An Independent Study of the Administration of Involuntary Non-Emergency Medications Under Act 114 (18 V.S.A. 7624 et seq.) During FY 2013

Report to the Vermont General Assembly

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Joy Livingston, PhD
joy@madriver.com

Donna Reback, MSW, LICSW
dreback@stowevt.net

402 Fletcher Farm Road, Hinesburg, VT 05461
www.flintspringsassociates.com
(802) 482-5100

EXECUTIVE SUMMARY

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 is 18 V.S.A. 7624 et seq – referred to in this report as Act 114. The statute requires two annual assessments of the Act's implementation, one conducted by the Department of Mental Health (DMH) and a second conducted by an independent reviewer. The following report summarizes Flint Springs Associates' independent assessment, providing a review of implementation during FY 13 (July 1, 2012, through June 30, 2013).

Prior to August 2011, 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. On August 28 of that year, Tropical Storm Irene flooded the Waterbury State Office Complex that housed VSH. For most of FY12, patients with acute needs who otherwise would have been referred to VSH, now designated as Level One patients, were served by Fletcher Allen Health Care (FAHC), the Brattleboro Retreat and Rutland Regional Medical Center (RRMC). In FY13, the Department of Mental Health (DMH) opened the Green Mountain Psychiatric Care Center (GMPCC) to serve patients until a permanent new psychiatric hospital is built. The Commissioner of Mental Health designated these four hospitals responsible for administering involuntary psychiatric medications under Act 114.

During FY 2013, 42 petitions were filed requesting court orders for non-emergency involuntary medication for 42 different individuals under the provisions of Act 114. Petitions were sought by physicians at the four hospitals (FAHC, RRMC, Retreat, and GMPCC), and sent through the Attorney General's DMH office to the court. Of those 42 petitions, 32 (76%) were granted, 8 (19%) were withdrawn, and 2 (5%) were denied.

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

- implementation of Act 114
- outcomes associated with implementation of the statute
- steps taken by the Department of Mental Health to achieve a mental health system free of coercion
- recommendations for changes

Key Findings

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

- Based on documentation review and interviews, staff at three of at the four hospitals demonstrated full implementation of the provisions of Act 114 in the administration of involuntary non-emergency psychiatric medication.

- Hospital staff want the process leading to involuntary medication to move as quickly as possible, while continuing to protect patients' rights. They believe that individuals for whom Act 114 petitions are filed suffer on many levels when not receiving psychiatric medication in a timely manner. There was widespread agreement across staff at the four facilities that if commitment and Act 114 hearings could be held simultaneously, patients would receive treatment more quickly. On average, it took 6 days from the

commitment hearing to the Act 114 order during FY13, which represented a reduction in time from the previous year.

- Peer representatives and Legal Aid lawyers believe that applications for involuntary, non-emergency court-ordered medication are filed too quickly and used more frequently than in past years. They believe that hospital staff should take more time to work with patients to explore and employ a wider range of approaches that respect patients' concerns and lead to their recovery.

- On average, all the patients under Act 114 orders in FY13 were discharged from psychiatric inpatient care about 2 months after the Act 114 order for medication was issued; the same time period as in FY12. This finding is important because, in comparison with average length of stay in previous years for patients at VSH, patients who received Act 114 medication at other hospitals in FY12 and FY13 had a shorter length of stay. .

- Responses from individuals who received medication under Act 114 and agreed to be interviewed for this annual assessment were mixed in terms of how they perceived the experience and benefits of receiving involuntary medication. Nearly half reported that receiving Act 114 medication was negative and coercive while the other half reported they felt they had been treated with respect and that the medication had positive benefits for them.

- All individuals interviewed have continued involvement with mental health services in the community and continued taking psychiatric medication. Opinions about their need for ongoing medication were mixed, with some people reporting they felt the medication helped them function better in the community while others said that the medication was required (under an Order of Non-Hospitalization – ONH) for them to stay out of a hospital setting.

Recommendations

Flint Springs Associates offers the following recommendations:

<u>Hospital Practices</u>

- 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 their options.

- Hospitals, with assistance from DMH legal staff, provide ongoing training and support activities, including annual "refreshers," to ensure that all staff are knowledgeable enough to implement Act 114 provisions.

- Staff from the four hospitals are trained together and share information on innovative practices. As part of that effort doctors should participate with other unit staff in orientation training provided by peer advocates.

- Hospitals should include the assigned peer representative in treatment team meetings whenever possible. Staff should dialogue more often with assigned peer

representatives to share information and perspectives in order to gain a fuller understanding of the patient's condition and develop the most effective treatment strategies.

- All hospitals should include the patient in treatment team meetings in an effort to identify and help the patient achieve long-term treatment goals.

- The new hospital in Berlin should provide outdoor space and a full range of activities to engage patients and prevent boredom.

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

Statutory Changes

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

- DMH should seek clarification on what criteria deems an Act 114 order subject to, or exempt from the use of the 30-day stay.

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

Annual Act 114 Assessment

- Hospitals involved in the annual assessment assume responsibility for providing evaluators with copies of documents drawn from case files. This would avoid concerns about whether or not documents do/do not exist or merely could not be located by the person conducting the assessment.

- The following steps continue to be used in future assessments of Act 114:

    - Provide a financial incentive for the participation of individuals who have received court-ordered medication

    - Request input from individuals who have received court-ordered medication through extensive outreach efforts to any person who received medication under Act 114 in previous years, not just the year under review, in order to learn about longer-term outcomes including individuals' engagement in treatment and their lives in the community as well as experiences receiving medication under Act 114 orders.

- Ask persons interviewed if they would like any family members to be interviewed and pursue these as permitted.

- If two assessments continue to be requested data for both the Commissioner's assessment of Act 114 implementation and the independent assessment on dates of admission, commitment, petition and court orders should come from the same source.

INTRODUCTION

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 is 18 V.S.A. 7624 et seq. The statute requires two annual assessments of the act's implementation, one conducted by the Department of Mental Health (DMH) and a second conducted by an independent reviewer. This report will refer to the statute as Act 114. Implementation of Act 114 commenced in late 2002.

This independent assessment report provides a review of implementation during FY13 (July 1, 2012, through June 30, 2013). The report also summarizes feedback from individuals who chose to be interviewed and who received medication under Act 114 between January 2003 and June 30, 2013.

As a result of the petitions filed during FY13, court orders for administration of involuntary non-emergency psychiatric medication under the provisions of Act 114 were issued for 32 individuals.

Prior to August 2011, 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. On August 28 of that year, Tropical Storm Irene flooded the Waterbury State Office Complex that housed VSH. For most of FY12, patients with acute needs who otherwise would have been referred to VSH, now designated as Level One patients, were served by Fletcher Allen Health Care (FAHC), the Brattleboro Retreat and Rutland Regional Medical Center (RRMC). In FY13, the Department of Mental Health (DMH) opened the Green Mountain Psychiatric Care Center (GMPCC) to serve patients until a permanent new psychiatric hospital is built. The Commissioner of Mental Health designated these four hospitals responsible for administering involuntary psychiatric medications under Act 114.

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

Section 1: The performance of hospitals (FAHC, RRMC, the Retreat, GMPCC) in the implementation of Act 114 provisions, including interviews with staff, interviews with judges, lawyers and peers, review of documentation, and interviews with persons involuntarily medicated under provisions of Act 114.
Section 2: Outcomes associated with implementation of Act 114.
Section 3: Steps taken by the Department of Mental Health to achieve a mental health system free of coercion.
Section 4: Recommendations for changes in current practices and/or statutes.

Flint Springs Associates (FSA), a Vermont-based firm advancing human-services policy and practice through research, planning and technical assistance, conducted this assessment. Flint Springs' Senior Partners, Joy Livingston, Ph.D., and Donna Reback, MSW, LICSW, gathered the required information, analyzed the data, and developed recommendations reported here. Marty Roberts, a peer advocate, played a critical role in recruiting persons who had experienced involuntary medication under Act 114 to participate in the assessment.

Section 1: Performance Implementing Provisions of Act 114

During FY13, 42 petitions were filed requesting orders for non-emergency involuntary medication under the provisions of Act 114 for 42 different individuals. Petitions were sought by physicians at the four hospitals (FAHC, RRMC, Retreat, and GMPCC), and sent through the Attorney General's DMH office to the court. Of those 42 petitions, 32 (76%) were granted, 8 (19%) were withdrawn, and 2 (5%) were denied. Table 1 provides information on the number of petitions for court orders that have been granted, denied or withdrawn over the previous four fiscal years of Act 114 implementation. "Other" court decisions include dismissal of the case, discharge of the patient by the court, or appeals. In most years, the vast majority of petitions were granted; during FY12, more petitions were withdrawn, primarily because individuals began to take medication voluntarily, thus bringing down the proportion of granted petitions. In FY13, the proportion of individuals voluntarily taking medications and thus resulting in withdrawn petitions decreased and the proportion of granted petitions increased.

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

Court Decision	FY of Petition Filing Date (7/1 to 6/30)									
	2009		2010		2011		2012		2013	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Granted	21	81%	26	87%	30	75%	28	63%	32	76%
Denied	1	4%	1	3%	0	0%	1	2%	2	5%
Withdrawn	2	8%	3	10%	9	23%	15	33%	8	19%
Other	2	8%	0	0%	1	2%	1	2%	0	0%
Total	26	100%	30	100%	40	100%	45	100%	42	100%

Petitions filed by the Retreat and RRMC were granted more than 80% of the time and withdrawn in less than 20% of cases. At FAHC, 73% of petitions were granted while 27% were withdrawn. Of the five petitions filed by GMPCC, two (40%) were denied; two (40%) were granted; and, one (20%) was withdrawn.

Updates on Hospital's Structure and Policies Related to Act 114

FSA senior partners, Joy Livingston and Donna Reback, conducted site visits at each of the designated hospitals now responsible for administering psychiatric medication under Act 114. During those site visits, interviews were conducted with administrative staff as well as psychiatrists, nurses, social workers and psychiatric technicians. At two sites, staff provided a tour of the facilities as well. Initial interviews focused on changes in hospital facilities, staffing, and procedures relative to administration of Act 114. Results from these initial interviews are summarized in the following descriptions.

Brattleboro Retreat

As noted in the FY12 assessment, the Retreat made a commitment to continue care for individuals with intensive needs. As a result, a new unit built to serve intensive-needs patients was opened in April 2013. This unit was designed to serve 14 Level One patients. The new space includes an outdoor courtyard accessible to patients; 14 single bedrooms; private interview rooms; community and programming space; a quiet activity room with a computer and iPad; and, an Adult Low Stimulation Area (ALSA). The ALSA is used for three to five patients at any one time. The unit has soft, comfortable chairs, and "space to move around and allow

people to self-separate." Staff described the new space as "much more comfortable and healing."

Rutland Regional Medical Center

After Tropical Storm Irene, RRMC also made a commitment to provide acute psychiatric care over the long-term. The hospital recently constructed a new psychiatric intensive care unit for individuals with the most acute needs. The new unit includes an outdoor space; private interview spaces; a quiet room; an activity room; and both single and double bedrooms.

Act 114 hearings continue to be held at the hospital; staff report that they are "getting better at it." Staff noted that they are "pleased with how quickly the court hearing is from filing the Act 114 petition."

In FY13 a VPS peer representative was assigned and has been a consistent presence for psychiatric patients. RRMC staff reported that the peer representative's presence has been helpful to patients.

Fletcher Allen Health Care

In FY12 FAHC reported that space limitations prevented staff from moving patients in crisis into separate, quiet space away from other patients, leading to a range of challenges for patients and staff. In FY13, staff reported that the patient population mix continues to shift toward more severe, higher-acuity needs. Staff members noted that "most patients are involuntary, most of those have been refusing medication at some point, the majority are on Act 114 orders or waiting for the process to take place." Although the psychiatric unit has 16 beds, staff reported they cannot provide patient safety for more than 8 to 12 patients given their acuity level. This has created a backlog of patients waiting for beds in other hospital departments, including the Emergency Department (ED).

To mitigate the impact on other hospital departments, FAHC increased the number of mental health technicians to go to other hospital units in order to work with people waiting for psychiatric beds. The ED began training all constant observers to be mental health technicians; training includes orientation in the psychiatric unit.

FAHC psychiatric department staff noticed an increase in the number of emergency involuntary procedures (EIP) so they developed a work group to reduce the number of EIPs. Staff reported that a "successful multi-disciplinary process has taken place; we have seen a change in culture, with significant decrease in EIPs."

In FY12, Act 114 hearings were held at the Courthouse in Burlington. During FY13 hearings were brought into the hospital, reducing the need for patient travel.

At present, FAHC staff do not anticipate having to serve high-acuity psychiatric patients once the new hospital facility in Berlin is open. They will continue to admit involuntary patients that meet their admission criteria.

Green Mountain Psychiatric Care Center

The Green Mountain Psychiatric Care Center (GMPCC) opened in January 2013 to provide Level I inpatient psychiatric treatment. The Department of Mental Health will operate this 8-bed

facility until the new, state-of-the-art hospital in Berlin opens to patients during the spring of 2014. Staff at GMPCC include many individuals who previously worked at VSH.

GMPCC provides outdoor space for patients as well as a low-stimulation room. Unlike VSH, Act 114 hearings are not conducted on-site.

Automatic 30 day stay

During FY13 the rule of law allowing a 30-day stay on any order to provide time for an appeal to the ruling was invoked by the Mental Health Law Project. It was determined that an automatic 30-day stay on an Act 114 order should be in place, unless there was a petition to revoke the stay and provide immediate administration of medication.

FAHC staff reported that since learning of this provision, they have argued for revoking the stay in order to allow immediate administration of medications. Staff report that the 30-day automatic stay was revoked in all instances during FY13.

GMPCC staff noted that the automatic 30-day stay was granted for two patients that received Act 114 orders.

RRMC staff reported that initially, they went back to court to ask for revocation of the 30-day stay; "now we are able to ask for immediate execution of the order at the hearing rather than having to go back with another petition." RRMC staff reported that immediate-execution orders have been granted "because of the patient's acute need."

Staff Feedback on Implementing Act 114 Protocol

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

Act 114 Implementation Training

Formal training on Act 114 was provided to staff at three designated hospitals (RRMC, FAHC and the Retreat) in September 2011, shortly after they began to serve patients who had been, or would have been, at VSH. This training was conducted by Kristin Chandler, Assistant Attorney General at the Department of Mental Health, along with three psychiatrists from VSH. Since that time, there does not appear to have been any formal training provided by DMH.

Training has been provided to newly hired nursing staff at all four hospitals as part of their orientation. At RRMC Act 114 provisions are reviewed annually and included in annual competency testing of staff. FAHC staff said they also received information about Act 114 through emails and staff meetings. Staff from all four hospitals also report learning about Act 114 "on the job" through knowledgeable physicians and other staff.

Each of the four hospitals adopted the VSH forms to document administration of court-ordered medications. Staff noted that the forms also provide useful education on the provisions of the statute.

Decision to File Order

Decisions to pursue an order for involuntary medication are ultimately the responsibility of the treating physician. Staff at all four hospitals reported that the decision grows out of daily treatment team meetings based on an assessment of a person's needs and treatment options. All make efforts to give an individual an opportunity to take medication voluntarily before a decision is made to seek an order for involuntary medication. First, a decision has to be made to seek involuntary treatment through a commitment order. In some cases, an Act 114 petition is prepared for filing immediately after a commitment order is issued. In other cases, the team takes more time in the hope that an individual will start to take medication voluntarily.

Patients' Rights

Physicians have the primarily responsibility for informing patients that an Act 114 petition has been filed and an order granted. Staff at GMPCC reported that the physician informs the patient about the medication that will be administered. At RRMC the physician and members of the treatment team have an "ongoing conversation" about medications. In addition, there is a consistently present peer representative with whom patients can talk.

Staff at the Retreat reported similarly, and added that they "regularly remind people that they have a right to representation, and tell them who they can go to for support." Retreat staff reported that the peer representative, who is on the unit weekly, also participates in new employee orientation, and there is an ongoing Consumer Advisory Council that meets monthly.

FAHC staff added that there are representatives from Disability Rights, Mental Health Law Project, and Vermont Psychiatric Survivors regularly present. "We encourage patients and give them the resources to talk with these folks. If someone is in distress and says they want to talk to their lawyer but can't get it together to do so, I'll phone their attorney and ask them to call the patient."

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

GMPCC staff said they work to engage patients and "encourage them to talk about what happened and to look at medication as a tool in their toolbox to get them back to their community…helping people to refocus on their discharge plans and goals."

Staff at the Retreat noted that "often people are concerned about side effects, so we give them a lot of encouragement reminding them of the known side effects and telling them that if they experience side effects we won't let you suffer, we'll change the dose, try another medication." Staff also noted that they talk with patients about how the medication is helping and ask how we can help them get through the part of medications they don't like.

Benefits of Act 114

The primary benefit cited by staff at the three hospitals was patient recovery. Comments about patient recovery included:

> *"If they get better – if drugs help to initiate the recovery process that's good*"
>
> *"Rewarding to see people get better and live the lives they choose to live. Before we did this, we only saw patients at their most ill and never saw them get well. Now we get to see patients as they move into recovery."*
>
> *"Getting people out of distress, able to care for themselves"*
>
> *"People get treated; they get treatment that has worked for them in the past. Allows them to regain independence a lot quicker, get better, go home and resume their lives."*

GMPCC staff noted that "medications are still a kind of blunt tool to treat this illness, but a great first step to help people gain perspective…down the road hopefully everything will be community-based."

Challenges Posed by Act 114

The staff from all four hospitals echoed the same sentiment they expressed last year, and that has been expressed by VSH staff over the eight years in which Act 114 was administered at VSH: the primary challenge Act 114 poses is the <u>time it takes to treat individuals</u> suffering from mental illness. For example:

> *"It shouldn't be an easy process but it should be expedited, patients should get medication as soon as they need it, should be much faster."*
>
> *"The long period of time before people are medicated is torture for the patients and for other patients observing the behavior."*

Staff across the four hospitals noted a number of concerns about delays in administration of medication:

- Inequitable treatment of mental illness
  - *"It is not fair to leave people ill; we wouldn't do it with any other illness"*
  - *"It is difficult to see people suffering so long particularly when they have a history of functioning well on medication. Hard to be present with someone in a lot of pain and suffering and knowing that there is something we can give to relieve suffering and cannot. I have seen patients not eat and drink for weeks and weeks, not take other meds that can help them (blood pressure, etc.)."*

- Right to treatment denied
  - *"Is medication infringement on liberty when their liberty is being infringed upon in terms of their space, where they are forced to live – This implies that the patient's time is not valuable*."
  - *"I am in favor of safeguards and patients' rights, but patients are losing the right to liberty and to live in community, and the right to treatment."*
  - *"Patients have been involuntarily hospitalized; we're willing to do that but not to provide involuntary treatment."*

- Injuries to other patients and staff
  - *"I worry about the risk of people getting hurt, hurting other patients, hurting staff, risks increase when people are on units for months without medication"*
  - *"We have injuries because people are not on medication…hit on a staff head, broken ribs."*

- Trauma to patient and others, including other patients and staff
  - *"We understand how traumatizing any hands-on intervention and seclusion/restraint is but delaying non-emergency medication dramatically increases emergency procedures which are traumatizing."*
  - *"More emergency involuntary events take place prior to court order that could be avoided; this is the result of acute pathology."*
  - *"It is a traumatic experience for patients being treated in [the] same space as someone out of control, as well as trauma for employees. There was a serious assault on a staff member…other patients were around and saw that. The person who did the assault is now on the unit and patients have to worry about their safety, they isolate in their rooms because of fear, disrupting the therapeutic impact of working in community."*

FAHC staff added another concern – resources required to maintain safety of other patients and staff: "This is a narrow population with very few patients, but this group is causing significant events and disruption to treatment of other patients with an enormous amount of resources going into this…Currently we have two patients on constant observation because of the behavior of a third party on the unit that is aggressive and intrusive. We can't have a constant observer on that person as it would aggravate the behavior of that person. This ends up being the least restrictive form of containment for a person without medication, and more restrictive for others."

Time delays were attributed to lag time for forensic psychiatrists to conduct requested outside evaluations and court delays due to limited court times, cancelled court dates and the 30-day automatic delay.

Staff at RRMC and GMPCC suggested that clinicians and advocates had different perspectives on the need for timely medication. Two comments that clarify this observation:

> *"There are some people who will get better without medications, but patients committed to the hospital are really ill and won't likely respond without medications…These folks are very ill and won't get better without meds. They also need other interventions, support, structure, case management, etc. But meds are a key part."*

> *"There is confusion between the refusal to take meds in the long term with what is needed for short-term crisis. Rules about involuntary meds mesh them all together. Inpatient stabilization enables people to make decisions for themselves. In the short term medications are effective in reducing psychosis, which is what we are about. I don't know how we justify keeping a patient ill."*

Hospital staff were asked to describe strategies they utilize to address the time delay to obtain an order for involuntary medication. In each hospital, staff discussed the variety of strategies used to engage patients and build relationships, particularly one-to-one conversations. In addition, staff spoke about other strategies as discussed below.

Staff at GMPCC said they use time outdoors in the yard to de-escalate, time in the quiet room, pet therapy, and group activities (including Recovery Services Group). Patients also have access to music and art. GMPCC staff reported that at least two individuals had left the hospital without ever having taken medication.

RRMC staff reported that they provide access to a quiet space, occupational therapy, Wii, access to the outdoor area, music, biofeedback, and a range of "activities that vary from day to day." Staff said that playing Wii, in which staff and patients "had a good time and relaxed together dancing made a huge difference." Staff also said they seek to involve outpatient providers and family members when possible.

FAHC does not have a low-stimulation room; staff have, however, arranged to allow one patient access to the garden twice a day to provide everyone with a break from tension on the unit. The staff said they were able to offer patients weighted blankets, ear plugs, radios, relaxation CDs, and arts and crafts of interest to individuals. Staff reported that they try to identify "things that might be of interest to the person such as books or videos" and make those available.

The Retreat staff reported that they work to get outpatient providers and family members involved. As noted above, patients at the Retreat have access to an outdoor area landscaped with grass, trees, and vegetable gardens as well as ALSA space inside that can accommodate several individuals at one time.

Staff Recommendations

The primary recommendation offered by staff at the four hospitals was to streamline the legal process so that it takes much less time to obtain an Act 114 order. There were a number of suggestions for reducing the time delay from admission to administration of medication.

- Combine the commitment and Act 114 hearings
  - *"That the commitment process stands separate from the court order may be positive but the time lapse seems absurd*."
  - *"Commitment to the hospital for treatment, since most of the time that treatment is medication, shouldn't have to go back for another hearing*."
  - *"We should consider combining these two and making commitment standards more stringent"*

- Establish and/or enforce time limits
  - *"Create a provision to shorten the time from commitment to court ordered medication"*
  - *"We should have the statute regulate the number of days a patient has to wait for a hearing."*
  - *"Be consistent with time limits in legislation"*
  - *"Have medication hearing within 7 days of commitment order"*
  - *"I am concerned that people's rights be protected, but if the appeals process to the decision on Act 114 continues to be there, it has to be a more speedy process."*

- Increase court resources
  - Provide sufficient number of judges to prevent delays to hearing date
  - Avoid delays due to judicial absences (e.g., due to vacation schedules)
  - Conduct all hearings on-site at hospitals
  - When MHLP requests second opinions, they should be done in a timely manner

- Revise the legislation so that the decision to administer medication is clinical not judicial
  - *"Make it a clinical not a judicial decision, have a panel of psychiatrists make the decision…balance the power by not having 3 psychiatrists in [the] same hospital make the decision."*
  - *"At present it seems that legal status rather than clinical status drives cases."*
  - *"Have a clinical second opinion – if our team decides court-ordered medications are needed – that's an excellent place to have additional medical review making the decision, versus a judge. A judge is not a clinical expert – a second outside clinical source (e.g., medical board) would be a better alternative."*

- Test viability of 30-day waiting period
  - Use data to determine whether the 30-day automatic waiting period after an Act 114 order is issued makes a difference by assessing:
    - Number of emergency procedures while waiting for the order
    - Number of people whose symptoms disappeared while waiting for order
    - Number of people who became asymptomatic during the 30-day extension
  - *"Most patients don't change their minds, no matter how long they wait."*

- More effectively use Orders of Nonhospitalization (ONH)
    - *"There is a high level of tolerance of not complying with ONHs and so patients get quite sick."*
    - *"We lack the ability to do involuntary meds in the community – this is a barrier since some folks won't take medications voluntarily. We could discharge more quickly if we could get involuntary medications in the community. ONH is supposed to do this, but patients figure out that they can violate ONH without consequences. If ONH had teeth and meaningful consequences that might prevent regulars from coming back so frequently."*
    - Patients come in repeatedly on an ONH "*why re-litigate the same issue again, why not use the ONH which requires medications. The patient was here, leaves, comes back because he or she stopped taking medications, and then we have to go back to court again. It would be good to say the order still stands. Most ONHs state that patient will take meds as prescribed.*

- Move more quickly to ensure medication for persons with history of success with medication
    - *"Don't treat people differently depending on whether or not someone's history is known; we may be able to try medication because we know that it worked in the past. If a patient is noncompliant with ONH, that patient comes in and has to start all over, in that sense we could have a different time frame."*
    - *"Consider people differently based on whether this is one's first psychotic break or a reoccurrence [sic]"*
    - *"There is a distinction between an individual who is 19 years old newly psychotic and the pool of people who have been to court, have a history, and both clinical pictures are treated the same by the courts – both individuals are waiting same time period"*
    - *"We have to start at the beginning even for people who have been through the system multiple times; it doesn't make sense if we already know how to treat them. Even if we have an advance directive it doesn't help if they're refusing the medications."*
    - *"I see mental illness often as a chronic illness, cyclical – what frustrates me is seeing a familiar face coming through the door who, when on medication, is doing so much better. We should be able to get those with recurrence on medication more quickly. It's a disservice to the client."*
    - *"Someone in a correctional setting and waiting for a bed in the hospital can't start the process of involuntary medication until they get the bed. By that time, they've spent months before we're able to medicate. If they are already getting psychiatric care in the corrections setting, they should be able to start the legal process for involuntary medication."*

Interviews with Judges, Lawyers and Peer Advocates

Last year, for the FY12 Annual Assessment, DMH leadership requested that judges, lawyers and advocates with Act 114 responsibilities be interviewed to determine how the closing of the Vermont State Hospital had impacted their roles and responsibilities toward the administration of Act 114 medication. This year, we were asked to talk again with these stakeholders with a view towards understanding:

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

In response to this request, Flint Springs Associates conducted interviews with two judges, one MHLP lawyer and three representatives of the mental health peer community to gain their perspectives on these questions. Those interviewed included:

- Judge Amy Davenport and Judge John Wesley
- Jack McCullough, Mental Health Law Project (MHLP) Lawyer
- Linda Corey, Kitty Gallagher and Michael Saborin, Vermont Psychiatric Survivors (VPS)

What is going well now?

Support for judges new to hearing Act 114 applications was provided in a number of ways. At the judicial conference held annually each June, an hour-long program focused on mental health cases and law, covering applications including Act 114 petitions and providing resource materials for judges. Judge Davenport makes herself personally available to respond to occasional calls from judges in need of technical assistance. This will be especially important as September 2013 saw a rotation of new judges into the courts hearing Act 114 applications.

As stated in last year's report, initially it was difficult for the three new courts (Chittenden, Rutland and Windham) to absorb this new caseload. It took some time for judges and clerks to adjust but now the court believes that the time from application to hearing is reasonable. Judge Davenport recently asked the Court Clerks in Windham, Rutland and Chittenden counties to review the number of business days it takes from the filing of the Act 114 application to the hearing. Included in the numbers were cases where continuances were requested, either by the state or by the defendant's lawyer (MHLP). Judge Davenport believed that continuances were requested in fairly equal numbers by the state and the defendant's counsel. The time periods were not aligned with our annual assessment – however, the results indicated that in Chittenden the time varied from as low as 4 days to as many as 11 days with most of the applications being heard between 4 and 7 business days from filing to hearing. In Rutland the number of days between filling and hearing range from 11 to 14 days and in cases where no continuance was requested hearings were all held within 7 business days.

Act 114 applications filed in the Windham court have taken more time to reach the hearing phase and Judge Davenport has offered to provide assistance in terms of a back-up judge if needed to move these applications through more quickly. Judge Wesley, who heard Act 114 applications in Windham County from the time VSH closed until September 2013, noted that during his assignment missing the time limit on hearing applications diminished to the point of being rare as the court became more mindful of its case-processing obligations.

From the perspective of the legal advocates, their representation has positively impacted patients' rights in a significant number of cases. First their representation has led to "a not insignificant amount of applications that are just denied – and there's a good number of cases where the hospital requested some agent or dose where the independent consultant (hired by MHLP) would note some contra-indication based on the history of the patient or knowledge that the dosage amount of the ordered medication is just too high – and sometimes we go to trial and the court agrees with our expert and reduces the dose – or other times the state will back down and reduce what is being asked for." While unable to provide exact numbers of cases where legal representation resulted in these types of modifications, MHLP believed they impacted a quarter to a third of findings. "Looking at 57 cases opened in 2013, 3 were entirely denied, 10 to 11 were dismissed …beyond that we don't have a way of identifying reductions."

Peer advocates talked about the differences between the four facilities administering medication ordered under Act 114. They have heard patients say they like GMPCC because the facility offers activities which help to engage patients in positive ways. The peer advocates noted that GMPCC has discharged some patients without medication orders and this seems an indication that staff are more open to accepting that some people can function without ongoing medication and working with patients toward that goal. When asked why that may be, peers speculated that many GMPCC staff came from VSH and were the recipients of "a lot of good training and guidance on how to treat people…[with the ultimate result that] towards the end of VSH there was huge reduction in grievances."

Peers noted they have been impressed with conditions at RRMC in terms of the number of involuntary medications and incidents of seclusion and restraint (they believed these were low). They attributed this to the fact that in building their new unit, staff took lots of input from peers and patients. Additionally RRMC's psychiatric unit has a community advisory board that meets monthly. Peers said, "We get few complaints from there and when we do, they are more or less about things the hospital can't deal with. We feel they are fair" in their treatment of patients.

What challenges exist in relation to implementation of Act 114?

During FY13 both MHLP and the state acted on a rule of law allowing a 30-day extension on a finding for an appeal. In practice this means a 30-day stay on the order for involuntary medication following the court order for medication. Both DMH and judges acknowledged that utilization of this provision had not been exercised until recently and there was a question about whether anyone had ever argued for this on Act 114 orders. Judge Davenport said that when DMH and the court became aware of an initial request for a 30-day stay, the court was asked to relieve the stay at the time of the hearing and that was granted. The DMH Commissioner was encouraged to examine the rule on 30-day stays to determine whether or not Act 114 orders fall into case types where stays do not apply. For instance, should the burden be on the patient and his/her attorney to demonstrate why there should be a stay – versus on the state to demonstrate why there should not be a stay? Any changes sought to the criteria which determine whether Act 114 cases can be stayed for 30 days could be made only by the legislature or the Supreme Court.

There was clearly a cultural divide between the medical perspective and the legal and advocates' point of view on the need for and timing of administering medication to persons committed to psychiatric inpatient treatment. These differences can become apparent for the sitting judge who hears from the medical profession that there is a powerful case to be made about how the element of time to getting medication can be beneficial or detrimental to a patient, as well as to the probability of hospital staff experiencing workplace injuries at the hands of patients not taking medication. On the other side, the sitting judge has to consider the

introduction of "some optimism that other treatment methods will work…." and yet, when there appears to be some compliance with treatment, hospital staff may take the position that a person experiencing delusions may be capable of feigning compliance by taking medication… "so from all perspectives – treatment, policy and patient rights - there's a delicate balance that has to be made."

From the perspective of the legal and psychiatric advocates, multiple challenges exist. First they said that things were handled differently in each court and in each hospital setting. In terms of case resolution, some courts get commitment cases resolved more quickly than others and this was attributed to how the clerks' offices individually handle scheduling. Windham, Chittenden and Rutland each devote a half-day per week to the mental health docket (not exclusive to Act 114 applications) yet it seemed more common that cases in Windham County got bumped two to three times in a row resulting in more court time passing between filing the application and hearing the case.

MHLP noted their records show a "disturbing trend of increasing reliance on these involuntary medication applications." Since January 1, 2013, the state has filed 57 Act 114 applications, compared to around 45 in the past couple of years and between 20 and 30 applications prior to that. When asked what might be precipitating this rise in applications for Act 114 orders, MHLP noted that they read the clinical charts and from their reading "it seems that the bulk of interaction between the doctor and patient is around having to take medication and the patient saying no." MHLP noted that no efforts were seen to do anything different, to offer alternatives, and therefore there was the question of how and whether forming a therapeutic alliance was possible when it appeared that, instead of giving a patient some time, doctors were applying for involuntary medication as the sole route of treatment earlier and earlier in their processing. From the experience of a defense lawyer it was not unusual that, once committed, people do come around to the conclusion that they may want to take medication voluntarily. If this possibility were pursued more frequently it "would be more consistent with the public policy of the state and reduce need for forced treatment."

Another trend noticed by MHLP was the frequency of orders for long-acting injectable medication as opposed to orders for oral medication administered daily. "There were years where [sic] we established that the hearing officer (Human Services Board) was unlikely to grant orders for long-acting injectable [medications]. This is [a] problem for a couple of reasons. If you get this and you get long-term side effects you can't take out the stuff from the system that causes side effects. There's a real difference between giving a person an injection for 28 days – which reduces the need to have interaction (between the doctor and the patient) every day-- and giving a person the option to take different medication."

The cultural differences between the medical community and legal and peer advocates appeared in the opposing views of how medication prevents or leads to permanent brain damage. Doctors cited research that shows that persons experiencing severe symptoms of mental illness left unmedicated for longer periods will suffer irrevocable brain damage. However MHLP is not sure there is evidence to substantiate this. On the other hand, MHLP noted their agreement with research showing that antipsychotics themselves cause a decrease in brain tissue so that taken over the long term the case cannot reasonably be made that antipsychotics result in improvements for all patients.

From the legal advocate point of view patient rights are central. "We believe in rights, but I don't feel the medical establishment believes in that concept – it's the way they believe in things that is different…altering chemistry and the way your brain works. [I] fundamentally don't think they believe people have a right to question and refuse treatment."

Peer advocates share, with MHLP, the impression that recently there has been an increase in use of involuntary medication. They raised an additional concern about how access to newly renovated spaces at the Retreat was determined for patients. It is their understanding that patients have to earn the privilege to use the new outdoor space, as opposed to having it available as a resource. Similarly it was peers' impression that the low stimulation spaces were used more for confining patients who were agitated rather than offering the spaces as another resource that any patient in need of quiet space could request.

Complaints were also noted about how doctors at the Retreat in particular treated patients. Peers felt that the doctors "need to be educated in bedside manners." Specifically they observed that psychiatrists "aren't allowing patients to be educated…they should be saying [to patients] 'we would like you to take the medication because'...[additionally] they don't tell people the side effects – and when [patients] do get the medication order the doctors up the dosage. People feel that doctors are treating them like kids and the doctors are gods….all they do is give [the] patient a slip of paper with the side effects. When people are on these medications, the first thing to go is eyesight and blurred vision. They can't see the written side effects. There's a problem."

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

Legal and peer advocates offered recommendations for improving the implementation of Act 114. Consensus emerged around the importance of doctors, in particular, taking more time to engage in building relationships and therapeutic alliances with patients as a first step prior to filing an application for involuntary medication.

Toward that end, both recommended that doctors should participate in any training that would help them understand the point of view of hospitalized patients and better equip them to work effectively with patients who resist medication. While the peer advocate assigned to the Retreat is part of the official team that orients new staff, she said that she has never had a doctor come to any orientation session she has given. She believed that if doctors would just sit for an hour, listen to peers, "sit in the other person's shoes" and see how it feels that would help them understand that "when you're in a strange place with strange people and your rights are being removed, it's either fight or flight!" This peer felt that providing doctors with a better understanding of what patients are experiencing may help address both the trauma patients experience by being forced to take medication and the trauma caused by the longer-term impacts and risks of medication on one's overall health.

Another suggestion from peers focused on including their input and that of patients more frequently in a more formal manner. All the hospitals "should be more proactive about including peers in meetings. At the Retreat they do rounds and that's primarily where decisions are made – sometimes medication will be changed without input from the patient. At VSH (in its last years) everyone sat down at the same time in the treatment team with the patient, talked about long-term treatment goals… I don't see that at the Retreat. At Fletcher Allen they do have meetings where the patient is included – peers aren't invited" but the peer knows this still goes on. Also, it was suggested that peer representatives be utilized as resources to medical and unit staff. "They should have conversations with the peer, discuss what they [staff] are seeing, ask [us]'is there more, do you agree with what we are seeing?'" in order to provide additional information about a patient for treatment purposes.

Peers also suggested that medical staff should be open to examining research on innovative practices that do not rely on medication such as Open Dialogue, an alternative approach coming

out of Finland that has demonstrated impact for treating and healing psychosis without the use of medication.

When the new hospital in Berlin starts accepting patients, MHLP hoped that the new beds will eliminate the practice of people being held by the state, from their perspective, "illegally" in hospital emergency departments without psychiatric treatment. Peer advocates were pleased with the planned quiet rooms and hoped that they will make more alternatives and activities available, which from their point of view can prevent boredom, which can lead to people acting out.

Peer advocates noted that these units need to make accommodations such as wheelchairs or canes for people with accessibility needs, which would enable them to maintain their freedom of mobility. They cited the case of one patient at the Retreat who was not allowed to bring in her own wheelchair. That person was forced to use a hospital wheelchair, which broke and left her injured and in need of medical hospital care.

A final recommendation – and one that has emerged over the years this study has been conducted – referenced the fact that the community system of mental health services and care is underfunded. More resources are needed to provide a wider range of alternatives that would help keep people out of the hospital. People acknowledged the state mental health system efforts to expand and improve alternative community resources but warned that as Vermont spends more money on resources like the new hospital in Berlin, funding for the community system may be adversely affected.

Review of Documentation

The Act 114 statute requires the Department of Mental Health to "develop and adopt by rule a strict protocol to insure the health, safety, dignity and respect of patients subjected to administration of involuntary medications." VSH had in place a protocol and set of forms intended to guide its personnel in adhering to the protocol, including written, specific step-by-step instructions that detailed what forms must be completed, by whom and when, and to whom copies were to be distributed. Quality Management at VSH was responsible for ensuring that the forms were complete and updated. Act 114 packets, which included instructions, the required forms and a checklist to guide staff on the documentation, had been developed. Forms included:

1. Patient Information: Implementation of Non-Emergency Involuntary Medication – completed once (triplicate: patient's copy, patient's record, medical records) – includes information on the medication, potential side effects and whether patient wishes to have support person present.
2. Implementation of Court-Ordered Involuntary Medication – completed each time involuntary medication is administered (duplicate: patient's record, medical records) – includes whether support person was requested and present, type and dosage of medication, and preferences for administration of injectable medications.
3. 30-Day Review of Non-Emergency Involuntary Medications by Treating Physician – completed at 30-, 60- and 90-day intervals (duplicate: patient copy, medical records) – includes information on dose and administration of current medication, effects and benefits, side effects, and whether continued implementation of the court order is needed.
4. Certificate of Need (CON) packet – completed anytime Emergency Involuntary Procedures (EIP), i.e., seclusion or restraint, are used. This form provides detailed guidelines for assessing and reporting the need for use of emergency involuntary procedures.
5. Support Person Letter – completed if a patient requests that a support person be present at administration of medication.

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

1. Copy of court order
2. Copy of Patient Information Form
3. Copies of every Implementation of Court-Ordered Medication Form
4. Copy of 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

These forms and protocols were reviewed during DMH's training on Act 114 provided to each hospital in 2011. Three hospitals adopted the VSH forms but did not establish separate file folders or sections within the files for Act 114 documents. Rather, these documents were included in patients' electronic or hard-copy files along with all the other medical information. GMPCC adopted the same forms as VSH and maintains separate Act 114 file folders for persons with such orders.

To assess the implementation of the Act 114 protocol, FSA reviewed documentation for patients under Act 114 orders during FY13 at each of the four hospitals. FAHC and RRMC use electronic records; staff at these facilities provided hard copies of Patient Information Forms, Implementation of Court-Ordered Medication Forms, and 30/60/90 Day Review Forms, along with any CON documentation. Staff at the Retreat provided hard copies of complete medical files for patients under Act 114 orders in FY13; FSA was responsible for locating needed documents within the large files. GMPCC maintains a separate file with all Act 114 documentation for every patient under Act 114 orders; medical records staff pulled needed documents from these files for review.

FSA reviewed forms completed by hospital staff for 25 of the total 32 persons with an Act 114 orders issued in FY 13 (July 1, 2012 - June 30, 2013). This included patients from Brattleboro Retreat (n=10), Fletcher Allen Health Care (n=5), Rutland Regional Medical Center (n=8), and Green Mountain Psychiatric Care Center (n=2). Records for the remaining 7 of the 32 persons with orders in the FY13 time period were not provided by hospitals probably due to confusion about time periods under review (for example, the Act 114 petition was filed in FY12 or FY14). In future site visits, FSA will provide each hospital with a list of cases to be reviewed for the study year, redacted for names, which include date of admission, date the Act 114 petition was filed, and date the order was issued. This list will allow FSA to coordinate with each hospital to ensure that all relevant files are available for review.

Patient Information Form

Patient Information forms were present for 21 of the 25 files reviewed; four Patient Information Forms at the Retreat could not be located. Most of the Patient Information Forms were completed fully. This form asks whether the patient wants a support person present when the medication is administered; one form from the Retreat and one from GMPCC left this item blank. Of the remaining forms, two patients (one at the Retreat and one at RRMC) requested a support person; 10 patients did not want a support person; and seven patients refused to discuss this issue.

The Patient Information Form also includes space for the patient to sign the form. All five FAHC and both GMPCC forms indicated that the patient refused to sign. Three patients signed the form at RRMC, and two did so at the Retreat. The remaining forms were not signed by patients.

In all but three cases, the Patient Information Forms had been completed, as required, prior to completion of the forms for Implementation of court-ordered involuntary medication. This means that in most cases, the patient received information about the medication and was asked about a support person prior to the first administration of medication. At the Retreat, one Patient Information Form had been completed 14 days after the first Implementation of court-ordered medication form had been completed, and 20 days prior in a second case. This meant that the Information form was completed after the first time medication was administered. Also, as noted, Patient Information Forms were not located for three Retreat patients. There was one Patient Information Form at FAHC that had been completed two days after the first administration of medication.

Form for Implementation of Court-Ordered Medication

FSA examined the forms documenting the first three administrations of involuntary medication following the court order, and then the same forms documenting administration of medications at 30 days and 60 days following the court order. Of the 112 Implementation Forms reviewed,

103 (92%) were complete. Three forms at RRMC, one at FAHC, and five at the Retreat were missing information on whether or not the patient wanted a support person.

In most cases, the first implementation form was completed on the same day or within one or two days following completion of the information form, and at least one day after the court order – complying with the provision that there be a 24-hour period between the court order and the first administration of medication. At the Retreat, there were two files in which the first Implementation form was completed on the day of the court order.

Two forms, from RRMC and the Retreat, indicated that the patient wanted a support person present when medication was administered. At the first administration of medication and thereafter, however, the patient did not want a support person present or the form noted the support person was "not needed."

In response to 17 (68%) of the orders, patients chose to receive medication orally beginning with the initial administration; in five cases (20%) the first administration of medication was given by injection and subsequent administration was oral; one individual (4%) received the first three doses by injection and orally thereafter; and two individuals (8%) received all medications through injection.

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

Required review forms (30, 60 and 90 days) were present and complete for all of the RRMC and GMPCC files. Of the five FAHC files, review forms were missing from two files. At the Retreat, none of the required review forms could be found for three files, and 60- and 90-day review forms were missing from an additional four files. Thus required review forms were missing from 7 of the 10 Retreat files.

Certificate of Need (CON) Form

CON forms were needed four times for RRMC patients, once for Retreat patients, and twice for GMPCC patients. These CON forms all accompanied administration of medications by injection. All needed CON forms were present and complete.

Attracting Participants

The 2013 annual assessment invited feedback from persons to whom medication had been administered under an Act 114 court order anytime between 2003 and June 30, 2013. In our conversation with the Adult Program Standing Committee following submission of our 2007 assessment, members suggested that the study should offer *anyone* who has received Act 114 court-ordered medication the opportunity to reflect on the experience. The suggestion was driven by an interest in whether individuals' perceptions of their experiences receiving involuntary medication might change over time and with their living situation, that is, at any of the hospitals responsible for administering Act 114-ordered medication or in a community setting. Thus beginning with the 2008 Annual Assessment, anyone who had been under an Act 114 court order (through June 30th of each year) was invited to participate in an interview.

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

- A peer advocate, well known and highly regarded in the peer community, was engaged by the consultant team to talk with individuals interested in learning more about the study, answer their questions, and refer interested parties to the consultant conducting interviews. A toll-free phone number was provided to make it as easy as possible for people to contact this individual.

- A brochure, intended to inform people and create interest in participating, was written for distribution.

- The Vermont Legal Aid Mental Health Law Project (MHLP) mailed a packet of information to all persons who were involuntarily medicated under an Act 114 court order between January 1, 2003, and June 30, 2013, and for whom they had postal addresses.

- This packet included a letter and the brochure referred to above, which describe the study, how one could get more information about the study, and compensation for participation.

- Vermont Psychiatric Survivors received a copy of the brochure and offered to make survivors aware of the study.

- Copies of the brochure were delivered to the Vermont office of the National Alliance on Mental Illness (NAMI-VT) which offered to distribute the brochure at its annual meeting and inform members of the study in the hopes of recruiting individuals who had ever received Act 114 medication and their family members.

- A letter from the Commissioner of the Department of Mental Health was e-mailed to each Community Rehabilitation and Treatment (CRT) Director along with an electronic copy of the brochure. The Commissioner urged the Directors to inform and encourage individuals they might know who had received Act 114 court-ordered medication to participate in the interviews.

- Compensation of fifty dollars ($50.00) was offered and paid to those individuals who had received involuntary medication under Act 114 and chose to be interviewed.

The results of these efforts yielded results similar to past years. Specifically, despite attempts to get out the word through VPS, NAMI-VT and the CRT Directors, all individuals who requested interviews learned about the project through the packets sent to them from the MHLP. Furthermore, no family members requested interviews despite outreach efforts made through NAMI-VT to inform them of the study.

Focus of Interviews

The assessment pursued two lines of questioning: one for persons hospitalized and receiving Act 114 medication orders at some point between July 1, 2012, and June 30, 2013, and another for those discharged from VSH, the Retreat, RRMC or FAHC at any time prior to July 1, 2012.

The interviews with persons who had been hospitalized and had received Act 114 medication orders during this annual assessment study period sought to understand how the event of receiving court-ordered, non-emergency medication was experienced, to what extent the protocols identified in the statute were followed and, because they are now currently residing in the community, what course of treatment and self-care they are following. Detailed information was sought from them regarding the extent to which provisions of Act 114 had been implemented including:

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

Persons discharged at any time prior to July 1, 2012, were asked the following:

- How the event of receiving court-ordered medication was experienced on reflection
- What impact receiving court-ordered medication has had on their current life
- What course of treatment they are currently engaged in and how they are caring for themselves

Finally, all persons interviewed were asked for their recommendation for improving the administration of court-ordered medication at FAHC, RRMC, the Retreat, the GMPCC and the facility in Berlin currently under construction.

Number of Persons Interviewed

Between 2003, when Act 114 court orders were first granted, and June 30th, 2013 (the end of this study period), MHLP records indicate that 166 individuals received Act 114 court-ordered medication. MHLP had addresses for and sent out letters to 125 of those individuals. The remaining 41 individuals were known to be homeless and therefore had no address or record of residence to which a packet could be sent. Nineteen letters were returned because the recipient was no longer at the known address. Therefore a total of 106 individuals received letters from MHLP inviting them to participate in an interview.

Of the 106 persons who received a packet, 12 requested an interview with FSA staff. However two of those individuals could not be interviewed. One person terminated the interview within the first few minutes, giving no reason for her action. The second person was denied access to the interviewers by staff at the nursing home where he resides. Three attempts were made to interview this individual, but nursing home staff first said that the person was too psychotic and would get disturbed by being interviewed, then they said they did not believe the individual had the ability to have contacted our peer representative (which he did) to request an interview, and finally they said that we would have to speak with the individual's guardian. The nursing home staff would not give FSA the guardian's name or contact information and instead asked for the interviewer's information and was told the guardian would contact us. However, the guardian never contacted FSA to follow-up. FSA contacted MHLP to see if anything could be done but no resolution was offered that would ensure maintaining our confidentiality agreements with individuals. As a result, a total of 10 individuals, representing 9% of persons who received letters from MHLP, participated in interviews (see Table 2). Four of the 10 participants had received Act 114 medication orders between July 1, 2012 and June 13, 2013. The remaining six had received Act 114 medication orders prior to July 1, 2012. All participants were living in community settings at the time of the interview.

Table 2: Most Recent Medication Order by Number of Times Interviewed

Date of Most Recent Act 114 Medication Order	First time interviewed	Interviewed two or more times	Total
During FY 2013	2	2	4
Prior to FY 2013	0	6	6
Total	2	8	10

As stated above, 9% of all persons receiving letters (n=106) sent by MHLP requested interviews. This response rate represents the first drop in participation since 2009. In 2012, 16% of persons contacted were interviewed, in 2011, 14% of persons contacted were interviewed, and in 2010, 11% of persons contacted were interviewed. In 2008 and 2009, 8% were interviewed, and in 2007, 10% of persons contacted by MHLP were interviewed.

Four of the ten persons interviewed received an involuntary medication order between July 1, 2012, and June 30, 2013. These four individuals represent 13% of the 32 persons given court-ordered medication in the study period, the second-lowest response rate since the annual assessments have been conducted (see Table 3). Two of these four individuals were interviewed for the first time for this study (see Table 2).

Table 3: Interview Participants as Proportion of All Persons under Act 114 Orders

Year of Court Order	Persons Who Received 114 Court Orders		
	Number With Orders Issued in Designated Study Period	Number Interviewed Who Received Order in Study Period	Response Rate of Interviews within Same Study Period as Order
2003	14	1	1%
2004	27	6	22%
2005	13	4	31%
2006	22	4	18%
2007	18	2	1%
2008(1/1/08–11/30/09)	12	4	33%
2009 (7/1/08 -6/30/09)	19	3	16%
2010 (7/1/09 -6/30/10)	26	4	15%
2011 (7/1/10 – 6/30/11)	29	4	14%
2012 (7/1/11 – 6/30/12)	28	6	21%
2013 (7/1/12 – 0/30/13	32	4	13%

Of the four persons interviewed who received Act 114 medication orders during FY13, two were at the Rutland Regional Medical Center, one was at Fletcher Allen Health Care and one was at the Brattleboro Retreat.

Responses from the four people hospitalized during FY13

The reason for refusing to take medication

People were asked to talk about their reasons for refusing medication. Two of the four persons hospitalized during the study period said they were already taking medication when doctors decided to increase the dosage and in both cases they disagreed with this decision. One of the two objected primarily to the fact that the doctor did not inform her of the increase. Whether being told would have made a difference in her willingness to take the medication was not clear from the response given. In the second case the individual simply disagreed with the assessment that more medication was needed.

A third person was unable to describe what led to both the hospitalization commitment as well as the reason for doctors to seek a medication order. "It just seemed arbitrary."

The fourth person, looking back, stated clearly that "I was delusional at the time…I had no idea that I was delusional…I didn't know at all that I needed medication."

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

Act 114 protocols stipulate that individuals be given information about the upcoming court hearing and the subsequent court order. Two of the four persons interviewed reported having attended the court hearing. In one case "the judge told me [about the medication order] right away in court….there was no waiting period." In the second the individual said that her "lawyer told me I had to go to court and the court ordered the medication."

For the two people who reported not having attended the court hearing one said no information was given while the other said that although "I wouldn't even go to the hearing I believe it was the doctors who spoke to me….I wouldn't even speak to my attorney…he tried hard but I wouldn't speak to him."

Act 114 requires that individuals be given information about the prescribed medication being ordered, the frequency and dosage, and possible side effects. When asked what information they were given about the medication order, people reported receiving different degrees of information and had conflicting memories of what transpired. The two persons hospitalized at RRMC and the one person at the Retreat reported the following:

> *"The psychiatrist told me about the medication….about the dosage and frequency [of administration]…and I was told about possible side effects by my doctor."*
>
> *"I was given information…but I can't remember exactly what…they did explain it to me"*
>
> *"I got a higher dose and they did tell me I was getting more."*

The fourth person who was hospitalized at FAHC during the study period gave conflicting reports.

> *"I was told nothing…they may have told me what the medication was but they didn't say it was psychiatric medication or what it was for…they didn't consult with me, didn't diagnose me, didn't give me the necessary reason."*

People were asked what they knew about the Act 114 protocols for administering court-ordered involuntary medication and whether they were aware of their right to file a grievance. Three respondents were not aware of the protocols regarding the administration of medications ordered under Act 114. The fourth person felt she had some knowledge of the protocols as she had been hospitalized and received court-ordered medication under an Act 114 order at other times, and likewise was aware of and had exercised her right to file grievances. This person's most recent hospitalization had been at the Retreat, where she reported having "filed a lot of grievances every time I was injured [in the process of receiving medication]." In this case it was unclear if the grievances were related to emergency or non-emergency medication.

Another individual who had been hospitalized at RRMC said that while she was probably aware of her right to file a grievance, "I think I did [know] but I really wasn't in the frame of mind to do anything…I probably would have complained that I didn't need it. I don't remember what I was thinking…."

<u>Treatment by staff during and after administration of involuntary medication</u>

The interviews ask people to comment on:

- how they felt they were treated by staff around, during and after the administration of court-ordered medication
- whether they were asked if they wanted a support person present when receiving medication, as stipulated in the protocols
- whether they were offered emotional support
- whether staff offered to help debrief them after receiving court-ordered medication

Responses varied in regard to questions about how they were treated by staff. No one reported being restrained in order to receive medication ordered under Act 114. Two individuals, both of whom had been hospitalized at RRMC, were very positive about how they were treated by staff. Their comments included the following:

> *"I didn't fight them so I didn't have restraints. It was always the women nurses – I would have felt embarrassed if it was a man because they sometimes gave [the medication] to me in my hip and had to pull my pants down. Some people were better at giving shots than others…They were respectful every time. They were kind."*
>
> *"They treated me well".*

The two other individuals interviewed were neutral in their feelings regarding staff treatment, saying nothing either negative or positive.

The law requires that individuals be asked if they want a support person present when given the medication. One of the two individuals hospitalized at RRMC reported being asked but responding that she did not request a support person because "Í didn't feel like it would make anything better. I'm not afraid of shots and I didn't trust what they were doing…wasn't relying on the support as far as the medication."

The other person hospitalized at RRMC reported that "[staff] never asked…if they had I would have asked for my son who was nearby." Similarly the individual hospitalized at FAHC reported not being asked, but also not being clear what her response would have been if asked. Finally the person at the Retreat could not remember being asked about a support person.

In response to inquiries about whether staff offered emotional support or opportunities to debrief with patients after receiving court-ordered medication, none of the four persons responded in the affirmative. However one of the persons at RRMC was consistent in acknowledging that she was delusional and did not, at that point, have the ability to accept support or offers to debrief during the early days of receiving court-ordered medication. Her appreciation of how she was treated emerged as her delusions decreased, which she attributed to the medication.

<u>Regarding the extent of force used to get people to take medication</u>:

People were asked to what extent they thought their wishes were respected and they felt they had some control over what was happening. First, people were asked if they were given a choice about how to take the medication – that is, orally or by injection. Both of the individuals hospitalized at RRMC said they were offered these options. One person chose to take the medication orally while the other person acknowledged that although she was offered the oral option on a daily basis, the illness kept her from being cooperative and led to her receiving medication by injection.

The person hospitalized at FAHC claimed not to have been given a choice but reported that she took the medication orally, while the individual hospitalized at the Retreat said that as soon as the court ordered the medication she was "voluntarily taking it orally."

In another line of questioning people were asked to assess the degree of force they felt was used to get them to take medication and the degree to which they had some control over what was happening. Again, none of the four people interviewed were physically restrained to make them take medication.

The person hospitalized at the Retreat said, "I ultimately agreed to take it orally because I felt it was the only way to get out of the hospital." In terms of experiencing some degree of control, she stated that she "had control over initiating when I took it within a certain time frame…I would go up to the window and ask for the medication."

The person hospitalized at FAHC reported that "Not much force was used… I didn't want the injection but I was never told why I was getting it."

One of the individuals hospitalized at RRMC said "I don't know if I really felt in control of anything, but looking back afterwards I realize that everything was done professionally and politely…I needed the medication but I just didn't know."

What was most helpful and unhelpful about the experience?

The interviewer asked people what was most unhelpful and most helpful about the experience of receiving court-ordered medication. In thinking about what was most difficult, three people responded that being forced to do something against their wishes was the most unsettling and unhelpful part of the experience. Specifically they noted that whether it was the requirement to take medication, or to have the dosage increased, or not to be informed of the reason for the medication order, there was an element of not being listened to and not having wishes acknowledged that was most difficult.

The fourth person, who was hospitalized at RRMC, identified the side effects of the first medication prescribed, which made her pass out, as most difficult. "It was so scary for me to pass out because I didn't have control over it and I didn't know what was happening." In response to a question about whether she talked to the medical staff about this, however, she said, "I didn't, maybe I should have…but they should have noticed."

When asked to think about what was most helpful about the experience of receiving court-ordered medication one person hospitalized at FAHC and one at RRMC reported that nothing was helpful or beneficial. The other two individuals, however, noted how important the kindness, caring and support of individual staff was to the experience. The person hospitalized at the Retreat was able to differentiate clearly between being forced to take medication without deliberation and input and the importance of how individual staff treated her. "People showed caring in the most simple ways – just like bringing cookies…I felt like people there really cared."

The second person hospitalized at RRMC noted that "there was a nurse and then a woman who ran groups…those two were the main people that I felt nurtured and supported by that really helped me through the whole process."

The interviewer asked people whether, looking back, they felt the state was right in giving them involuntary, court-ordered, non-emergency medication. The same two individuals who felt there was nothing beneficial or helpful answered "no" to the question. The person hospitalized at the Retreat noted that "Medication alone is not sufficient - It's one piece of the puzzle but they didn't offer psychotherapy and that would have been helpful –there was no help for people who'd been traumatized and there was nothing for PTSD – medication is just one ingredient in the process."

The other individual who had been hospitalized at RRMC was unequivocal - "Yes - I am so grateful because I would have never gotten help – they just totally gave me my life back."

What course of treatment and self-care are you engaged with now that you are living in the community?

Each of the four individuals who received Act 114 court-ordered medication during FY13 continues to take medication. One individual transitioned from a residential facility into a private residence. She is involved with her church, goes to Bible study with her father, and has gone through a whole health, wellness, and resiliency training program, Wellness Recovery Action Plan (WRAP – as developed by Mary Ellen Copeland and taught around the state through programs administered by Vermont Psychiatric Survivors) and a program called HEARTS. Her goal is to regain custody of her child and she is working conscientiously toward that end. "I guess…it seemed that everything happened the way it was meant to happen."

Another person who moved from the hospital setting into a therapeutic residence regularly sees a therapist and is in the process of looking to share a home with someone.

The two other individuals interviewed gave few details beyond the fact that they continue to take medication and remain connected to their local mental health center.

Responses from people who had been discharged prior to July 1, 2011, and living in the community during this study period:

This year six people living in the community during the study period completed interviews. None of these individuals had received a court order for involuntary, non-emergency medication between July 1, 2012, and June 30, 2013. Because of confidentiality protocols, MHLP is unable to provide us with exact information about the length of time people had been in the community since their last discharge from any of the hospitals administering Act 114 medication. As a result, information presented below in Table 4 comes from self-reports. Some people had a precise memory of their release date, others knew the year of their last discharge, and one person could not remember when he/she had last been discharged. Everyone living in the community during FY13 has been interviewed at least one other time.

Table 4: Year of Most Recent Discharge from Inpatient Psychiatric Hospital

Most Recent Discharge	Number of Persons Interviewed
2012	1
2011	3
2010	1
Unsure/Can't Remember	1
Total	**6**

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

In response to the question of how receiving court-ordered medication under Act 114 was experienced, none of the six individuals provided positive feedback, regardless of where they were hospitalized. Their accounts and perspectives varied from one person to the next. Three people referenced the coercive nature of receiving medication.

> *"I had no cooperation from my doctors. They gave me medication against my will…I felt it was malpractice."*

"I don't remember this at all…they wouldn't tell me anything [except that] I had a mental illness. The medication doesn't do anything for me, I feel the same."

Another person reported being traumatized and scared and having memories of earlier abuse come into his consciousness. "I didn't know much about what [the doctor] was injecting me with. I still have dreams about it…..It was such an uncomfortable thing for me. I was reminded of abuses I suffered as a kid…how I was held down…and I was expecting the abuse to happen after the inoculation."

One individual believed – and continues to believe – that hospital staff were practicing witchcraft on her.

Another person who was at VSH remembers the experience as exhausting. Over time she was able to negotiate with doctors around the type of medication prescribed as she was "hesitant about taking the Depacote and willing to take Prolixin."

One person, who had been hospitalized at VSH and then at FAHC, initially said that he was treated no differently at the two places. He edited that comment ultimately, however, saying that "they weren't too bad. They sent me to so many mental hospitals I can't remember….but Fletcher Allen was a little better than past times."

<u>What impact has receiving court-ordered medication had on your current life?</u>

People were asked to describe how they felt their current lives had been affected by receiving Act 114 medication. Five of the six individuals responded to this question. Two people were clear that the medication has had a positive impact on their lives and ability to function in their community.

"I'm glad now that I'm receiving meds – they are helping. They help me deal with the anxiety attacks that I suffer – alleviate them, help me get through them."

"My mood is stable…the Prolixin is enough. I like the town I live in – it's very friendly and everything is in walking distance. I walk around, go shopping, have my hair done."

Another person expressed ambivalence, saying at first that he is "better without the medication." But when asked why he continues to take it he said, "I feel it helps me…it give[s] me clearer thoughts…I don't get mind-boggled."

Another person felt that he couldn't tell if the medication is doing anything, and another believes that his new medication is causing problems with his short-term memory.

<u>What course of treatment they are currently engaged in and how they are caring for themselves:</u>

People were asked what, if any, course of treatment they are following and what activities and events they participate in that they view as beneficial. Table 5 reveals that each of the respondents reported involvement in ongoing treatment and community-based mental health services. The degree of their reported involvement varies from infrequent visits with psychiatrists to regular involvement with caseworkers as well as psychiatrists. Four of the six individuals report living in either a community mental health group residence or supported apartment setting while two report living in an independent private setting. Everyone interviewed is taking psychiatric medication – five of the six individuals report that they are

under an Order of Non-Hospitalization (ONH). Three people with ONHs view the medication as beneficial to their functioning and emotional wellness, while two believe it is not needed and they would not take it without the ONH.

Four people said that they take part in a range of activities and hobbies including fishing, watching movies, listening to music, being with friends, and taking public transportation downtown to shop. Three persons exercise through walking and swimming. One person is happy and proud to have gotten part-time employment over the past year shoveling snow and taking on small handyman projects, and he anticipates getting more work of this kind with a local landlord.

Table 5: Reported Treatment Participation and Self-Care Activities

Key Responses	Number of Responses
Involved in some way with mental health professional services (has caseworker, sees MD)	6
Currently taking psychiatric medication	6
Living in Community Mental Health residential support setting (apartment, group home)	4
Engaging in pleasurable activities and hobbies alone and/or with friends	4
Takeing medication because of court order(ONH) and view it as needed and beneficial to how they feel and function	3
Exercising regularly (swimming, taking walks)	3
Taking medication because of court order (ONH) but believes it is not needed	2
Takes medication, reports not to be on ONH, unclear about benefit	1
Working part time and enjoying it	1

Individuals who feel medication has been beneficial said the following:

> *"I'm glad now that I'm receiving medication, they are helping me deal with the anxiety attack that I suffer. The medication alleviates them, helps me get through them….I'm working now…that's good, I like it."*

> *"I still agree with taking the Prolixin. I go everywhere and the medication helps me with the panic attacks that I used to have…so now I can go everywhere, I walk a lot."*

Another person, who would prefer not to take medication but acknowledged its value, noted that a change in medication from Abilify to Haldol has been positive for him. He believes that he experienced "suicidal effects" from the former medication and says of the Haldol "yes, I do find it to be a better medication" in that it helps him think more clearly.

One of the respondents, who did not offer an appraisal of whether the medication is beneficial, said of his psychiatrists that "his mind is made up about everything…people are asking me questions about how I am."

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

This section describes responses from the ten people interviewed this year, four of whom were hospitalized during FY13 and received Act 114-ordered medication and six of whom were living in the community and received Act 114 medication in earlier study periods. People were asked for their recommendations on what the current and future administering facilities (Brattleboro Retreat, FAHC, GMPCC, RRMC and the Berlin facility under construction) could do to improve the experience for people receiving Act 114 involuntary court-ordered medications in non-emergency situations. Consistent with findings in previous years, a majority of recommendations focused on communications between staff and patients, staff interpersonal skills and provision of information to patients about the medication. Key themes include the following:

- Staff should engage with patients in more gentle, patient and personable ways.

  "They should seriously study how Rutland handles things because I just had the nicest experience there…it doesn't have to be mean or how they handled it at the state hospital."

  "I would support people in developing positive respectful caring relationships between staff and patients…more use of verbal de-escalation rather than physical intervention would have set the stage for a more trusting relationship sooner."

  "[Staff] should be more sensitive, have more kindness. Don't badger patients, but talk to them about why they need [medication], how they think it will help them."

  "I don't think they should go so harsh, using handcuffs and forcing them to do drugs…it was nice to go to the mental hospital and have a cigarette."

- Doctors and staff should listen more to patients regarding their concerns about medication and its side effects.

  "I would make sure [patients] have a chance to find out why they have to have it. I feel that now that I'm not in the hospital I don't need medication."

  "Doctors have their minds made up…they need input from the person. Most people don't like to take their medicine."

- Efforts should be made to help individuals understand how medication could be beneficial.

  "Could they make a documentary from people who receive treatment to talk about the progress [they have experienced] from treatment? It would be helpful to someone who is about to receive medication."

- Time and activities should be better structured in the hospitals.

  "Anything that helps structure the time is definitely positive and [the Retreat] did a good job of that…they have a good amount of groups."

"Best thing is that people are able to go for a walk more than a half-hour. You can get fat not doing anything there. There's just no exercise. Put in a nice big lap pool."

Key Findings Emerging from Interviews

It is important to offer the following information about the interviews. First, the people who volunteered to participate in the interviews were self-selected. Therefore, one cannot view the findings as representative of all people who received Act 114 court-ordered involuntary medication between January 1, 2003, and June 30, 2013. Second, in some cases, people chose not to comment, were unable to remember, or were confused and unable to clarify their responses to some of the circumstances surrounding the court order and administration of medication.

In recruiting people who received court-ordered medication over an eleven-and-one-half-year period, we hoped to:

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

In this year's assessment, no one was hospitalized at the time interviews were conducted, making this the first year in which all persons interviewed were living in the community. The overall percentage of people requesting interviews (n=12) and those ultimately participating in interviews (n=10) represented only 9% of those who received packets sent out by MHLP (n=106). This represents a sharp decrease in participation from past studies – a phenomenon we are unable to explain, especially in light of extra efforts to recruit participants and family members – through NAMI-VT and the Commissioner's letter to CRT directors.

This year, as in years 2009 through 2012, two different sets of questions were posed to study participants, based on whether they were hospitalized at some point during the study period or had been discharged prior to July 1, 2012, and were living in the community.

Responses from the four individuals who were hospitalized and received involuntary medication through an Act 114 order at some point between July 1, 2012, and June 30, 2013, showed mixed responses in terms of:

- recollections and reports of how the Act 114 protocols were followed
- feelings about how they were treated, supported and respected during that experience
- the value and benefit of receiving court-ordered medication in their current situation

Three of the six people interviewed who had received court-ordered medication prior to July 1, 2012, viewed the current medication they were on as beneficial while five of the six were clear that the experience of receiving Act 114 medication was negative.

All ten individuals interviewed continue to take medication regardless of whether they believe they need it. Nine of the ten participants report ongoing involvement at various levels with community mental health services. Living situations for these people vary from private

residences to housing supported by community mental health services. One respondent reported having paid part-time employment at the time of the interviews.

Similar to previous years, a majority of people say they continue to take medication because they are under an ONH. This year, similar to last year's findings, complaints about side effects from current psychiatric medications were less prevalent than ever as no concrete examples were cited. The majority of participants indicated that whether or not they believed they need medication, the current prescription is acceptable.

As in past years, participants were asked if they would like any family member to be interviewed. One participant suggested that we contact her father, but gave the caveat that he is difficult to reach. Repeated attempts to talk with him over the phone failed as no one ever answered the phone call nor had a message service. Thus, no family interviews were conducted.

Finally, people noted again the critical role that communication and interpersonal skills demonstrated by mental health professionals may play in helping them feel they have and can exercise more choice in their treatment, and in viewing medication as beneficial and stabilizing.

Section 2: Outcomes from Implementation of Act 114

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

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

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

For FY13, achievement of outcomes was as follows:

- Staff awareness of Act 114: Staff at all four hospitals currently administering medications under Act 114 were aware of the provisions as shown by documentation of adherence to Act 114 provisions.
- Time between admission and petition: In FY13, 26% of Act 114 petitions were filed within 30 days of the date of hospital admission; 38% were filed 61 to 180 days after admission (see Table 6). The proportion of petitions filed 61 or more days after admission was higher in FY13 than in previous years.

Table 6: Time (in days) Between Admission to VSH and Filing Act 114 Petition

Time from Admission to Petition	FY of petition filing (7/1 to 6/30)							
	2010		2011		2012		2013	
	Freq	Percent	Freq	Percent	Freq	Percent	Freq	Percent
<30 days	8	27%	13	33%	11	26%	11	26%
30-60 days	14	47%	15	38%	20	48%	15	36%
61 - 180 days	4	13%	7	18%	11	26%	16	38%
181 - 365 days	0	0%	3	8%	0	0%	0	0%
>365 days	4	13%	2	5%	0	0%	0	0%
Total	30	100%	40	100%	42	100%	42	100%

It took on average 58 days from admission to filing the Act 114 petition (see Table 7). Overall, it took about 67 days from admission to the Act 114 order in FY13. In previous years, the shortest time period from admission to petition for VSH patients was 36 days in 2008, but this had risen to 68 days in 2011 (see Table 7). It took on average 13 days (two weeks) from the date the petition was filed to the date an order was issued. Average time from admission to order was 72 days for the Retreat, 58 days for FAHC, 55 days for RRMC, and 94 days for GMPCC.

Table 7: Mean Time Delays between Steps in Act 114 Process
(Excluding cases in which petition filed more than 1 year after admission)

FY of Petition (7/1 t0 6/30)	Time (in days) from:					
	Admission to Petition		Petition to Order		Admission to Order	
	Mean	*Std. Dev.*	Mean	*Std. Dev.*	Mean	*Std. Devi*
2007	84.64	*92.67*	29.43	*15.20*	114.07	*90.83*
2008	35.80	*26.69*	25.13	*8.06*	67.25	*31.62*
2009	79.24	*80.86*	8.86	*81.48*	88.10	*120.80*
2010	40.12	*19.94*	16.39	*12.25*	55.57	*21.54*
2011	68.37	*77.43*	15.29	*9.68*	83.66	*77.27*
2012	50.21	*35.07*	14.38	*6.82*	65.67	*35.03*
2013	57.55	*40.91*	13.44	*9.64*	66.71	*39.71*

In past assessments, and again this year, hospital staff report that time delays in the Act 114 process are due to the legal procedures. The first of these is separation of the commitment and Act 114 hearings. In FY13, it took an average of 6 days from the commitment date to the date on which Act 114 petitions were filed. As shown in Table 8, nearly one third of Act 114 petitions had been filed prior to the commitment orders; 41% were filed within seven days of the commitment date. Once a petition has been filed, the time for an order to be issued has decreased over the years (see Table 7): in FY13 the average was 13 days.

Table 8: Time between Date of Commitment and Act 114 Petition Filing Date

Petition filed:	FY10		FY11		FY12		FY13	
	Freq	Percent	Freq	Percent	Freq	Percent	Freq	Percent
Before commitment	4	13%	7	19%	5	13%	13	31%
Same day as commitment	1	3%	9	25%	4	11%	2	5%
Within 7 days of commitment	12	40%	8	22%	13	34%	15	36%
8 - 30 days following commitment	11	37%	10	28%	13	34%	9	21%
30+ days after commitment	2	7%	2	6%	3	8%	3	7%
Total	30	100%	36	100%	38	100%	42	100%

- Length of stay: Of the 25 case files reviewed for patients under Act 114 orders in FY13, 21 (84%) were discharged from psychiatric inpatient care, on average, 123 days (approximately 4 months) after admission, and 71 days after the Act 114 order was issued. The average order-to-discharge figure does not include data from three patients who remained in the hospital for more than one year. Compared to average length of stay in previous years for patients at VSH, patients treated in FY12 and FY 13 spent less time in the hospital (see Table 9). Over the past several years, the trend shows a decreased time from Act 114 order to discharge; in FY13 this trend reversed slightly.

Table 9: Length of Stay for Patients under Act 114 Orders Who Were Discharged from Hospital

FY Petition Filing (7/1 t0 6/30)	**Average Length of Stay (in days) from:**			
	Admission to Discharge		**Order to Discharge**	
	Mean	*Std. Dev.*	Mean	*Std. Dev.*
2007 (n=25)	267.04	*152.12*	146.00	*70.69*
2008 (n=12)	160.08	*64.58*	93.33	*36.36*
2009 (n=22)	211.36	*141.19*	97.73	*94.81*
2010 (n=24)	153.46	*79.33*	86.71	*38.15*
2011 (data unavailable)	--	--	--	--
2012 (n=23)	128.09	*67.41*	63.52	*40.48*
2013 (n=21)	123.38	*41.34*	71.00	*38.89*

- Readmission Rates: Of the 25 patients under Act 114 orders in FY13 whose files were reviewed, 22 had been discharged by the time of this review. Records did not indicate that any of these individuals had been readmitted.

- Satisfaction with Process: Hospital staff members would like the process to move more quickly. Of the four persons interviewed who received Act 114 medication during FY 13, one person who was hospitalized at RRMC praised hospital staff for treating her with respect and caring throughout her stay. The second person hospitalized at Rutland also noted that she had been treated well by staff through the process. A third person who was at the Retreat noted that initially she felt staff were too aggressive in their efforts to get her to take medication and wished they had done more to de-escalate the situation by talking with her, offering alternatives and psychotherapy. She noted that over time individual staff demonstrated more caring and acts of personal kindness towards her. The fourth individual who was hospitalized at FAHC was neutral about staff treatment.

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

The Department of Mental Health (DMH) leadership team, including the Commissioner and Deputy Commissioner met with Flint Springs Associates (FSA) to review steps DMH took during FY13 toward achieving a non-coercive mental health system. These include:

1. Offering treatment options from acute inpatient care to a range of community-based services:

    - A new state-of-the-art psychiatric hospital was designed during FY13. The hospital is designed to have a maximum of 25 beds divided into three units with flexibility in the arrangement of space. Each unit can have eating and sitting areas; all have access to comfort rooms, low stimulation areas, outdoor space, exercise room, activity room, and conference rooms. The hospital was designed with extensive stakeholder involvement, including consumers and family members. The goal was to create a congenial and calming environment. In addition, staff training for the hospital will emphasize a recovery model.

    - The Green Mountain Psychiatric Care Center opened in January 2013 to serve as an interim option for Level 1 patients. When the new hospital in Berlin is complete, staff from GMPCC will transfer to the new facility. Strategies that will be used in the new hospital have been implemented at GMPCC (for example, changes in recruitment and hiring of staff). GMPCC now has recovery specialists rather than psych techs (positions that had been in place at VSH). DMH staff reported that GMPCC leadership has been working to bring recovery principles into the hospital.

    - DMH continued to create a range of acute inpatient beds during FY13, in addition to those established in FY12. An 8-bed intensive residential recovery program was established in Westford and a therapeutic community residence (TCR) was developed in Middlesex. The Middlesex TCR provides a secure setting in the community but is less restrictive than inpatient psychiatric care.

    - DMH included peer-supported programs as part of the system of mental health care for persons with acute needs. One such program, Alyssum, opened in the fall of 2011 (FY12), and another, Soteria House, was expected to open in FY13 but is currently still in development; current expectations are to open it in summer 2014. In addition, DMH continued to work with the hospitals, designated agencies and Vermont Psychiatric Survivors to provide peer support to people in crisis in hospitals throughout the state, including emergency rooms and psychiatric units.

    - DMH sought to expand capacity to treat people closer to home by working with the Brattleboro Retreat and Rutland Regional Medical Center to expand their ability to treat people with more acute needs. During FY13, both hospitals completed new units providing acute inpatient care allowing individuals to receive treatment closer to their home communities.

2. Ensuring least-restrictive transport alternatives for involuntary inpatient hospitalization: The main focus of this initiative, begun in FY11 and continued through FY13, has been transportation that prioritizes no restraints. This includes adoption of methods that assure physical safety at the same time as sensitivity to trauma. Training for law enforcement began in FY12 and continued into FY13. The training focusses on developing relationships,

not just transporting individuals, and includes sheriffs and emergency departments. DMH funded a pilot program in Lamoille County; an unmarked van was purchased for transporting individuals, sheriffs wore plain clothes and received training. DMH also funded Second Spring and Howard Center to use regular vehicles and staff for transporting individuals.

3. Coordination between law enforcement and emergency response teams: DMH provided designated agencies with enhanced funding to increase their mobile capacity to respond at the site of a crisis. These efforts have included training for police officers to identify a situation as a mental health crisis and bring in the designated agency (DA). The DA can respond on-site, thus reducing the need for arrest and involvement of criminal justice. Howard Center has an embedded staff member in the police department to accompany police in responding to a crisis.

4. Enhancing peer-support services. DMH continued to fund peer support services, increasing Alyssum's budget for crisis stabilization. In the Northeast Kingdom, DMH supported development of a peer workforce able to respond to individuals in crisis. DMH provided funding for a statewide warm line operated by Pathways to Housing. In addition, DMH has supported Howard Center to use the Open Dialogue approach to work with people experiencing a crisis in their homes. The team includes peer- support workers along with clinicians.

5. Ombudsman position in Disability Rights Vermont. DMH continued to fund this position to oversee grievance responses for individuals admitted to hospitals, intensive residential recovery residences, and the secure recovery residence.

6. Summer Study Committee on involuntary treatment laws. DMH established a committee to review the statutes and identify areas that may need clarification and language changes. The 19-member Study Committee includes peers and advocates.

Section 4: Recommendations

The review for FY13 indicates hospital staff understand the provisions of Act 114. Documentation was generally in good order and demonstrated that staff have implemented the statute as required.

Hospital Practices

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

FSA recommends that hospitals, with assistance from DMH legal staff, provide ongoing training and support activities, including annual "refreshers," to ensure that all staff receive specific training to implement Act 114 provisions.

In addition, FSA recommends cross-hospital training and information-sharing around innovative practices. As part of that effort doctors should participate with other unit staff in orientation training provided by peer advocates.

Hospitals should include the assigned peer representative in treatment team meetings whenever possible. Staff should dialogue more often with assigned peer representatives to share information and perspectives in order to gain a fuller understanding of the patient's condition and develop the most effective treatment strategies.

All hospitals should include the patient in treatment team meetings in an effort to identify and help the patient achieve long-term treatment goals.

The new hospital in Berlin should provide outdoor space and a full range of activities to engage patients and prevent boredom.

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

- Copy of court order
- Copy of Patient Information Form
- Copies of every Implementation of Court-Ordered Medication Form
- Copy of 30/60/90-day reviews
- Copies of Support Person Letter, if used
- Copies of CON or other documentation of emergency procedure, if needed
- Summary of medications based on court order
- Specific timeline of court order based on language of court order

Statutory Changes

As in years past, FSA again recommends that DMH and the legislature work together to examine ways in which Act 114 may be revised to expedite the time needed while continuing to assure thorough attention to due process. Suggestions to hold both commitment and medication hearings on the same day should be carefully examined.

FSA recommends that DMH seek clarification on the criteria around the 30-day stay on Act 114 orders to determine if any Act 114 orders are subject to, or exempt from, a stay.

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

Annual Act 114 Assessment

FSA recommends that all hospitals involved in the annual assessment be responsible for providing copies of documents drawn from case files. This would avoid concerns about whether or not documents do/do not exist or merely could not be located by the person conducting the assessment.

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

- Provide a financial incentive for the participation of individuals who have received court-ordered medication

- Request input from individuals through extensive outreach efforts to any person who received medication under Act 114 in previous years, not just the year under review, in order to learn about longer-term outcomes including individuals' engagement in treatment and their lives in the community as well as experiences receiving medication under Act 114 orders.

- Ask persons interviewed if they would like any family members to be interviewed and pursue these as permitted.

- Use the same source of data on dates of admission, commitment, petition and court orders for both the Commissioner's assessment of Act 114 implementation and the independent assessment.

Conclusion

During FY13, a fourth hospital was added to the facilities responsible for administering involuntary non-emergency psychiatric medication under Act 114. Fletcher Allen Health Care, Green Mountain Psychiatric Care Center, and Rutland Regional Medical Center have adopted documentation and generally completed these fully enough to indicate that all provisions of Act 114 were implemented in FY13. The Brattleboro Retreat has adopted the same documentation, but several forms were not found in case files. Consistent with VSH staff in the past, hospital staff now responsible for administering medication under Act 114 advocate for a process that moves as quickly as possible, as they believe that patients suffer on many levels when not receiving treatment. Staff in the four hospitals shared the view that use of involuntary medication is a last resort and prefer to engage patients in voluntary treatment. Nevertheless they believe that procedures that decrease time delays while preserving due process to protect patient rights are needed. However, defense lawyers and peer advocates present a different perspective. Specifically they disagree that involuntary medication is used as a last resort and instead feel that Act 114 applications are increasingly sought quickly and with little effort made by medical staff to find common ground where patients will voluntarily engage in treatment.

Persons interviewed for this year's study, whether hospitalized during or prior to FY13, gave mixed reports about how they were treated in receiving court-ordered medication. For the most part, people still described the experience as coercive and felt they had little to no control over medication decisions. However two of the four people hospitalized during the study period reported that staff treated them with dignity and respect throughout the process, and one said that as time went on staff showed acts of kindness and caring. When asked for recommendations about how to improve the administration of medication a majority of responses focused, as in years past, on the importance of staff employing communication and interpersonal skills. People want to feel that they have information about medication and side effects and that their concerns are acknowledged and addressed directly with them.

DMH continues its efforts to create a mental health system that that provides a broad array of service options, primarily in community-based settings. As in past years, stakeholders agree that community options and a collaborative culture are needed to create a non-coercive mental-health system.