaps and Shortcomings in the Mental Health System

1. Adequacy of housing and community resources available to divert patients from involuntary hospitalization;

This information is included in the Act 82 Sections 3 and 4 report due December 15, 2017.

2. Treatment modalities, including involuntary medication and non-medication alternatives available to address the needs of patients in psychiatric crises;

Non-Medication Alternatives

There are several non-medication alternatives that have been shown to address the needs of individuals in psychiatric crisis:

Crisis Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified Crisis Services as one of the most beneficial and cost-effective methods for meeting the needs of individuals in psychiatric crisis. This array of services can include:

- Mobile crisis services
- 24/7 crisis hotlines
- 23-hour crisis stabilization/observation beds
- Short-term crisis residential services and crisis stabilization beds
- Collaborative mental health and law enforcement response
- Pre-crisis telephone support lines (i.e. "warmlines")
- Peer crisis services

SAMHSA states that there is strong evidence that crisis services can "divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing [psychiatric] crisis."[1] In addition, crisis services have been shown to be highly cost effective. SAMSHA states: "…. a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes."[2] Reduced use of hospitalization and diversion from emergency rooms, coupled with an appropriate level of community-based services, leads to lower costs.

While Vermont has a long history of utilizing crisis services to address the needs of individuals in psychiatric crisis, including an expansion of these services through Act 79 in 2012, we believe additional expansion of this continuum of services would further help to address the needs of these individuals and reduce the need for involuntary interventions. **Additional analysis of how existing crisis services could be used to avoid the need for involuntary treatment may also be warranted.**

[1] https://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf

[2] https://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf

Soteria

The Soteria model was originally founded in 1971 by psychiatrist Loren Mosher in San Jose, California as an alternative community-based, non-medical approach to traditional hospitalization for people diagnosed with schizophrenia.[3] The approach emphasizes the following principles:

- A small, community-based, residential treatment environment with strong use of peer and para-professional staffing rather than clinical staff;
- A focus on empowerment, peer support, social networks, and mutual responsibility and reciprocity between residents staying at the program and staff;
- Minimal use of psychotropic medication based on personal choice of the resident.[4]

While some members of the psychiatric community have been, and continue to be, critical of approaches that minimize or avoid the use of psychotropic medication during the first phases of psychosis[5], there has been a strong push among peers and mental health advocates nationally and in Vermont to increase access to this type of support. In addition, systematic reviews of research on this model suggest that it can offer an effective non-medication alternative to individuals in psychiatric crisis. In a 2007 meta-analysis of the Soteria model published in *Schizophrenia Bulletin*, the authors state that while further research is needed, current studies suggest that the Soteria model "yields equal, and in certain specific areas, better results in the treatment of people diagnosed with first- or second-episode schizophrenia spectrum disorders (achieving this with considerably lower use of medication) when compared with conventional, medication-based approaches."[6]

Vermont currently supports a 5-bed Soteria House in Burlington, as well as an 8-bed program, Hilltop, in southeast Vermont that is informed by the Soteria model. Given the research that suggests that the Soteria model can be as effective as traditional treatment while offering a non-medication alternative, **further analysis may be warranted to assess how Vermont's future support and implementation of the Soteria model can reduce the need for involuntary medication for individuals experiencing a psychiatric crisis.**

Six Core Strategies for the Reduction of Seclusion and Restraint

When an individual is hospitalized or being treated in a hospital emergency room for a psychiatric crisis, there are times when hospital staff may be required to use seclusion and restraint (S/R),

[3] https://en.wikipedia.org/wiki/Soteria_(psychiatric_treatment)

[4] ibid; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2632384/

[5] https://mentalillnesspolicy.org/medical/involuntary-medication.html

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2632384/

including the administration of involuntary, short-acting medication, if an individual is presenting an immediate threat to harm themselves or someone else. While necessary to ensure immediate safety, these interventions have been shown to have both short-term and long-term negative effects on both patients and the staff performing the intervention. SAMHSA states, "Studies have shown that the use of seclusion and restraint can result in psychological harm, physical injuries, and death to both the people subjected to and the staff applying these techniques."[7]

To address this issue, SAMHSA has supported the development and promotion of the *Six Core Strategies for Reduction of Seclusion and Restraint*. This approach focuses on organizational training and consultation focused on changing the organization' s culture, management, and policies and procedures to prevent the need for S/R. The six strategies address:

1) Leadership support
2) Debriefing after the use of seclusion or restraint
3) Using data to inform organizational improvements
4) Workforce development and training for all staff
5) Specific tools for S/R reduction (e.g. Sensory Modulation)
6) Inclusion of former patients and their family members in planning and implementation of the strategies

This approach has been found to be effective in reducing the percentage of patients secluded and the proportion of patients restrained, as well as the number of hours that patients spent in seclusion or restraint.[8]

Vermont has supported the implementation of the *Six Core Strategies for the Reduction of Seclusion and Restraint* in both the Vermont Psychiatric Care Hospital (VPCH) and the Designated Level I Hospitals, and several of these inpatient programs have experienced significant success in reducing their use of S/R. **DMH recommends that Vermont continue to support implementation of these strategies and consider expansion of the approach in other hospital inpatient units and emergency rooms that are experiencing a significant level of S/R.**

Sensory Modulation

Sensory Modulation is a therapeutic intervention that provides opportunity for the care provider to help the patient deescalate safely when they are in Phase II of the Assault Cycle. Sensory Modulation includes a number of therapeutic interventions such as a variety of colored lenses, varying types of music, board games, card games, or coloring books. It can also be a time when lighting or noise is reduced or increased. These are all methods that are hoped will distract the patient from thoughts

[7] https://www.samhsa.gov/trauma-violence/seclusion

[8] https://www.psychiatry.org/newsroom/news-releases/evidence-based-package-of-strategies-reduces-use-of-seclusion-and-restraint

of assaultive or aggressive behavior(s). These therapeutic methods can also help to deescalate the patient and help them to maintain a mood of calmness once the patient is returning to their level of baseline behavior or maintaining it. While the goal of Sensory Modulation is to help them return to their baseline of behavior and maintain that level while paying strict attention that the patient care staff is maintaining a necessary level of safety.

About two years ago Tina Champange, a leading expert in this county on Sensory Modulation, gave a two-day workshop on Training Modulation at VPCH. Her workshop was well attended and well received. She was available for talks with staff that were well used by these attendees. She also provided displays of tools that could be used in the provision of Sensory Modulation by staff to our patients. The provision of Sensory Modulation by our staff to patients was met with great enthusiasm by staff for the first 3 or 4 months, mostly by Recovery Staff and Social Workers, but also by some Nurses. Unfortunately, it became difficult to maintain a continuous, regularly scheduled provision of these sessions and soon they ended.

During February of 2018, Tina Champaign will return to VPCH to provide us with two days of training in Sensory Modulation. What will be different about these two days of her workshop is that she will provide us with a Train-The-Trainer program for our staff. **This provides us with strong plans that will help us to keep Sensory Modulation as a viable, ongoing program on a regularly scheduled basis.**

<u>Collaborative Networks Approach</u>

The Collaborative Networks Approach is a Vermont-based initiative that aims to train practitioners in the Vermont mental healthcare system in therapeutic practices originating from Open Dialogue, other needs-adapted approaches, and reflecting processes. This is an intensive, 100-hour training course that takes place over a span of nine months. The primary learning modalities include interactive processes such as role-play and reflective process consultations, as well as didactic presentation and review of relevant literature.

In this model, psychotic reactions are attempts to make sense of one's experience, and to cope with experiences so difficult that it has not been possible to construct a rational spoken narrative about them. Hence, symptoms are treated as meaningful attempts to communicate, and practitioners "join with" patients to create a shared understanding of the problem. Patients are encouraged to participate in all discussions about their care, and are included in every level of decision making. Regular meetings are held with patients whether they are receiving medications or not, so that practitioners can be as flexible as possible in responding to the changing needs of patients throughout their care.

In parts of Europe where similar approaches have been used, this way of working has been shown to have significant benefits for individuals and the communities in which they reside. Outcome research has demonstrated that this approach is associated with decreased reliance on antipsychotic

medication, decreased need for hospitalization, and decreased incidence of new cases of schizophrenia. In one study of patients experiencing first-episode psychosis, it was found that after two years, 83% of patients were working or job-seeking, and 77% did not have residual psychotic symptoms, despite the fact that only 27% of patients were using antipsychotic medications.

Although it is impossible to transplant an entire system of care from Europe to Vermont, the Collaborative Networks Approach has begun to adapt fundamental aspects of Open Dialogue and similar approaches to our own mental healthcare system. Last year, which was the inaugural year of the program, approximately 25 mental healthcare workers from across the state were trained in dialogic and reflective practices. The Vermont Psychiatric Care Hospital sent three full-time nurses and two attending psychiatrists to this training. This year, six new people are being sent and several of the trainees from last year are returning to complete an advanced course. Part of the focus for this more advanced training will be on teaching related principles and practice methods to others at the hospital so that this model can spread throughout the care delivery system. **Plans for implementing ongoing consultation and supervision of people trained in this work are currently being formulated.**

3. Other characteristics of the mental health system that contribute to prolonged stays in hospital emergency departments and inpatient psychiatric units

TAC Report

In early 2016, in response to an upcoming SAMHSA grant opportunity for funding to States to examine existing state laws and potentially develop more robust Assisted Outpatient Treatment "AOT" policies, DMH engaged in preliminary discussion with SAMHSA regarding eligibility and fit for Vermont. Through these discussions it was determined that existing mental health statutory language would render Vermont ineligible to benefit from grant funds as intended in the current round of applications. SAMHSA, however, recommended that free technical assistance was available to states and recommended outreach to the Treatment Advocacy Center (TAC) for follow-up discussions. The TAC organization is not without controversy, as it is a staunch advocate for effective treatment services (including medication). Some advocates and individuals living with a mental illness view these as forms of coercion and antithetical to self-directed, person-centered treatment.

In efforts to capture all perspectives, in late 2016, Brian Stettin of TAC traveled to Vermont to review our statutes and to meet with and hear from a wide range of stakeholders including state agency program and legal representatives, judges, inpatient and outpatient treatment providers, advocates, and self-identified peers and/or individuals with lived mental health system experience. A final report was issued in October 2017. It included findings and potential remedies intended to assist

Vermont in operationalizing existing statutes into practices that would improve mental health treatment services and individual outcomes.

Specific to Vermont, the report outlines a number of high level observations:

1. Current Orders of Non-hospitalization (ONH) practices have very limited influence on only a small percentage of eligible individuals.
2. The courts play no vital role in monitoring progress during the period of the order.
3. An ONH issued by the Criminal Court, for criminal defendants who typically have been found incompetent to stand trial, serves the State's Attorney as a means of disposing of the criminal matter without input of mental health professionals or having to wait indefinitely for competence to be restored.
4. Many ONHs are the result of stipulation without court hearing and patient or treatment team full understanding of their mutual responsibilities.
5. The ONH revocation process requires fresh evidentiary showing that the individual is a "person in need of treatment" rather than retain the status throughout the period of the ONH. It appears no easier to secure hospital care for non-adherent individuals on an ONH.
6. Despite statutory language conveying authority to medicate individuals on ONH, who were previously on an Order of Hospitalization (OH) and over their objection when clinically indicated, the practice remains limited to hospitals in Vermont.
7. Decentralized involuntary hospitalization and annual rotation of judiciary contributes to variability in process in the state and the basic tenets of the AOT model.

Recommendations flow from the above observations and include:

1. Piloting a city or county with buy-in of one assigned Judge and the local Designated Mental Health Agency in the tenets of the AOT Model.
2. Exclusion of individuals under ONH by Criminal Court.
3. Involvement of Court in the ONH process and monitoring of progress.
4. Dedicated inpatient beds if individuals require hospitalization.
5. Recognition that status as "a patient in need of further treatment" is retained throughout the period of ONH.
6. Data collection and evaluation of outcomes of changes.

The TAC report, *"Reimagining ONH: A Report to the Vermont Department of Mental Health"* is an addendum to this Act 82 report update.

4. Interplay between the rights of staff and patients' rights and the use of involuntary treatment and medication.

Given the complexities of this question, DMH felt the best way to answer this would be to seek input directly from direct care staff members. DMH solicited input from the VSEA's VPCH chapter, the Vermont Association of Hospitals and Healthcare Systems (VAHHS), the Vermont Medical Society, and Vermont Care Partners. As of the writing of this report we have received input from the VSEA VPCH chapter and VAHHS.

Several staff members at VPCH submitted comments. What quickly became evident is that while we asked staff to discuss the interplay between the rights of staff and patients' rights, and they did touch on that, by far their biggest concern was for the welfare of their patients. The suffering they witness day in and day out is what weighs on them most heavily and has motivated them to ask the legislature to consider changes.

This is clearly a controversial issue. While of course patient autonomy is very important, there are very real consequences to staff when patients remain untreated when medication is what their psychiatrist feels is what they need to treat their illness. There needs to be a balance between the rights of both groups. Currently, it often takes weeks or months for someone to be involuntarily medicated. DMH believes this period of time is too long and results in increased risk of harm to staff members who are caring for these patients. It is important to remember that it is a very small percentage of people involuntarily committed who need involuntary medication, 11% (51 of 465), but these are often the most acute patients and thus those that can be the most assaultive to staff. They are also the patients that are suffering the most from remaining untreated.

An analysis done by VPCH Quality showed that in FY 2017, 17 patients at VPCH received court ordered medication. Ten of those had emergency involuntary procedures (EIPs) prior to their medication order. As indicated in the analysis below, most of these untreated patients had several EIPs before they started on involuntary medications.

Number of court orders for non-emergency medication	17
Individuals with one or more EIP prior to granting of court order	10
Individuals with no EIPs prior to granting of court order	7

	Emergency Involuntary Procedures	
Patient A	8 seclusions 6 mechanical restraints	9 included manual restraint
Patient B	1 seclusion 3 mechanical restraints	All included manual restraint
Patient C	4 seclusions	4 included manual restraint

	4 mechanical restraints	
Patient D	2 seclusions	Both included manual restraint
Patient E	1 seclusion 1 mechanical restraint	
Patients F and G	1 mechanical restraint	Included manual restraint
Patient H	1 seclusion	5 manual restraints
Patient I	1 seclusion	Included manual restraint
Patient J		1 manual restraint
7 Patients	No EIPs	

It is the opinion of the clinical team that a large majority of these EIPs could have been avoided if these patients had received the clinically determined appropriate treatment in a timelier fashion. EIPs can be incredibly traumatic for patients. No matter how mindful staff are, the experience for patients often replicates a painful and frightening history. EIPs violate the sense of safety and compassion patients expect when hospitalized. A repetition of interpersonal violence (no matter how sensitively delivered) increases an adversarial and self-protective response. Collaboration becomes much more difficult for people who have experienced the fear and pain associated with an intervention that counters patient expectations and providers' desire to provide a positive mental health experience.

Taking EIPs out of the equation increases the likelihood of focused treatment delivered from a positive behavior support paradigm. Relationships are maintained in a mutually respectful way, thus helping to reduce lengths of stay and demonstrating to patients that caregivers can be trusted members in an overall recovery plan. Being able to cut down on these numbers by allowing psychiatrists to treat their patients with the treatment they deem, in their clinical judgment, to be the most appropriate for their illness would improve the patient's experience and create a safer environment for the patient, other patients, and staff.

This is also a very timely subject of discussion given the recent VOSHA investigations at VPCH and the Brattleboro Retreat. Some staff at VPCH clearly conveyed to VOSHA that they felt there were too many assaults by patients resulting in an unsafe environment. Discussions with staff revealed the same themes as the statements below: in addition to other factors, staff believe there are too many untreated acute patients on the units and that in turn creates an unsafe environment for patients and staff.

Input from VPCH

Scott Brumenschenkel, Psychiatric Nurse III

My name is Scott Brumenschenkel and I am an RN working at VPCH as a day shift charge nurse and occasional nursing supervisor. In these roles I am charged with the safety and management Vermont's most acutely ill psychiatric patients and the staff who care for them. Below I have outlined my perspectives on Vermont's shortcomings in the treatment of these individuals, the impact on those who care for them, and suggestions for improvements that could improve safety for all.

Delayed Pharmacological Treatment:

Vermont is unique in withholding the ability of psychiatrists and nurses to treat individuals pharmacologically in a timely manner even though they have been involuntarily hospitalized because of an acute psychiatric need. An exception to this are the patients who take medication voluntarily, or receive emergency medications given when presenting with an imminent risk of harm to themselves or others.

The state suspends the individual's liberty and then denies the ability of clinical staff to provide the accepted standard of care. These lapses in treatment exacerbate the individuals long and short- term prognosis, delay recovery, postpone their liberty, endanger other patients and staff, and incur unnecessary costs to the taxpayers.

I do not profess that medication is a panacea for all individuals. I do believe it is often the first step in recovery for the majority of individuals who are admitted to our facility. It is particularly troubling to care for individuals who are acutely ill, and who have a documented history of recovery with pharmacological treatments, and yet goes without while we wait on the often-lengthy delays of our court system. I would ask our legislators and citizens, what would you like us to do with these folks who are suffering under the weight of their psychosis if we cannot treat them?

VPCH is blessed with a therapeutic environment, adequate staff minimums, and active initiatives to eliminate the use of seclusion and restraints. However, there is a limit to the effectiveness of these interventions in curbing assaults when individuals are actively psychotic. Psychosis is a break with reality that often suspends the individual's ability to actively engage in communications around their needs and emotions. Individuals in this state often act out of fear, or are motivated by delusional beliefs. Patients and staff are particularly vulnerable to assault during the exacerbation of these episodes, which can occur without warning or precipitating events.

Our staff accept that there is some inherent danger in working in a psychiatric hospital, but our patients should not be subjected to acts of violence during hospitalization while there are pharmacological treatments available to help mitigate the risk. Timely pharmacological

treatment of individuals who are actively psychotic will improve safety, patient recovery, and shorten the length and associated costs of prolonged hospitalization.

I have cared for acutely psychotic, and manic patients who went untreated for months due to delays in adjudication. Moreover, our psychiatrist's recommendations for pharmacological treatments are often modified by judges who are not trained in psychiatry, or who impart limits on dosages that result in under-treatment. These hindrances to adequate treatment increase the risk of assault for everyone interacting with the patient and impair the recovery of others sharing the milieu through increased acuity on the units.

Appropriate Placement:

Presumably because of funding, we currently hospitalize individuals accused of murder and other violent crimes with geriatric psychiatric patients and young adults who have are experiencing their first acute psychiatric hospitalization. Individuals who have been exposed to life in corrections require a higher level of security than most of our civilian population. The hospital has a limited ability to blend these forensic patients amongst the different units to avoid conflicts that can result in patient to patient assault. Civilian patients through no fault of their own are then vulnerable to individuals with violent histories exhibiting antic-social behaviors for which there is little to no successful treatment.

Forensic patients are often sent to VPCH from corrections to be treated so that they can regain competency to stand trial for violent crimes. Some of these individuals will likely never regain competency and remain hospitalized for years. The state seems to have no clear guidelines on the limits of these attempted treatments to regain competency, and there by subjects a rotating civilian population to an ongoing potential of assault.

Some forensic patients improve from an acute state but not to the point of competency. It was not the intended purpose of VPCH to be a long-term care facility for psychiatric patients. The state should address this costly use of acute care beds with a forensic psychiatric facility, such as most states have, and explore the funding of community based care for individuals who need a higher level of supervision but are no longer in need of acute care in a locked facility.

Continuity of Treatment:

Patients who refuse voluntary pharmacological treatment and are then ordered to engage in pharmacological treatment receive court ordered medications while hospitalized. When they are ready to reenter the community they typically agree to an order of non-hospitalization or ONH. These contracts vary with the individual but are generally focused around continuing pharmacological treatment and outpatient appointments with a psychiatrist, community,

agencies, and therapist. If the ONH is violated the individual may be re-hospitalized, however the enforcement of the ONH is sporadic and many individuals fall through the cracks and are not seen again until they are arrested for dangerous behaviors or end up in an emergency room to start the process of hospitalization and court ordered medication all over again.

The irony is that the state of Vermont has legislation on the books to implement court medications in the community through ACT 114 but they have failed to do so. Invoking this legislation would close a loop hole in the care of our most acutely ill citizens, keeping them safe in the community saving the taxpayers millions and freeing up more acute care beds.

About half of individuals with a diagnosis of schizophrenia never have insight into their illness, and do not believe they are ill. This creates a pattern of medication non-compliance exacerbating the illness, impairing overall quality of life and creating a revolving door of hospitalization. We should give individuals the freedom to live their lives as they see fit, but when they repeatedly threaten harm to themselves or others then it is the responsibility of the state to override the rights of the individual to insure the rights of the majority to public safety.

Conclusion:

I acknowledge that pharmacological treatments for psychiatric illnesses do not have the accuracy of medications for hypertension or other medical conditions and they are not they are only one facet of what should be a multi-pronged approach, however for individuals who have a history of recovery with pharmacological treatments we must act to expedite their return to wellness and the community through more timely treatment and judicial review. Patients hospitalized against their will have a right to safety, and it is the State of Vermont's responsibility to insure their safety through appropriate placement of extremely dangerous individuals in forensic units detached from the civilian population. The judiciary needs to provide clear expectations and limitations when ordering treatment to regain competency for individuals. Expanding our community placement options for geriatric and low risk individuals who are no longer in need of acute care in a locked facility would save money and give increased oversight as people transition to the community. Continuing treatment in the community and corrections by invoking ACT 114 would stop the cycle of medication non-compliance and improve the long-term prognosis for individuals and save money.

Curtis Karr, Associate Mental Health Specialist

I'm writing this testimonial regarding my advocacy for greater alacrity in the process for administering involuntary medications. This is my third stint working as floor staff at the Vermont State Hospital; twice at the old hospital in Waterbury and now three (3) plus years at our new facility in Berlin, the Vermont Psychiatric Care Hospital.

To clarify the driving force behind my advocacy, it is first and above all, out of the wellbeing of my patients. This is closely followed by my concern for my co-worker's safety. However, my motivation for my advocacy is not to put all my patients in a "chemical straightjacket" a soon as possible to make managing my patients easier. As noted my chief concern is for my patient's welfare and wellbeing.

I have lost count over the course of my career in this occupation how many patients have been able to again move on with their lives once their medication is reintroduced and they are able to stabilize sufficiently to move on to a community facility or even home. So many times, I have personally witnessed my patients suffering the ravages of their illness for months on end because of the snail's pace with which a Med Application moves through the court system.

To be absolutely clear, I am not advocating for a system where we medicate first and ask questions later. Fortunately, there are patient advocacy groups that fight for a patient's right to refuse medication and indeed, this is a necessary tension in the dialectical process between involuntary medications and voluntary medications.

However, it seems that the pendulum has swung too far in the opposite direction of involuntary medication. What I'm hoping will come to pass is that legislation will coax the pendulum back to the middle. This is because when a patient goes off their medication, they seem to lose the ability to realize that the medication is in their best interest. Unfortunately, so many mental illnesses are illnesses that tell you that you don't have an illness. Hence, the revolving door. A patient is discharged, goes off their medication, and end up back at the hospital, often with more legal charges against them for their behavior unchecked by medication.

In closing, if someone with a mental illness is not a danger to themselves or others, then I support their right to decide for themselves whether medication is warranted or not. But, if they do pose danger to themselves or others and are readmitted to the hospital, it seems inhumane to allow them to suffer for so long because of a court system that seems to have only two speeds: really slow, and agonizingly slow.

Rhett Williams, Psychiatric Nurse II

The laws that enable psychiatric patients to receive the medications they need are inadequate in the state of Vermont. It is more difficult than it should be to administer involuntary medications for patients in level 1 psychiatric facilities. It takes far too long for the legal system to give doctors, nurses and other care providers the ability to effectively treat the symptoms our patients experience.

The most important effect of the prolonged process of obtaining the right to administer involuntary medications is patients suffer incredibly and unduly. VPCH can

provide treatment for our patients in a variety of forms. Our patients are at the highest rating scale, Level 1, and reflect inpatients at the highest level of acuity in need of constant observation and/or requiring significant staff resources that may include emergency involuntary interventions. The most effective treatment for our patients are medications. Every day our patients cannot get the most effective treatment is another day they have to endure debilitating symptoms that include extreme paranoia, fear, anxiety and suicidal depression. It is inhumane to let these people suffer acute stages of illness for prolonged periods of time.

The second reason our state needs to speed up the process of obtaining a court order to administer medications is that often as patients remain in protracted acute stages of illness their symptoms are more difficult to treat once the order to administer medications involuntarily has been obtained. As we inhumanely allow them to remain in an acute stage of illness we make it more difficult to assist them in their recovery. We are allowing people to remain in an acute stage of psychosis when we do not treat them with the most effective treatment we have, medications. The longer people remain in an acute stage of psychosis the more likely their new baseline, once treated adequately, will be at a lower level of functioning. In addition, people who return to a baseline that reflects a lower level of functioning will be more likely to have a relapse in symptoms. This cycle causes a revolving door at our facility whereby people become sick, are treated, and then become sick again, ad infinitum.

The third reason Vermont needs to accelerate our ability to adequately treat our most acutely mentally ill people is the danger inadequately treated patients pose to staff at VPCH and elsewhere. While many of our patients go through long waits to determine their competency before they can even be legally hospitalized at our facility they assault staff over, and over again. Corrections officers can take measures to protect themselves from people who have been deemed competent. Some of the people we work with are by far the most dangerous people in our state. They walk amongst us and we wait to be assaulted trying our best to maintain safety, always treating them with the utmost respect and dignity all people deserve. That is more than can be said for a legal system that allows them to remain untreated suffering with the most acute symptoms of psychosis of anyone in this state.

Barb Lowe, Associate Mental Health Specialist

I work at the Vermont Psychiatric Care Hospital. Often when patients are admitted they are psychotic, and can be assaultive. The majority of these patients have not been taking medications consistently, or have been underdiagnosed. After their admission we frequently have to wait for weeks, even months to get them to court for commitment. Often times, many weeks after commitment, they have court for

medication(s). Usually, shortly after this medication is granted. From my observation, I see how ill these patients are and how long they wait for court ordered medication, and I believe this is detrimental to the patient and is abusive to their needs. I have seen how medication has greatly improved a patient's well-being. It would be great if the time it takes to grant court-ordered medication would be greatly shortened.

Sarai Richardson, Mental Health Specialist

I've been here for five years. Prior to becoming a Mental Health Specialist, I was a Guardian for my mother-whom suffered from mental illness and later in life other medical complications on top of her mental health. My experience being her guardian was during the last six years of her life.

The current mental health system needs major changes. One of those changes I'd like to address is the length of time a person in crisis must wait for the proper treatment, not limited to but included, court-ordered medication. The current process when someone comes into our facility takes an unnecessary amount of time to get the patients court-ordered medication, even if it's a current medication the patient has for treatment.

This is causing great harm to the patient. This process almost always causes the patients to be admitted for a stay of six (6) months or more. During those months, not only does the patient lose their housing, but jobs and/or connections that they had in the outside world. It's also causing unjust pain and suffering to the patient. It's forcing them to live with whatever illness that is affecting them, in an acute state, without any relief.

I have personally seen these damaging effects happen over and over. I have personally witnessed events such as this happen to my biological mother. After getting my mother on a healthy treatment plan and getting her life back in order, a result that was needed after her 18 months stay at Fletcher Allen Baird 4, I made sure that her care was of utmost importance and her treatment followed to the letter. After becoming her guardian, I would never allow such a gap in treatment. She needed to be stabilized before she would lose her housing—which was only ten (10) days.

From what I see, the mental health system currently causes the constant mental health crisis that Vermont is facing. The system causes patients greater harm and risk of failure in the outside world. The system causes a housing crisis because the patient loses their housing and possibly homeless, and trapped in the system while a place is found. It causes the patient to lose so much, adding more trauma to their lives and creating a higher risk of being readmitted. Not to mention that the longer period of time without treatment, the greater the health risks occur.

I implore you. Please help fix this system. It would be more beneficial to patients and their lives, and/or families. Fixing the system means establishing a better quality of life for the patient. It would be more efficient and effective for the state to speed up the process of court ordered medication.

Janet Isham, Psychiatric Nurse II

Patients are sent here involuntary Level 1. Their treatment is delayed along with court ordered medication, which keeps them from returning to their lives sooner. They are robbed out of time.

Patients who are getting treatment can be delay with their own when sharing a unit with a very disruptive patient who scream all day. This is not therapeutic for anyone involved.

Our goal should be in and out, not waiting months to receive involuntary medication. Look at the number of patients who have to wait weeks in the Emergency rooms.

The longer patients are without medication, the longer it takes them to get well.

Input from VAHHS

Provider #1

Most direct care staff dealing with certain patients get hurt, but staff suffers much more seeing patients in intense discomfort (fear, rage, panic, delusions etc.) for inhumanly long periods of time due to Vermont's law regarding involuntary medication. Most patients see relief shortly after the hospital receives the court order to allow treatment. It's particularly distressing to see patients with bipolar disorder suffering for months, then seeing them quickly recover, but only after several months of being hospitalized, which on an intensive care psych ward amounts to a form of torture. And the cost to the State is significant, not only in dollars, but in a misused resource that could benefit so many more people if treatment could be sped up. It's exhausting seeing such an obvious fix being unutilized due to the objections of patients not capable of making rational decisions.

Provider #2

Staff are truly saddened by our patient's suffering. The term "compassion fatigue" is a well-known term in the nursing field, and something all of our staff experience at one time because of their compassion for those we care for. Our patients who decline treatment are often one of the greatest contributors to this compassion fatigue. Imagine watching an individual lie in bed

staring at the wall for months, refusing all interventions and interactions. Imagine caring for an individual who has constant hallucinations of people trying to harm them, and will hit and threaten staff unprovoked. Imagine seeing the signs of gradual neuropathy, vision decline, and permanent cardiovascular decline as a patient continues to refuse all medication and treatments due to their paranoia.

What is most painful for staff is knowing that these patients have suffered unnecessarily for so long. It is amazing to see a patient after a few weeks of medication making plans with their family, laughing with staff, and cheering for their favorite football team. Seeing a patient who is no longer fearful of everyone in their environment, and smiles while staff give them a manicure or style their hair. Seeing a patient no longer constantly grimacing from their headaches or nausea that accompanied their refusal of medication for a medical condition they were to paranoid to accept treatment for.

Often these same patients return within the year, and the process begins again. Staff are again hit and threatened on a daily basis by an individual who is having hallucinations that people are attacking her. Overtime, this wears away at some staff as they begin to feel personal failure, fear, and a lack of confidence in the care they are providing to the patient. Sometimes a staff member gets seriously hurt. Unresolvable compassion fatigue sets in and those individuals often choose a different field of healthcare, decrease their hours, retire early, leave healthcare completely, or cannot return at all because of an injury.

Provider #3

I've worked at the hospital for about 7 years, and truly, the most challenging aspect of this work is witnessing patients suffering needlessly. By suffering, I mean the unrelenting anguish of a patient who has a delusional belief that they have murdered their entire family, whose horror and grief is real because their symptomology is so powerful. Patients who are endlessly plagued by cruel voices that tell them that if they take medication they or their loved ones will be killed. Patients who are violent without effective treatment, impacting the treatment of others.

As a hospital clinician, it can be so difficult to sit with the knowledge that our teams each have highly trained doctors who have spent a substantial part of their lives learning and practicing psychiatric medicine, skilled nurses who can effectively administer medication and monitor effects, responsive mental health workers who can offer in-the-moment support, and compassionate social workers to engage in therapy and discharge planning. We have a pharmacy stocked with potential opportunities for wellness. And so often, we just have to wait. Wait and witness the suffering, do what we can to help someone find comfort or safety until the order for involuntary medication is granted. It's better than it used to be, but it's still a wait, and for many patients, that wait is a delay in return to functioning, which is a delay in

returning to family, community, and home. Our goal as a treatment team is to help people return to their communities able to live their lives in a healthiest way possible. I respect that that concept can look very different for a lot of people, and I don't carry the belief that everyone needs to be symptom free to live a full life. However, some of our patients are not able to connect with reality in a way that leaves any room for comfort, contentment, or safety without medication. It can feel difficult to know that relief is available, and that the symptoms of the illness that needs to be treated are what is preventing effective care.

Options

The discussions around involuntary treatment include a vast spectrum of opinions but, without a doubt, a common theme for all is the goal of providing treatment to individuals who require interventions to keep themselves or others safe. DMH believes we must consider the full treatment array including community based, social determinants, therapies, and emergency services to name just a few, to have an effective goal-driven discussion regarding involuntary treatment.

During the process of working on the different sections of the Act 82 reports involuntary treatment has been discussed (including at a DMH-hosted public forum focused on involuntary medication). We know this is a topic we will not achieve agreement on every aspect, but below we will present some ideas or areas of focus we think deserve further discussion. We believe it is important to hear from individuals who have different opinions through a more formal legislative process. We also recognize statutory changes were made in 2014 and that it was a trying process for all involved. However, despite these changes, not all issues were addressed. Some of the continued challenges may be because of statutory requirements but also may be because of human behavior or clinical opinion in response to the statutes.

The first area we would recommend exploring is specific to the forensic population. VT Psychiatric Care Hospital, Rutland Regional Medical Center, Brattleboro Retreat, and Department of Corrections are all experiencing an increase in population of individuals with mental health challenges and criminal offenses. Some of these individuals are found incompetent to stand trial while others are still in the process of a competency determination pursuant to a criminal court orders. And while we can provide treatment to an extent and address some of their mental health issues, we are often challenged by not being able to provide the full extent of treatment options.

Mandate to Treat

Vermont does not have a statutory requirement to restore competency and we were asked to consider this. We are not exploring a restoration to competency statute (although pursuant to your specific request, information about this is included later in this report) but would like to explore a mandate to treat. Below are some options to consider:

1. Reduce timeline for Applications for Involuntary Medications (AIM) in Forensic cases

Patients who are hospitalized through criminal court orders for competency and/or sanity exams (commonly referred to as "forensic patients") often have longer judicial timelines than those hospitalized through family court. Resolving their competency and/or sanity issues can take months. In almost all instances, involuntary medications cannot be requested until the person has been involuntarily hospitalized by order of either the criminal or family court. Resolution of the competency and sanity issues must occur before a hospitalization order is issued. This results in forensic patients, who are often accused of very serious offenses, remaining untreated for months.

DMH believes there are a few ways to try and help this issue.

- Allow AIMs to be filed in family court while competency and sanity is still being determined in criminal court.
- Allow DMH to have party status in criminal court, and then provide a mechanism for the department to seek an expedited hospitalization hearing while the competency and sanity determination continues on a separate track.

The goals of these changes would be to reduce the duration of untreated illness for forensic patients, reduce the rates of seclusion, restraint and staff and patient injuries, and to reduce hospital length of stays. As it would reduce length of stays, it would reduce the wait-time for hospital beds in EDs and DOC.

2. Support DOC in implementing 18 V.S.A. § 7624

   This statutory provision allows DOC to medicate convicted felons in correctional institutions. While we appreciate this would be new and challenging to implement, DMH would commit to working with DOC to address their concerns to allow individuals to continue their medication in correctional settings. This would potentially prevent some inmates from decompensating and requiring repeated inpatient care.

3. Determine a temporary setting for forensic individuals. More information regarding this will be in Secretary Gobeille' s Facilities Report due January 15, 2018.

4. Opening the Forensic Unit within DOC as set forth in language from Act 78 would also support this flow continuum.

Other ideas to explore include:

5. Allow private guardians to consent to psychiatric medications

   Unlike some other states, for example New Hampshire, Vermont guardianship statutes do not allow guardians to consent to psychotropic medications. VPCH has treated several individuals that could be transferred to a more appropriate, less restrictive, level of care more quickly if this consent had been allowed. DMH believes it would be helpful to amend Title 14 to allow a

private guardian to consent to the use of involuntary psychiatric medications by petitioning the court for this specific power. While this is arguably a small group of people, it is an important group.

6. Amend current statutory language regarding expedited motions
   A few years ago, there were modifications made to the involuntary hospitalization and medication statutes that allowed for an expedited motion to be filed 7615(a)(2)(i) if the court finds "that the person demonstrates a significant risk of causing the person or others serious bodily injury as defined in 13 V.S.A. § 1021 even while hospitalized, and clinical interventions have failed to address the risk of harm to the person or others". However, this has been interpreted by courts to be an incredibly high standard needing an actual injury to meet the threshold. This means that a staff member or other patient has likely been harmed and the patient themselves probably received at least one EIP resulting from the incident. It would helpful to clarify this language and make it clear that the provision can be used not just when a patient has become violent, but when there is a clear potential for violence. It is not good treatment nor is it fair to the patient, other patients, and/or staff to wait until there is an actual assault before being allowed to treat the person in the way in which their doctor believes is clinically appropriate.

7. Administrative Option

   Some states, such as New Jersey and Connecticut, approach involuntary medications not through the court system but through an administrative approach. The idea is that independent physicians are making the medical decision around whether someone would benefit clinically from involuntary medications rather than the court. DMH's new director of nursing moved from CT and has shared her experiences with this process. DMH believes this is an area worth exploring given that it assures physicians trained to prescribe medications are making clinical decisions and it results in patients being treated much more quickly when that is the clinically appropriate prescribed course of treatment.

Statutory Directive

To provide the General Assembly with a wide variety of options, the analysis shall examine the legal implications, rationale or disincentives, and a cost-benefit analysis for a statutory directive to the Department of Mental Health to prioritize the restoration of competency where possible for all forensic patients committed to the care of the Commissioner. To provide the General Assembly with a wide variety of options, the analysis shall examine the legal implications, rationale or disincentives, and a cost-benefit analysis for enabling applications for involuntary treatment and applications for

involuntary medication to be filed simultaneously or at any point that a psychiatrist believes joint filing is necessary for the restoration of the individual's competency.

The request in this section contemplates changing statute to add the concept of competency restoration. Competency/sanity evaluations are quite common in Vermont. While historically VPCH had about 30% forensic cases, we have been over 50% for several months and there are no indications this will lessen any time soon. Other facilities also are experiencing an increase in forensics. As discussed above, the judicial timelines for these patients are generally much longer than those committed through the civil process.

In many cases, if someone is found incompetent due to psychosis they are unlikely to resume competency without antipsychotic medication. In 2003 the United States Supreme Court heard a case on this subject, *Sell v. US*.[9] That case established four factors that must be considered when a court is contemplating ordering involuntary medications to an incompetent pretrial detainee. 1) Did the defendant commit a serious crime? 2) Is there a substantial likelihood that involuntary medication will restore the defendant's competence and do so without causing side effects that will significantly interfere with the defendant's ability to assist counsel? 3) is the involuntary medication the least intrusive treatment for the restoration of competency? 4) Is the proposed treatment medically appropriate?

One study did a retrospective record review of all incompetent defendants in the entire U.S. federal court system (N: 132) involuntarily treated under *Sell* over a 6-year period (June 2003-December 2009). Results indicated the majority (79%) of treated defendants suffering from a psychotic related illness were sufficiently improved to be rendered competent to stand trial. The study also found high rates of treatment responsiveness were found across all diagnoses.[10]

One study, from 2016, reviewed various competency restoration programs and outlined a model for best practice competency restoration program.[11] The article listed several elements:

1. Systematic Competence Assessment

   Defendants, upon admission, would undergo a comprehensive assessment to determine the specific reasons for the incompetence, be they psychotic and confused thinking, limited intelligence, mood fluctuations, or brain impairment.

2. Individualized Treatment Program

[9] 539 U.S. 166 (2003).

[10] Robert E. Cochrane, Bryon L. Herbel, Maureen L. Reardon, and Kristina P. Lloyd, *The Sell Effect: Involuntary Medication Treatment Is a "Clear and Convincing" Success*, Law and Human Behavior,107–116 (2013).

[11] Lenore E.A. Walker, ET. AL., *Best Practices for the Mentally Ill in the Criminal Justice System*, Springer Briefs in Psychology: Behavioral Criminology, 51, 51-54 (2016)

Each defendant would have treatment program tailored to her or his specific needs. Deficits identified in the initial assessment would be addressed by specific treatment modalities.

3. Education

A didactic component consisting of education surrounding charges, sentencing, plea bargaining, roles of courtroom personnel, the trial process, and understanding evidence.

4. Anxiety Reduction

Defendants would be taught anxiety reducing techniques to help them deal with the stress of court proceedings.

5. Additional Education for Defendants with Limited Intelligence

If incompetence stems from intellectual deficits, a specific intervention based on the results of an intellectual assessment at the outset would be used. Didactic material may be reviewed a number of subsequent times in individual sessions to address aspects of the group program that were not well understood by the defendant.

6. Periodic Reassessment

Each defendant would be reassessed on at least two occasions, focusing on the individualized treatment modules to see whether progress is being made.

7. Medication

For those defendants whose incompetence is based on psychosis or mood disorders, appropriate medications would be prescribed and regularly monitored. Medication reassessment would coincide with the periodic reassessment of competence to see if the pharmacotherapy needs to be altered.

8. Assessments of Capacity

A procedure would be created to set in place for the assessment of competency to make treatment decisions, especially when medication is involved.

9. Risk Assessment

Because some defendants who are un-restorable need to be evaluated for involuntary commitment, there needs to be a standard protocol for assessing risk of future violence using empirically based instruments.

DMH's General Counsel and Medical Director have reached out to forensic psychiatrists and attorneys in the neighboring states of MA and CT to better understand how they developed and now administer competency restoration programs in their states. DMH is happy to provide an update on these discussions during testimony on this section.

As for the cost-benefit analysis requirement we understand the intent to better recognize the impact of statutory changes on the cost of services delivered, however we have not viewed this as a financial discussion but about appropriate treatment. We are interested in that outcome of a cost-benefit analysis, but first and foremost we are committed to assuring appropriate and effective treatment, therefore if there were savings we would propose redirecting those resources to other evidence based and effective treatment options for people to reduction or eliminate the need for involuntary treatment. Furthermore, to do an accurate cost benefit analysis we would need more time and consultation from experts in analyzing claims, reviewing service level data, doing time studies with other entities such as courts and gather other important factors to draw any conclusions regarding savings.

Request for Information

On or before November 15, 2017 the Department shall issue a request for information (RFI) for a longitudinal study comparing the outcomes of patients who received court-ordered medications while hospitalized with those of patients who did not receive court-ordered medication while hospitalized, including both patients who voluntarily received medication and those who received no medication, for a period from 1998 to the present. The request for information shall specify that the study examine the following measures:

(A)the length of an individual's involuntary hospitalization;

(B) the time spent by an individual in inpatient and outpatient settings;

(C) the number of an individual's hospital admissions, including both voluntary and involuntary admissions;

(D) the number of and length of time of an individual's residential placements;

(E) an individual's success in different types of residential settings;

(F) any employment or other vocational and educational activities after hospital discharge;

(G) any criminal charges after hospital discharge; and

(H) other parameters determined in consultation with representatives of inpatient and community treatment providers and advocates for the rights of psychiatric patients.

Request for information proposals shall include estimated costs, time frames for conducting the work, and any other necessary information.

DMH has received three responses to the RFI: one from Hornby Zeller Associates from Troy, NY; one from ICF Macro, Inc. from Fairfax, VA; and one from Flint Springs from Hinesburg, Vermont.