VERMONT 2018

The Implementation of Act 114:

Fiscal Year 2018 (July 1, 2017 – June 30, 2018)

Report from the Commissioner of Mental Health
to the General Assembly

January 15, 2019

Department of Mental Health
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Vermont's 1998 Act 114 (18 V.S.A. §7624 et seq.)

Summary

Vermont's Act 114 addresses three areas of mental-health law:

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

The statute allows for orders of non-hospitalization, whether ninety-day or one-year orders, to be renewed following a hearing. Prior to implementation of Act 114, ninety-day orders could not be renewed.

The Act also replaced administrative hearings on applications for non-emergency involuntary medication with judicial hearings in family court. When the statute was passed in 1998, it permitted the administration of involuntary psychiatric medication in nonemergency situations to patients committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in addition to the state-operated Vermont State Hospital (VSH) in Waterbury. Until August 29, 2011, when Tropical Storm Irene forced the evacuation of the State Hospital, nonemergency involuntary psychiatric medications were given only at VSH. Vermont has seven designated hospitals where involuntary psychiatric medications in nonemergency situations might be administered:

- The University of Vermont Medical Center (UVM-MC), in Burlington
- Rutland Regional Medical Center (RRMC), in Rutland
- The Brattleboro Retreat (BR), in Brattleboro
- Central Vermont Medical Center (CVMC), in Berlin
- The Windham Center (WC), in Bellows Falls
- The Vermont Psychiatric Care Hospital (VPCH), in Berlin
- The Veterans Administration Hospital (VA-WRJ), in White River Junction

Section 5 of Act 114 requires an annual report from the Commissioner of Mental Health on the implementation of the provisions of the act to the House Judiciary and Human Services Committees and to the Senate Committees on Judiciary, and Health and Welfare. The statute specifies the requirements for the Commissioner's report which are detailed below. Act 114 also requires an annual report from an independent research entity (Section 6). DMH continues to recommend that only one comprehensive, independent report be required in the future.

Act 114 Language Pertaining to Report Requirements[1]

Sec. 5. REPORT

(a) On January 15, 1999 and annually thereafter, the commissioner of developmental and mental health services shall report to the House and Senate Committees on Judiciary and Health and Welfare on the following:

(1) Any problems that the department, the courts, and the attorneys for the state and patient have encountered in implementing Sec. 4 of this act.

(2) The number of petitions for involuntary medication filed by the state pursuant to 18 V.S.A. § 7624 and the outcome in each case.

(3) Copies of any trial court or supreme court decisions, orders, or administrative rules interpreting Sec. 4 of this act.

(4) Any recommended changes in the law.

(b) Before submitting the report required in this section, the department shall solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct care providers, persons who have been subject to proceedings under 18 V.S.A. § 7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

(c) The department shall also present the report required in this section and the study required in Sec. 6 of this act to its Systems Improvement Committee for analysis and recommendations to the department.

Sec. 6. STUDY AND REPORT[2]

(a) An annual independent study shall be commissioned by the Department of Mental Health which shall:

(1) evaluate and critique the performance of the institutions and staff of those institutions that are implementing the provisions of this act;
(2) include interviews with persons subject to proceedings under 18 V.S.A. § 7624, regardless of whether involuntarily medicated, and their families on the outcome and effects of the order;
(3) include the steps taken by the Department to achieve a mental health system free of coercion; and
(4) include any recommendations to change current practices or statutes.
(b) The person who performs the study shall prepare a report of the results of the study, which shall be filed with the General Assembly and the Department annually on or before January 15.

(c) Interviews with patients pursuant to this section may be conducted with the assistance of the mental health patient representative established in 18 V.S.A. § 7253.

[1] Accessed May 17, 2018, found online at http://www.leg.state.vt.us/DOCS/1998/ACTS/ACT114.HTM
[2] Modified to include amended language from 2014 Act 192
https://legislature.vermont.gov/assets/Documents/2014/Docs/ACTS/ACT192/ACT192%20As%20Enacted.pdf

Introduction

This annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health (DMH). This report covers FY 2018 (July 1, 2017 – June 30, 2018).

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

Among the stakeholders who receive annual requests to respond to the Commissioner's questionnaire about their perspectives on Act 114, Vermont Legal Aid, Disability Rights—Vermont (DRVT), the Vermont Chapter of the National Alliance on Mental Illness (NAMI—VT), and family members, peers, and friends who wish to remain anonymous sent written responses to the Department of Mental Health for this report.

In the development of the 2019 Act 114 report, there was an oversight in the full solicitation process routinely undertaken by DMH for previous years' reports, resulting in the omission of key partner input. While we have included comments from the judiciary, Vermont Legal Aid, Vermont Psychiatric Survivors, NAMI, the Vermont Psychiatric Care Hospital and all individuals who responded, there is feedback from only a single designated hospital and none from Disability Rights-Vermont.

In recognition that this year's report is absent this information, DMH will submit an addendum to this report that is consistent with prior Act 114 report content and reflective of its broader engagement process by January 31st.

For the comments and responses received to date, please see the section on "Input from Individuals and Organizations as Required by Act 114."

Number of Petitions and Outcomes for Each Case (1998 Act 114 §5(2))

Court-Ordered Involuntary Medication Petitions FY 2018 (July 2017 – June 2018)

Outcome of Petition	#	% Total
Granted	78	87%
Withdrawn or Dismissed	12	13%
Denied	0	0%
Total Number of Petitions	**90**	**100%**

The state filed 90 petitions for involuntary medication under Act 114 during that twelve-month time period. Twelve (12) of those petitions were withdrawn or dismissed before a court hearing. The courts granted the state's requests in the remaining seventy-eight (78) petitions and issued orders for involuntary medication of those individuals.

Input from Advocacy Organizations and Individuals

All state entities, organization and individuals who provided comments and recommendations responded to these six questions:

1. Were you directly involved with any individuals involuntarily medicated under Act 114?
2. Are you aware of any problems encountered in the implementation of this process?
3. What worked well regarding the process?
4. What did not work well regarding the process?
5. In your opinion was the outcome beneficial?
6. Do you have any changes to recommend in the law or procedures? If so, what are they?

Summary of feedback

1998 Act 114 §5(1) - Any problems that the department, the courts, and the attorneys for the state and patient have encountered in implementing Sec. 4 of this act.

Input in this section comes from:

- Vermont Department of Mental Health and its attorneys
  - Mourning Fox, Deputy Commissioner, Department of Mental Health
  - Karen Godnick Barber, General Counsel, Department of Mental Health
  - Matt Viens, Senior Assistant Attorney General, Department of Mental Health Legal Division
- The Office of the Administrative Judge for Trial Courts
  - Brian J. Grearson, Chief Superior
  - Judge Cortland Corsones, Family Division of the Rutland Superior Court
  - Judge Mary Miles Teachout, Civil Division of the Washington Superior Court
  - Judge Katherine Hayes, Windham Family Division, Windham Superior Court

Parties external to the Department were asked to complete a questionnaire containing the following questions:

- Were you directly involved with any individuals involuntarily medicated under Act 114?
- Are you aware of any problems encountered in the implementation of this process?

- What worked well regarding the process?
- What did not work well regarding the process?
- In your opinion was the outcome beneficial?
- Do you have any changes to recommend in the law or procedures? If so, what are they?

Assessment from the Vermont Department of Mental Health

From DMH's perspective, there continues to be some delay in providing timely and effective treatment to patients through the involuntary medication process. This delay is most frequent in the context of individuals who are awaiting hospitalization hearings in the Vermont Superior Court Criminal Division. DMH believes that certain changes to the involuntary medication statute enacted through Act 192 have produced positive results. They include the change permitting an expedited hospitalization hearing under 18 V.S.A. § 7615(a)(2) that may be consolidated for hearing with an application for involuntary medication, as well as that allowing a consolidated hospitalization and medication hearing for a patient who has been held on an application for involuntary treatment for longer than 26 days under § 7624(a)(6).

DMH believes these changes have, while not perfect, proved to be effective tools for providing certain patients with more timely treatment. This is particularly true for patients who continue to pose significant threats to themselves, other patients, or hospital staff after their hospitalization or who discontinue medication treatment after an initial period of compliance.

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.

Beginning with the years in which patient representatives employed by Vermont Psychiatric Survivors (VPS) have been interviewed, the report has included a recommendation that, with consent of the patient, patient representatives be included in treatment team meetings. As patient representatives bring the unique perspective of persons with lived experience, their inclusion could support both the interests of patients and the efforts of hospital staff seeking to help patients achieve recovery in the least-coercive manner.

In order to maintain clear records for documenting implementation of Act 114 in accordance with provisions of the statute, all hospitals have followed past FSA recommendations that each hospital maintain an electronic file or section within the electronic file for persons receiving medication under Act 114. This practice should continue, and files 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
- 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
- Further, while most documentation was present and complete, we recommend that:
- RRMC 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.
- VPCH and Retreat ensure that all 7-day reviews are completed and documented on 7 Day Review forms.
- Retreat continue efforts to ensure staff fully completed Implementation Forms so that information about support persons and gender of person administering IM medication are included.

Assessment from Vermont Judiciary

For the 2018 Commissioner's Report to the General Assembly on Act 114, Chief Superior Judge Brian J. Grearson submitted responses from three Vermont judges "who regularly presided over the largest number [of] Involuntary Medication requests" in calendar year 2018. Those judges were:

- Judge Cortland Corsones, Family Division of the Rutland Superior Court;
- Judge Mary Miles Teachout, Civil Division of the Washington Superior Court; and
- Judge Katherine Hayes, Family Division of Windham County.

Judge Corsones noted a single problem with implementation of the Act 114 process, saying that it can be challenging to schedule involuntary medication petitions within the required seven days, given the full docket the courts already have.

In Rutland, where Judge Corsones presides, involuntary medication hearings are held at the Rutland Regional Medical Center when judicial staffing allows and when a hospital conference room is available for use as a courtroom. Judge Corsones listed this as what works well in the Act 114 process in Rutland, since patients avoid the potentially traumatizing experience of being restrained during transport in a Sheriff's car and are therefore better able to participate.

In addition, according to Judge Corsones, there is excellent cooperation between the Attorney General's Office and Legal Aid on involuntary medications cases.

Under "what did not work well," Judge Corsones said the impact on staff and judge-time is significant, with no additional staff to assist. Involuntary medication cases also take top priority which means that already-scheduled juvenile cases, which are also considered a priority, are delayed.

Judge Corsones said the process is beneficial to the patient, particularly for those who are violent. He noted, however, that the process does not benefit those whose cases are delayed to make room for the involuntary medication cases. He also noted that the long-term benefits are unknown, with regards to the potential for reducing future need for involuntary medication.

Judge Mary Miles Teachout, who, as the presiding judge in Civil Division for Washington Superior Court, hears the cases at the Vermont Psychiatric Care Hospital and as such has heard more of these cases than

most other judges. Judge Teachout has responded to requests for feedback under Act 114 for the past three years, and this year provided an overview of her experience. She said she saw no problems or need for improvement in the process. Judge Teachout noted that the hearings are scheduled promptly and she typically rules on the record at the close of the hearing. If she cannot rule then, the decision is issues with a few days of the hearing.

The issues Judge Teachout highlighted were that sometimes doctors request more medication options than needed, and that requests for a year-long order that combines the Involuntary medication order and an ACT (Application for Continued Treatment (ACT) order is too long without judicial review.

Judge Katherine Hayes presides in the Windham Family Division where she hears cases from the Brattleboro Retreat. Judge Hayes said the problem she finds in the system is the time it takes from the point a person is involuntarily committed to when medication can be administered involuntarily, especially when hearings are consolidated. Judge Hayes noted there are almost invariably one, and sometimes more. Per statute (Sec. 7624(a)(6)) the petition for involuntary medication is not filed until after 26 days of hospitalization.

Requests for continuance are filed in order to consolidate hearings and have a more efficient process, Judge Hayes wrote. Instead, however, Judge Hayes believes that rather than making the process more efficient, the move to consolidate hearings results in a process that is as much as twice as long as it would otherwise be. In the meantime, the order for involuntary medication is also delayed. Judge Hayes said she has seen no use of the expedited hearing provision under Sec. 7615, which she believes would be a more effective avenue to getting treatment for a patient.

Judge Hayes said that counsel is prepared for these hearings and do an adequate job in court, communicating "very effectively" about the cases prior to the hearing. Further, Judge Hayes said that it seems that filing for Involuntary Medication often leads to the patient accepting medication voluntarily, and the petition is then dismissed.

For what has not worked well, Judge Hayes said that there are "far too many" delays and that the hearings "Seem to be becoming longer, more complex," and require more court time. Judge Hayes said the reasons for this are not clear.

The outcomes, Judge Hayes said, appear to be beneficial, but she wishes that acutely ill patients could be treated more quickly, given their evident suffering.

Judge Hayes recommends creation of "some method" to enable involuntary medication orders for patients who already have a non-hospitalization involuntary order that includes medication, if they stop taking the medication and begin to decompensate. "I think an effective method to ensure that they took their medications would significantly reduce their needs for hospitalization," Judge Hayes wrote. Judge Hayes suggested that a means of doing this that protects the individual's "due process rights" might include hospitalization of 30 days or less for involuntary medication only, with a set discharge date once medication compliance is established. Judge Hayes suggested this become part of the order of non-hospitalization 'revocation' process. Judge Hayes also requested clarity regarding the requirements for a competent advance directive.

Solicited Comments from Organizations and Individuals

1998 Act 114 §5(b) - Before submitting the report required in this section, the department shall solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct care providers, persons who have been subject to proceedings under 18 V.S.A. § 7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

Act 114 requires DMH to solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct-care providers, persons who have been subject to proceedings under 18 V.S.A. §7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

To meet this requirement, DMH solicited comments from Vermont Legal Aid, the Judiciary (see above for summary, appendix for full response), the National Alliance on Mental Illness-Vermont and its members, and Vermont Psychiatric Survivors and its members. DMH also included the Flint Springs independent findings.

Assessment from Vermont Legal Aid, Inc. (Mental Health Law Project)

Letter from John J. McCullough III, Project Director – see appendix for attachment of scanned letter

Vermont Legal Aid-Mental Health Law Project (MHLP) recommends that the state consider alternatives to involuntary medication and reduce use of what it called an "extremely intrusive practice." MHLP noted that the number of requests for involuntary medication has more than tripled since 2008, when 23 cases were filed. (MHLP stated that there were 89 cases filed in 2018, but DMH recorded 90, with 12 withdrawn or dismissed.)

MHLP cited "the extremely short time frames in which these cases are scheduled," and said they made it difficult to prepare properly in order to fairly represent their clients. With hearings scheduled with "as little as three- or four-days' notice," MHLP counsel finds it "extremely difficult to review several hundred pages of records, obtain an independent psychiatric examination, and adequately prepare for trial."

MHLP noted, however, that the Act 114 process resulted in withdrawals or denials of close to one third of all the cases filed for involuntary medication. MHLP also noted the state's practice of consolidating applications for involuntary treatment with a medication application under 18 V.S.A. S 7624 (a) (6), resulting in combined hearings and a more efficient scheduling process.

When responding to the question of what did not work well in the process, MHLP said the state is relying more frequently on the use of long-term medications, based on the patients' history of noncompliance. This is problematic, according to MHLP, since an application for involuntary medication requires refusal to take medication, which is recorded as "noncompliance." MHLP said this practice "demonstrates the general hostility on the part of the State and the State's psychiatrists toward patient autonomy and self-determination, which is inimical to the values of patient rights and voluntary treatment embodied in the statute."

MHLP stated that it is difficult to claim benefit from an order for involuntary medication, since "the entire process undermines the opportunity for patients to develop mutually respectful relationships

with their treatment providers." MHLP called for a study of the long-term outcomes of people who experience involuntary medication.

For changes to the law or procedure, MHLP recommended repeal of provisions in Act 192 that made the process to schedule involuntary medication and commitment cases faster. MHLP also recommends that the state restrict the use of long-acting involuntary medications "as a standard and routine treatment modality."

Assessment from Vermont Psychiatric Survivors

Email from Anne Donahue, then-acting executive director – see appendix for attachment of scanned email

Vermont Psychiatric Survivors submitted comments stating that clients face a "threat of legal action" from physicians to compel the patient to take medication, rather than the physician taking time to building a therapeutic relationship with the individual. In addition, such threats are reported to be used in order to get a patient to either change medications or increase the dosage of the medication they are taking when they resist a change in prescription. The process of involuntary medication and restraint is also cited as creating "a great deal of anxiety" about upcoming court dates, and feelings of powerlessness and mistrust and a feeling of imprisonment in the psychiatric facility. VPS state that it "has not seen anything that could be described as working well under this process."

VPS further questioned the use of medication, noting that "Many patients receiving involuntary medications do not seem to improve in any sense in their medically identified symptoms," and that the medications often have undesirable side effects. When patients' symptoms do improve, VPS noted a "corresponding flattening of the person's affect and obvious sedation." And while a patient's lack of insight into their illness may be cited by the state as justification for involuntary medication, VPS argues that a "perceived 'lack of insight' doesn't negate the patient's knowledge of "well-documented risks and dangers of the anti-psychotic medications" that may be given under an involuntary medication order.

Finally, VPS stated that the Vermont law which allows an individual to establish an advance directive to allow involuntary medication should they become incapacitated with mental illness obviates any need for involuntary medication based on court order.

Assessment from NAMI-VT

Letter from Laurie Emerson, executive director – see appendix for attachment of scanned letter

The National Alliance on Mental Illness-Vermont (NAMI) was contacted by individuals who were medicated involuntarily (and one who was not medicated but who was committed involuntarily) as well as family members and family support group leaders. There was no indication how many individuals provided feedback to NAMI.

Family members of some of those who were involuntarily medicated reported that the court-ordered process takes too long, which delays medication and leads to longer recovery times before the person can return home. At least one family member said that the process could be expedited if judges did not choose to review the involuntary commitment and treatment process separately,

Family members said they were traumatized by witnessing their loved one decompensate once medication they had been on is stopped; and further, that the patient's records of medication are not considered by psychiatric hospitals as part of the treatment plan.

When asked what worked well regarding the process, families and patients said that they found staff experienced and caring and that they established a good rapport with the patient. On the other hand, when asked what wasn't working well, at least one patient said they experienced a lack of respect, saying "this was the most traumatic experience of their life." A lack of continuity of care following discharge or while waiting in the emergency department was noted, with no follow-up once home. There was a specific request for "more services and support upon discharge when returning home," from at least one patient.

Feedback from family members regarding the outcomes of involuntary medication were that medication led to recovered wellness for their loved one.

Recommended changes in the law or the procedure were to:

- Treat people with respect throughout the entire process. A mental health crisis is a traumatic and overwhelming experience.
- All transporters need to be provided with soft restraints and educated about the use of them. Collecting data on all transports will help ensure oversight.
- Provide more trauma-based care and education for staff.
- Families want their loved one to receive treatment in a more timely manner.
- Provide continuity of care. Include the person's preferred psychiatrist and/or prescribing primary care physician in decision-making. Include the patient's preferred doctor on the treatment team.
- Involve the person's preferred family members/friends on the treatment team. Involve them in discharge planning.
- Individuals who are in the emergency department waiting for treatment may not understand their rights going through the involuntary hospitalization and medication process. Providing an explanation and copy of their rights will help inform the process.

Assessment from Vermont Psychiatric Care Hospital

Email from Dr. Alisson Richards – see appendix for attachment of scanned letter

Dr. Alisson Richards, Medical Director at the Vermont Psychiatric Care Hospital, said that there continue to be delays in getting the court order. "It is getting better," Dr. Richards wrote, "but it depends on which judge it is." She said that the process of giving the medication in the hospital usually proceeds with "no issues."

What worked well regarding the process?

Dr. Richards said that the ability to combine hearings for an Application for Involuntary Medication (AIM) and an Application for Continued Treatment (ACT) is helpful. "All legal parties take it seriously and it is addressed in a timely manner," she wrote.

What did not work well regarding the process?

Dr. Richards said problems arise when the order is delayed. This results in an extended length of stay for the patient, which necessarily delays discharge as well.

Another problem Dr. Richards noted was when the physician "doesn't feel they are allowed" to prescribe medications they feel are most appropriate for that patient.

In your opinion was the outcome beneficial?

Dr. Richards said that the statute is beneficial since it "facilitates discharge and starts the recovery process."

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

Dr. Richards said the time required to wait for a combined hearing could be shorter than the 26 days now in effect. She said that in her experience, the prolonged wait time strengthens the patients' determination to refuse medication, "locks them in a hospital," and increases the amount of time during which a patient may become violent.

Dr. Richards said that family members often ask why the doctors are waiting "so long."

"Physicians use ACT 114 as the last resort," she wrote. "No one wants to go to court but sometimes it's unavoidable."

Assessment from Rutland Regional Medical Center

Email from Dr. Julie Poulin – see appendix for attachment of scanned letter

Dr. Julie Poulin from Rutland Regional Medical Center said that the Act 114 process benefits patients and while delays to treat have been shortened, they continue to be longer than is best for the patients' welfare.

What worked well regarding the process?

Dr. Poulin said the delays for getting court-ordered medication are shorter than they have been.

What did not work well regarding the process?

While the delays are shorter, they continue to be too long when safety is at risk.

In your opinion was the outcome beneficial?

The outcome of involuntary treatment is beneficial according to Dr. Poulin.

Do you have any changes to recommend in the law :

Dr. Poulin recommends that treatment start on the day of admission.

"Hospitalization is for medical treatment," she wrote, "which means giving antipsychotic medications to psychotic persons who cannot make rational decisions due to their acute brain disease."

If a court hearing is need, then it should happen within 72 hours, Dr. Poulin wrote. Even then, she wrote, 72 hours represents "a significant clinical and costly delay," when the patients well-being and the hospital costs are calculated.

"It is possible," she wrote. "Other states are doing it."

Input from Individuals

All commenters requested anonymity – see appendix for scanned copies of all submissions

DMH received comments from two individuals who received medication involuntarily during fiscal year 2018, and one parent of someone who was treated involuntarily.

COMMENTS FROM INDIVIDUAL #1

Treatment at Brattleboro Retreat

Was the treatment fair?

One person who was treated at Brattleboro Retreat said they were not treated fairly and reported that it was a "violent experience." This individual reported that they were punched in the face and "concussed" and that they "went into shock."

Were the advantages and disadvantages of medication clearly explained, and why did you choose not to take medication?

They did not know what was happening, and that the reasons for the medication were not adequately explained until "a few days later," when they did understand. This person also noted that they had refused medication because they thought they could "handle triggers of my PTSD symptoms without medication with other coping strategies: Tai Chi, vitamins, herbal remedies, Tylenol, [illegible], meditation & aromatherapy & regular therapy appointments."

Are there differences between taking medication and not taking it?

To the question asking if the person notes any differences between the times when they are taking the medication and when they are not, they said "no," but then added a note saying "I have noticed with Zyprexa that I am less emotionally reactive and less emotionally vulnerable."

Was anyone helpful?

This person said Dr. Jeffries was "very helpful," with "amazing, compassionate listening skills and is willing to change treatment (the dosage of Zyprexa) according to patient needs." An assistant named Kerry was "extremely helpful" finding clothes for the patient. "I had no [illegible] clothes and we went through a closet one day laughing and reorganized the closet. It was the first time I have laughed in a

long time." Another assistant, Bob, helped the patient with their art work and helped hang their paintings. "Bob has….[been] helping me look ahead and talking art & photographing my work!"

"Painting again started to make me smile, again [sic]. All 3, Dr. Jeffries, Kerry & Bob were part of this wonderful change for me. Ann, my social worker has been like dream come true [sic]. Everything I asked for needing help she took care of. I have never had such consistent care, positivity and compassion. She's a keeper!"

Recommendations

The changes this person recommends is more kindness and consistency. This individual said that after they experienced the concussion, they were given a bag of ice for a swelling on their face. When the shift changed, however, three nurses said this person wasn't allowed a bag of ice, even though their face was still swollen.

COMMENTS FROM INDIVIDUAL #2

Was the treatment fair?

The second individual who submitted feedback reported that they were fairly treated at the University of Vermont Medical Center.

Were the advantages and disadvantages of medication clearly explained?

This person also said the advantages and disadvantages of taking medication were explained adequately to help them decide whether to take medications or not. "The advantages," this person wrote, "were that I was fairly treated, treatment was very well accepted and my life skills were repaired and enhanced through this entire process. Thank you for your understanding."

Are there differences between taking medication and not taking it?

This individual answered "yes," and listed the differences as "1) clarity in my understanding, 2) thought-perceptions makes all things easier to mentally RECEIVE, 3) I am physically, emotionally and spiritually well and healthy."

Was anyone helpful?

This person said that the RNs [registered nurses], group therapists, charge nurses, psychiatrists, doctors, LNAs [licensed nurse assistants] and LPNs [licensed practical nurse] all worked with them "in my mental illness. This treatment brought about a change in my perspective….I became more self-aware, trusting and believing in myself and trusting in the medical staff."

Recommendations

This individual asked that changes be made in the law to use adjectives that are person-focused and "appealing, such that a patient in crisis become aware of the peaceful presence of the psychiatric and medical staff."

COMMENTS FROM INDIVIDUAL #3

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

The single family member who provided feedback reported that their loved one waited seven weeks for treatment, due to delays in the court process. This was too long, the commenter wrote. “It is inhumane to sit by and watch someone deteriorate; to become incapacitated almost to the point of no return because of their psychosis; to lose their ability to function and all sense of reality.” The commenter stated that research shows that delaying treatment until the person becomes so ill risks brain damage. “If someone came into the emergency department unconscious and in need of oxygen, it would be administered,” the commenter wrote. “No one would let brain damage set in while waiting for a court process to unfold.”

What worked well?

The commenter said that what worked well in the process was that their family member received treatment. What did not work well was the long time required to get the court order processed. The commenter said an “expedited process” is needed.

What did not work well?

The process took too long, the commentator wrote. “We are doing harm when there are barriers in place *that prevent accessing timely treatment.”*

Was the outcome beneficial?

The outcome was beneficial, according to the commenter.

Recommendations

This family member recommended that judges be required to render a decision in three days at the most.

Comments from Individual #4

Treated at Vermont Psychiatric Care Hospital

Was the treatment fair?

This person said the treatment was not fair. They said they had no court hearing specifically regarding involuntary medication.

Were the advantages and disadvantages of medication clearly explained?

This person answered no and further said that they had chosen not to take medication due to concerns over weight gain and becoming dependent on the medication.

Are there differences between taking medication and not taking it?

They said they have noticed they are gaining weight.

Was anyone helpful?

This person said a nurse “was particularly kind and offered many words of encouragement,” while and a mental health specialist “was able to connect with me very well as well.”

Recommendations

The commenter said there were “no particular” recommendations.

COMMENTS FROM INDIVIDUAL #5

Patient at Brattleboro Retreat

Were you treated fairly?

The person said that yes, they were treated fairly.

Were the advantages and disadvantages of medication clearly explained?

Yes, they said, they were.

Are there differences between taking medication and not taking it?

This person said yes, that they are “less miserable” and “not as afraid.” “It really helps me,” the respondent wrote.

Was anyone helpful?

Yes, this person said, two nurses were “really nice,” as was a Dr. Krasnow. In addition, this person happened to know the person in the room next door, and that person said taking medication and eating the food and drinking the water at the Brattleboro Retreat was safe. This person had been afraid those things were “poison.”

One of the nurses brushed this person’s hair and put it into a braid, “which made me feel she cared,” this person wrote.

Recommendations

This person did not make any recommendations for changes. Instead, they wrote that “it was really important for me to get my medication and to be at Brattleboro, even though at the time I didn't want to because I thought everyone was trying to kill me.”

“If that ever happens to me again, I want my team to support me and get me the help I know I might need,” this respondent wrote.

Recommendations from the Department of Mental Health

Two Reports on Implementation of the Act 114 Process

For several years both the Commissioner’s Report and the Independent Report on the Implementation of Act 114 have recommended that one report should be considered sufficient for legislative review and oversight. The DMH Commissioner reiterates previous recommendations that the General Assembly strongly consider the current redundant content of these two reports on Act 114, eliminate the annual report from the department, and expect an independent report to capture both departmental actions and individual experiences in this area together with recommendations for changes in the law.

DMH will continue to monitor the numerous variables that impact and influence the implementation of Act 114, which may influence future legislative changes

Opportunities for Improvement

Focus on Recovery

For many years Vermont's Department of Mental Health has emphasized the concept of recovery as invaluable both for providers and for recipients of mental-health serv-ices. Recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." It is DMH's desire to focus on recovery as a way to help individuals live healthier lives as the healthier the individual, the less need for involuntary treatment (including hospitalization and medication).

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

- Health
- Home
- Purpose
- Community

The ten guiding principles of recovery are:

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

The next challenge is to move the concepts of recovery into tools and strategies that can be implemented in areas of health and wellness education, illness self-management and self-awareness, and appreciation of the negative impact of inadequate care for self on family, significant others, and the greater community. Individual stability and self-sufficiency are also compromised when compensation strategies are not identified in the absence of timely treatment for an acute phase of mental illness.

Maximizing Individual Preference and Systemic Resources

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

- Expanded mobile crisis capacities all over the state,
- Hospital diversion and step-down,

- Peer-supported alternatives such as Alyssum and Soteria House
- The Vermont Psychiatric Care Hospital in Berlin
- Continued emphasis on least-restrictive transport
- Support for training in the Six Core Strategies for reducing seclusion and restraint
- Efforts to identify the most effective ways to support individuals experiencing early-episode psychosis (for example, Open Dialogue and the additional requirement for Mental Health Block Grant funding to use 10% of the state's allocation to explore approaches to the onset of early severe mental illness)
- Team Two training for collaboration between mental health providers and law enforcement, looking toward more individualized responses to people in emergency situations
- Working toward making orders of non-hospitalization more effective as treatment tools in the community through technical assistance
- Potential opportunities to collaborate with the Vermont Ethics Network in facilitating stakeholder discussions regarding community-driven priorities for mental-health system change, treatment intervention, and individual engagement strategies, and accountability tools that would improve individual and system outcomes
- Expansion of Warm Line hours

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

In Closing

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

DMH still believes that it will be necessary to revisit statutes, specifically Titles 13 and 18, in the future to seek changes that would:

- Better support best practices for active treatment of individuals experiencing mental illness in psychiatric inpatient care,
- Affirm expectations for restoration of capacity when possible during psychiatric hospitalization, and,

- Endorse community-based treatment approaches and service models that proactively promote psychiatric stability and community participation

Appendix

Copies of Any Trial Court or Supreme Court Decisions, Orders, or Administrative Rules Interpreting 1998 Act 114 §4

There were no relevant court decisions in 2018.

Response from Vermont Superior Court

VERMONT SUPERIOR COURT

VERMONT SUPREME COURT
109 STATE STREET
Brian J. Grearson
MONTPELIER, VT 05609-0701
Chief Superior Judge
Tel: 802-828-3278

Office of the Chief Superior Judge

November 30, 2018

Mourning Fox, Acting Commissioner, Department of Mental Health
c/o Ms. Emma Harrigan
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010

Dear Mr. Fox,

I am writing in response to your letter of August 14, 2018, requesting comments from the judiciary regarding the experience with the implementation of Act 114 during the last year.

The letter requested a response to specific questions relating to the Judiciary's experience with Involuntary Medication proceedings. Due to the small number of medical facilities that address the needs of the patients involved in such proceedings, the responses were correspondingly limited to the relatively small number of judges who routinely preside over these cases. The following responses are from the judges who regularly presided over the largest number Involuntary Medication requests.

Judge Cortland Corsones presides in the Family Division of the Rutland Superior Court and responded to the specific questions as follows:

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

2. Are you aware of any problems encountered in the implementation of this process?
    - It can be a challenge trying to set the involuntary medication petitions within 7 days. It does affect the rest of the docket – including mental health cases and juvenile cases.

3. What worked well regarding the process?
    - In Rutland, we try to hold these hearings at the Rutland Regional Medical Center, where we have set up a courtroom in a conference room. This increases participation by the patients. It also reduces the trauma of transport with a sheriff, where the patients are restrained (shackled). It can be a challenge to schedule the room however, as the hospital also uses this

room for other purposes. Also, we sometimes have to hold the hearings at court because we are short-staffed and cannot afford to lose a staff member and judge from the courthouse.

It should also be noted that there is excellent cooperation between the A.G.'s and Legal Aid in these cases, and these two entities communicate well with the court to make the process work.

4. What did not work well regarding the process?

- The impact on the staff and judge-time is significant. It has created more work, and we have not received any more staffing. It also means that we have to bump already-scheduled juvenile cases (which is also a priority docket) to schedule the mental health hearings in the time required by statute.

5. In your opinion was the outcome beneficial?
    - It's beneficial to the respondent in the mental health cases, but not beneficial to the parties whose cases get bumped so that we can hear the mental health cases. In particular, it appears to be beneficial in the cases where the patient is acting out violently in the hospital. In the long run, we do not know how beneficial the new process with be for the patients, as far as reducing future involuntary medication applications.

6. Do you have any changes to recommend in the law or procedures? If so, what are they?
    - Only that we receive increased staffing and judge-time commensurate with the new responsibilities and workload.

Judge Mary Miles Teachout has been the presiding judge for the last three years in the Civil Division in Washington Superior Court which includes jurisdiction over the Vermont Psychiatric Care Hospital where most hearings are conducted. Judge Teachout probably has had the most experience of any judge in these types of proceedings and has responded in the past to this request on a question by question basis but offers the following narrative commentary on her experiences over the last year:

- I have conducted several hearings during the last year, and the process seems to function efficiently for the parties and the court. I cannot think of any problems or needed improvements.
- Hearings are scheduled promptly with input from the attorneys as to the type of hearing needed, conference or hearing on the merits. The hearings are scheduled within a week of a request for a contested hearing. I generally rule on the record at the close of the hearing or the decision will be issued within a couple of days of the hearing.
- The doctors will sometimes request more medication options than they really need, given the person's history, and are usually frank about admitting that they do not think they would need option #2 but like to have the option.
- Sometimes when an IM hearing is combined with an ACT hearing, DMH will ask for a year-long order coterminous with the ACT order. Those are usually case-specific, but generally, I believe that can be too long without a judicial review.

Mourning Fox, Mental Health Services Director

Judge Katherine Hayes has been presiding in the Windham Family Division where she hears the majority of the cases from the Brattleboro Retreat. Her response follows:

1. Were you directly involved with any individuals involuntarily medicated under Act 114?
    - Yes.
2. Are you aware of any problems encountered in the implementation of this process?
    - I have ongoing concerns about the delays in this process. Typically, a patient enters the hospital involuntarily, a petition for involuntary treatment is filed, and the application for involuntary medication is filed after 26 days (per Sec. 7624(a)(6)). There are then almost invariably at least one and sometimes more requests for continuance, stipulated to by both parties, in order to have a more efficient consolidated hearing. In fact, however, my experience suggests these hearings are not more efficient (they seem to take about twice as long), and they result in significant delay in the issuance of orders of involuntary treatment. My sense is, and I have included this in my findings in recent cases where it seemed of particular relevance, that a patient who would not be eligible for an expedited hearing, pursuant to 7615 is much more likely to be willing/able to voluntarily accept medication if s/he is subject to court order for involuntary hospitalization for 90 days. Then, the conversation with care providers can and will include the reality that the patient's discharge from the hospital is likely to require them to take medications, whether they fully accept that they are effective or necessary, or not. I have seen NO applications for expedited hearing under 7615, and I think that process is much underutilized.

3. What worked well regarding the process?
    - Counsel are prepared and do an adequate job in court. Counsel are able to communicate very effectively about cases prior to hearing. Often, it appears, patients are willing to accept treatment after a petition for IM is filed, and the petition can then be dismissed. We see some cases in which a patient is discharged from the hospital before any involuntary treatment or IM order is issued, even after petitions for both are filed. (Most cases that are filed for IM do require hearings, however).

4. What did not work well regarding the process?

- See above. There are far too many delays, and the hearings themselves seem to be becoming longer, more complex and requiring more court time. The reasons for this are not clear.

5. In your opinion was the outcome beneficial?
    - In general, I think so. I just wish that patients who are very severely ill and suffering could obtain the medications they need more quickly. The current system does not make that happen, particularly if motions to expedite hearings for IT are not filed.

6. Do you have any changes to recommend in the law or procedures? If so, what are they?
    - See above. I also wonder whether there is not some method to enable IM orders for patients who are on non-hospitalization involuntary orders, including medication requirements, who begin to decompensate when they choose to stop taking their medications. I think an effective method to ensure that they took their medications would significantly reduce their needs for hospitalization. I would hope that a process to protect their due process rights and enable their perhaps very brief (30 days or even less?) hospitalization for IM alone and discharge on a date certain with medication compliance could be constructed. This could be made part of the ONH "revocation" process, I would think, which currently has very little substance to it. Clarity regarding the requirements for a competent advance directive would also be helpful.

I trust this responds to your inquiry but in the if you require further information, or clarification of any of the above information, please contact my office.

Very truly yours,

Brian J. Dearson

Brian J. Grearson

Chief Superior Judge

Response from Vermont Legal Aid, Inc. Mental Health Law Project

Comments received via email November 30, 2018

VERMONT LEGAL AID, INC,
MENTAL HEALTH LAW PROJECT
P, O. Box 1562
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OFFICES

BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

October 26, 2018

Mourning Fox
Deputy Commissioner
Department of Mental Health
280 State Dr., NOB 2 North
Waterbury, Vt. 05671-2010

Re: Annual Act 114 study

It is the policy of the General Assembly to work toward a mental health system that does not require coercion or the use of involuntary medication. 18 V.S.A. 7629(c)

Dear Deputy Commissioner:

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

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

Our records show that the Department of Mental Health filed eighty-nine involuntary medication cases in fiscal year 2018 to date, which would equal the all-time calendar year record set in 2016. [1] This continues the pattern of continuous increases in involuntary medication since 2008, as this table demonstrates. Since 2008 the number of involuntary medication cases filed by the State has more than tripled, and it has more than doubled since 201 1, the year the State Hospital closed.

YEAR	INVOLUNTARY MEDICATION CASES FILED
2008	23
2009	30
2010	31
2011	39
2012	45
2013	64
2014	77
2015	79
2016	82
2017	80
2018 FY	89

Were you directly involved with any individuals involuntarily medicated under Act 114 in 2017? The Mental Health Law Project was appointed by the Superior Court to represent the respondents in all of these cases. To my knowledge there were no cases in which the respondent was either represented by outside counsel or pro se.

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

While the statute allows for a continuance for good cause, the Department generally opposes requests for continuance filed by the MHLP in these cases, regardless of the grounds or merits for the continuance request. It is important to note that the Department has the advantage in this situation, since it has complete control over when it files these cases.

What worked well regarding the process? Act 114, and the availability of court-appointed counsel to represent the patients in the State's custody, is the only mechanism available to either prevent unjustified use of involuntary medication or to restrict the State's psychiatrists from administering medications or doses that would likely be harmful to the patients. Consistent with previous years, in 2017 approximately one third of the involuntary medication cases filed resulted in a denial by the court, a dismissal by the State, or an order from the court limiting the medications sought or the method of administration; in other cases, the State, after hearing from the independent psychiatrist, agrees to exclude a requested medication or reduce the requested dose.

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

One pattern we have noted is the state's increased use of the statutory process to consolidate an application for involuntary treatment (AlT) with a medication application under 18 V.S.A. S 7624(a)(6), which allows a combined hearing in cases where the AIT has been pending for more than twenty-six days. This is often accomplished by agreement of the parties, and results in a more efficient scheduling process than might otherwise be possible.

What did not work well regarding the process? In the past few years we have noticed a trend for the State to routinely request

[1] We have changed to the use of fiscal year data, which seems to be what the state has been using. 89 exceeds the number of medication applications in our records for any calendar year.

authorization to involuntarily administer long-acting medications. A few years ago when the statute was changed to raise the legal standard for long-acting medications we observed that courts took the mandate of the law seriously and were less likely to approve these applications; as a result it appeared that the state became more selective concerning the cases in which it requested long-acting medications. The tide seems to have turned, though, and the state seems to be relying more frequently on this extremely intrusive measure with no more substantial basis than the patient's history of "noncompliance". Since "noncompliance", or refusal of prescribed medications, must be present whenever there is an application for involuntary medications, basing an application on this is the opposite of the individualized showing the statute requires. As I note below, this practice demonstrates the general hostility on the part of the State and the State's psychiatrists toward patient autonomy and self-determination, which is inimical to the values of patient rights and voluntary treatment embodied in the statutes.

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

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

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

patient self-determination and autonomy in any regime of forced treatment.

In addition, a growing body of evidence demonstrates that in the long run, keeping patients on psychotropic medications does not result in improved functional outcomes. Pursuing forced treatment is a choice by the mental health system to favor immediate convenience over the long-term good of the patient. We continue to believe that Vermont needs a study of the long-term outcomes of people who are subjected to forced medication.

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

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

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

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

Very Truly Yours,

John J. McCullough III
Project Director

Response from Vermont Psychiatric Survivors

Via email, December 11, 2018
Responses to DMH regarding Act 114

1. VPS peer support staff have been directly involved with a number of individuals medicated under Act 114, most frequently because of the many individuals at the Brattleboro Retreat who are medicated through court order, particularly on the Tyler 4 unit.

2. The most common problem with implementation that we have seen is the use by physicians of the threat of legal action to compel patients to take medication rather than building any kind of therapeutic alliance. This is directly contrary to the recognized priority of building a therapeutic alliance as the best practice. We have also heard from many patients that their doctors have threatened them with involuntary medication orders to get them to change from medications that they are currently taking or to increase the amount of those medications when they don't want to. Further, patients often report adverse reactions to medications. Patients with whom our staff have spoken describe experiencing a great deal of anxiety surrounding court dates regarding their care and cite a feeling of powerlessness.

3. VPS has not seen anything that could be described as working well under this process.

4. As noted in the response to question 2, patients report that involuntary medication is a source of great anxiety and feelings of powerlessness. They also report that it creates a great deal of mistrust towards their care teams. It also prompts a greater feeling of being imprisoned in the psychiatric facility.

5. The outcome of these processes does not seem beneficial to VPS staff. Many patients receiving involuntary medications do not seem to improve in any sense in their medically identified symptoms, and patients have frequently reported undesirable side-effects. When there is a reduction in medically identified symptoms, there is a corresponding flattening of the person's affect and obvious sedation occurring.

In prior reports on Act 114 there have been references to patient lack of insight into illness and that this somehow invalidates their understanding and awareness of the risks associated with the medications normally ordered under Act 114 proceedings. These seem like separate issues to our staff -- a perceived 'lack of insight' does not invalidates a patient's knowledge of the well-documented risks and dangers of the antipsychotic medications that are generally ordered involuntarily.

VPS also notes that for those patients who report a benefit from medications and a desire to have them ordered if they are found not competent and do not consent (none of whom our staff have encountered) Vermont law creates an option to execute an advance directive that is not revocable during times of incapacity. This option negates a need to support involuntary medication laws based upon the reports of individuals in that subgroup.

Submitted by Anne Donahue, Interim Executive Director
Vermont Psychiatric Survivors
December 10, 2018

Response from NAMI Vermont

December 21, 2018

Kathleen Hentcy
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010

Dear Ms. Hentcy,

Thank you for the opportunity for the National Alliance on Mental Illness of Vermont (NAMI Vermont) to provide comment to the Department of Mental Health for your report on Act 114.

When families or individuals are in crisis and need education and support, they contact NAMI Vermont's 800 Resource Referral Line. Additionally, NAMI Vermont shared the Act 114 questions with our membership to request their feedback if they have been involved with the process. The comments below are responses from conversations we've had with individuals and/or families who have gone through the involuntary court-ordered medication process.

1. Were you directly involved with any individuals involuntarily medicated under Act 114 in 2018?
    - NAMI Vermont was contacted by individuals who identified as either a patient, family member, or family support group leader who had direct experience with the involuntary medication process and/or involuntary commitment process. One individual was involuntarily committed, but not involuntarily medicated. The feedback provided is in regard to how the involuntary process could be improved.
2. Are you aware of any problems encountered in the implementation of this process?
    - Feedback from patients:
        - Lack of privacy in the emergency department while changing into gown and throughout 7-day stay, lights always on, unable to rest.
        - Unable to rest at in-patient unit with 15-minute checks all night with flashlight.
        - No follow-up and check-ins by the designated agency throughout the emergency department waiting period.
        - Wanted a re-evaluation at 72 hours - did not receive it.
        - Telehealth evaluation with a cell phone was used on the second day. Patient reported that this was impersonal and did not provide a realistic evaluation for assessment.
        - Metal shackles were used to transport to the psychiatric hospital when the patient reported not being hostile or agitated.

        - Did not receive a copy of the Involuntary Rights document while in the emergency department to know patient rights at the beginning of the process.
    - Feedback from families:
        - Supportive family members who are caregivers for their loved one experience trauma in seeing their mental health decompensate – due to stopping medication that had stabilized them previously.
        - The court ordered process takes too long.
        - Judges use their discretion as to whether the involuntary commitment and treatment process is reviewed together or separately. The process could be expedited if done together.
        - Long wait times to receive medication impacts longer recovery time to return home.
        - The individual's historical records with medication are not considered by psychiatric hospitals as part of the treatment plan.
3. What worked well regarding the process?
    - Both families and patients reported experienced, caring staff, who establish a good rapport with the patient worked well.
4. What did not work well regarding the process?
    - Feedback from patients:
        - Lack of respect – felt that this was the most traumatic experience of their life.
        - Lack of continuity of care upon discharge or while waiting in the emergency department. No follow-up or check-ins while home.
        - Need for more services and support upon discharge when returning home.
    - Feedback from families:
        - The screening and assessment process should be done in a timely manner.
        - Alternative emergency rooms for mental health crises have advantages and disadvantages. Benefit with having a separate, calm environment for people in crisis, however one family member reported that the wait in this alternative room was extremely long (3 weeks). Questioned whether other patients were given priority since this alternative room was available.
    - Both Families and Individuals:
        - Reports of confrontations in the emergency department with security who were not empathetic or have an understanding of how to communicate effectively – only escalating the situation.
        - Security and sitters need better training on how to interact with someone who is experiencing a crisis or psychosis.
        - Reports that there needs to be better continuity of care upon discharge to home or the community.
5. In your opinion, was the outcome beneficial?
    - Feedback from families:
        - Once medicine was at a therapeutic level, their loved one's wellness returned over time.
    - Feedback from patients:
        - No. The involuntary commitment process was the most traumatic experience they had been through.
6. Do you have any changes to recommend in the law or procedures? If so, what are they?
    - Feedback from respondents:

- Treat people with respect throughout the entire process. A mental health crisis is a traumatic and overwhelming experience.
- All transporters need to be provided with soft restraints and educated about the use of them. Collecting data on all transports will help ensure oversight.
- Provide more trauma-based care and education for staff.
- Families want their loved one to receive treatment in a more timely manner.
- Provide continuity of care. Include the person's preferred psychiatrist and/or prescribing primary care physician in decision-making. Include the patient's preferred doctor on the treatment team.
- Involve the person's preferred family members/friends on the treatment team. Involve them in discharge planning.
- Individuals who are in the emergency department waiting for treatment may not understand their rights going through the involuntary hospitalization and medication process. Providing an explanation and copy of their rights will help inform the process.

Thank you

Laurie Emerson, Executive Director

NAMI Vermont

Response from Vermont Psychiatric Care Hospital

Comments by Dr. Alison Richards

Received via email January 11, 2019

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

8. Are you aware of any problems encountered in the implementation of this process? In regards to the court process - there are sometimes delays in getting the order from the judge. It is getting better but it depends on which judge it is. In regards to giving the medication in the hospital, there are usually no issues.

9. What worked well regarding the process? The change in statute where we could combine hearings (AIM & ACT) was helpful. All legal parties take it seriously and it is addressed in a timely manner.

10. What did not work well regarding the process?
    i. When there is a significant delay in the order from judge and the patient is getting emergency procedures in the meantime which extends the length of stay/discharge.
    ii. When the physician doesn't feel they are allowed to choose the medications that they feel are most appropriate for that patient.

11. In your opinion was the outcome beneficial? Yes, the outcome of using Act 114 is beneficial as it facilitates discharge and starts the recovery process.

12. Do you have any changes to recommend in the law or procedures? If so, what are they? The time the AIT is filed, we have to wait 26 days for a combined hearing - That time could be shorter as my experience is waiting longer when someone is adamant that they are not taking meds, it prolongs their autonomy and locks them in a hospital, and a patient could be violent during that time. Feedback from family is often why are we waiting so long. Physicians use ACT 114 as the last resort. No one wants to go to court but sometimes it's unavoidable.

Response from Rutland Regional Medical Center

Dr. Julie Poulin

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

   yes

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

   yes

3. What worked well regarding the process?

   Shorter delay to get court ordered medications

4. What did not work well regarding the process?

   Still too long before patient can get court ordered medications when safety is at risk

5. In your opinion was the outcome beneficial?

   yes

6. Do you have any changes to recommend in the law :

Hospitalisation is for medical treatment which means giving antipsychotic medications to psychotic persons who cannot make rational decisions due to their acute brain disease, so ideally treatment should always start on the day of admission to ED/Hospital.

Realistically, if a court hearing for commitment and court ordered treatment (medications) is necessary by the law, this should happen in 72h... which is already a significant clinical and costly delay when calculating cost of hospital day for patients who are not being treated yet. It is possible, other states are doing it.

Individual Responses Received

Response from Individual #1

Comments received via email, December 9, 2018
Treatment at Brattleboro Retreat

Based on your experiences ~~at~~ at Brattleboro Retreat [hospital] this year, please answer the following questions:

1. Do you think you were fairly treated even though the process is involuntary?
   Yes_____ No X

   If your answer is no, please describe what you felt was unfair about the process. If you went to court for your medication hearing, please tell about the court first and then tell about your experience in the hospital. It was a violent experience. I was punched in the face without touching or threatening anyone & concussed without knowing what was happening at the Brattleboro Retreat.
   In court:

   At [hospital]:

2. Do you think that the advantages and disadvantages of taking medications were explained clearly enough to help you make a decision about whether or not to take them?
   Yes_____ No X Not in the beginning, but a few days later I understood and it was explained to me. I went into shock after I was hit and the face, fell down, and was concussed

3. Why did you decide not to take psychiatric medications?
   I thought I could handle to triggers of my PTSD symptoms without medication with other coping strategies: Tai Chi, vitamins, herbal remedies, tylenol, mudras, meditation, & aroma Therapy & regular Therapy appointments.

4. Now that you are on medication, do you notice any differences between the times you are taking your medications and the times you are not? I have noticed with Zyprexa that I am less emotionally reactive and less emotionally vulnerable.
   Yes_____ No X

   If your answer is yes, please tell about the differences that you notice.

VERMONT

5. Was anyone particularly ~~helpful?~~ Anyone could include staff at the hospital or a community mental health center, a friend, a family member, a neighbor, an advocate, someone else who is in the hospital where you were medicated—really, anyone. (You do not have to give the names of individuals, just your relationship to them.)

Yes X No

Who was helpful? Once Dr. Jeffries and I got to know each other under the ~~circum~~ circumstances he was very helpful. He has amazing compassionate listening skills and is willing to change treatment (the dosage of Zyprexa) according to patient needs. Kerry was extremely helpful. I had no contact clothes and we went through a closet one day laughing and

In what ways was he/she helpful? reorganizing the closet it was the first time I had laughed in a long time. Bob has helped me with my art work getting me masking tape to hang the paintings where other staff members refused to give it to me. Painting again started to make me smile again all 3, Dr. Jeffries, Kessy, & Bob were part of this wonderful change for me... (con't)

6. Do you have any suggestions for changes in Act 114? Don't know it - Can't answer questions.

Yes No

Please describe the changes you would like to see.

More kindness. After my concussion I was allowed ice in a plastic bag for 12 hours (9x). Then suddenly even though my face was still swollen, 3 nurses told me I wasn't allowed ice in a bag. Even though once I ~~learned~~ learned they needed the bag I made sure I gave them the empty bag. ~~Have~~ More consistency from one shift to the other on rules.

Thank you for taking the time to complete this questionnaire.

Ann, my social worker has been like dream come true. Every thing I asked for needing help she took care of. I have never had such consistent care, positivity, and compassion. She's a keeper!

Bob has just been helpful with tape but helping me look ahead and talking art & photographing my work!

Kerry just overall has been very concerned with how I am doing each day...

VERMONT

Response from Individual #2

Comments received via mail, November 14, 2018

Treatment at University of Vermont Medical Center

Please help the Commissioner of Mental Health prepare a report on involuntary non-emergency medication in Vermont. As a patient who has been through the process of an application for involuntary treatment, you can offer invaluable information and insights that could help improve inpatient psychiatric care.

Your answers to these questions are very important. You do not have to answer them, but we hope that you will. You do not have to answer all of them at once if you do not want to. You may answer as many as you want at any one time and then answer the rest at other times when you feel ready to do it. You will be eligible to receive an honorarium of $50.00 for taking the time to answer these questions.

All of your answers will be considered confidential and will not be used in any way that would identify you individually.

Based on your experiences at UVMMC in 201B please answer the following questions:

1. Do you think you were fairly treated even though the process is involuntary?
Yes __X__ No_____

If your answer is no, please describe what you felt was unfair about the process. If you went to court for your medication hearing, please tell about the court first and then tell about your experience in the State Hospital.

In court:

At the UVMMC:

2. Do you think that the advantages and disadvantages of taking medications were explained clearly enough to help you make a decision about whether or not to take them?
Yes__✓__ No_____

The advantages were that I was fairly treated, treatment was very well accepted and my life skills were repaired and enhanced throughout the entire process. Thank you for your understandings.

4. Now that you are on medication, do you notice any differences between the times you are taking your medications and the times you are not? Yes__✓__ No_____

If your answer is yes, please tell about the differences that you notice.

1, Clarity in my understandings.
2, Thought-Perception makes all things easier to mentally RECEIVE,
3, I am Physically, Emotionally and Spiritually well and healthy.

3. Why did you decide not to take psychiatric medications?
At the time that I was ill, it was difficult to discern the process of healing.

5. Was anyone particularly helpful? Anyone could include hospital staff for a community mental health center, a friend, a family member, a neighbor, an advocate, someone else who is hospitalized at the hospital where you are (or were)—really, anyone.

_____ _____ Yes v/ No

Who was helpful? (You do not have to give the names of people. You might say a nurse, a doctor, a friend, or anyone else who was helpful.)
RN's - Group Therapists - Charge Nurses, Psychiatrists, Doctors, LNA's CPN's.

In what ways was he/she helpful?
Each of them worked with me in my mental illness. This movement brought about a change in my perspective. Resulting from this I became more self-aware, trusting and believing in myself and trusting in the medical staff.

6. Do you ha e any suggestions for changes in the law called Act 114? Yes ✓ No_____

Please describe the changes you would like to see.
Use adjectives that are more personal and appealing, such that a patient in crisis becomes aware of the peaceful presence of psychiatric and the medical staff. — Thank you

Response from Individual #3

Comments received via email, 11/20/2018

Treatment of a Loved One

Were you or your loved one involuntarily medicated under Act 114 in 2017?

Yes - loved one

Are you aware of any problems encountered in the implementation of this process? (If yes, see question below to respond.)

Yes - it took seven weeks from the time we brought our family member to the ED, to the time they received medication. They lacked capacity for informed consent - not knowing the implications for accepting or refusing treatment. We had to wait for the court process to unfold. It is inhumane to sit by and watch someone deteriorate; to become incapacitated almost to the point of no return because of their psychosis; to lose their ability to function and all sense of reality. There is research that shows that the longer someone remains in an actively psychotic state, the higher the risk for brain damage. If someone came into the emergency department, unconscious, and in need of Oxygen, it would be administered. No one would let brain damage set in while waiting for a court process to unfold.

What worked well regarding the process?

Ultimately, our family member received treatment.

What did not work well regarding the process?

The timeline - waiting for the court hearing date, then the hearing, then a decision by the Judge about whether our family member could be treated. This process took too long. We need an expedited process. People should not be allowed to suffer, to deteriorate while a prolonged Judicial process is followed. We don't wait until stage 4 to treat cancer, when it is the most difficult to treat. We intervene as early as possible, when the response to intervention has the best chance. "First, do no harm" - the Hippocratic Oath, the ethical standard in medicine, should be applied equally for mental health treatment if we want true parity. We are doing harm when there are barriers in place that prevent accessing timely treatment.

In your opinion, was the outcome beneficial?

Yes, but the process was too long.

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

The process needs to be expedited. Patients are languishing and suffering in EDs and hospitals without treatment. Family members feel helpless about how to assist their

loved one. Court hearing dates must happen more quickly. Decisions by Judges must be made within a certain time frame - three days maximum.

Response from Individual #4

Comments received via email December 9, 2018
Treatment at Vermont Psychiatric Care Hospital

Please help the Commissioner of Mental Health prepare a report on involuntary non-emergency medication in Vermont. As a patient who has been through the process of an application for involuntary treatment, you can offer invaluable information and insights that could help improve impatient psychiatric care.

Your answers to these questions are very important. You do not have to answer them, but we hope that you will. You do not have to answer all of them a once if you do not want to. You may answer as many as you want at any one time and then answer the rest at other times when you feel ready to do so. You will be eligible to receive an honorarium of $50.00 for taking the time to answer these questions.

All of your answers will be considered confidential and will not be used in any way that would identify you individually.

Based on your experiences at *Vermont Psychiatric Care Hospital* in *Berlin, VT* , please answer the following questions:

1. Do you think you were fairly treated even though the process is involuntary?

Yes_____No___*X*____

If your answer is no, please describe what you felt was unfair about the process. If you went to court for your medication hearing, please tell about court first, then tell about your experience in the hospital.

In court:

I was not given a court hearing during which there was specific discussion of involuntary medication. I did attend one court hearing at a different hospital (UVMMC), but involuntary medication was not discussed during the hearing.

At the hospital:

Before I chose to take an involuntary medication at VPCH, I was simply told by a hospital staff member that that medication was "court-ordered", without having received a formal court hearing about involuntary medication prior to taking it.

2. Do you feel that the advantages and disadvantages of taking medications were explained clearly enough to help you make a decision about whether or not to take them?

Yes_____No___*X*____

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

I decided not to take them because of their usual harmful side effect of weight gain and the possibility of becoming dependent on them.

4. Now that you are on medication, do you notice any differences between the times you are taking your medications and the times you are not? Yes___*X*_____No_____

If your answer is yes, please tell about the differences that you notice.

The only difference I notice is the medication's side effect of weight gain.

5. Was anyone particularly helpful? Anyone could include hospital staff or a community mental health center, a friend, a family member, a neighbor, an advocate, someone else who is hospitalized at the hospital where you are (or were). Yes___*X*_____No_____

If your answer is yes, please tell about who was helpful. (You do not have to give names of people. You might just say a nurse, a doctor, a friend, etc.)

A nurse and a "mental health specialist", both at VPCH in Berlin.

In what way were they helpful?

One of the nurses was particularly kind and offered many words of encouragement. A "mental health specialist" who worked on my unit was able to connect with me very well as well.

6. Do you have any suggestions for changes in the law called Act 114?

Nothing in particular.

Response from Individual #5

Comments received via mail, January 7, 2019

Treatment at Brattleboro Retreat

State of Vermont
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
http://mentalhealth.vermont.gov/

Agency of Human Services
Department of Mental Health
[phone] 802-241-0090 [fax]
802-241-0100
Itty] 800-253-0191

Please help the Commissioner of Mental Health prepare a report on involuntary non-emergency medication in Vermont. As a patient who has been through the process of an application for involuntary treatment, you can offer invaluable information and insights that could help improve impatient psychiatric care.

Your answers to these questions are very important. You do not have to answer them, but we hope that you will. You do not have to answer all of them a once if you do not want to. You may answer as many as you want at any one time and then answer the rest at other times when you feel ready to do so. You will be eligible to receive an honorarium of $50.00 for taking the time to answer these questions.

All of your answers will be considered confidential and will not be used in any way that would identify you individually.

Based on your experiences at The Brattleboro Retreat in February 2018 , please answer the following questions:

1. Do you think you were fairly treated even though the process is involuntary?
   Yes x_____No_____

If your answer is no, please describe what you felt was unfair about the process. If you went to court for your medication hearing, please tell about court first, then tell about your experience in the hospital.

In court:

At the hospital:

2. Do you feel that the advantages and disadvantages of taking medications were explained clearly enough to help you make a decision about whether or not to take them?
Yes ___x_____No_____

3. Why did you decide not to take psychiatric medications? I was too afraid. I thought it was poison and would kill me.

4. Now that you are on medication, do you notice any differences between the times you are taking your medications and the times you are not? Yes x_____No_____

If your answer is yes, please tell about the differences that you notice.

I am less miserable. I am not as afraid. It really helps me.

5. Was anyone panicularly helpful? Anyone could include hospital staff or a community mental health center, a friend, a family member, a neighbor, an advocate, someone else who is hospitalized at the hospital where you are (or were). Yes x No_____

If your answer is yes, please tell about who was helpful. (You do not have to give names of people. You might just say a nurse, a doctor, a friend, etc.)
A friend was in the next room just by fate. Also, there were two nurses there that were really nice. Also, Dr. Krasnow was really nice.

In what way were they helpful?
My friend told me it was okay to take the medicine, and also she said it was okay to eat the food/drink the water. it wouldn't poison me. She is the one who helped me start eating again and told me I could take a shower, especially since I didn't know the other people at the hospital. The nurses were really nice. One would even brush my hair and put it into a braid for me, which made me feel she cared. Dr. Krasnow was funny and listened to me.. . even though he really scared me at first because he had a beard.

6. Do you have any suggestions for changes in the law called Act 114? The only thing I can say is that it was really important for me to get my medication and to be at Brattleboro, even though at the time I didn't want to because I thought everyone was trying to kill me. I had stopped eating and drinking and showering because I thought for sure that I was being poisoned and that everyone around me was trying to kill me. I now know that the Bratteboro Retreat isn't a bad place. If that ever happens to me again, I want my team to support me and get me the help I know I might need. I didn't know what was real and what wasn't. I was not able to understand anything at the time I was so out of it.