



Flint Springs

An Independent Study of
the Administration of
Involuntary Non-Emergency
Medications
Under Act 114
(18 V.S.A. 7624 et seq.)
During FY 2016

Report to the Vermont General
Assembly

Submitted to:

Senate Committees on Judiciary
and Health and Human Services

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and Human Services

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EXECUTIVE SUMMARY

The Vermont statute governing administration of involuntary nonemergency psychiatric medications to clients of the public mental health system committed to the care and custody of the Commissioner is 18 V.S.A. 7624 et seq – referred to in this report as Act 114. The statute requires two annual assessments of the Act’s implementation, one conducted by the Department of Mental Health (DMH) and a second conducted by an independent reviewer. The following report summarizes Flint Springs Associates’ independent assessment, providing a review of implementation during FY16 (July 1, 2015, through June 30, 2016).

This report examines implementation of Act 114 at designated hospitals responsible for administering involuntary psychiatric medications under Act 114 during FY16.

During FY16, DMH reported that 88 petitions were filed requesting orders for nonemergency involuntary medication under the provisions of Act 114 for 74 different individuals. Petitions were sought by physicians at the hospitals designated to administer the medications and sent through the Attorney General’s DMH office to the court. Of those 88 petitions, 66 (74%) were granted, 16 (18%) were withdrawn, and six (7%) were denied.

In compliance with statutory requirements for the annual independent assessment, this report provides information on:

- Implementation of Act 114
- Outcomes associated with implementation of the statute
- Steps taken by the Department of Mental Health to achieve a mental health system free of coercion
- Recommendations for changes

Key Findings

Among the findings, this year’s assessment found that:

- Based on documentation review and interviews, staff at four of the designated hospitals-- the Brattleboro Retreat, University of Vermont Medical Center (UVMHC), Rutland Regional Medical Center (RRMC) and Vermont Psychiatric Care Hospital (VPCH)
- --demonstrated full implementation of the provisions of Act 114 in the administration of involuntary nonemergency psychiatric medication. Several files at the Retreat were missing documents, an issue the Retreat is aware of and seeking to resolve. The fifth designated hospital, Central Vermont Medical Center (CVMC), had no Act 114 orders during FY16 and thus no documents were reviewed there.
- An interview with the judiciary revealed that psychiatrists new to the Vermont mental health system are not fully knowledgeable about information required in Act 114 applications.
- Hospital staff feel that the process leading to involuntary medication should move as quickly as possible, while protecting patients’ rights. They believe that individuals for whom Act 114 petitions are filed suffer on many levels when not receiving psychiatric medication as soon as possible.

- As in past years, Vermont Psychiatric Patient Representatives and lawyers from Legal Aid/Mental Health Law Project (MHLP) and Disability Rights Vermont (DR-VT) believe that applications for involuntary, nonemergency court-ordered medication are filed too quickly and used more frequently than in past years. They believe that hospital staff should take more time to work with patients to explore and employ a wider range of approaches that respect patients' concerns and lead to their recovery.
- On average, all the patients under Act 114 orders in FY16 were discharged from psychiatric inpatient care about three months after the Act 114 order for medication was issued. In comparison, the average length of stay for patients without Act 114 medication, across the five hospitals, was 47 days (about 1.5 months).
- Responses from individuals who received medication under Act 114 and agreed to be interviewed for this annual assessment were mixed in terms of how they perceived the experience of receiving involuntary medication. The majority of individuals described the experience of receiving medication as coercive; however, all continued to take medication whether currently hospitalized or living in the community.
- None of the individuals interviewed who were hospitalized during FY16 reported that they were not offered a support person, while three persons said they were offered some emotional support around receiving medication. Some of the individuals who were interviewed reported they knew the name of the medication that was ordered, but all said they did not get information about the dosage or possible side effects.
- In terms of the degree of control people felt they had, three of the six persons interviewed who received medication under Act 114 during FY16 said they were given a choice of whether to take the medication orally or by injection. One person reported that his request to receive medication at a certain time of day was granted.
- All individuals interviewed have continued involvement with mental health services in the community and have continued taking psychiatric medication. The majority of individuals report that their current medication helps them function better in the community.

Recommendations

Flint Springs Associates offers the following recommendations:

Hospital Practices

FSA recommends that staff at hospitals administering Act 114 medication continue efforts to help patients understand the reasoning behind the decision to seek an order for involuntary medication and to invest time in talking with patients about the process and available options.

In order to make it easier and less stigmatizing for patients to attend Act 114 hearings, each hospital should create a "real" courtroom in a location outside of the patient's ward and lawyers should ensure that patients are asked directly if they want to attend the hearing.

All hospitals should include the patient representative in treatment team meetings, with consent of the patient, in an effort to support both patients and staff toward achieving recovery in the least-coercive manner.

Patient representatives should be able to access information as to where people are located in the system and whether they are receiving Act 114 medication or applications have been filed under Act 114. This would help patient representatives reach out to more people.

In order to maintain clear records for documenting implementation of Act 114 in accordance with provisions of the statute, FSA recommends that each hospital maintain a separate file or section within the file for persons receiving medication under Act 114. This file should contain:

- Copy of court order
- Copy of Patient Information Form
- Copies of every Implementation of Court-Ordered Medication Form
- Copy of 7-day reviews – Hospitals should use a specific 7-day review form, rather than progress notes, to ensure that three specific issues are addressed: continued need for involuntary medication, effectiveness of medication, and side effects of the medication.
- Copies of Support Person Letter, if used
- Copies of certificate of need (CON) or other documentation of emergency procedure, if needed
- Summary of medications based on court order
- Specific time line of court order based on language of court order

Training

- DMH should provide training for psychiatrists new to the state mental health system focused on identifying the type of information required in applications for Act 114 medication.

Statutory Changes

As noted in past assessment reports, the statute requires two separate assessments of Act 114 implementation, one by DMH and one by independent contractors. In practice this means that information is gathered twice, often requiring hospital staff, and more significantly patients, to participate in somewhat duplicative interviews and surveys. FSA recommends that the legislature consider requiring only one annual assessment conducted by an independent evaluation team.

The legislature should clarify the purpose of its request that the independent assessment offer interviews to persons for whom an Act 114 petition was filed but not granted. In addition, the legislature should define the time period for which it seeks this information (e.g., the FY under review only or additional years).

Annual Act 114 Assessment

FSA recommends that the following steps continue to be used in future assessments of Act 114:

- The annual assessment should require research on the use of involuntary, court-ordered, nonemergency medication to identify:
 - Outcomes for people who engage in treatment involuntarily versus voluntarily
 - Outcomes for people who take long-term medication versus short-term medication
 - Alternatives and complements to involuntary medication

- Provide a financial incentive for the participation of individuals who have received court-ordered medication.
- Request input from individuals through extensive outreach efforts to any person who received medication under Act 114 in previous years, not just the year under review, in order to learn about longer-term outcomes including individuals' engagement in treatment and their lives in the community as well as experiences receiving medication under Act 114 orders.
- Ask persons interviewed if they would like any family members to be interviewed and pursue these as permitted.
- Use the same source of data on dates of admission, commitment, petition and court orders for both the Commissioner's assessment of Act 114 implementation and the independent assessment.

INTRODUCTION

The Vermont statute governing administration of involuntary nonemergency psychiatric medications to clients of the public mental health system committed to the care and custody of the Commissioner is 18 V.S.A. 7624 et seq. The statute requires two annual assessments of the act's implementation, one conducted by the Department of Mental Health (DMH) and a second conducted by an independent reviewer. This report will refer to the statute as Act 114. Implementation of Act 114 commenced in late 2002.

This independent assessment report provides a review of implementation during FY16 (July 1, 2015, through June 30, 2016). The report also summarizes feedback from individuals who chose to be interviewed and who received medication under Act 114 between January 2003 and June 30, 2016, as well as from one person on whom an application was filed but denied by the court.

As a result of the petitions filed during FY16, court orders for administration of involuntary nonemergency psychiatric medication under the provisions of Act 114 were issued for 58 individuals.

Prior to August 2011, all persons receiving involuntary nonemergency psychiatric medication were hospitalized at the Vermont State Hospital (VSH) at the time of the court order and receipt of medication. On August 28 of that year, Tropical Storm Irene flooded the Waterbury State Office Complex that housed VSH and other departments of state government. For most of FY12 through FY14, patients with acute needs who otherwise would have been referred to VSH, now designated as Level I patients, were served by the University of Vermont (UVM) Medical Center, previously Fletcher Allen Health Care, the Brattleboro Retreat and Rutland Regional Medical Center (RRMC). In FY13, the Department of Mental Health (DMH) opened the Green Mountain Psychiatric Care Center (GMPCC) in Morrisville to serve patients while the new psychiatric hospital was under construction; GMPCC became the Vermont Psychiatric Care Hospital (VPCH) and moved to its permanent location in Berlin in July 2014. At that time UVM Medical Center stopped serving Level 1 patients but continued to provide medication under Act 114. During FY15, Central Vermont Medical Center (CVMC) was designated to administer medications under Act 114. The Commissioner of Mental Health has thus designated these five hospitals responsible for administering involuntary psychiatric medications under Act 114 through FY16.

This report, in compliance with statutory requirements for the annual independent assessment, provides the following information:

Section 1: The performance of hospitals in the implementation of Act 114 provisions, including interviews with staff, interviews with judges, lawyers and peers, review of documentation, and interviews with persons involuntarily medicated under provisions of Act 114.

Section 2: Outcomes associated with implementation of Act 114.

Section 3: Steps taken by the Department of Mental Health to achieve a mental health system free of coercion.

Section 4: Recommendations for changes in current practices and/or statutes.

Flint Springs Associates (FSA), a Vermont-based firm advancing human-services policy and practice through research, planning and technical assistance, conducted this assessment. Flint Springs' Senior Partners, Joy Livingston, Ph.D., and Donna Reback, MSW, LICSW, gathered the required information, analyzed the data, and developed recommendations reported here.

Section 1: Performance Implementing Provisions of Act 114

During FY16, 88 petitions were filed requesting orders for nonemergency involuntary medication under the provisions of Act 114 for 74 different individuals. Petitions were sought by physicians at the hospitals designated to administer the medications and sent through the Attorney General’s DMH office to the court. Of those 88 petitions, 66 (74%) were granted for 58 individuals, 16 (18%) were withdrawn, and six (7%) were denied. Table 1 provides information on the number of petitions for court orders that were granted, denied or withdrawn over the last five fiscal years of Act 114 implementation. “Other” court decisions include dismissal of the case, discharge of the patient by the court, or appeals brought by patients. In most years, the vast majority of petitions were granted; during FY13, more petitions were withdrawn, primarily because individuals began to take medication voluntarily, thus bringing down the proportion of granted petitions. The number of petitions and individuals affected by Act 114 rose noticeably in FY14, and continued to rise into FY16.

In FY16, the designated hospitals’ psychiatric units served a total of 510 individuals; the 58 individuals who received medication under Act 114 represented 11% of the hospital patients served.

Table 1: Court Decisions for Cases Filed during Last Five Fiscal Years

| Court Decision | FY of Petition Filing Date (7/1 to 6/30) | | | | | | | | | |
|-----------------------|---|------|------|------|------|------|------|------|------|------|
| | 2012 | | 2013 | | 2014 | | 2015 | | 2016 | |
| | Freq | % | Freq | % | Freq | % | Freq | % | Freq | % |
| Granted | 28 | 63% | 32 | 76% | 55 | 80% | 56 | 74% | 66 | 75% |
| Denied | 1 | 2% | 2 | 5% | 2 | 3% | 6 | 8% | 6 | 7% |
| Withdrawn | 15 | 33% | 8 | 19% | 11 | 16% | 6 | 8% | 16 | 18% |
| Other | 1 | 2% | 0 | 0% | 1 | 1% | 8 | 11% | 0 | 0% |
| Total | 45 | 100% | 42 | 100% | 69 | 100% | 76 | 100% | 88 | 100% |

Updates on Hospitals’ Structure and Policies Related to Act 114

FSA senior partners, Joy Livingston and Donna Reback, conducted site visits at each of the designated hospitals responsible for administering involuntary nonemergency psychiatric medication under Act 114 in FY16. During those site visits, interviews were conducted with administrative staff as well as psychiatrists, nurses, social workers and psychiatric technicians. Initial interviews with leaders focused on changes in hospital facilities, staffing, and procedures relative to implementation of Act 114. Results from these initial interviews are summarized below.

Brattleboro Retreat

During FY16, there were changes in several key leadership positions including the chief medical officer, director of adult intensive services, and nursing. A new position was created, Director of Consumer Advocacy, to handle patient concerns and grievances. The person in this role has a clinical background and is on units daily to work directly with patients.

As part of its efforts to implement the Six Core Strategies for reducing seclusion and restraint, staff received training in a number of areas including trauma-informed care and suicide risk

assessment. In addition, the Committee of the Whole (COW) meets weekly to address quality-of-care issues, including nonemergency use of psychiatric medication. A new performance improvement data management system was instituted in FY16, enabling the COW to track trends in the use of medication as well as seclusion and restraint.

During FY16, the Retreat piloted the use of the electronic health record to capture the 7-day psychiatrist review for patients under Act 114 orders. The pilot was successful, and in FY17 these reviews will be captured electronically.

Central Vermont Medical Center

CVMC did not have any new patients during FY16 under Act 114 orders. This is not surprising since CVMC does not admit Level 1 patients but, rather, requires patients to be “willing to engage in active treatment,” which includes willingly taking medications. In FY15 CVMC served one patient under Act 114 orders, but this was unusual.

The hospital has been involved with the Six Core Strategies to reduce seclusion and restraint. This has included staff training, a Behavioral Support Team that assists throughout the hospital, and an Emergency Department transitional care area. The ED transitional care area offers a safe space for patients and staff separate from the rest of the ED, and it enables patients to receive some forms of treatment while waiting for psychiatric beds.

As a result of the work on Six Core Strategies, CVMC has seen a significant reduction in involuntary emergency procedures (IEP) – including many months without any IEPs. From April 2016 through the end of July 2016, there were two IEPs, both with the same patient.

Rutland Regional Medical Center

RRMC also continues to implement the Six Core Strategies for reducing the use of seclusion and restraint, including staff training in trauma-informed care. RRMC has seen “tremendous progress” in reducing seclusion and restraint and in engaging patients. During FY16, Vermont Psychiatric Survivors (VPS) had a patient representative regularly present on the units. The more regular presence of VPS has had a positive impact on helping patients access a range of services.

UVM Medical Center

UVM Medical Center engaged in the implementation of Six Core Strategies as well; some staff received training in FY15, with more staff doing so in FY16. All new staff receive training in ProACT.

As of July 1, 2014, after the opening of the Vermont Psychiatric Care Hospital serving high-acuity psychiatric patients, UVM Medical Center stopped serving Level 1 patients without an Act 114 order. During FY16, the hospital did serve one Level 1 patient who needed medication but was not aggressive and therefore did not present as much of a challenge to the overall acuity level on the unit.

Vermont Psychiatric Care Hospital

VPCH leadership reported there has been a frequent turnover in psychiatrists on staff. Otherwise, there have not been any notable changes that might have an impact on the implementation of Act 114 orders.

Staff Feedback on Implementing Act 114 Protocol

The following section summarizes findings from interview questions focused on implementation of Act 114 provisions.

Act 114 Implementation Training

Staff members receive both formal and informal training on the provisions of Act 114. Training has been provided to nursing staff at four of the hospitals as part of their orientation and annual mandatory training. At RRMC, Act 114 provisions are reviewed annually and included in annual competency testing of staff. Documentation forms also served as a training tool in all of the hospitals; the forms' questions outline required protocols. Staff also report learning about Act 114 on the job through knowledgeable physicians and other staff.

Decision to File Application for a Court order

Decisions to pursue an order for involuntary medication are ultimately the responsibility of the treating physician. Staff at the designated hospitals report that the decision grows out of daily multidisciplinary treatment team meetings based on an assessment of a person's needs, history, treatment options, and responses to treatment efforts. All staff work to give an individual the opportunity to take medication voluntarily before a decision is made to seek an order for involuntary medication. If the patient is well known to the treatment team from previous admissions, the decision to file an Act 114 petition may be taken more quickly. A decision first has to be made to seek involuntary treatment through a commitment order. Although the statutory change taking effect in FY15 allows the Act 114 petition to be heard at the same time as commitment petition, staff all report that this provision applies in very limited circumstances and has not been applicable for most patients. Indeed, some staff raised concerns that judges commit persons to the hospital but deny applications for involuntary psychiatric medication.

Patients' Rights

Physicians are primarily responsible for informing patients that an Act 114 petition has been filed and an order granted. Staff at all hospitals report that the physician informs the patient about the order and medication that will be administered; however, members of the treatment team regularly talk with patients about medications both prior to and after the order. The treatment team also informs patients of their rights – including encouragement to contact Legal Aid, sometimes assisting with making the phone call.

Representatives from Disability Rights Vermont (DRVT), Vermont Psychiatric Survivors (VPS), and Vermont Legal Aid visit hospitals at least once a week. Written information about rights, along with contact information for DRVT, VPS, and Legal Aid, is provided to patients. UVM Medical Center offers a UVM Medical Center Patient Advocate in addition to those offered by DRVT and VPS. RRMC staff report that the presence of Vermont Legal Aid, VPS, and DRVT gives patients a helpful third party to talk with about their rights.

Capturing a concern raised by many designated hospital staff, one staff member noted: "Our approach to patients' rights ends up impinging on rights. We are restricting autonomy and freedom by NOT allowing medication. We seem to see it as more unjust to medicate unwillingly than to hold someone in a psychiatric hospital unwillingly."

Sense of Control

In response to a question about increasing patients' sense of control when receiving medications involuntarily under an Act 114 order, staff at all hospitals talked about providing as much choice as possible within limited parameters. This includes choice on the time of day and the location (e.g., a patient's own room or elsewhere) to take medications. Sometimes patients may choose the specific medication or work with their physician on specific doses. Medications are always offered orally first, and staff offer as much education on medications as possible. Patients are also reminded that they have a right to a support person, who can be a staff person if the patient wishes. If a patient prefers to receive medications from a particular nurse, every effort is made to have that staff member present.

Staff in several hospitals said that they validate how unhappy patients are about the situation and the loss of control. For example, RRMC staff said they "validate that we know they don't want to take it [court-ordered psychiatric medication] and acknowledge that the patient is taking medication because it was ordered by a judge."

Alternatives to Medication

Hospital staff were asked about strategies they use as alternatives to medication prior to filing and receiving an Act 114 order. All hospitals provide opportunities for activities, therapies, and continued conversations about the value of medications.

The Retreat has a low stimulation area and a range of programming and activities. RRMC has a sensory modulation cart, an outdoor space, movies, tablets, music and a comfort room. VPCH gets patients outside and off the unit, offers activities such as movies and music, and gives patients many opportunities to talk about their feelings individually and in groups.

Benefits of Act 114

The primary benefit cited by most hospital staff was patient recovery. Comments about patient recovery included:

- *"Getting them to take medication would make their stay shorter, let them get out, have a life, get on with it."*
- *"Without medication, some patients wouldn't be able to return to [the] community."*
- *"Medication allows people to recover family involvement/repair relationships."*

Staff also noted that Act 114 "makes requirements and process of administration consistent across all institutions." Staff felt that there "needs to be a 'check' in place," and Act 114 requires ongoing review through the assessment.

Challenges Posed by Act 114

The staff from all hospitals designated in FY16 echoed the same sentiment staff expressed last year and in every year in which Act 114 has been administered: the primary challenge Act 114 poses is the time it takes to treat individuals suffering from mental illness. For example:

- *“Lives being shattered until they are stabilized.”*
- *“Length of time to get patient better – hear this from families, patients (once they are better) and from other patients who live on the ward with them --- Once patient begins getting well, they begin to feel so badly about how disruptive their behavior was to other patients.”*
- *“People shouldn’t have to be/get to being violent to get to medication.”*
- *“It takes too long – we’re watching patients degrade and not benefiting them with anything. The longer it takes to bring them back to a baseline that they never can achieve again.”*
- *“With someone who is 50, with history, with our knowledge of what works, it’s just not right to let them have so much time to decompensate.”*

Staff across hospitals identified concerns about delays in administration of medication:

- Impact on other patients and staff:
 - Creates a disruptive, nontherapeutic milieu -- *“Leads to anger issues for all of the patients.” Difficult for (other) patients to heal in this situation where one person is so ill and disruptive.*
 - Jeopardizes safety for other patients and staff – *“When you work in environment where you do feel safe will make it difficult for staff to interact effectively with this/other patients.”*
 - Emotional and verbal abuse from one patient may institute trauma in other patients.
- Impact on patients’ recovery
 - Less ability to “bounce back” the longer the delay -- *“The longer it takes to bring them back to a baseline that they never can achieve again.”*
 - *“When patients are stabilized, many may be horrified when they learn what they did when they were off their medications. Another burden they have to carry with them when they walk out the door.”*
 - *“It is clearly documented that when people are having another psychotic crisis a wait to get medication and the frequency of prior crises leads to our contributing to deterioration.”*
 - *“We have patients who are angry that they didn’t get medication sooner, and could have been released from hospital sooner.”*

Staff noted a number of factors contributing to the delay in receiving court orders. These factors included:

- In most cases, a commitment hearing must still be held before a hearing on Act 114 medication. *“The criteria for coupling application for commitment with medication is [sic] too narrow.”*
- Advice from defense attorneys may delay receipt of medications -- *“When attorneys tell patients the week before the court hearing to take meds, then the hearing is extended*

because the person is taking meds (i.e., they are compliant) then the person stops when the hearing doesn't take place," and the application process is repeated.

- Court scheduling can impact timing, particularly when the court hears Act 114 petitions on only one day of the week – if that day is a holiday or the judge is not available, the hearing date will be moved forward at least a week.

Several physicians and other staff were concerned that the process puts medical decisions in the hands of judges. Comments included:

- *"The doctor is limited to [a] small number of medication options that have injection back-ups – dosage may be limited and may not be adequate amount – so there are certain medications that fit into that category."*
- *"Judges are making dosage/medication decisions."*
- *"Different interpretations of the law by different judges leads [sic] to them making medical decisions. Some judges make decisions about dosage."*
- *"The Judiciary is playing the role of physician."*

Staff Recommendations

The primary recommendation offered by hospital staff was to streamline the legal process so that it takes much less time to obtain an Act 114 order. A number of suggestions for reducing the time delay from admission to administration of medication, including

- Combine commitment and Act 114 hearings for all patients, not just a select few.
 - *"Decreasing threshold for combined hearing."*
 - *"Would be useful to expand, widen the criteria for coupling commitment and medication hearings."*
- Use information on patient's history to expedite the process:
 - *"We have repeat patients that need the same medication they've taken before."*
 - *"Look at record of patient's refusal and make that record available to the court -- expedite the process for those persons where the history is that taking medication has been beneficial."*
 - *"If the patient has an outpatient treatment team, that should be valid reason to medicate someone quickly."*
- Reform the use and enforcement of orders of nonhospitalization (ONH):
 - *"Documentation from other providers, an ONH, that should be enough to show a judge."*
 - *"If the ONH is still active and person comes in for inpatient care, the Designated Agencies (DA) should be able to get an order to put them back on meds (while they are at the hospital)."*
 - *"Implement Act 114 order as soon as possible if the individual is admitted to the hospital with an ONH."*
 - *"Allow for medications under Act 114 to be administered in the community. Order begun [as] inpatient should be continued into community."*
 - *"Avoid the cycling: get meds on Level 1, go into mid-level community setting, stop taking meds and end back up in ED. No mechanism to require them to use med, except ONH that is not enforceable. Need a mechanism that is enforceable to keep people taking meds."*

- *“Enforcement of the ONH - Not taking medication when on ONH is not a reason to bring someone in. Legislation should back up, give designated agency authority to medicate/versus do nothing.”*

Other recommendations include:

- Allow physicians to have all medications available rather than being limited to one or two allowed by the court – *“if neither of those work, need to go back to court/seek new order.”*
- Provide more inpatient beds for a range of patients: level 1, forensic, geriatric and children. At present patients in these groups often wait for beds tying up the ED beds that could be used by others.
- Increase the number of transitional step-down beds in the community.
- Improve the connection between a first-time inpatient with DA’s Community Rehabilitation and Treatment (CRT) teams and physicians so that individuals returning to the community after a first-time hospitalization have immediate access to CRT services and the DA’s physician.

As one staff member summarized: *“If medication laws change, we still need to provide the whole range of approaches; treatment is not just medication.”*

Interviews with Judges, Legal Services and Patient Representatives

This year, following up from interviews conducted during the prior four studies, we interviewed two judges, lawyers from the Mental Health Law Project (MHLP) and Disability Rights Vermont (DRVT), and patient representatives from Vermont Psychiatric Survivors (VPS) in order to learn from their perspectives:

- What is going well in relation to implementation of Act 114?
- What challenges exist in relation to implementation of Act 114?
- What could be done to improve the implementation of Act 114?

What is going well in relation to implementation of Act 114?

MHLP notes that the statute enables patients to receive high-quality legal representation from those who are specialists and experts in this area of law. This enables patients to challenge applications and have evidence presented to the court on their behalf thus giving them a voice in response to what the state's psychiatrist is seeking.

Because cases are concentrated in just a few courts the judges tend to know quite a bit about the subject as they have developed a level of expertise. This also creates a reasonable expectation that Act 114 cases will be heard and judged fairly.

From the judicial perspective, there is a sense that the legal process for ruling on Act 114 applications has speeded up as a result of changes in the law requiring that findings of probable cause be made within seventy-two hours of filing the application. This should have a positive impact on situations in which people may be waiting too long, especially in hospital Emergency Departments, before receiving a hearing.

Attorneys for the two sides demonstrate a willingness to agree on scheduling hearings as well as allowing delays of hearing in cases in which an individual is making progress. While they are properly confrontational on procedural matters, they work well together.

From the patient representatives' perspective, things are going well when an application has not been granted. In essence, denials of applications demonstrate that the act of filing an application for Act 114 medication is not and should not be automatically equated to a patient receiving court-ordered involuntary medication.

What challenges exist in relation to implementation of Act 114?

Lawyers from DR-VT noted first that a shortage of beds in psychiatric units around the state has had a negative impact on clients in numerous ways. First people are being held in Emergency Departments for days or weeks while the mental health system is seeking a psychiatric bed. In this situation, there is little chance an individual would get to see a psychiatrist immediately, allowing a situation to escalate and in the longer term making it harder for a patient to make his/her own decision to take medication versus having to receive medication involuntarily. From the legal services perspective, this has contributed to more petitions being filed and does not lead to building positive relationships between the doctor and patient.

Lawyers also report that they see lots of people under involuntary medication orders who aren't getting better and would concede that in some cases getting an individual onto medication would be what makes the difference in helping that individual get into a different mental state. One lawyer, however, hypothesized that doctors and staff are not reporting when their patients

regain capacity to make health care decisions because that would mean the end of continuing medication orders for those individuals.

MHLP verifies the increase in the number of applications filed and granted and believes this is a real concern but assumes the state doesn't share that view. This is concerning as the increase in filings demonstrates that actual practice in Vermont is at variance with state's desire to get away from coercion in the mental health system. Lawyers feel that the state's psychiatrists really do not consider overriding a patient's will by seeking an Act 114 order a problem and view this as the state's first, not last, line of action.

The increase in numbers of filed applications makes it harder to provide legal services as legal resources are limited. As an example, MHLP points out that it is nearly impossible to find psychiatrists in the southern part of state to consult and provide independent exams on these cases.

From the judicial perspective, things work well in general regarding hearings on Act 114 applications. That said, judges do face some challenges. In the case of persons with mental illness who have cycled in and out of hospitals, have been under an ONH in the community and then gone into crisis as a result of stopping medication, changes in the law allow applications for involuntary treatment (AIT) and Act 114 medication to be filed at the same time. However, applications for AIT and Act 114 medication frequently are filed in different locations (e.g., the AIT may be from Chittenden County, where the person was first brought to a hospital, and the petition for involuntary medication from the current hospital, perhaps in Washington County, where the patient is being held and where the judge receiving the applications is sitting), so that a judge may receive the 114 application before the AIT application. In order not to violate a patient's civil rights, detailed information in the Act 114 application should not be considered by a judge until a commitment hearing that meets legal standards (i.e., sworn testimony, cross-examination) takes place.

Another challenge to ensuring that a patient's civil rights be upheld can result from inadequate efforts to ensure that a patient has been given every chance to attend the Act 114 hearing. Taking the word of hospital staff that a patient does not want to attend a hearing, or where a hearing held outside of the hospital results in the transport of an individual in shackles to the court are examples of situations that need to be avoided.

From the judicial perspective, additional training, both for judges and for psychiatrists, is needed. A number of Act 114 applications come to judges sitting in counties away from the location of the five hospitals where court-ordered, nonemergency involuntary medication can be administered and where a regular mental health docket exists. As these judges and their courts deal infrequently with these cases, they may not be clear about what to do with the applications. Ongoing training through the Trial Operations arm of the court is needed to ensure that court staff understand that:

- these cases need to be addressed essentially on an emergency basis
- once an application is filed, they need to make sure it is followed up in a timely manner

One judge questioned whether new psychiatrists had received an orientation to court standards. She has observed that newer psychiatrists do not seem to understand what information the court needs in the Act 114 application and, as a result, judges lack needed information. As a specific example, when the state has to prove "dangerousness" newer doctors may rely on staff reports about various incidents that happened in the hospital but those doctors may not have been present as direct witnesses to what happened. The court cannot rely on hearsay evidence of this kind.

The judge also observed that, in practice, psychiatrists always ask for authority to administer at least two psychiatric medications and two medications to address known side effects of the psychiatric drugs. In her estimation, this is a reasonable practice for applications on new patients for whom nothing is known about their history and response to medication. For patients with a known history of effective medication, however, this practice raises the question of why the court is being asked to authorize an alternative medication with no demonstrated need. From a legal point of view the court should be interfering as little as possible.

From the perspective of the VPS patient representatives, it seems rare that an Act 114 application is not granted, making the filing of an application akin to automatic administration of involuntary medication. With this in mind, representatives say they are not given information about the outcomes of hearings and, unlike their former role at the Vermont State Hospital when it was open, they play a very limited role in treatment planning activities in any of the hospitals. Unless a patient requests their presence at treatment team meetings, they are not included in hospital team efforts to work with patients, present alternatives and monitor and encourage the use of best practices. At neither the Retreat nor RRMC have they been invited into treatment team meetings. They report having no way of knowing about and therefore no way of responding with alternatives to proposals on use of medication. Specifically, they are concerned that administration of medication under the provisions of Act 114 may be habitually exceeding U.S. Food and Drug Administration (FDA) recommended daily dosages. While MHLP responds to the court case, the patient representatives feel that once an application is approved there is no legal review or oversight of how people are medically treated.

Finally, from their perspective, there is frequent co-morbidity in patients taking psychiatric medication, as evidenced in the emergence of serious, chronic physical conditions and symptoms related to tardive dyskinesia. It is their belief that although psychiatric medication may have a short-term impact on allaying symptoms of mental illness, over time it is not effective and has long-term damaging consequences for individuals.

What could be done to improve the implementation of Act 114?

Suggestions from lawyers: Lawyers from DR-VT feel that the use of involuntary, court-ordered, nonemergency medication should be informed by long-term studies intended to identify:

- outcomes for people who engage in treatment involuntarily versus voluntarily
- outcomes for people who take long-term medication versus short-term medication
- alternatives and complements to involuntary medication

From the legal perspective, there is no current evidence that Vermont is working towards a system free of coercion. The state should not compromise a person's due process rights. The issue of one's capacity to make medical decisions is central to their rights. Legally doctors can't give a patient medication without informed consent. Therefore, if a doctor thinks a patient is so sick so that s/he cannot provide informed consent "because you aren't in your right mind," then a guardian should be appointed to make medical decisions.

Access to a robust community mental health system in Vermont would decrease the demand for Act 114 medication and hospital beds. For those in need of hospitalization and court-ordered medication, more community mental health resources would reduce the pressure to discharge patients quickly. In the absence of nonhospital alternatives there are people backed up into Emergency Departments, people in hospitals who don't need to be there, people stuck in hospitals beyond the amount of time needed to regain stability.

The mental health system should give serious thought to the long-term effects of receiving involuntary medication. The overall ideology of the system continues to uphold the practice of hospitalizing and medicating, thus creating dependence on medication for the rest of one's life despite any evidence, in the opinion of lawyers interviewed, that this leads to a high quality of life for people with mental illness.

Suggestions from judges: Judges suggest that court proceedings related to Act 114 be filed in a centralized place for the entire state. Centralization of information would address the frequent movement and transfer of individuals from their county of residence to hospitals and community treatment organizations in different locations and allow the court to have timely access to filings for both AIT and Act 114. A centralized filing place would:

- reduce the number of hearings that people subject to hearings would have to attend
- reduce the amount of time and staff required
- result in a coordinated docket that would let judges know that an AIT had been filed elsewhere.

Attorneys on both sides are totally in favor of this proposal but current technology in Vermont is not adequate to support the needed electronic docket.

In terms of training needs, the court should engage in training for judges and court staff in locations that infrequently receive Act 114 applications. The state should provide training for psychiatrists new to the state mental health system focused on identifying the type of information required in applications for Act 114 medication.

Finally, in order to make it easier and less stigmatizing for patients to attend Act 114 hearings, each hospital should create a "real" courtroom in a location outside of the patient's ward and lawyers should ensure that patients be asked directly if they want to attend the hearing.

Suggestions from Patient Representatives

In order to reduce the revolving door that many individuals experience (i.e., involuntary medication, discharge to community, stop medication "because it is intolerable", crisis, return to hospital) efforts should be made to increase community support for people wanting to come off medication safely. Slowly, with doctor supervision, community supports could prevent dramatic crises. Holistic doctors and nurse practitioners not associated with the designated agencies should be included as resources. Additionally, educated peer support services should be available to individuals to help them address mistrust of the mental health system. In the opinion of one patient representative, the courts should "sunset a ruling" when it proves to be ineffective in getting someone out of the hospital.

For people who do not want to take medication, community supports should:

- Exhibit patient-centered principles and practices
- Expand peer-run respites which can provide an opportunity to be somewhere supportive and safe
- Allow time to explore alternatives
- Use therapies and programs such as Hearing Voices Network and cognitive therapies and Open Dialogue
- Encourage more involvement from friends and family

In order to be proactive in providing greater support to those persons hospitalized and receiving Act 114 medication, the hospitals should provide patient representatives with information

about the patient, the representatives should be notified in a timely manner of when treatment team meetings are scheduled and the place, and they should be invited participants in those meetings.

Review of Documentation

The Act 114 statute requires the Department of Mental Health to “develop and adopt by rule a strict protocol to insure the health, safety, dignity and respect of patients subjected to administration of involuntary medications.” VSH had in place a protocol and set of forms intended to guide its personnel in adhering to the protocol, including written, specific, step-by-step instructions that detailed what forms must be completed, by whom and when, and to whom copies were to be distributed. As other hospitals took on responsibility for administering medication under Act 114, they utilized the forms VSH had developed. Forms included:

1. Patient Information: Implementation of Nonemergency Involuntary Medication – completed once (triplicate: patient’s copy, patient’s record, medical records) – includes information on the medication, potential side effects and whether patient wishes to have support person present.
2. Implementation of Court-Ordered Involuntary Medication – completed each time involuntary medication is administered in nonemergency situations (duplicate: patient’s record, medical records) – includes whether support person was requested and present, type and dosage of medication, and preferences for administration of injectable medications.
3. 30-Day Review of Nonemergency Involuntary Medications by Treating Physician – completed at 30-, 60- and 90-day intervals (duplicate: patient copy, medical records) – includes information on dose and administration of current medication, effects and benefits, side effects, and whether continued implementation of the court order is needed. On January 1, 2015, changes to Act 114 went into effect requiring a 7-day review rather than 30-day review – some hospitals changed their forms to accommodate this change.
4. Certificate of Need (CON) packet – completed anytime emergency Involuntary procedures (EIP), i.e., seclusion or restraint, are used. This form provides detailed guidelines for assessing and reporting the need for use of emergency involuntary procedures.
5. Support Person Letter – completed if a patient requests that a support person be present at administration of medication.

VSH protocol included a requirement that each patient on court-ordered medication have a separate file folder maintained in Quality Management including:

1. Copy of court order
2. Copy of Patient Information Form
3. Copies of every Implementation of Court-Ordered Medication Form
4. Copy of reviews
5. Copies of Support Person Letter, if used
6. Copies of CON, if needed
7. Summary of medications based on court order
8. Specific time line of court order based on language of court order

To assess the implementation of the Act 114 protocol, FSA reviewed each hospital’s documentation for patients with Act 114 orders for whom the petition had been filed during FY16. UVM, RRMCM, and the Retreat use electronic records; staff at these facilities provided hard copies of Patient Information Forms, Implementation of Court-Ordered Medication Forms, and 7-Day Review Forms (or Progress Notes if review forms were not used), along with any CON documentation. VPCH maintains a separate file with all Act 114 documentation for every patient under Act 114 orders; medical records staff pulled needed documents from these files

for review. Staff at the Retreat provided separate Act 114 files for each patient, along with useful summary sheets built from tracking data. CVMC did not serve any patients under Act 114 orders during FY16, and so no documents were provided or reviewed.

FSA reviewed forms completed by hospital staff for 55 of the total 58 persons with Act 114 applications filed and granted in FY16 (July 1, 2015 - June 30, 2016). This included patients from Brattleboro Retreat (n=18), Rutland Regional Medical Center (n=15), Vermont Psychiatric Care Hospital (n=19), and UVM Medical Center (n=3).

Patient Information Form

Patient Information forms were present for 47 of the 55 files (86%) reviewed; eight Patient Information Forms at the Retreat and one at VPCH had not been completed. Forty of the Patient Information Forms that were reviewed were completed fully. Nine forms (1 at VPCH, 3 at RRMC, and 5 at the Retreat) left blank the item that asks whether the patient wants a support person present when the medication is administered. Among the forms that included responses to this item, one at UVM Medical Center and two at RRMC indicated that the patient wanted a support person present. The remaining forms indicated that the patient either did not want a support person or refused to discuss the issue.

The Patient Information Form also includes space for the patient to sign the form. Again, in most cases patients did not sign the form and the document noted that the patient either refused to sign or was not able to discuss signing the form. Three VPCH patients, one UVM Medical Center patient, two RRMC patients, and two Retreat patients signed the form.

The Patient Information Forms should be completed prior to the first administration of court-ordered nonemergency involuntary medication. This is indicated by the Patient Information form completion date at least one day prior to the date of the first Implementation of Court-Ordered Medication form. All the Patient Information Forms had been completed either a day or two prior to first administration of medication or on the same day as first administration.

Form for Implementation of Court-Ordered Medication

FSA examined the forms documenting the first three administrations of involuntary medication following the court order, and then the same forms documenting administration of medications at 30 days and 60 days following the court order. Of the 269 Implementation Forms reviewed, 233 (87%) were complete. Most missing information concerned whether or not the patient wanted a support person (the Retreat 18/84; VPCH 3/88). Some forms were also missing the gender of the person administering injections (21/29 IM forms at the Retreat, and 5/10 IM forms at VPCH). At the Retreat two files had missing implementation forms for blocks of time between the first and final administration of medication.

One patient at RRMC asked for a support person to be present when medication was given; the support person was not available to be present. Two patients at VPCH asked for support persons; one was not present and one was present.

Patients chose to receive medication orally beginning with the initial administration in the majority of cases (n=39, 71%). Six patients received the first administration of medication by injection and subsequent administrations orally; 10 individuals received most medications through injection.

Review of Nonemergency Involuntary Medications by Treating Physicians

Required review forms (every 7 days after January 1, 2015) were present for the three UVM Medical Center files. One VPHC file included only one 7-day review form for a three-month period. One RRMC file included two review forms missing information on side effects of medication. Otherwise, forms that were present in files for UVM, VPHC and RRMC were complete.

Physicians at the Retreat used progress notes rather than a 7-day review form. As noted earlier the Retreat piloted an electronic 7-Day Review Form in FY16 and is implementing its use for FY17. Among Retreat case files, two were missing information on the continued need for medication, five were missing information on the effectiveness of medication, and sixteen did not have information about medication side effects. While all three of these issues should be addressed in the review form, they are not consistently addressed in Retreat progress notes. RRMC case files did not include a review form either, but progress notes did contain information in these three areas.

Certificate of Need (CON) Form

The forms documenting administration of medication include a check box to indicate whether or not a CON form was needed. The check boxes indicated that CON forms were needed for three VPHC patients, six RRMC patients, and five Retreat patients. These CON forms were present and complete for these patients, and all accompanied administration of medications by injection. In the case of four Retreat patients receiving medication by injection, the check box on the need for a CON was left blank. There were no accompanying CON forms for these patients, so it may be the case that CONs were not needed.

Perspective of Persons Receiving Involuntary Medication

Attracting Participants

The 2016 annual assessment invited feedback from persons to whom medication had been administered under an Act 114 court order anytime between 2003 and June 30, 2016, as well as from persons for whom an application for an Act 114 court order had been filed and denied by the court. In our conversation with the Adult Program Standing Committee following submission of our 2007 assessment, members suggested that the study should offer *anyone* who has received Act 114 court-ordered medication the opportunity to reflect on the experience. The suggestion was driven by an interest in knowing if and how individuals' perceptions of their experiences receiving involuntary medication while hospitalized might change over time with changes in their living situation to a community setting. Thus, beginning with the 2008 Annual Assessment, anyone who had been under an Act 114 court order (through June 30th of each year) was invited to participate in an interview. Additionally, in the 2014 legislative session, legislators asked that beginning in the FY 2015 assessment interviews be offered to individuals on whom a petition was filed during the assessment period but NOT granted by the court. Therefore, invitation letters were sent by MHLP both to:

- Individuals for whom an Act 114 application was filed and granted
- Individuals for whom any Act 114 application filed between 2003 and June 30, 2016 had not been granted.

The following steps were used to engage individuals in this study:

- A brochure, intended to inform people and create interest in participating, was written for distribution.
- The Vermont Legal Aid Mental Health Law Project (MHLP) mailed a packet of information to all persons who were involuntarily medicated under an Act 114 court order between January 1, 2003, and June 30, 2016, and for whom they had postal addresses.
- This packet included a letter and the brochure referred to above, which described the study, how one could get more information about the study, and compensation for participation.
- A toll-free phone number was provided to make it as easy as possible for people interested to learn about and schedule an interview.
- A peer advocate, well known and highly regarded in the peer community, was engaged by the consultant team to talk with individuals interested in learning more about the study, answer their questions, and refer interested parties to the consultant conducting interviews.
- Compensation of fifty dollars (\$50.00) was offered and paid to those individuals who received the packet from MHLP and chose to be interviewed.

Focus of Interviews

The assessment pursued two lines of questioning: one for persons hospitalized and receiving Act 114 medication orders at some point between July 1, 2015, and June 30, 2016, and another for those discharged from VSH, the Retreat, RRMCC, GMPCC or UVM Medical Center at any time prior to July 1, 2015.

The interviews with persons who had been hospitalized and had received Act 114 medication orders during this annual assessment study period sought to understand:

- How the event of receiving court-ordered, nonemergency medication was experienced
- To what extent the protocols identified in the statute were followed, and
- What recommendations they might have for improving the experience of receiving Act 114 medication.

Detailed information was sought from them regarding the extent to which provisions of Act 114 had been implemented including:

- Conditions and events leading up to the involuntary medication
- How well individuals were informed regarding how and why they would be receiving involuntary medication
- Whether and how individuals were apprised of their rights to have a support person present and to file a grievance
- Conditions and events related to the actual experience of receiving involuntary medication
- Each individual's view of what was most and least helpful
- Current engagement in treatment and self-care.

Persons discharged at any time prior to July 1, 2015 were asked the following:

- How the event of receiving court-ordered medication was experienced on reflection
- What impact receiving court-ordered medication has had on their current life
- What course of treatment they are currently engaged in and how they are caring for themselves
- What recommendations they have for improving the administration of court-ordered, non-emergency, involuntary medication at the UVM Medical Center, Rutland Regional Medical Center, the Brattleboro Retreat, Central Vermont Medical Center and the Vermont Psychiatric Care Hospital

Number of Persons Interviewed

Between 2003, when Act 114 court orders were first granted, and June 30th, 2016 (the end of the FY16 study period), MHLP records indicate that a total of 301 individuals received Act 114 court-ordered medication.

MHLP had correct addresses for and sent letters to 223 individuals. Of those, 198 were persons whose application for Act 114 medication was granted by the court anytime between 2003 and June 30, 2016, and the remaining 25 were persons on whom applications filed were not granted anytime between FY 14 and FY 16. Thirty-nine letters sent to persons who received Act 114 medication were returned and three letters sent to individuals who had a medication application filed but not accepted were returned. As a result, 181 letters sent by MHLP were received by:

- 159 individuals for whom Act 114 medication applications were granted
- 22 individuals for whom applications were not granted by the court between FY 14 and FY 16

The recruitment efforts yielded phone calls from twenty-six individuals interested in learning more about the project. Ultimately, eighteen of the 181 individuals who had received letters were interviewed and provided feedback, which is summarized below.

Of those eighteen persons interviewed:

- Six had been hospitalized and received Act 114-ordered medication between July 1, 2015, and June 30, 2016.
- One person who responded and was living in the community for more than a year beyond the study period had an application for Act 114 medication denied.
- Eleven persons living in the community for more than a year beyond the study period received court ordered nonemergency involuntary medication prior to FY 16.

Table 2: Interview Participants as Proportion of All Persons under Act 114 Orders in Each Study Year

| Year of Court Order | Persons Who Received 114 Court Orders | | |
|-------------------------|--|---|---|
| | Number with Orders Issued in Designated Study Period | Number Interviewed Who Received Order in Study Period | Response Rate of Interviews within Same Study Period as Order |
| 2003 | 14 | 1 | 1% |
| 2004 | 27 | 6 | 22% |
| 2005 | 13 | 4 | 31% |
| 2006 | 22 | 4 | 18% |
| 2007 | 18 | 2 | 1% |
| 2008(1/1/08–11/30/09) | 12 | 4 | 33% |
| 2009 (7/1/08 -6/30/09) | 19 | 3 | 16% |
| 2010 (7/1/09 -6/30/10) | 26 | 4 | 15% |
| 2011 (7/1/10 – 6/30/11) | 28 | 4 | 14% |
| 2012 (7/1/11 – 6/30/12) | 28 | 6 | 21% |
| 2013 (7/1/12 – 6/30/13) | 32 | 4 | 13% |
| 2014 (7/1/13 - 6/30/14) | 55 | 6 | 11% |
| 2015 (7/1/14 - 6/30/15) | 50 | 6 | 12% |
| 2016 (7/1/15 - 6/30/16) | 62 | 6 | 10% |

Of the six persons interviewed who received Act 114 medication orders during FY15, one had been hospitalized at the Brattleboro Retreat, one at the Rutland Regional Medical Center, and four at the Vermont Psychiatric Care Hospital (VPCH). At the time the interviews were conducted, two of the six individuals who received Act 114 medication were still hospitalized while the other four were living in community settings.

Responses from the six people who received Act 114 medication during FY16

The reason for refusing to take medication

Two individuals reported their refusal to take medication was based on their beliefs that they were not sick and that the diagnosis leading to the court order was not warranted. The remaining four individuals cited adverse side effects as the primary reason they refused medication. One person felt that the medication could negatively impact brain signals, the production of adrenaline and vital organs. Two others noted that the medication generally made them feel bad and resulted in a loss of energy. A fourth person had stopped using street drugs before admission to the hospital and at that point felt that taking any drug would be bad.

Information about the court hearing, the court order, the Act 114 protocols, and the right to file a grievance

Act 114 protocols stipulate that individuals be given information about the upcoming court hearing and the subsequent court order. Four of the six persons interviewed reported they were aware of the upcoming court hearing and the decision on the application. Two of the four said they learned about the hearing on the application and the ruling by the court from their lawyers while the other two persons could not remember specifically how they learned of the hearing. No one reported attending the hearing on the application for medication.

While Act 114 requires that individuals be given information about the prescribed medication being ordered, including its name, the frequency with which it would be administered and the dosage, interview responses indicated that most people knew what medication they were receiving but did not get information about the level of specificity about dosage, frequency and delivery method that the law says should be given to patients at the time of the order. One person said s/he received information from staff describing the risks and potential side effects of the prescribed medication but the remaining five persons said they were not informed about this. Two persons who received Act 114 medication at VPCH said they asked for printed information about side effects and additionally conducted their own research online to get more information. Another individual, after having received initial doses of the medication, reported experiencing anxiety, breathing problems and tardive dyskinesia. Not understanding these were side effects was most upsetting as this person felt having this information would have prevented significant suffering s/he experienced. Additionally, this person, who received medication at RRMC, believes it is the policy of medical staff not to mention side effects because, if told, patients would have another reason to refuse taking medication.

Finally, people were asked what they knew about the Act 114 protocols for administering court-ordered involuntary medication and whether they were aware of their right to file a grievance. In two instances people reported knowing something about the protocols for receiving medication. Two individuals reported they had filed an appeal of the court order but did not indicate they understood their right to file a grievance over how the medication was administered as stated in the law. Two other individuals said they knew nothing about the protocols or their rights to file a grievance.

Treatment by staff during and after administration of involuntary medication

The interviewer [?] asks people to comment on:

- How they felt they were treated in general by staff around, during and after the administration of court-ordered medication.

- Concern that staff showed for a patient’s interest in being afforded privacy when medication was being administered.
- Whether they were asked if they wanted a support person present when receiving medication, as stipulated in the protocols.
- Whether they were offered emotional support.
- Whether staff offered to help debrief them after administration of court-ordered medication.

Responses regarding how people were treated by staff in relation to the administration of the court- ordered medication revealed mixed reactions. None of the six respondents said they had been treated throughout their stays in either a uniformly positive or negative way by all staff. One person said that sometimes staff treatment was fair, other times unfair. Another person said staff treatment could have been more respectful, but did not elaborate. Two female respondents, each of whom had been at different hospitals when receiving medication, described incidents of being restrained as physically forceful and resulting in their being hurt.

Patients receiving Act 114 medication should be asked by staff if they would like a support person present when receiving medication, and should receive offers from staff to debrief the experience of receiving involuntary medication and to receive emotional support. Respondents said they had not been asked if they wanted a support person present when receiving court-ordered medication; however, one individual reported having read in the law that offering a support person was required. This individual reported having asked for a support person, a specific staff member - but said that request was refused. As a result, the individual reported filing a grievance with the hospital and writing letters to the medical, social work staff and chief executive officer (CEO) about this, along with sending copies to Disability Rights Vermont (DR-VT) and Vermont Psychiatric Survivors (VPS).

When asked whether staff offered to debrief with or provide emotional support to them regarding receiving the medication, three people said they received some support from staff after receiving medication, one person could not remember and two others said no to both questions. Responses to these questions were rather vague, as people could not provide specific examples of ways in which they had received support or offers to debrief.

The interviewers asked respondents how, in overall terms, they felt staff at the hospitals demonstrated concern and respect for their dignity, safety and health. Two individuals reiterated that at times they were treated with dignity and felt their health and safety were respected, while at other times this was not the case. Three individuals felt they were not treated with respect at any time. The sixth individual said “they insured my health but there isn’t much dignity in being injected with medication when you don’t want it.”

Regarding the extent of force used to get people to take medication:

The interviewers [?] asked people overall how much force they felt was used to get them to take medication. Each of the six individuals reported they had been restrained anywhere from five minutes up to an hour at one or more points during their hospitalizations in order for staff to administer court-ordered medication. One person said, “They told me they would give me an injection if I didn’t take it - so that’s a lot of force.” Another person said that although s/he was restrained, “not much [force was used] ...they knew I wouldn’t fight them”. People were unclear about how often restraints were used but indicated that eventually they complied with the medication orders.

When asked to describe whether any of their wishes were respected or if they were given any opportunity to exercise some control over what was happening to them, only two people responded. One individual said, "When I decided to start taking the medication I felt I had some control because people weren't hurting me anymore." At that point s/he chose the time of day to receive medications, preferring to receive them later as they made the individual sleepy. One other person also reported making the request - to which staff complied - that medication be given later in the day "so I can do things first [before feeling tired]".

Three people said they were given a choice of whether to take the medication orally or by injection, two people reported they were never asked and one person was unclear. One individual said injections were given without having been offered any choice, while another said s/he chose to receive injections initially. The side effects were so severe for this person, however, that after receiving the first two doses by injection s/he agreed to take the medication orally.

What was most helpful and unhelpful about the experience?

The interviewer asked people what was most unhelpful and/or negative and most helpful and/or beneficial about the experience of receiving court-ordered medication. In thinking about what was most difficult about receiving court-ordered medication, three people responded. One said being put in seclusion was what seemed most negative. Two other persons reiterated the effect that the court-ordered medication had on how they felt. According to one person, the medication "made me completely unfunctional...puts me in a bad mood and makes me completely unhealthy." The other person simply said that getting the medication was difficult as it "made me groggy."

When asked what if anything was most helpful or beneficial two people provided feedback. One person said simply that "maybe one of two of the medicines worked for a while". The other individual elaborated by saying, "My head cleared up. I wasn't paranoid anymore...I had quite the soap opera going on my head. Fortunately the medication works one hundred percent. I am very fortunate".

Both positive and negative comments reported above came from persons hospitalized in different facilities. The responses do not indicate any relation between where a person was hospitalized when receiving the medication and the content of their answers.

The interviewer asked people whether, looking back, they felt the state had made the right decision in giving them involuntary, court-ordered, nonemergency medication. Only one person felt that the state's decision to seek and administer involuntary medication was a good decision, saying, "I am glad now that they gave me the medication - I need it, but I was so sick that I didn't know it at the time."

Four people stated unequivocally that they did not think the decision was a good idea, with one person going further by saying, "No, it wasn't the right thing because they ordered medication that didn't work well for me."

Responses from people who had been discharged prior to July 1, 2015, and were living in the community during this study period:

Twelve people living in the community during this study period completed interviews. Each of these individuals last received a court order for involuntary nonemergency medication prior to July 1, 2015. Two persons reported that Act 114 court orders had been granted more than six years ago, one person last received medication under Act 114 in 2011, and the remaining nine individuals said the most recent court orders had been granted as early as 2012 and as late as 2015. Two individuals last received court-ordered medication at the Vermont State Hospital, three at the Brattleboro Retreat, three at RRMC, two at UVM Medical Center, and one at Green Mountain Psychiatric Care Hospital. One person was at the UVM Medical Center, where an application was filed but denied by the court. Finally, it appears that the majority of respondents has been hospitalized and received Act 114 court orders multiple times in more than one hospital.

People living in the community were asked to reflect on the following:

- How the event of receiving court-ordered involuntary, nonemergency medication was experienced
- The impact of receiving medication on their current life
- Their current involvement in self-care and treatment activities

How was the event of receiving court-ordered medication experienced?

Responses to this question were mixed. Most people, however, reported that despite their reasons for refusing to take medication, hospital staff overall had treated them with respect and a focus on helping them get better. *Negative experience:* Three persons view their hospitalizations as negative experiences. One individual described the experience of receiving court-ordered medication as “harsh” and leaving her confused and dazed. Another individual described the event as traumatizing, and emotionally and physically abusive in that staff treatment resulted in her leaving the hospital with bruises, post-traumatic stress, and a distrust of mental health professionals in general and psychiatrists in particular. A third individual reported that while hospitalized and taking court-ordered medication her attempts to get attention for a physical condition were ignored - and in her opinion resulted in the emergence of longer-term heart problems.

Mixed to positive responses: Seven individuals said that while under court orders to take medication they felt hospital staff for the most part treated them well. One person noted that she did not like the first psychiatrist working with her but she “finally got a doctor there who understood me.... he was excellent.” Another respondent said that staff “treated me with respect like anyone else. They put their full attention on me to help me live like a normal person outside the hospital.” A third individual said that she was mostly well-treated and felt lucky that one of the staff she liked working with during her hospitalization ultimately became her caseworker in the community. A fourth respondent, who felt that her family had betrayed her by getting her hospitalized, noted that she was “treated well by the staff...they were good employees.” Another individual said, “They were good to us.... they helped me to get on the right meds so I could get better.”

One respondent was more reflective in answering the question, noting that hospitals should provide a safe space where patients can “unwrap issues” related to their mental health and illness. Instead, involuntary medication creates “a power struggle between doctors and patients” and becomes a “bargaining chip” that is held out for people who want to be discharged and returned to the community. He sees this as offering people a “false choice”

either to take the pill “or we will shoot you full of medication.” Concurring with information we received from persons who received 114 orders during this year - and in previous study years - this person said there is not a full discussion with the patient about both the benefits and side effects of the medication. Without that information, patients are really not giving their informed consent when they finally stop their resistance to taking medication. While some staff may treat people relatively well during their hospitalization, the overall experience is “pretty dehumanizing” as some staff abuse rules by treating different patients inconsistently. This person noted that the hospital psychiatrists spend the least amount of time with patients of any staff, know the patient less than any staff and, as a result, do not see the consequences and impact of the ordered medication on either the patient or other staff.

What impact has receiving court-ordered medication had on your current life?

People were asked to describe how their current lives had been affected by receiving medication under the provisions of Act 114. Each of the twelve persons interviewed report they continue to take medication although, in some cases, changes have been made in the type and/or dosage of medication from the last Act 114 medication order. A number of individuals were specific about the positive benefits of taking medication. One person noted that prior to taking medication she would have panic attacks “in wide open spaces,” but the medicine now allows her to go out into public places alone. Another person said, “The medication makes me think clearly...I don’t skip meals, I eat what everyone else eats...I sleep good.” A third person said the medication has helped him live better. “I would be afraid without the medication.” Another individual commented that “I wished I had taken the medication earlier - the only way they could get me to take it was to take me to court.”

Two persons stated their belief that they do not need medication, although they continue to take it. Both individuals, who have an order of nonhospitalization (ONH), feel the medication they are currently taking is ineffective and causing unwanted side effects.

- “[The medication] doesn’t do anything... I’m trying to get new medication.... I am hearing voices and the medication doesn’t help the voices.”
- “The medication [I’m taking] makes me tired...I have less energy.”

One individual noted for himself and others that the long-term use of psychiatric medications “will kill you,” as they lead to a decline in overall health as evidenced by increased damage to vital organs, increases in incidents of diabetes and permanent effects of tardive dyskinesia.

As a result of this experience, two individuals are engaged in different forms of advocacy for persons with mental illness, including participating in advisory committees to a mental health center, working on a helpline and helping individuals with mental illness find housing.

What course of treatment they are currently engaged in and how they are caring for themselves:

People were asked to discuss how they are taking care of themselves. Specifically, they were questioned about what activities and events they participate in that they view as beneficial and what, if any, course of treatment they are following.

Each of the twelve persons interviewed continues to take medication and each maintains some ongoing relationship with the community mental health system and/or private mental health providers. Regarding the value of taking medication now, people said the following:

- “While in the past I didn’t think I needed them, now I do. Medication benefits me now...I’ve come to accept that I need medication.”
- “I would not dare to go off medication again, it’s part of my routine...if anything happened to me I would call the psychiatrist.”
- “I take medication recognizing it’s an ongoing need of mine.... [having been] arrested so many times and have been given a second chance due to having a mental illness, if I tried to go off these drugs I wouldn’t have a lot of support...from my family, friends, the system.”

Each of the respondents continues to see a psychiatrist primarily to monitor their medication. Only one person reported participating in some form of mental health group activity.

Eight persons reported having a case manager associated with their area community mental health agency. One person gets mental health support services through the Veterans Administration and two others report they use mental health services through private practices. Persons with case managers seemed satisfied with the support they receive. One individual, whose case manager is at Health Care and Rehabilitation Services of Southeastern Vermont (HCRS), said, “Anytime I have a problem I can call her and she takes care of it immediately - it’s a great feeling.” A second person responded that her case manager (also from HCRS) is “very good.” Another person says her case manager provides transportation and “takes me shopping and to appointments” in addition to visiting her weekly to talk. “She is very attentive.”

Seven persons interviewed live in their own homes, either with family members or on their own. The remaining five live in individual or group housing residences supported by their local mental health agencies. One person reports being employed full-time, another is employed part-time, and two others have part-time jobs which were arranged through their mental health agency.

In terms of participating in enjoyable and self-caring activities, responses from individuals varied widely. Some persons engage in minimal social activity, stay home, watch television and look to the case manager for outside contact. Three people mentioned they exercise, others said they read, one person participates in programs at the area mental health agency and one individual is writing a novel.

Mention of engagement with family members and involvement in relationships with significant others was very limited. One individual who lives with her husband and children expressed her anger with and distrust of them as she feels they incorrectly see her as needing medication. Another individual says she is just beginning to repair relationships with her children. At least eight of the individuals interviewed mentioned that they are single, leaving the status of the other individuals unclear.

Table 3: Reported Treatment Participation and Self-Care Activities

| Key Responses | Number of Responses |
|--|----------------------------|
| Involved in some way with mental health professional services (has caseworker, sees MD, participates in individual and/or group therapy) | 12 |
| Currently taking psychiatric medication | 12 |
| Living in independent housing | 7 |
| Living in Community Mental Health residential support setting (apartment, group home) | 5 |
| Exercising regularly (exercises, taking walks, etc.) | 4 |
| Working full- or part-time and enjoying it | 4 |
| Engaged in social activities in the community | 3 |
| Engaging in new hobbies or learning new skills | 2 |

Recommendations for improving how court-ordered involuntary medication should be administered at the hospitals and planned new facilities in Vermont

This section describes responses from sixteen people interviewed this year, six of whom were hospitalized during FY16 and received Act 114-ordered medication and twelve of whom were living in the community and received Act 114 medication in earlier study periods. People were asked for their recommendations on what the current designated facilities (Brattleboro Retreat, CVMC, RRM, UVM Medical Center, and VPCH) could do to improve the experience for people receiving Act 114 involuntary court-ordered medications in nonemergency situations.

Consistent with findings in previous years, recommendations focused on the quality of communications between staff and patients, the importance of staff interpersonal skills in dealing with patients, and provision of information to patients about the medication. The following section presents many of the thoughts put forward by respondents:

- In order to reduce or, ideally, eliminate the force and coercion recipients of Act 114 medication report they experience, staff should engage with patients in more gentle, patient and personable ways.
 - “Having staff you can have a non-crazy dialogue with....and meaningful interactions with.”
 - “It’s never nice to be out of control of a situation. Talk with patients.... see where their heads are...Explain to them why they are experiencing certain things.... seeing things that aren’t there. Be encouraging.”
 - “Doctors should listen to the patient...they listen more to outsiders.”
 - “Staff should use more respect and compassion.”
 - “Make people feel secure with the doctor - build some trust.”
 - “There shouldn’t be staff working [in hospitals who] like to fight with mentally ill people verbally and physically.”
 - “Ensure there is no physical or mental abuse [towards patients] in the hospital...no games.”
 - “Be as nice as you can to the people.”

- “Let the doctors go one-on-one with patients. Psychiatrists are cowards, they come from a place of fear. They should be the ones on the front line [working with patients].”
- Staff should give patients information about the medication including why it is needed, its potential benefits and side effects, address fears and concerns that patients may have.
 - “[Staff] should explain the reason why [patients] need the medication...what benefit it would give”
 - “Make it clear how the medicine would help you.”
 - “If a person can understand what the medicine is for... [staff should] do a better job of explaining”
 - “[Doctors] should explain how their interview makes them decide you can’t make a decision.”
 - “The side effect issue.... [patients] need to be told about the side effects.”
- Activities and resources should be available to better structure the time and reduce the boredom experienced by people hospitalized.
 - “To empower people [hospitals should] give them activities to do such as art. It was good to do the outside activities and get exercise.”
 - “Give people good food and diet.... group meetings.”

Key Findings Emerging from Interviews

It is important to offer the following information about the interviews. First, the people who volunteered to participate in the interviews were self-selected. Therefore, one cannot view the findings as representative of all people who received Act 114 court-ordered involuntary medication between January 1, 2003, and June 30, 2016. Second, in some cases, people chose not to comment, were unable to remember, or were confused and unable to clarify their responses to some of the circumstances surrounding the court order and administration of medication.

In recruiting people who received court-ordered medication over the span of time between 2003 and June 30, 2016, the study aimed to:

- Generate an increased amount of feedback from individuals who received involuntary medication under Act 114
- Gain new information from people now in the community and no longer under an Act 114 court order about:
 - How receiving involuntary medication has impacted their current circumstances
 - Choices they have made regarding whether and how they are currently engaged in any form of (voluntary) treatment

In this year’s assessment, two persons were hospitalized at the time interviews were conducted. The overall percentage of people for whom medication applications were granted and who participated in interviews (n=17) represented 10.7% of those who received packets sent out by MHLP (n=159). This represents a decrease from last year’s response rate of 12%. One person for whom the medication application was denied was interviewed; this represents less than 0.5% of the 22 persons whose applications were denied and who received interview invitation letters from MHLP.

This year, as in years 2009 through 2015, two different sets of questions were posed to study participants, based on whether they were hospitalized at some point during the study period or had been discharged prior to July 1, 2015, and were living in the community.

Responses from the six individuals who were hospitalized and received involuntary medication through an Act 114 order at some point between July 1, 2014, and June 30, 2016, showed mixed responses in terms of:

- Reports of how the Act 114 protocols were followed. The majority of individuals reported they were not offered a support person, emotional support or the opportunity to debrief after receiving court-ordered medication. Four were unaware of the Act 114 protocols, but most knew they could file a grievance. Most said they knew what medication(s) they were receiving, but most did not receive information regarding the dosage or frequency of receiving medication. Two people researched on their own potential side effects, but no one said they were given information about potential risks and side effects from staff.
- Sense that they had some control. Three individuals said they were asked whether they wanted the medication given orally or by injection, and one person said he asked to receive medication later in the day in order to have energy earlier.
- Feelings about how they were treated, supported and respected during that experience. Responses from participants indicated mix feelings about how staff treated them.

Regarding the value and benefit that receiving court-ordered medication has had on their current situations, one individual felt the state did the right thing, four disagreed with the decision to be medicated, and one person was unclear.

Of the seventeen individuals who received Act 114 orders, all continue to take medication, with the majority feeling they need it. Additionally, the one person whose order was not granted also continues to take medication. All report ongoing involvement at various levels with community or private mental health services. Living situations for these people vary from private residences to housing supported by community mental health services. Four respondents reported being engaged in paid part-time employment at the time of the interviews. These findings are similar to those reported in last year's assessment.

As in past years, participants were asked if they would like any family member to be interviewed. All participants refused the offer, so no family interviews were conducted.

Finally, those interviewed noted the critical role that communication and interpersonal skills of hospital staff can and should play in:

- Treating patients with more compassion and sensitivity
- Helping patients understand why medication is being recommended
- Providing patients with the information needed to exercise more choice in their treatment

Section 2: Outcomes from Implementation of Act 114

As part of earlier assessments, stakeholder input was used to identify a set of outcomes that would be expected with successful implementation of Act 114. These outcomes include:

- Hospital staff awareness of Act 114 provisions
- Decreased length of time between hospital admission and filing petition for involuntary medication
- Decreased length of stay at hospital for persons receiving involuntary medication
- Reduced readmission rates and increased length of community stay for persons receiving involuntary medication

In addition, persons currently living in the community were asked to describe the impact that receiving nonemergency involuntary medication had on their current lives and their engagement in treatment.

For FY16, achievement of outcomes was as follows:

- Staff awareness of Act 114: Staff at all four hospitals administering medications under Act 114 in FY16 were aware of the provisions as shown by documentation of adherence to Act 114 provisions.
- Time between admission and petition: In FY16, 30% of Act 114 petitions were filed within 30 days of the date of hospital admission; 26% were filed 30-60 days after admission (see Table 4). This finding was consistent with the past two years.

Table 4: Time (in days) Between Admission to VSH and Filing Act 114 Petition

| Time from Admission to Petition | FY of petition filing (7/1 to 6/30) | | | | | | | |
|---------------------------------|-------------------------------------|---------|--------|---------|--------|---------|--------|---------|
| | FY2013 | | FY2014 | | FY2015 | | FY2016 | |
| | Freq | Percent | Freq | Percent | Freq | Percent | Freq | Percent |
| <30 days | 11 | 26% | 18 | 26% | 23 | 30% | 26 | 30% |
| 30-60 days | 15 | 36% | 22 | 32% | 23 | 30% | 23 | 26% |
| 61 - 180 days | 16 | 38% | 18 | 26% | 21 | 28% | 26 | 30% |
| 181 - 365 days | 0 | 0% | 9 | 13% | 4 | 5% | 5 | 6% |
| >365 days | 0 | 0% | 2 | 3% | 5 | 7% | 8 | 9% |
| Total | 42 | 100% | 69 | 100% | 76 | 100% | 88 | 100% |

In FY16, it took on average 68 days from admission to filing the Act 114 petition (see Table 5). Overall, it took about 80 days from admission to the Act 114 order. This is consistent with previous years. It took on average 12 days from the date the petition was filed to the date an order was issued. This was less time than in most previous years.

Table 5: Mean Time Delays between Steps in Act 114 Process
(Excluding cases in which petition filed more than 1 year after admission)

| FY of Petition (7/1 to 6/30) | Time (in days) from: | | | | | |
|---------------------------------|------------------------------|-----------|-------------------|-----------|--------------------|-----------|
| | Admission to Filing Petition | | Petition to Order | | Admission to Order | |
| | Mean | Std. Dev. | Mean | Std. Dev. | Mean | Std. Dev. |
| 2012 | 50.21 | 35.07 | 14.38 | 6.82 | 65.67 | 35.03 |
| 2013 | 57.55 | 40.91 | 13.44 | 9.64 | 66.71 | 39.71 |
| 2014 | 93.17 | 107.36 | 16.16 | 8.11 | 109.33 | 109.41 |
| 2015 | 64.93 | 55.89 | 15.87 | 9.65 | 81.13 | 61.01 |
| 2016 | 67.60 | 61.37 | 12.21 | 6.91 | 79.63 | 63.01 |

In past assessments, and again this year, hospital staff reported that time delays in the Act 114 process were often due to legal procedures. The first of these is separation of the commitment and Act 114 hearings. In FY16, half of the Act 114 petitions were filed within eight days of the commitment (see Table 6). As shown in Table 6, 36% of Act 114 petitions had been filed prior to the commitment orders; 15% were filed within seven days of the commitment date; and, 29% were filed 30 days or more after the commitment. On average, it took 30 days from the commitment date to the date on which Act 114 petitions were filed. Once a petition was filed, it took an average of 12 days in FY16 for an order to be issued (see Table 5).

Table 6: Time between Date of Commitment and Act 114 Petition Filing Date
(Excludes cases in which time was 1 year or more)

| Petition filed: | FY13 | | FY14 | | FY15 | | FY16 | |
|----------------------------------|------|---------|------|---------|------|---------|------|---------|
| | Freq | Percent | Freq | Percent | Freq | Percent | Freq | Percent |
| Before commitment | 13 | 31% | 16 | 24% | 15 | 22% | 25 | 36% |
| Same day as commitment | 2 | 5% | 10 | 15% | 6 | 9% | 1 | 1% |
| Within 7 days of commitment | 15 | 36% | 19 | 28% | 13 | 19% | 10 | 14% |
| 8 - 30 days following commitment | 9 | 21% | 12 | 18% | 15 | 22% | 13 | 19% |
| 30+ days after commitment | 3 | 7% | 11 | 16% | 20 | 29% | 20 | 29% |
| Total | 42 | 100% | 68 | 100% | 69 | 100% | 69 | 100% |

- Length of stay: Of the 58 individuals with Act 114 orders in FY16, 41 (71%) were discharged from psychiatric inpatient care, on average, 153 days (approximately 5 months) after admission, and 59 days (about 2 months) after the Act 114 order was issued. By way of comparison, the average length of stay (LOS) for patients without Act 114 medication was shorter by 60 to 80 days at the Retreat, RRMC and the UVM Medical Center (see Table 8); while the average LOS was only 11 days shorter for patients without medication under Act 114 at VPCH.

Table 7: Length of Stay for Patients under Act 114 Orders Who Were Discharged from Hospital

| FY Petition Filing (7/1 to 6/30) | Average Length of Stay (in days) from: | | | |
|-------------------------------------|--|-----------|--------------------|-----------|
| | Admission to Discharge | | Order to Discharge | |
| | Mean | Std. Dev. | Mean | Std. Dev. |
| 2012 (n=23) | 128.09 | 67.41 | 63.52 | 40.48 |
| 2013 (n=21) | 123.38 | 41.34 | 71.00 | 38.89 |
| 2014 (n=35) | 154.67 | 125.92 | 85.77 | 62.99 |
| 2015 (n=45) | 149.60 | 87.87 | 97.07 | 69.56 |
| 2016 (n=41) | 152.83 | 121.00 | 58.93 | 49.00 |

Table 8: Number of Days from Admission to Discharge for Patients with and without Act 114 Orders (FY16)

| Designated Hospital | Mean Number of Days from Admission to Discharge | | |
|---------------------|---|--------------------------------|--|
| | Patients with Act 114 Order | Patients without Act 114 Order | Difference Between Patients with and without Act 114 Order |
| Retreat | 135.0 | 77.4 | 57.6 |
| RRMC | 84.4 | 25.5 | 59.0 |
| UVMC | 115.8 | 31.2 | 84.6 |
| VPCH | 120.6 | 109.6 | 11.0 |

- Readmission Rates: Of the 41 patients with Act 114 orders in FY16 who had been discharged, seven individuals had been readmitted by the time of this review.

Section 3: Steps to Achieve a Non-Coercive Mental Health System

The Department of Mental Health (DMH) leadership team, including the Commissioner, met with Flint Springs Associates (FSA) to review steps DMH took during FY16 toward achieving a noncoercive mental health system. These include:

1. In partnership with the Vermont Cooperative for Practice Improvement and Innovation (VCPI), DMH continued to provide staff training on the Six Core Strategies for reduction of emergency interventions such as seclusion and restraint at designated hospitals; staff at all designated hospitals had received training by the end of FY16.

The Veterans Administration (VA) Hospital has inpatient psychiatric beds and is interested in becoming a designated hospital. DMH began working with the VA Hospital during FY16 to make it a designated hospital and train staff in the Six Core Strategies.

As a result of the Six Core Strategies implementation, DMH reported declining numbers of emergency involuntary procedures (EIP) during FY16.¹ DMH receives data on EIPs and Certificates of Need (CON) for EIPs from the designated hospitals. These data are reviewed regularly by the EIP Review Committee and compared with national data to track performance. A Quality Management Specialist who is a Registered Nurse also reviews CONs on a weekly basis to identify concerns and provide technical assistance to designated hospitals on how to improve practices.

In addition, during FY16 DMH promulgated an administrative rule on EIPs.² This administrative rule is directed toward reducing seclusion and restraint, as outlined in the description of purpose:

The Vermont Department of Mental Health is committed to establishing and maintaining treatment environments on psychiatric units in designated and state-operated hospitals that are safe, clinically effective, and non-violent. Hospital staff providing treatment for involuntary patients must be trained in non-physical, non-coercive skills and attitudes that emphasize the prevention of emergencies...

The Department of Mental Health also shall ensure that emergency involuntary procedures are used as safety measures of last resort. The standards for the use of emergency involuntary procedures are being implemented with the intention of preventing or minimizing violence in a manner consistent with the principles of recovery and cognizant of the impact of trauma in the lives of many hospitalized individuals. The standards are designed to protect and promote each patient's rights while at the same time protecting patients and others from harm...

The Department of Mental Health has established these standards to meet or exceed and be consistent with standards set by the Centers for Medicare and Medicaid Services and the Joint Commission, as well as rights and protections that reflect evidence-based best practices aimed at reducing the use of emergency involuntary procedures of seclusion, restraint or emergency involuntary medication on individuals in the custody or

¹ See DMH scorecard with these data at: <https://app.resultsscorecard.com/Scorecard/Embed/10396>

² The full policy can be found at: http://mentalhealth.vermont.gov/sites/dmh/files/policies/EIP_Rule_FINAL_2016.pdf

temporary custody of the Commissioner of the Department of Mental Health. In addition, the standards require the personnel performing emergency involuntary procedures to receive training and demonstrate competency in the use of these procedures.

2. During FY15, DMH restructured the care management team so that one care manager's sole function is to work with the hospitals and designated agencies with a focus on getting people out of hospitals, rather than into hospitals. This work continued into FY16 along with efforts to develop a Results-Based Accountability (RBA) Scorecard to track wait times. DMH reports that there has been a reduction in wait times for access to inpatient psychiatric care.
3. DMH continued to support training for police officers to identify a situation as a mental health crisis and bring in the designated agency (DA) in the area. The DA can respond on-site, thus reducing arrests and the involvement of criminal justice. During FY15, the Department of Public Safety (DPS) became a financial contributor to this effort, and continued its financial commitment during FY16. During FY16, DMH expanded training to include emergency dispatch staff.
4. In FY15, DMH funded two pilot sites to implement Open Dialogue, a service-delivery model with proven effectiveness in lowering the rates of hospitalization and medication use for persons with schizophrenia. The pilot program included clinical training, implementation of the model, and evaluation of outcomes. The program continued in two sites during FY16, providing training to others beyond the two pilot sites.
5. DMH instituted a telepsychiatry program to bring psychiatry to small hospitals in FY15. This allows hospitals without a psychiatrist on staff to obtain the two certifications needed for involuntary hospitalization without requiring the patient to be transported to another hospital. During FY16, the program was expanded to include persons going to court.
6. DMH continues the initiative, begun in FY11, to ensure that no restraints remain a priority in the transportation of individuals with mental health needs. This includes adoption of methods that assure physical safety at the same time as sensitivity to trauma. DMH notes that when information and training wane, so do appropriate responses. DMH gathers data to track use of restraints in transportation.
7. DMH established a work group in FY14 to explore ways to reduce the use and length of time for ONHs. The group completed its work in FY15 and, in FY16, completed and distributed an ONH manual to hospitals and designated agencies. The primary objective of the manual is to create consistency across the state in ONH procedures and practices, including involvement of the care management team (see above #2).
8. DMH was able to expand the implementation of the Zero Suicide model from two pilot sites to three in FY15. The model includes training in Collaborative Approach to Managing Suicide (CAMS) for designated agencies and partner agencies, including home health agencies. Since the model encourages screening for suicidality and depression, case managers and RN's have received training on suicide screening and mental health first aid. In addition, DMH partnered with the Center for Health and Learning's Vermont Suicide Prevention Center to establish a Gun Shop Project in Vermont. The model encourages gun shops, firearms ranges and gun dealers to take an active role in suicide prevention, both by displaying suicide prevention posters and receiving training to identify signs and strategies for prevention.

9. During FY15, DMH began research with the Department of Health to identify the population of individuals with first-episode psychosis. During FY16, DMH formed a work group to examine models, identify directions, and begin to develop strategies to address the needs of this population.

Section 4: Recommendations

The review for FY16 indicates that hospital staff understand the provisions of Act 114. Documentation was generally in good order and demonstrated that staff have implemented the statute as required.

Hospital Practices

FSA recommends that staff at hospitals administering Act 114 medication continue efforts to help patients understand the reasoning behind the decision to seek an order for involuntary medication and to invest time in talking with patients about the process and available options.

In order to make it easier and less stigmatizing for patients to attend Act 114 hearings, each hospital should create a “real” courtroom in a location outside of the patient’s ward and lawyers should ensure that patients are asked directly if they want to attend the hearing.

All hospitals should include the patient representative in treatment team meetings, with consent of the patient, in an effort to support both patients and staff toward achieving recovery in the least coercive manner.

Patient representatives should have access to information as to where people are located in the system and whether they are receiving Act 114 medication or applications have been filed under Act 114. This would help patient representatives reach out to more people.

In order to maintain clear records for documenting implementation of Act 114 in accordance with provisions of the statute, FSA recommends that each hospital maintain a separate file or section within the file for persons receiving medication under Act 114. This file should contain:

- Copy of court order
- Copy of Patient Information Form
- Copies of every Implementation of Court-Ordered Medication Form
- Copy of 7-day reviews – Hospitals should use a specific 7-day review form, rather than progress notes, to ensure that three specific issues are addressed: continued need for involuntary medication, effectiveness of medication, and side effects of the medication.
- Copies of Support Person Letter, if used
- Copies of CON or other documentation of emergency procedure, if needed
- Summary of medications based on court order
- Specific time line of court order based on language of court order

Training

- DMH should provide training focused on identifying the type of information required in applications for Act 114 medication for psychiatrists new to the state mental health system.

Statutory Changes

As noted in past assessment reports, the statute requires two separate assessments of Act 114 implementation, one by DMH and one by independent contractors. In practice this means that information is gathered twice, often requiring hospital staff, and more significantly patients, to participate in somewhat duplicative interviews and surveys. FSA recommends that the legislature consider requiring only one annual assessment conducted by an independent evaluation team.

The legislature should clarify the purpose of its request that the independent assessment offer interviews to persons for whom an Act 114 petition was filed but not granted. In addition, the legislature should define the time period for which it seeks this information (e.g., the FY under review only or additional years).

Annual Act 114 Assessment

FSA recommends that the following steps continue to be used in future assessments of Act 114:

- The annual assessment should require research on the use of involuntary, court-ordered, non-emergency medication to identify:
 - Outcomes for people who engage in treatment involuntarily versus voluntarily
 - Outcomes for people who take long-term medication versus short-term medication
 - Alternatives and complements to involuntary medication
- Provide a financial incentive for the participation of individuals who have received court-ordered medication.
- Request input from individuals through extensive outreach efforts to any person who received medication under Act 114 in previous years, not just the year under review, in order to learn about longer-term outcomes including individuals' engagement in treatment and their lives in the community as well as experiences receiving medication under Act 114 orders.
- Ask persons interviewed if they would like any family members to be interviewed and pursue these as permitted.
- Use the same source of data on dates of admission, commitment, petition and court orders for both the Commissioner's assessment of Act 114 implementation and the independent assessment.

Conclusion

UVM Medical Center, the Brattleboro Retreat, Vermont Psychiatric Care Hospital, and Rutland Regional Medical Center used documentation and generally completed it fully enough to indicate that all provisions of Act 114 were implemented in FY16. Several Retreat files were missing documentation – an issue that the Retreat was aware of and seeking to resolve. On average, it took about two months from the time a patient was admitted to the time a petition for medications under Act 114 was filed, and then another 12 days for a hearing and judicial decision on the petition.

Hospital staff responsible for administering medication under Act 114 throughout the state advocate for a process that moves as quickly as possible, as they believe that patients suffer on many levels when not receiving treatment. Staff in the designated hospitals in FY16 shared the view that use of involuntary medication is a last resort and they prefer to engage patients in voluntary treatment. Nevertheless, they believe that procedures that decrease time delays while preserving due process to protect patient rights are needed. Defense lawyers and peer advocates present a different perspective, however. They cite the increase in Act 114 petitions over the past several years as evidence that involuntary medication is not being used as a last resort. Instead they feel that Act 114 applications are increasingly sought quickly and with little effort made by medical staff to find common ground where patients will voluntarily engage in treatment.

The majority of persons interviewed for this year's study, whether hospitalized during or prior to FY15, continue to view the experience of receiving court-ordered involuntary medication as a coercive set of events in which they have little or no control over medication decisions. Of the seventeen individuals interviewed who received Act 114 orders and the one person whose application was denied by the court, all continue to take medication and the majority feel they need it. All reported ongoing involvement at various levels with community or private mental health services. People interviewed hold mixed opinions about whether the decision to medicate them was a right decision, but the majority of those interviewed reports that the manner in which the administration took place could have been improved. Consistent with past years, the majority of persons interviewed felt their concerns had not been heard and acknowledged and that their need to understand the reasoning behind the application was not met.

Similar to past years, people who were hospitalized during FY16 had mixed feelings about how hospital staff treated them. Three of the six persons interviewed reported they were not well-treated by staff, one person said the opposite and two individuals had no comment. None of the individuals reported being offered a support person, or the opportunity to debrief. Three persons said that some staff had offered emotional support around receiving court-ordered medication. Most were unaware of the Act 114 protocols or their right to file a grievance about how the medication was administered, while most understood and some had exercised their right to appeal the Act 114 order. Finally, the majority said they were given limited or no information about the potential side effects of the medication ordered.

When asked for recommendations about how to improve the administration of medication, the eighteen individuals interviewed addressed the following: staff communication and interpersonal skills in engaging with patients; provision of information about the medication, potential benefits and side effects; and access to a wider range of stimulating and enjoyable activities during hospital stays.

DMH reports continued efforts to create a mental health system that provides an array of service options and staff with training in a range of skills. As in past years, stakeholders agree that community options and a collaborative culture are needed to create a noncoercive mental-health system.