

An Independent Study of the Administration of
Involuntary Non-Emergency Medications
Under Act 114 During 2007

Report to the Vermont General Assembly

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Submitted to:

The Senate Committees on Judiciary and Health and Human
Services

And

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INTRODUCTION

Act 114 is the Vermont statute governing administration of involuntary non-emergency psychiatric medications to clients of the public mental health system committed to the care and custody of the Commissioner. The statute requires an annual independent review of its implementation. Implementation of Act 114 commenced in late 2002. To date, there have been four annual reports providing assessment of Act 114 implementation; this is the fifth such report and reviews implementation during 2007.

During 2007, court orders for administration of involuntary non-emergency psychiatric medication under the provisions of Act 114 were issued for 18 individuals; for one individual there were two separate orders. Additionally, in 2007, there were 14 persons receiving involuntary non-emergency psychiatric medication under 2006 orders. Thus, in 2007, a total of 32 persons received medication under the provisions of Act 114. All persons receiving involuntary non-emergency psychiatric medication were hospitalized at Vermont State Hospital (VSH) at the time of the court order and receipt of medication.

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

1. An evaluation of the performance of VSH and its staff in the implementation of Act 114 provisions for 32 persons receiving involuntary medication in 2007.
2. A summary and analysis of what resulted based on interviews with persons involuntarily medicated under the provisions of Act 114. While the statute includes family members, none of the persons interviewed wanted family members to participate.
3. A review of steps taken by the Department of Health (DMH), to achieve a mental health system free of coercion.
4. Recommendations for current practices and/or statutes.

Flint Springs Associates, a Vermont-based firm specializing in social policy research, assessment and planning, conducted this assessment. Flint Springs' senior partners, Joy Livingston, Ph.D., and Donna Reback, MSW, gathered needed information, analyzed the data, and developed recommendations reported here. Marty Roberts, a consumer advocate, played a critical role in recruiting persons who had experienced involuntary medication under Act 114 to participate in the assessment.

Information for this report was gathered through a review of VSH documentation, DMH data, written responses and interviews with:

- VSH staff (Executive Director and Medical Director)
- DMH administrators
- Recipients of involuntary medication under Act 114 from 2004 through 2007

VSH Performance Implementing Provisions of Act 114

During the calendar year 2007, decisions were made on 25 petitions requesting orders for non-emergency involuntary medication under the provisions of Act 114; five of the petitions had been filed in 2006. In all cases, petitions were sought by VSH staff physicians and sent through the Attorney General's DMH office to the court. Of the 25 petitions, 19 (76%) were granted and one (4%) was dismissed. Four of the petitions (16%) were withdrawn; in one of these cases, a petition was filed, and granted, a second time. One petition filed in 2006 was granted in 2007 and has been on appeal since January 2007. The 25 petitions filed represent a total of 21 individuals, 18 of whom received medications under Act 114 in 2007. Table 1 provides information on the number of filings for court orders over the past five years during which Act 114 has been implemented.

Table 1: The number of cases filed in which orders were granted, denied or filings withdrawn during calendar years in which Act 114 has been implemented

Cases Filed	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007
Granted	15 (68%)	29 (88%)	14 (64%)	22 (61%)	19 (76%)
Denied	2 (9%)	1 (3%)	2 (9%)	4 (11%)	1 (4%)
Withdrawn	5 (23%)	3 (9%)	6 (27%)	5 (14%)	4 (16%)
Total	22	33	22	31	25*

*One of the petitions (filed in November 2006, granted January 2007, remains on appeal)

Over the past five years, a small percentage of petitions for non-emergency involuntary medication have been denied. Generally, at least two-thirds of petitions are granted, with less than one-fifth withdrawn.

The proportion of patients admitted to VSH who receive psychiatric medication under Act 114 has remained near or less than 10% (see Table 2).

Table 2: Proportion of VSH Patients Receiving Medication under Act 114

Calendar year	Number of new Act 114 Patients	Percent of all VSH Patients
2003	15	7%
2004	27	12%
2004	13	6%
2006	22	11%
2007	18	7%

Review of Documentation

The Act 114 statute requires the Department of Mental Health (DMH) to “develop and adopt by rule a strict protocol to insure the health, safety, dignity and respect of patients subjected to administration of involuntary medications.” VSH has in place a protocol and set of forms intended to guide personnel in adhering to the protocol. As of April 2005, VSH instituted a streamlined documentation process to provide clearer, more consistent evidence of protocol implementation, including written, specific step-by-step instructions. Instructions outline in explicit detail forms that must be completed, by whom and when they must be completed, and to whom copies are distributed. The Medical Records Specialist is responsible for ensuring that forms are complete and updated. Act 114 packets have been developed which include instructions, needed forms and a checklist to guide staff on the protocol and documentation. Forms include:

1. Patient Information: Implementation of Non-Emergency Involuntary Medication – completed once (triplicate: patient’s copy, patient’s record, medical records)
2. Implementation of Court Ordered Involuntary Medication – completed each time involuntary medication is administered (duplicate: patient’s record, medical records)
3. 30-Day Review of Non-Emergency Involuntary Medications by Treating Physician – completed at 30, 60 and 90 day intervals (duplicate: patient copy, medical records)
4. Certificate of Need (CON) packet – completed any time Emergency Involuntary Procedures (EIP), that is, seclusion or restraint, are used
5. Support Person Letter – completed if a patient requests that a support person be present at administration of medication.

The protocol includes a requirement that each patient on court-ordered medication will have a separate file folder maintained in Medical Records including:

1. Copy of court order
2. Copy of Patient Information Form
3. Copies of every Implementation of Court Ordered Medication Form
4. Copy of 30/60/90 day reviews
5. Copies of Support Person Letter, if used
6. Copies of CON, if needed
7. Summary of medications based on court order
8. Specific timeline of court order based on language of court order

The 2005 assessment report provides detailed descriptions of the four key forms included in the Act 114 packet and the 2006 report describes revisions to the Certificate of Need (CON) form modified during 2006.

To assess the implementation of the Act 114 protocol, we reviewed forms completed by VSH staff for all persons receiving involuntary medication during 2007. Medical records provided copies of relevant forms from files, removing all identifying information to protect patient confidentiality, for each of the 18 persons under 2007 orders and the 14 persons receiving medication in 2007 under 2006 orders.

Patient Information Form

Patient Information forms were present and complete for all 32 patients receiving medication under Act 114 provisions in 2007. All of the patients refused to sign the form, as indicated by a check-box on the form. All of the Patient Information forms had been finished, as required, prior to completion of the Implementation of Court Ordered Involuntary Medication forms. All of the forms were complete, including information on whether or not the patient wanted a support person present when medication was administered.

Implementation of Court-Ordered Medication Form

We looked at the forms documenting the first three administrations of involuntary medication following the court order, and then at the forms used for administration of medications at 30 days and 60 days following the court order. Implementation forms were present and fully completed for nearly all patients. Implementation forms were present for one patient with regard to a 2006 order and but not for the 2007 order. In all but one case, the first implementation form was finished within one or two days following completion of the information form. For the one exception there was a lag of two weeks between the information and implementation form. None of the forms indicated that any of the 20 patients who first received medication in 2007 wanted a support person present when medication was administered. Of the patients who first received medication in 2007, 10 (56%) received medication orally beginning with the initial administration; 6 (33%) received medication initially by injection, subsequent administration was oral; and, 4 (18%) patients received all medication through injections.

30-Day Review of Non-Emergency Involuntary Medications by Treating Physicians

Review forms (30, 60 and 90 days) that should have been completed in 2007 were present in all but five instances. Review forms were missing for four patients, one patient's file was missing forms for two required reviews. These forms should have been completed during the months of February through June, 2007. During this time there was a change in Medical Records staffing. Review forms included in files were complete, including all appropriate signatures.

Certificate of Need (CON) Form

During 2007, there were four patients for whom some form of restraint was needed for initial administration of involuntary non-emergency psychiatric medication, in all four cases through injection. A Certificate of Need Form was present for all four patients. Two of the forms were complete (these files also included completed Involuntary Procedure Order Forms), while two did not include responses to two of the questions (Items 6 – attending physician post-incident considerations, and 7 – frequency considerations for involuntary procedures). CON forms were needed for the first two administrations of medication for one patient and for the first administration for three patients. Thereafter, implementation forms indicated there was no need for any form of restraint for these patients.

Staff Feedback on Implementing Act 114 Protocol

In past years, we have conducted group interviews with VSH psychiatrists, nurses, social workers, and psychiatric technicians. As it has often been difficult to schedule time with these staff members, and once scheduled, hard to gather more than a few individuals, we tried a new strategy this year. Each staff member received a written set of questions and was asked to provide written responses via email. Unfortunately, this strategy was not successful; only one staff member responded. Therefore, we conducted an interview with the Executive Director and Medical Director to identify any possible changes in circumstances from previous years.

Act 114 Implementation Training

VSH has added an annual refresher as part of mandatory annual training to ensure that staff members understand Act 114 and its provisions.

Decision to File Order

While clinical decisions to pursue an order for involuntary medication are made in the same manner as in past years, the Medical Director now encourages physicians to come to the decision in as timely a way as possible. This is part of an effort to reduce the time between admission and receipt of treatment in order to help patients stabilize and return to the community more quickly.

Patients' Rights

There have not been any substantive changes in the way patients are informed of their rights over the past year. The Patient Information Form documents discussion of specific rights, including whether or not the patient would like a support person present. As in past years, 2007 Patient Information Forms indicate that none of the patients requested support persons to be present.

In the past we have asked staff how they work to increase patients' sense of control when receiving involuntary medication. Strategies such as providing as many choices as possible (e.g., receiving medication orally or by injection, location to receive medication) continue to be in use. New to VSH, though, is an organizational expectation for all staff to work cooperatively and collaboratively with patients to avoid use of any emergency procedures. The effort to build cooperative relationships is also part of how non-emergency involuntary medications are administered.

Patient Involvement

To determine the degree to which patients were involved in treatment planning, we examined initial treatment plans developed at hospital admission for the 10 patients admitted in 2007 who went through the Act 114 procedure. During 2007, there were three different treatment planning forms in use: an older form, which includes an item indicating whether the patient was directly, indirectly or not at all involved in treatment planning; one newer form which includes a place for the patient's signature, indicating an attempt to engage the patient in treatment planning; and a third form, which includes a

place for the team to describe why the patient was/was not involved in treatment planning.

None of the 10 patients under Act 114 orders and with initial treatment plans in 2007 were involved with their initial treatment or follow-up plan. In nine of the 10 cases, treatment plans indicated that attempts had been made to engage patients, either by noting that patients had refused to participate, providing an explanation, or signing the section on attempts to engage. One of the 10 sets of treatment plans did not include a patient signature or any explanation.

Benefits and Challenges of Act 114

Each year, we have asked VSH staff to identify what they see as the benefits and challenges Act 114 presents. The benefit of Act 114 cited by the Executive Director and Medical Director, much like staff have noted in past years, is that it provides a form of due process to safeguard the rights of persons when clinicians seek to provide care against the patient's will. The process provides assurance that "our doctors are medicating for clinical reasons only." Since it takes a lot of work to pursue an order for involuntary medication, this "matches well with physicians' reluctance to involuntarily medicate."

The challenge Act 114 presents, as noted this year and in past years, is the time it takes to provide patients with needed medication. "The process of providing due process is too lengthy; as a result we have the undesirable outcome of people languishing for inordinate time in active psychotic states." VSH would like to preserve due process but have the process accelerated. One way of accomplishing this, while preserving the current structure, would be to hold involuntary hospitalization and medication hearings on the same day. The court might first decide on the commitment issue, and then, with all the players already present and needed information provided, the court could decide on the medication issue.

Outcomes from the Perspective of Persons Receiving Involuntary Medication

Participation

Based on recommendations made in the 2006 report and accepted by the Department of Mental Health, the 2007 Annual Assessment of Act 114 pursued an expanded strategy for gaining feedback from recipients of Act 114 medication. The 2007 annual assessment invited feedback from persons to whom medication had been administered under an Act 114 court order over the four year period covering 2004 through 2007. The rationale for expanding the opportunity to participate was based on a desire to gain a range of perspectives from people who were currently under court order and hospitalized at VSH to people who had had previous court orders and were now living in community settings. Therefore, 64 people who had been under court order in the four year period were contacted and invited to discuss their experiences receiving involuntary medication ordered under Act 114. Of those, 18 people received Act 114 medication orders in 2007 and the remaining 46 individuals had court orders for involuntarily administered medication between 2004 and 2006.

The following steps were used to engage individuals – and their family members – in this study:

- A consumer-advocate, well known and highly regarded in the consumer community, was engaged by the consultant team to talk with individuals interested in learning more about the study, answer their questions, and refer interested parties to the consultant conducting interviews. A toll-free phone number was provided to make it as easy as possible for people to contact this person.
- A brochure, intended to inform people and create interest in participating, was written for distribution.
- The consumer-advocate contacted the Community Rehabilitation and Treatment (CRT) Directors across the state, discussing the study and distributing the brochures with the intention of generating interest and recruiting persons who had received medication through Act 114 orders within the four-year period.
- The Vermont Legal Aid Mental Health Law Project mailed a packet of information to each individual under a court order for involuntary medication. This packet included a letter and the brochure referred to above, discussing the study, describing how one could get more information about the study, and offering compensation for participation.
- Compensation of fifty dollars (\$50.00) was offered and paid to individuals who chose to be interviewed.
- Notices were posted in two publications of Vermont Psychiatric Survivors, “Survivor” (a monthly newsletter) and *Counterpoint* (a quarterly publication featuring news, stories, art, and other contributions from the mental-health community), informing readers of the project, the opportunity to be interviewed and the compensation available, and giving people the toll-free number and name of the contact person from whom they could get more information.

- Contact was made with the Executive Director of the National Alliance for Mental Illness of Vermont (NAMI—VT) for the purpose of eliciting feedback from family members of persons who received involuntary medication. A notice about the assessment was posted through the NAMI—VT e-mail list.
- The Mental Health Law Project sent out a follow-up letter with brochures to individuals who received medication under Act 114.

In response to these recruitment efforts, a total of ten people initially contacted us about being interviewed and ultimately six individuals were available and agreed to be interviewed. Of the four who were not interviewed:

- Two people, who were at VSH when they responded, left the hospital with no valid forwarding address before we were able to conduct the interview.
- One person, who was living in the community, did not return two phone messages left in November and December and finally called back in January as this report was being drafted. There was not sufficient time to send and receive a release form (his home would have required a phone interview) that would allow us to interview him over the phone and include his feedback by the January 15th submission timeline.
- The fourth person was also living in the community. He did not leave a personal phone number where he could be reached. The consultant team sent out two mailings to his home address, offering to let him send in written answers (in the event that he did not have a phone) to the interview questions, but he did not respond.

Of the six individuals who did participate:

- Two persons were at VSH at the time of the interviews.
- Two persons were living in community-based residential group home settings.
- The final two individuals were living in their private homes.

Although the number of respondents was small, representing approximately 9.5% of those contacted, the differences in their current living situations provided the assessment with viewpoints and perspectives of people at different “distances” from the time they received a court order and initial administration of involuntary medication at the state hospital.

Three interviews took place in person, including two with persons still at VSH and one with an individual in a community group home setting. The remaining three interviews were conducted on the phone. None of the persons interviewed expressed an interest in having family members be interviewed for this part of the assessment. No family members of persons who had received medication under Act 114 responded independently to notices put out by NAMI—VT or articles placed in “Survivor” and *Counterpoint*.

Focus of Interviews

In accordance with the desire of the legislature to evaluate the implementation of Act 114, the interview questions focused on understanding:

- Conditions and events leading up to the involuntary medication
- How well individuals were informed regarding how and why they would be receiving involuntary medication
- Whether and how individuals were apprised of their rights to have a support person present and to file a grievance
- Conditions and events related to the actual experience of receiving involuntary medication
- Each individual's view of what was most and least helpful
- Recommendations individuals had for improving the process of administering involuntary medication

Responses from People Receiving Involuntary Medication under Act 114

Information about court hearing and about the court order

Four persons reported that they were given some information about the court hearing that led to the Act 114 order. Of these, two persons said they were informed by their Legal Aid lawyer, one person reported that staff at VSH informed her and the fourth person could not remember how she learned. One of these four attended the hearing and described the proceedings by saying that the judge, having listened to the psychiatrist's recommendations, ordered the medication without knowing what it was or what its side effects were. Another person reported making the decision not to attend the hearing because she did not feel well represented by Legal Aid who, in her belief, "*didn't try hard*". She wanted her own private lawyer but couldn't obtain one and "*decided to not go into the court room because the Legal Aid lawyer was in there*".

Regarding how people learned the court had ordered medication: two persons reported that they could not remember if or how they had been informed of the court order. One of those remembered getting a letter that might have notified her of the order, but said that she would not open un-postmarked letters. The remaining four persons reported being informed in different ways: the person who attended the hearing was present and therefore knew its outcome; one individual was informed by the Legal Aid lawyer; one was informed by the psychiatrist; and another person said that one of the VSH staff passed on this information.

Understanding of the reason for the involuntary medication court order and individual reasons for not wanting to take medication

The annual assessment seeks to understand what reasons people have for not agreeing to take recommended medication voluntarily. All of the six individuals interviewed felt that the order that resulted in the administration of involuntary medication was unjustified and led to unhealthy consequences. None of them believed – or currently believe – that they needed the medication. Each interviewee pointed to the negative side effects they

experience including, but not limited to, the involuntary, repetitive, persistent, stereotyped movements known as tardive dyskinesia, dry mouth, blurred vision, disturbed sleep patterns, extreme fatigue and lack of energy, and depression. Two individuals characterized the medication as unhealthy and harmful to their bodies, and one said it violated her religious beliefs.

Information about court ordered medication

Persons were asked what information they were given regarding the medication they were ordered to take. Specifically, the assessment wants to know “what did they learn about the medication itself, how it would be administered, how often, in what doses and what side effects, if any, were associated with it?” One respondent reported having been told nothing, while the remaining five persons said they knew the name of the medication they were being given. Some said they had taken the ordered medication prior to their hospitalization and court order.

Each described a different experience but what was common to all was an absence of information about the medication and its potential side effects. In general, the interviewees painted a picture of being uninformed about anything other than the medication’s name, and used this question as an opportunity to describe how they were treated. The uniform feeling of anger and experiences of powerlessness and coercion came through in each of the discussions.

Information about Act 114 protocols including the right to file a grievance

Persons interviewed were asked about their knowledge of the protocols that govern the administration of involuntary medication under Act 114 and whether they understood their right to file a grievance regarding possible violation of the protocols. None of the respondents said they knew about the specific protocols and procedures outlined in the statute.

Two people reported being unaware of their right to file a grievance and three others said they knew they had a right to file a grievance. One of the three was told of the grievance rights by a staff person while another said that he felt the grievance procedure “*was so complicated that I didn’t do it. The letters you have to fill out, the people you have to write to.*” The third person said she had once filed a grievance and “*nothing happened.*”

It was not clear from these interviews whether persons who reported knowing they had grievance rights understood those rights as they related specifically to Act 114, whether they had filed a grievance specific to receiving involuntary medication, or whether they were referring to a sense that they had generic legal grievance rights.

What is most important in this finding is that people who received Act 114 court-ordered medication in 2007, and (as we review the Annual Assessment Reports from 2003 to the present) persons interviewed in years past consistently report being unaware of the protocols for administering medication as described in the statute.

Choices leading to method of receiving medication

Here the assessment is interested in whether persons were given adequate choices for how the medication would be administered. One person reported that he wanted to get the medication via injection because his past experience with taking the medication orally proved to be difficult in terms of negative side effects. However, he said that he was not asked, in the sense of being given a choice.

The five others reported receiving the medication orally. However, two of these persons later described situations in which they were held down by staff for medication delivered through injection. Most probably these two initially received the court-ordered medication by needle and then later agreed to take it orally. Finally, the fifth individual said *“I was given an ultimatum – I would not call it a choice – I could take the medication orally but if I refused”* she knew she would get an injection.

Offer of and desire for a support person

Each of the six persons said they had not been asked if they wanted a support person present when receiving the medication and each of them said that they did not request a support person. When asked why, one person responded, *“nobody asked”* and another said she *“was not offered that.”*

Setting in which medication was administered

This question tries to find out whether the specific location in which the medication is administered is important to recipients in terms of the level of privacy it does and/or should provide.

Four people reported getting the medication at the nurse’s office/medicine room. One of the four said that *“privacy wasn’t an issue, because I knew I had to take it but since others had to also, it didn’t bother me much.”*

Another person said she *“believes there could be better places (to get the medication) – the psychiatrist could give it and talk with the patient – they could do it off the unit, off the floor – there are many other possibilities if someone wanted to make [VSH] a kind place.”*

One person who received medication via injection in his own room responded as follows: *“a needle is an ultimate invasion of privacy”* so the privacy of the physical setting was, for him, not as much a violation of privacy as was being ordered to receive a shot in his body.

Treatment by staff during and after administration of involuntary medication

Respondents were asked a number of questions regarding their assessment of how hospital staff treated them during and after receiving involuntary medication.

Re: respect, dignity and safety: One person said that she felt she was “treated ok.”. Another respondent had this to say: “My health was only endangered by other patients who were very disturbed – I found dignity and respect in some, but not all places.”

Three other individuals were left with more negative feelings in regards to this question. The following statements sum up their experiences:

“ . . .the doctor didn’t tell you about why the meds were needed, about your diagnosis . . .would have liked the doctor to be sure of the correct diagnosis and the physical health of the patient before giving more medication – talking to the patient more than relying on the chart and comments of the people who were involved in sending you to the hospital. Not all the statements are true that are written in the chart.”

“I felt like I wasn’t even a person anymore – they took away my full rights”

“ . . .they were telling lies about me. Basically, getting the needle in the hip was an affront to my dignity – my health is in poor condition because of the severe side effects . . .”

A fifth response used expletives to express his sense of how he was treated. In all, no one expressed any sense that their health, dignity and general well-being were being attended in the process of being medicated.

Re: receiving emotional support: Two persons reported that they felt supported by a specific person or persons. One former patient said “Yes I did – the UVM student nurses who aren’t part of the staff and the chaplain also is helpful - out of 45 workers only 3 were helpful - they were qualified to understand. . . .”

Another former patient said “A person was assigned to me – a one-to-one, but no one seemed to care about the effects and I complained all the time – complained to nurses, staff – nobody put anything in my chart . . . even though I told them I wanted this information documented.”

Re: debriefing after receiving involuntary medication: We asked respondents whether, after receiving involuntary medication (especially in the beginning), hospital staff talked with them about the experience in an effort to debrief, help people understand what happened, answer questions and generally process their feelings.

The six respondents all said that no one had attempted, or offered, to debrief them after receiving the medication. One person reported that “the one-to-one person [was] just there if I needed a drink or cigarette. They check the room to see how you were.”

Similar to last year’s finding, those interviewed reflected that the process of reviewing, processing feelings and debriefing around the experience was not available to them.

Re: extent to which wishes were respected and sense of having some control over what was happening: People felt they had no control and were not respected in terms of what they wanted. Specifically, they responded as follows:

“My wishes were not respected. I didn’t feel that I had any control over what was happening. The side effects [of the medication] are uncomfortable to deal with.”

“No, not at all – the fault was partly mine . . . I didn’t trust (the psychiatrist) – he’d put me in the seclusion room when I was at VSH earlier – and I remembered that and I didn’t take him into my confidence – I made the condition that I wouldn’t talk with him unless my former husband was with me and he wouldn’t agree to this.”

“None – never.”

“None-don’t have a say at all...”

“My wishes weren’t respected – no control”

Re: extent of force used to get people to take medication: Three of the six persons interviewed reported that in the initial administrations of the medication they were held down by a number of staff – as many as five in one report - in either their rooms or in a seclusion room. Physical restraints were NOT used in any of these instances. People described these experiences with different degrees of emotion ranging from resignation to resentment to overt anger.

A fourth person said she *“wasn’t physically restrained because I absolutely didn’t want to be given a shot.”* She felt that when the medication was being given to her, *“there was an attitude of ‘I told you so’”* amongst the staff.

In all cases people felt that the experience of having medication administered through the Act 114 order was a highly coercive one over which they had no discernible control.

Problems and benefits resulting from court-ordered involuntary medication

People were asked to talk about what was difficult and/or unhelpful and what was helpful in the process of receiving involuntary medication.

Two persons noted the helpfulness of specific staff persons (mentioned above) who were perceived as supportive throughout their experience and stay at VSH. The remaining answers focused on:

- the negative nature of the experience of receiving unwanted medication
- the unwanted and debilitating side effects of the medication
- the actual experience of being hospitalized at the VSH

These themes are reflected in the following statements:

“My rights are being denied as far as I’m concerned.”

“I am severely weakened and fatigued [by the side effects of the medication] . . . walking, moving, coordinating my legs are all difficult . . . I sleep all day and all night [because of the medication]”

“It’s [VSH] a closed-in situation – there’s nothing to do – it’s boring – a lot of patients are around but most of them keep to themselves. Sometimes there are problems in the TV rooms and there aren’t always staff around to correct them. Not much good air to breathe...If you don’t get to meals on time, they don’t let you eat – they only give you a short time to eat.”

“I go to repeat groups and I’m sick of doing this over and over – goals, sick of goals and nobody helps you do anything.”

“Social workers at VSH thought of themselves as making aftercare arrangements – I would have liked more from the Social Workers – there’s no reaching out. My Legal Aid difficulty was as great a factor – I did not have money for my own lawyer and had to rely on VT Legal Aid – it’s very bad.”

“Most staff didn’t care.”

Suggestions for improvements for administering involuntary medication

Our final inquiry, seeking input on ways to improve the administration of involuntary medication, yielded a range of ideas and comments from five of the six respondents. Some of the comments addressed general ways in which to improve the environment and everyday life of patients while living at VSH and under court orders to receive medication and included comments like:

“People should be able to go outdoors every day” and “they should put the client to work on a farm – gardening – right now we’re in classes for 2 to 3 hours and there’s nothing to do.”

However, others answered the question more directly. One former patient expressed his belief that *“schizophrenia is a communication problem”* and he suggested that the *“treatment plan be devised to teach the patient communication skills instead of medicating the patient.”*

Elaborating on the conviction that the psychiatrists at VSH should see and interact more closely with the patients, a respondent said, *“The doctor should be more aware of how the patient is feeling, of side effects – they shouldn’t let so much time go by without speaking to the patient – they should speak to patients more frequently and especially after they give new medication – they should be around more, like on the weekends, to speak to the patients.”*

Another person suggested: *“There should be a change in the methods and attitudes of persons involved in care – they should not make the evaluation period a test of endurance – a patient is in shock when abruptly taken to VSH. The patient should be given a notebook where everything is written up and reviewed weekly with the patient – and a lawyer should be there to be a witness. The state hospital atmosphere should be one of kindness and gentleness.”*

Two persons interviewed discussed the Annual Assessment by expressing their approval – *“I feel it’s wonderful that the Legislature requires an annual review – it’s a confidence giver – it’s wonderful when someone asks you ‘what do you think?’”* and gratitude at the opportunity to *“tell my story”* and give their opinions and thoughts on this issue. People who lived in the community were grateful to be able to conduct the interview by phone.

Regarding our recruitment efforts, one person noted she liked the brochures that accompanied the letter from Legal Aid and suggested the following: *“It would be good if the law required the brochure be given to the patient by the person who gives the unwanted medicine and even read together– and also read together with the person who is working with the [former patient] at the [community] mental health center.”*

The same person also commented that our outreach to persons who received Act 114 medication in the four-year time period was good because *“patients are able to express themselves differently at different times . . . they should be contacted periodically by Legal Aid about the study . . . Your home makes you more strong – you’re not that strong when you’re in the hospital.”*

A second individual said the following about the Annual Assessment: *“Everyone has the right to voice their opinion with someone like you – and to put their opinions in some of the newsletter like Survivor or Counterpoint – I am a survivor.”*

Key Findings Emerging from Interviews

It is important to offer the following information about the interviews. First, the people who volunteered to participate in the interviews were self-selected. Therefore, one cannot view the findings as representative of all people who received Act 114 court-ordered involuntary medication between 2004 and 2007. Rather, the reader can view these as “suggestive.” Second, in some cases, people were unwilling to comment on, or unable to remember, some of the circumstances surrounding the court order and administration of medication. Of the six people interviewed, we believe that three received Act 114 medication within the past year.

In recruiting people who received court ordered medication over a four-year period, we hoped to:

- generate an increased amount of feedback from individuals who received involuntary medication under Act 114
- generate an increased amount of feedback from family members
- gain a range of perspectives based on one’s temporal proximity to the experience of receiving a court order and unwanted (involuntary) medication within the Vermont State Hospital
- observe any differences in viewpoints and feedback based on the amount of time that had passed from the court order and administration of the medication at VSH and on the opportunity to reflect longer on the experience.

Our first two goals were not met. Despite the increased outreach, this year's response by Act 114 medication recipients proportionally decreased. The only feedback that we have received comes through our consumer-advocate who talked personally with most of the CRT Directors and distributed our brochures to them. She reports there is a general opinion that persons currently living in the community who received medication under Act 114 do not want to talk about and therefore revisit that experience.

Our recruitment effort this year was aimed at giving people more than a single chance (in the one calendar year in which they had an Act 114 court order) to reflect on the experience of receiving court-ordered medication. Based on the six interviews conducted, we can observe that there are very few differences, whether the respondents currently reside at VSH or have been living in the community for one or more years, in:

- their recollections and reports of how the Act 114 protocols were followed
- their feelings about how they were treated, supported and respected during that experience.

In terms of adherence to the protocols, there continue to be wide discrepancies between the reports of consumers interviewed for this assessment and the written and oral reports of VSH staff. To that end, our key recommendations encourage that current efforts be intensified, and new efforts developed:

- to inform people of the protocol
- to review the protocol with them
- to make significant efforts to provide levels of support that would be meaningful
- to provide an environment that is viewed as caring
- to provide meaningful activities.

Steps to Achieve a Non-Coercive Mental Health System

In addition to talking with VSH staff, this year we gathered input from the Department of Mental Health (DMH) central office staff through written responses to questions on DMH's efforts to achieve a mental-health system free of coercion.

Vermont State Hospital Efforts

Time to Treatment

Efforts at VSH have focused on decreasing the time between admission and receipt of treatment, ultimately to reduce the length of stay at the hospital. One way of speeding treatment is to reduce the time between admission and filing petitions for the court order for involuntary non-emergency medication. As noted earlier, the Medical Director has been working with physicians to facilitate more timely decisions to file petitions for involuntary medication under Act 114.

Indeed, there has been a substantial decrease in time from admission to petition for individuals admitted in 2007. On average in 2007, there were 33.5 days from admission to filing a petition, less than half as long a time period as in past years (2006 = 79.5 days; 2005 = 80 days; and 2004 = 90 days). The reduction in time from admission to filing contributed to a reduction in time from admission to the court order, an average of 58.5 days, as compared to 109 days in 2006. Comparisons in time to filing and orders between 2007 and 2006 are presented in Table 3, again confirming the reduction in time from admission to filing and thus court order.

Table 3: Time (in Days) Between VSH Admission and Filing Petition and Granting Order for Non-Emergency Involuntary Medication

Time from Admission	2006				2007			
	To Filing		To Order		To Filing		To Order	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
30 days or less	5	16%	1	5%	6	46%	2	18%
31 to 60 days	8	26%	5	23%	6	46%	4	36%
61 to 90 days	3	10%	1	5%	1	8%	3	27%
91 or more days	15	48%	15	68%	0	0%	2	18%
Total	31	100%	22	100%	13	100%	11	100%

Emergency Involuntary Procedures Reduction Program (EIPRP)

DMH has recently received a federal Substance Abuse and Mental Health Services Agency (SAMHSA) grant to continue efforts to reduce seclusion and restraint at VSH and the children's inpatient unit at Brattleboro Retreat. Staff at VSH were actively involved in developing this grant-funded program, which involves implementing sensory modulation technology at both VSH and Brattleboro Retreat.

As part of the Department of Justice settlement agreement there is a monitoring plan to improve emergency involuntary practices at VSH. At the most recent monitoring visit, VSH was ranked as being in “partial compliance” with the agreement, which was within the target for this stage in the agreement. Significant progress had already [?] been noted in physicians’ assessments for any person placed in restraint or seclusion (completion of Certificates of Need) and in accuracy of data regarding the use of seclusion and restraint.

VSH has also enhanced its training for staff to include a monthly hour-long course on communication skills and de-escalation techniques as part of the Non-Abusive Psychological and Physical Interventions (NAPPI) training. Staff members are required to have 8 hours of ongoing training after initial NAPPI certification is complete; however, many choose to participate in all 12 sessions.

In addition, VSH introduced a new staff debriefing tool to be used after any emergency involuntary procedure takes place. VSH expects to develop a similar tool for use with patients in the coming year. The debriefing process was introduced last year, while the tool to help direct the discussion is new this year. The discussion focuses on how the staff might be more effective in avoiding emergency involuntary procedures as well as more effective when the procedures are needed.

During 2007, VSH staff also participated in training on communication that included attention to the impact of interactions among staff on patients and the ways in which indirect communication with patients may be perceived as coercive. A communication module is also included in orientation training for new staff at VSH.

In 2008, VSH will partner with Vermont Protection and Advocacy (VPA) to provide VSH staff with training on involuntary procedures. This will be the first time VSH and VPA will partner in a training program for VSH staff.

In 2007, patients filed 101 grievances, 8 of which pertained to involuntary procedures; of these VPA has pursued two cases. VSH Executive Director reports that grievances are now examined to determine if staff members have made mistakes in deviating from policy or not providing adequate documentation. When mistakes are noted, apologies are made to patients. The goal is to use grievances as an opportunity to look carefully at practice and take responsibility for mistakes when they are made.

Treatment Mall

A significant trend in psychiatric inpatient therapeutic programming is an approach referred to as the Treatment Mall. This approach is comprised of layers of individual and group psycho-educational and recovery-oriented sessions on multiple topics offered daily in off-unit sites. VSH implemented the Treatment Mall in the summer of 2007 with the goal of providing every patient with at least 20 hours of individual and group offerings each week. The expectation is that the Treatment Mall will decrease coercion by giving patients the opportunity for real input into their daily treatment and support activities. A Patient Advisory Council has been created to help guide the development of the programming.

Patient Representative

VSH has hired a new patient representative. The primary responsibilities of the patient representative are to inform each patient about his/her rights as outlined in the Vermont Bill of Rights for Hospital Patients, as well as to inform each patient about the right to make a formal or informal, written or oral complaint, about any concern related to hospital care and services.

Last year's assessment recommended that the new Patient Representative help provide information to patients on their rights under Act 114. The Executive Director reports that she will explore ways for the Patient Representative to play a more active role. In addition, the newly formed Patient Advisory Council will likely discuss implementation of Act 114, providing additional input on means to inform patients of their rights.

DMH-Community Efforts

VSH Futures

As reported in the 2006 assessment, the Futures Advisory Committee recommended an integrated plan to replace VSH including both inpatient care and community-based programs. VSH is now the only institution administering non-emergency involuntary medications under Act 114, any replacement will have to take on this function. DMH notes that general hospitals have significant concerns about the time it takes to obtain court orders for non-emergency involuntary medication. Hospitals fear they cannot provide satisfactory justification to health insurers that they are providing “active treatment” during the time delay. General hospitals’ concerns on time lags under Act 114 may make integrating psychiatric and general hospital inpatient care difficult to achieve.

DMH clearly expresses interest in maintaining Act 114’s due process guarantees to patients. It also notes that it has an obligation to provide treatment to individuals in conformance with prevailing medical standards. Taking these two commitments together, DMH will seek to partner with the legislature to amend the statute to shorten the time frame between admission to inpatient psychiatric care and authority for involuntary medication. A change would allow persons treated in Designated Hospitals through the commitment process to receive involuntary medication when clinically needed. As noted by the VSH administration, the current due process procedures could be amended to provide commitment hearings and involuntary medication hearings on the same day, thus expediting the time frame.

Community Hospitals

In 2006, DMH addressed policies regarding conditional voluntary status in community hospitals. The practice has been that individuals could agree to admission to a community hospital under conditional voluntary status, which allowed the hospital to hold them involuntarily for up to four days. DMH changed this to eliminate the four-day hold and institute a single voluntary admission status. If a psychiatrist determines there is a safety issue, and therefore a potential need for involuntary admission, than the Emergency Examination (EE) process for involuntary admission begins immediately, without a four-day holding period. This change has not been in effect long enough to determine the impact, though the expectation is that it will shorten the time that a community hospital can hold a patient before starting an involuntary admission process.

Transporting Persons for Inpatient Treatment

In 2005, VSH instituted a policy that no longer assumes persons needing to be transported to the hospital require restraint. In 2006, DMH required VSH and designated mental health agencies to conduct an analysis of whether or not an individual requires secure transportation prior to each transport.

Data compiled most recently indicates that between October 2006 and September 2007, there were 882 incidents of involuntary transportation; 32% involved secure transport (provided by sheriffs with use of restraints) while 68% were non-secure.

In addition, to further improve the nature of involuntary transportation, DMH entered into a contract with Washington County Mental Health in July 2007. The contract enables Washington County Mental Health to provide alternative non-secure transportation to people on involuntary status needing transport to inpatient psychiatric care without use of sheriffs.

As part of the process around involuntary transportation, VSH and designated agencies complete a Transportation Checklist that tracks the type of restraint (metallic or polyurethane, or none) used when transporting individuals. DMH reports that historically it was difficult to have the form completed by designated agencies; completion of the sheriff's form was less problematic as it was linked to the billing process for their services. In July 2007, DMH's Acute Care Team moved the item on type of restraint from the designated agency form to the sheriff's form. This shift has allowed more consistent and accurate tracking of the type of restraint used in involuntary transportation.

Recovery Education

DMH continues to support Recovery Education in both community and hospital-based mental health services. Vermont Psychiatric Survivors (VPS) is the primary organization promoting recovery education in Vermont. VPS reports that most community and inpatient providers have become more accepting of recovery education principles and have worked to incorporate elements of recovery education into treatment. A number of recovery education activities are underway including recovery education groups taught by VPS at VSH, as well as training on recovery in the orientation for new staff.

Second Spring Community Recovery Residential Program

As discussed in the 2006 assessment, the Second Spring program has been seen as an important step to provide non-coercive psychiatric treatment. This residential program was designed to serve as a voluntary alternative for patients who would otherwise remain at VSH (voluntary, in that the patient consents to reside in the program—although that individual may be on an order of nonhospitalization). An active steering committee of consumers, family representatives and program leaders worked together to develop discharge and transition protocols, review and develop key programming, and help to identify and resolve implementation issues.

Second Spring opened in 2007 with a plan to build gradually to its full capacity of 11 residents. The program is voluntary; patients must agree to go to the program and be willing to stay there. In this way, the program has reduced coercion in the system; it has also reduced the number of patients at VSH during the second half of 2007.

DMH reports that there was a "lively debate" about the potential to use Second Spring for patients who no longer need inpatient care but refuse to go to Second Spring. While an order of non-hospitalization could legally be written to require a patient to reside at Second Spring, the mental-health stakeholder community did not want to compel patients to go to Second Spring. The community asked DMH to find another resolution for patients who no longer need inpatient care; DMH reports that it will work with stakeholders to design a new level of non-hospital care to address this issue.

Outcomes from Implementation of Act 114

In prior assessments we identified, through stakeholder input, a set of outcomes that would be expected with successful implementation of Act 114. These outcomes include:

- VSH staff are aware of Act 114 provisions
- Decreased length of time between hospital admission and filing petition for involuntary medication
- Decreased length of stay at VSH for persons receiving involuntary medication
- Reduced readmission rates and increased length of community stay for persons receiving involuntary medication
- Satisfaction with non-emergency involuntary medication process among patients, family members, and VSH staff

In 2007, we were able to assess achievement of the following outcomes:

- VSH staff members are aware of Act 114 provisions as shown by documentation of adherence to Act 114 provisions.
- The length of time between VSH hospital admission and orders for involuntary medication decreased significantly in 2007 from previous years.
- VSH data indicate that in 2007, the average length of stay for all patients was 149 days; the average length of stay for patients receiving medication under Act 114 in 2007 was 429 days, ranging from 76 to more than 11 years. Among patients under Act 114 who were discharged in 2007, the average length of stay was 150 days.
- In 2007, none of the persons receiving medication under Act 114 and then discharged were readmitted to VSH. In previous years, none of Act 114 patients had been readmitted within 30 days and 12% had been readmitted within 180 days. This compares to 11% and 21% of other patients, respectively.
- VSH staff, for the most part, express satisfaction with the provisions of Act 114, although they would like the process to move more quickly.

Recommendations

The review for 2007 indicates that VSH administration and staff continue to be careful to document implementation of the provisions of Act 114. This documentation demonstrates that staff members are implementing the statute as required.

VSH Practices

Interviews with patients receiving medication under Act 114 are important to understanding each patient's experience. Our efforts to gain input from people who are at different points in time from their stay at VSH and experience of receiving court-ordered medication should be continued. Although the number of responses was small, we found that the reports from people interviewed, no matter where they currently reside or what their current medication status, continue to be at odds with the oral reports and written documentation provided by VSH and DMH personnel around issues of patients feeling they were:

- informed
- given choices
- given emotional support
- treated well with regard to their health, dignity and respect.

In 2007 a Patient Representative position was added to the VSH staff. We recommend that the position be given direct responsibility for providing patients affected by Act 114 with:

- clear and understandable information about the Act 114 protocols
- a review of the rights to and process for filing grievances
- a reminder of one's right to have a support person present when receiving medication under Act 114
- an opportunity to debrief after receiving the medication
- ongoing emotional support about receiving court-ordered medication throughout the patient's stay at VSH

In order to provide information about the Patient Representative's actions with regard to supporting patients under Act 114 orders, we recommend that these actions be documented in a simple written form.

We also recommend that VSH staff continue efforts to help patients understand the reasoning behind the decision to seek an involuntary medication order. In order to facilitate continued improvement in staff efforts, we recommend development of an Act 114 Debriefing Tool similar to the tool now in place to help staff discuss and improve responses to emergency involuntary procedures. The Patient Representative should have the same responsibility for filling out this tool as other state hospital staff.

Statutory Changes

We recommend that DMH, VSH and the legislature work together to examine ways in which Act 114 may be revised to expedite the time needed while continuing to insure thorough attention to due process. Suggestions to hold both commitment and medication hearings on the same day should be carefully examined.

The statute presently requires two separate assessments of Act 114 implementation, one by DMH and one by independent contractors. In practice, this means that information is gathered twice, often requiring VSH staff to participate in duplicative interviews. We recommend that the legislature consider requiring only one annual assessment.

Annual Act 114 Assessment

We recommend that the following steps continue to be used in future assessments of Act 114:

- Provide a financial incentive for patient participation.
- Request patient participation through extensive outreach efforts to any person that received medication under Act 114 in previous years, not just the year under review
- Gather and manage information that allows assessment of longer-term outcomes such as length of stay at VSH and time in community to determine the impact of Act 114 implementation

Conclusion

Vermont State Hospital uses written protocols and record-keeping forms to guide adherence to the provisions of Act 114. In 2007, documentation was complete and indicated that all provisions of Act 114 were implemented.

The time between hospital admission orders for involuntary medication decreased significantly in 2007. Efforts on the part of physicians to make more timely decisions on the need for involuntary medication have reduced the time delay for treatment. However, VSH staff continue to argue for a process that moves as quickly as possible as they believe patients suffer on many levels when not receiving treatment. While VSH and DMH see the use of involuntary medication as a last resort and prefer to engage patients in voluntary treatment, all agree that procedures to decrease time delays while preserving due process to protect patient rights are needed.

Persons interviewed who received involuntary medication under Act 114 between 2004 and 2007 gave reports about receiving information and support, and about the nature of their treatment at the state hospital that were at odds with reports from VSH staff and records. Any and all efforts to reduce the experience of coercion for mental-health clients should be maintained.

For Vermont, the continuing challenge is to build a mental-health system that provides a broad array of service options, primarily in community-based settings. All stakeholders agree that a range of options is essential to creating a non-coercive mental-health system.