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Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 114:

January 1-November 30, 2014

January 15, 2015

VERMONT

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VERMONT'S ACT 114 (18 V.S.A. 7624 et seq.)

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

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

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

Among other things, the Act replaced administrative hearings on applications for non-emergency involuntary medication with judicial hearings in family court. When the statute was passed in 1998, it permitted the administration of involuntary psychiatric medication in non-emergency situations to patients committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in the community in addition to the Vermont State Hospital (VSH). Until August 29, 2011, when Tropical Storm Irene forced the evacuation of the State Hospital, non-emergency involuntary psychiatric medications were given only at VSH. When VSH patients were relocated to other hospitals and facilities around the state, then-Commissioner Christine M. Oliver designated three hospitals in the state for involuntary medication procedures: Fletcher Allen Health Care (now known as the University of Vermont Medical Center, abbreviated as UVM Medical Center), Rutland Regional Medical Center (RRMC), and the Brattleboro Retreat (BR). DMH renewed the two-year designations for those hospitals in the summer and fall of 2013. Beginning January 2, 2013, the Green Mountain Psychiatric Care Center (GMPCC), in Morrisville, also administered psychiatric medications under the provisions of Act 114. GMPCC was an eight-bed state-operated inpatient facility intended to supplement other inpatient capacities in the statewide system at the time. GMPCC changed its name to the Vermont Psychiatric Care Hospital (VPCH) on April 7, 2014, and shortly afterward moved to a newly constructed site in Berlin. VPCH opened its doors for inpatients at the new site in July 2014. Finally, the Central Vermont Medical Center (CVMC), also in Berlin, received designation to begin administering psychiatric medications under Act 114 in July 2014.

Section 5 of Act 114 requires an annual report from the Commissioner of Mental Health on the implementation of the provisions of the act to the House Judiciary and Human Services Committees and to the Senate Committees on Judiciary, and Health and Welfare. The statute specifies four sections for the Commissioner's report to set forth:

I. Any problems that the department, the courts, and the attorneys for the state and patient have encountered in implementing the provisions of the statute
II. Number of petitions for involuntary medication filed by the state pursuant to 18 V.S.A. §7624 and the outcome in each case

III. Copies of any trial court or supreme court decisions, orders, or administrative rules interpreting Section 4 of this act, and
IV. Any recommended changes in the law.

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

INTRODUCTION

The annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health (DMH). The state filed 73 petitions for involuntary medication under Act 114 between January 1 and November 30, 2014. Nine of those petitions were withdrawn before a court hearing as the patients began taking medication voluntarily. Five other petitions were denied throughout the year and three were pending at the end of November 2014. The courts granted the state's requests in the remaining fifty-six petitions and issued orders for involuntary medication of those individuals.

Nine people who were involuntarily medicated under the Act 114 process in 2014 answered the Commissioner's questionnaire about their experience. The other forty-seven people who were under orders for involuntary psychiatric medications through November 30 had not responded to the Commissioner's questionnaire by December 10, 2014 (but it must be noted that court orders for nine of the forty-seven were issued in November; it is unlikely that any of the individuals in question would have become well enough to respond so soon).

It is worth repeating from previous reports that DMH does not consider the use of Act 114 a panacea for persons who are seriously ill and receiving inpatient psychiatric treatment. The medication is only a part of the treatments that can move individuals toward recovery. Additionally, recovery can be slow. Further, it is always possible that persons may stop the use of medication following discharge from the hospital. The situation is far from ideal, as the use of coercion to assure medication that will address a patient's symptomatology is the least-preferred means of moving toward recovery. A trusting relationship between the provider and an individual may, in fact, be more effective in a person's decision to take medication as prescribed. Medication, whether voluntary or involuntary, is often a component of recovery and symptoms can be alleviated through its use.

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

PROBLEMS WITH IMPLEMENTATION

The implementation of Act 114 procedures for administering involuntary psychiatric medication in five different hospitals around the state is considerably more involved than carrying them out in a single location, as had been the case while the Vermont State Hospital was still open before Tropical Storm Irene forced its evacuation at the end of

August 2011. DMH has provided extensive training to the staff of all of the hospitals where Act 114 medications are now administered: the Brattleboro Retreat; the University of Vermont Medical Center (UVMMC), in Burlington; Rutland Regional Medical Center (RRMC); Central Vermont Medical Center, in Berlin; the Green Mountain Psychiatric Care Center (GMPCC), in Morrisville (from January 1-July 1, 2014), and the Vermont Psychiatric Care Hospital, in Berlin (beginning in July 2014). Additional thoughts on problems with Act 114 from the perspective of hospital staff are collected under the section on "Input from Organizations and Individuals as Required by Act 114."

Act 192, passed during the last legislative session, alleviates several of the problems with the implementation of Act 114 that have been identified in the past. Specifically, Act 192 addresses both the length of time from hospitalization to medication hearing and the delay that resulted from the automatic stay when medication cases were appealed.

The first major change resulting from the passage of Act 192 is the ability of the Department of Mental Health (DMH) to request an expedited hearing on an application for involuntary treatment in certain circumstances. Because an application for involuntary medication cannot be filed (or granted) before an individual is committed, the ability to request a court to schedule a commitment hearing quickly will mean that, in some cases, the involuntary medication application can be filed sooner. The motion to expedite must be granted when the court finds that the person demonstrates a significant risk of causing the person or others serious bodily injury, even while hospitalized and receiving other clinical interventions. A motion to expedite may be granted in situations in which the court finds that the person has received involuntary medication during the past two years and has shown improvement. If the motion to expedite is granted, the commitment hearing must be held within 10 days.

Another change brought about by Act 192 relates specifically to the applications for involuntary medications. The new law added more circumstances when an application for involuntary medication can be filed: when a motion to expedite the application for involuntary treatment has been filed; when an application for involuntary treatment has been filed *and* the proposed patient waives the hearing and agrees to proceed on the application for medication without being committed; and when an application for involuntary treatment has been pending for more than 26 days without a hearing. The intention with all of these changes was to shorten the time period before an individual who is a "person in need of treatment" can be treated involuntarily with medication.

As in previous years, the Department of Mental Health continues to hold that the length of time from hospitalization to medication of individuals who are ill and dangerous was a particularly problematic aspect of Act 114. It seems safe to say that the designated hospitals were extremely frustrated by what they saw as an unnecessary delay in their ability to treat the patients admitted to their facilities, even though the judiciary was responsive to both DMH's and the designated hospitals' requests for hearings to be held within the statutory time frames. The changes brought about by Act 192 should make the time from commitment to treatment more efficient.

The new legislation did not address the ongoing frustration of treating physicians at the designated hospitals (including Vermont Psychiatric Care Hospital) with the role the court plays in determining the prescribed course of treatment for individual patients. The judges continue to have discretion to limit the amount, manner and type of medications that can be given.

The final issue addressed by Act 192 was the automatic stay of the order for involuntary medication, which resulted in a delay in treatment for patients who filed an appeal of the medication order. The statute removed the automatic stay and shifted the burden to the patient to request and demonstrate the need for a stay.

NUMBER OF PETITIONS FOR INVOLUNTARY MEDICATION FILED BY THE STATE PURSUANT TO 18 V.S.A. §7624 AND THE OUTCOME IN EACH CASE IN CALENDAR YEAR 2014

It should be noted that the number of petitions for involuntary medication for psychiatric treatment in eleven months of 2014 was more than double the number in 2010, the last full year that the Vermont State Hospital was in operation. Petitions in all of 2010 numbered only 31 as compared with 73 from January through November of 2014. Nine petitions were withdrawn in 2014, five were denied, and three were pending as of November 30, the end of the period covered by this report.

COPIES OF ANY TRIAL COURT OR SUPREME COURT DECISIONS, ORDERS, OR ADMINISTRATIVE RULES INTERPRETING §4 OF ACT 114 IN 2014

None.

INPUT FROM ORGANIZATIONS AND INDIVIDUALS AS REQUIRED BY ACT 114

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

To meet the statutory mandate for input from organizations, DMH solicited input in writing from:

- Vermont Psychiatric Survivors (VPS), a statewide organization of adults with experience of severe mental illness

- the National Alliance on Mental Illness of Vermont (NAMI—VT), the state chapter of the national organization of families of adults with severe mental illness
- the Office of the Administrative Judge for Trial Courts
- Vermont Legal Aid (VLA), Mental Health Law Project, which offers legal counsel to Vermonters with low incomes, who are elderly or who have disabilities, and
- Disability Rights Vermont (DRVT), the federally authorized disability protection and advocacy system in Vermont pursuant to 42 U.S.C. 10801 et seq., and the Mental Health Care Ombudsman for the State of Vermont pursuant to 18 V.S.A. §7259.

For the report to be filed on January 15, 2015, three of the above organizations responded: Disability Rights Vermont, Vermont Legal Aid, Inc., and Vermont Superior Court. DRVT and VLA answered the individual questions, while Administrative Judge Amy Marie Davenport used her own outline and format to note problems and concerns regarding the implementation of Act 114 during calendar year 2014 from the perspective of Vermont's trial courts.

Besides these responses, DMH received input from Michael Sabourin, who is the VPS/DMH psychiatric resident representative. He is identified as "MS" below.

Additionally, the statute requires input from individuals who received psychiatric medication involuntarily under Act 114 at the state's designated hospitals. DMH received nine responses to the Commissioner's questionnaire from patients who were involuntarily medicated at those hospitals in 2014, and their responses are included in this report.

Finally, DMH central office staff held telephone interviews to solicit input from physicians, nurses, and other hospital staff during the weeks of December 15 and 22, 2014.

INPUT FROM ORGANIZATIONS

The questionnaires for organizations and the courts all asked the same six questions:

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

The responses given below are taken verbatim from correspondence to the Department of Mental Health from DRVT and VLA. The letter from the Office of the Administrative Judge for Trial Courts follows those responses.

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

DRVT: During the last year [2014] DRVT staff have often come in contact with patients subject to the Act 114 process.

VLA: As of today's date [November 3, 2014] our records show that the Department of Mental Health has filed sixty-four involuntary medication cases in calendar year 2014, matching the record high the Department established for an entire year in 2013. At this pace we can expect a total of more than seventy-six involuntary medication cases for the year, far exceeding the totals of forty-five in all of 2012, thirty-nine in 2011, and only thirty-one in 2010. The Mental Health Law Project was appointed by the Superior Court to represent the respondents in all of these cases.

MS: Though individuals involved with the Act 114 process are not directly identified to the patient representatives, we obviously engage with these individuals during our work. Outside of typical interactions in the inpatient setting, I attended one court hearing and was a support person in another instance.

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

DRVT: DRVT identified a lack of significant progress in 2013 in many facilities towards the statutory goal of working toward a system that does not rely upon forced medication and coercion (18 V.S.A. §7629) as a problem with the implementation of the Act 114 process. Still today it is apparent that many psychiatric facilities do not exhaust the options for alternatives to applying for and implementing forced medication orders, but rather consider only forced medication to be "active treatment." All too often the violence and lack of bed capacity that has been the focus of much of the discussion regarding our mental health system has been blamed on delay in getting forced medication orders and last year the legislature changed the laws to allow more and faster use of this very traumatic procedure. DRVT's experience has been that people who are subjected to forced medication orders sometimes do not improve and move off the unit for long periods of time even after the orders are implemented. In addition DRVT's experience has been that patients are genuinely afraid of being subjected to forced medication orders and the disruption that causes in their relationship with their treatment providers. Among many individuals there is a fear that inpatient treatment will inevitably involve coercion and being forced to take drugs they believe will cause them harm. Thus, even when in crisis, some avoid voluntary treatment and this leads to a cycle in which forced treatment is administered, poorly tolerated, and then abandoned when circumstances allow. This creates a situation at odds with the legislative mandate to move to a non-coercive mental health system.

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

While the statute allows for a continuance for good cause, the Department has apparently decided that it will strenuously oppose every request for continuance filed by the MHLP in these cases, regardless of the grounds or merits for the continuance request. It is important to note that the Department has the advantage in this situation, since it has complete control over when it files these cases, and the decision to oppose all requested continuances evidences the Department's disregard for the patients' right to a vigorous and well-prepared defense.

MS: I am aware of at least two cases w[h]ere individuals became more violent after losing the initial hearing[,] with one of these cases not being mitigated until the patient was transferred to another inpatient unit.

People stay locked up a long time "after" [quotation marks in the original] their forced[-]drugging orders. Contrary to the Commissioner of DMH ascertainment[,] involuntary inpatient psychiatry is proving to be a long[-]term and not a short/acute situation.

What worked well regarding the process?

DRVT: DRVT found that in 2014 the Mental Health Law Project worked well as part of the Act 114 process to assert patients' rights to avoid this form of involuntary treatment.

VLA: The clearest answer I can give to this question is that Act 114, and the availability of court-appointed counsel to represent the patients in the State's custody, is the only mechanism available to either prevent unjustified use of involuntary medication or to restrict the State's psychiatrists from administering medications or doses that would likely be harmful to the patients. Every year we handle a number of cases in which an involuntary medication application is denied, and other cases in which either the court restricts the medication or dose requested by the state or the State, after hearing from the independent psychiatrist, agrees to exclude a requested medication or reduce the requested dose. In one particularly egregious case in late2013 the state psychiatrist requested permission to administer involuntary medications by means of nasogastric intubation, but the court denied this barbarous request. In every one of these cases, if the hospital had had its way, free of judicial review and an effective defense, the patient would have been forcibly medicated, but the court process allowed the patient to successfully defend against what was determined to be an unwarranted or excessive intrusion.

MS: I think as in the past individuals are more responsive to time spent as an inpatient then [sic] to the process itself.

When [i]ndividuals feel like they are adequately represented by their legal representatives and listened to by their treatment providers [phrase left as an incomplete sentence]

One facility tried to get an order to FORCIBLY DRUG BY NG [sic] TUBING [capital letters in the original]; which was fortunately denied.

What did not work well regarding the process?

DRVT: DRVT found that the failure to adequately attempt creative alternatives to forced medication on the part of [the] Department and its contractors continues to be the biggest problem with the implementation of Act 114 this past year. In addition, the public dialogue fostered and echoed by the Department, resulting in changes to the forced[-]medication laws last legislative session, as well as the Department's efforts to further expand the use of forced medications by denying patients the rights they had at VSH to have a licensed medical doctor, and not a more available and less qualified independent practitioner, order and review the use of force and forced medications are indications that the Act 114 process is devolving from one where real efforts are made to reduce and even end the use of force against patients to one in which the use of force is considered common and acceptable and to be encouraged and facilitated by the Department. Finally, a complete lack of response by the Department to critics of the use of forced medication in terms of the long[-]term outcomes for patients subjected to that process and criticisms of the use of those medications from authors such as Robert Whittaker continues [sic] to be a problem with the process.

VLA: VLA did not answer this question.

MS: There was at least one alleged incident of treatment providers initiating an emergency procedure to facilitate an individual[']s eventual acceptance of taking medication.

One facility obstructed an individual[']s attempt to enact an advance directive.

The competence of individuals accepting medications is still an ongoing issue; i.e. PEOPLE ARE SIMULTANEOUSLY CONSIDERED COMPETENT TO ACCEPT DRUGS AND INCOMPETENT TO REFUSE THEM[.] [Capital letters in the original.]

One individual reports being confined because DMH has stated that it is to[o] expensive to have a wraparound or 24/7 staffing to enable that person to live in the community.

In your opinion, was the outcome beneficial?

DRVT: DRVT has found that in some cases implementation of Act 114 orders for forced medication has helped patients in the short term to stabilize and be discharged from designated units, but that in other cases the stress and trauma of the proceedings has [sic] not resulted in either short-term or long-term improvement. DRVT urges the Department to conduct a long-term study of the immediate, middle and long-term impacts of forced medications on Vermonters.

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

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

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

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

Finally, as I noted above, the State has chosen to rely more and more heavily on forced medication. While the policy of the State of Vermont is "to work towards a mental health system that does not require coercion or the use of involuntary medication" (18 V.S.A. § 7625(c)), this dramatic increase and the Department's successful advocacy for legislative proposals to even further expand and accelerate involuntary medication demonstrate that the Department has abandoned this policy and chosen to pursue forced medication as its predominant method of treatment. I would urge the

Department to take the legislative policy seriously and work to reduce coercion in every component of the mental health system.

MS: During the past year I believe I had only one patient tell me that they [sic] benefitted from the experience; others may have benefitted but most individuals are more resigned to the situation and others are discharged with minimal change in character or receive insufficient benefit and continue indeterminate stays on inpatient units.

I would hope that it is the rare case where clinicians enact the law as provided in the recent Act 192. Typically patients need time to assimilate rather then [sic] rush through the process.

A direct quote "I recall there was no real treatment offered other than drugs. [A]lso, the length of time it took to get a forced drugging order was not the problem. [T]he problem was the way they treated you and the fact that they sought the order in the first place. [A]lso, you stayed locked up for months after they got the order[.]"

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

DRVT: DRVT suggests that the Department stop advocating for the increased use of force against patients in the form of allowing non-medical doctors to write the orders, without personal observation. This effort on the part of the Department will surely increase the use of forced medications generally. DRVT suggests again that the goal of the Department and the Hospitals of more prompt forced[-]medication orders, in what should be fewer and fewer cases, could be attained more reasonably by increasing the resources available to the attorneys and the courts, including the availability of independent expert review, rather than conflating hearings for commitment and forced medication into one hearing in an effort to speed up the process. In addition, DRVT suggests a study of long[-]term outcomes for patients who are subjected to the process in order to provide policy makers with information necessary to determine if any changes in this process are needed to further restrict the use of forced medication consistent with the legislative mandated [sic] noted above at §7629.

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

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

MS: The law should be changed [so] as to not allow orders of hospitalization for a year.

The law should be changed [so] as to not allow a previous history to be a condition allowing for an expedited or combined hearing.

The law should be changed to allow for supported withdrawal in inpatient settings. If it's warranted someone should be able to sign themselves into a facility similar to how they might sign themselves in to get off heroin or other addictive drugs.

The law should be changed in such a way that "alternative" [quotation marks in the original] modalities have to be considered and certified as to their availability or practicality.

The law should be changed to have penalties associated with long[-]term confinement of individuals that are not acute or do not meet the status of "in need of hospitalization" outside of lack of "ADL" [quotation marks in the original] [(activities of daily living)] skills, etc.

INPUT FROM AMY M. DAVENPORT
ADMINISTRATIVE JUDGE
FOR TRIAL COURTS

FY 14 was another unusually busy year for the courts with respect to the adjudication of applications for involuntary medication. As you know, these cases have a very low settlement rate and very short time deadlines. In addition, as a result of Irene and the destruction of the State Hospital, these cases were heard in four different counties in FY 14: Rutland, Chittenden, Lamoille and Windham. Rutland and Windham typically reserve one day per week for AIT [applications for involuntary treatment] and AIM [applications for involuntary medication] hearings. This has meant less hearing time available for other pressing family division cases such as CHINS (child in need of supervision) abuse and neglect cases, domestic violence protection orders and contested divorce and parentage proceedings.

What has been the most significant change in FY 14is the steep increase in the number of cases filed—from 42 in FY 13 to 78 in FY 14. See attached chart. This amounts to an 86% increase in a docket where, as mentioned above, the cases rarely settle and the time frame between filing and hearing is exceptionally short, with no additional resources for judge time, staff time or attorney time.

One of the busiest mental health dockets in 2014 is in Windham [County,] where the number of AIMs [applications for involuntary medication] doubled in FY 14. Here are the comments from the presiding judge in the Family Division, the Hon. Katherine Hayes:

Since January 2014, we've had 25 involuntary medication petitions filed. Of these 19 were decided after hearing. 18 were granted (although on a couple of occasions with slight modifications from the specific relief requested regarding dosage), one was denied. 6 were dismissed by the State—usually because the respondent began taking medications voluntarily. In general I think the process works very well, and I am convinced that patients have improved outcomes, reduced suffering, higher functionality, and shortened hospitalizations due to IM orders being granted. [Italics in the original]

She notes the following issues:

**The statute does not specifically address or provide for the usual practice of having a patient take two different antipsychotic medications simultaneously, with decreasing dosage of one, and gradually increasing dosage of the other, when the patient is being switched to a new medication. This is the standard practice, and it would be useful to have specific statutory authorization for this.*

**It is very frustrating that there is apparently no practical means to require medications that can address mood disorders, because they are not available in injectable form. This results in patients with bipolar illness having longer hospitalizations than they really should, because we can't effectively require them to receive the medications they need. There's no obvious solution to this problem, since it's the pharmaceutical industry that creates the medications.* [Italics in the original]

Since the legislature adjourned in May of 2014, the Courts have spent a significant amount of time on the implementation of S. 287, including training for judges and court staff on the changes in the law, amendments to forms and to the case management system to allow us to better track the number of cases where the AIT and AIM are consolidated under the new legislation and, finally, implementation of changes that went into effect on November 1 relatedto the timing of AIT hearings and venue.

INPUT FROM INDIVIDUALS INVOLUNTARILY MEDICATED UNDER ACT 114

Nine patients who were involuntarily medicated under Act 114 From January 1-November30, 2014, responded to the Commissioner's questionnaire about their experiences during their hospitalization for psychiatric care.

The Commissioner's questions and the patients' answers are as follows:

1. **Do you think you were fairly treated even though the process is involuntary?**
   Yes: 5
   No: 5

One respondent answered both yes and no to this question, adding the following details about his/her experience:

> In court: "I was very quiet [in court] and I don't think the judge even looked at me. She just judged me by what the doctor said."
>
> At a designated hospital: "I fought every injection [in the hospital] and the staff were mean then but after they were okay."

Three of the remaining respondents who answered yes added the following information about their experiences:

> Respondent A:
>
> In court: "I felt like I didn't need to be committed."
>
> At a designated hospital: "If they wanted me on [a particular psychiatric medication] they should have started me on that. I was treated fine. I decided to stay until I found the right meds."
>
> Respondent B:
>
> In court: "I don't think I got time in court to rebuttle [sic] [a named witness] after he spoke but I needed medication[.]"
>
> At a designated hospital: "The medication was an overdose [,] I feel at first[,] but I was hallucinating and needed it.
>
> Respondent C:
>
> In court: "I did not go to court because I was at [one of Vermont's designated hospitals]."
>
> At a designated hospital: "When I was very sick, I didn't get up out of bed. I stayed right there too. I said no to anyone who wanted to take me and walk around the unit with me. No to anyone [sic] of the group leaders who wanted to take me to group therapy[.] [N]o to those who wanted the [sic] talk to me like the doctors, nurses too."

The fifth respondent who answered yes to this question offered no further commentary.

Three of the four respondents who answered no to this question added the following information:

Respondent D:

In court: "My Doctors was not takeing [sic] care of . . ." The respondent did not finish this sentence.

Respondent E:

At the hospital: [B]eing forced on medication was like torture. It was unfair and took away my human rights. I saw there was no need to talk to the doctor since he did not listen."

Both in court and at a designated hospital: "I feel that no one should be medicated against thier [sic] will under any circumstances ever."

The fourth respondent who answered no to this question offered no further commentary.

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

Yes: 6
No: 3

Five of the six respondents who answered yes to this question had nothing further to add. The sixth wrote that "at first I didn't want the medicine because I was so sick. I was on not a good ward and I was not aware of the medication." After moving to another ward that was quiet, the patient "began to take my medicine" and got better.
None of the three respondents who answered no to this question added any commentary.

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

Six of the nine respondents had something to offer on their decisions not to take psychiatric medications:

- "I didn't want them in my body. The chemicals they injected me with were not good for me. Plus I went from 115 lbs. to 200 lbs. taking [prescribed psychiatric medication."

- "Being on them [psychiatric medications] was a nightmare. I don't need them and being on them my whole life would be like never-ending torture."

- "Sexual side effects of the [prescribed medication]"
- "Allergy to it and will be counter[-]effective with medication taken"

- "They did bad things to me."

- "I did not take the medicine in the past because I didn't know how serious it was. This time I hit bottom such as an alcoholic person does. Being so sick I thought I was in hell. The evil one told me there he was saying I am saying bad things about people and I am going to blame it on you, [name of respondent]. This was my illness talking."

4. <u>Now that you are on medication, do you notice any differences between the times you are taking your medications and the times you are not?</u>

Yes: 9
No: 2

Seven of the eight respondents who answered yes, they could notice differences between the times they are taking medications and the times they are not, added the following details:

- "I feel better than before!"

- "Sometimes"

- "These are diferent [sic] medications and are tolurable[sic]."

- "I am myself again with the medication a small dose and not hallucinating"

- "I'm more myself, more talkative, making more sense. No hallucinations. My friends feel I am better. My moods are better. Mood swings are better."

- "When on meds, my thinking is more clear and I am less hyper."

- The medication made those bad thoughts go away. Not only was the medication helping me with the terrible bad thoughts which was [sic] going on in my head, I had to distract these thoughts because it was often. I was having them and I took the medicine and it made the repeating of the bad thought[s] so often cease [and] that was a blessing. Now I have a method to stopping them[.] I used to look at Bat Man [sic] comics. He used to hit the Joker and when he did the word appeared on the picture Zap. I used this once before. So now before the bad thoughts come in I say Zap Zap Zap and repeat them and they stop."

The respondent who answered no to this question did not explain why.

5. <u>Was anyone particularly helpful? Anyone could include staff at a designated hospital or a community mental health center, a family friend, a neighbor, an advocate, someone else who is in the same hospital you are/were—really, anyone.</u>

Two of the nine respondents to the Commissioner's questionnaire answered no to this question. Of the remaining seven, all answered yes but only six mentioned individuals who had been helpful. A few of the individuals are unidentifiable, as only first names were given. Others were not named but identified as hospital staff, usually doctors, nurses, and social workers.

Answers to the question "In what ways was he/she helpful?" included the following from six respondents:

- "Support"
- "She is taking care of me"
- [Two hospital staff] "helped me with the exercise bike . . . & talked to me."
- "Try[ing] to work with me in getting my mood stabilized and me stabilized to go home"
- "[Name of individual] the Angel. She saved my Soul and Spirit. Love + Kindness + Wisdom gushed from her into me."
- "My doctor was helpful, he gave me a medicine to get rid of the fluid that was in my Edema legs. The doctor of the mind increased my medicine and in both cases I got relief. The Psychiatrist or the mind doctor was very thorough in explaining it very well. The nurses were helpful too. The nurse would explain to me the saline helped my eyes. It worked and washed out the infection by reducing the infection to small bubbles and substances. When I told the Psychiatrist about a certain theory about the subconscious mind and he agreed with me[,] that was helpful. The resident Psychiatrist told me he would not kill anybody[;] that was very helpful and now with the confidence he gave me now I have a new home to live in as long as I take my medication always. I hit bottom and now I will never cease my medication again[.] [I]f I do that bottom <u>will</u> be worse than before and the doctors (mind) won't be able to help me"

6. <u>Do you have any suggestions for changes in the law called Act 114? Please describe the changes you would like to see.</u>

Yes:	5
No:	3
Did not answer the question:	1

The five respondents who answered yes to this question said:

- "NO INVOLUNTARY MEDICATION!" [capital letters in original]
- "More exercise + activities"
- "Talk to patient more and explain what they were doing wrong in advance"
- "Offer voluntary first"
- "I'm not shure [sic] what the Act 114 law is. But if it's about forcibly injecting humans with substances against their [sic] will, I think it should be abolished imediatly [sic]."

INPUT FROM PSYCHIATRISTS, NURSES, AND OTHER HOSPITAL STAFF

During the weeks of December 15 and 22, 2014, central office staff of the Department of Mental Health conducted telephone interviews with hospital staff at all four of Vermont's designated hospitals for involuntary patients where Act 114 medications are administered—the Brattleboro Retreat, Rutland Regional Medical Center, Central Vermont Medical Center, and UVM Medical Center—in addition to the Vermont Psychiatric Care Hospital in Berlin. Hospital staff answered the following eight questions:

1. **How well overall do you think the protocol for involuntary psychiatric medication works?**

The most positive response from any hospital staff to this question was "not well," while the most negative was "very poorly." The staff of the various hospitals were unanimous in characterizing the process as taking too long—sometimes weeks or months, causing patients to suffer unnecessarily while their illness worsens, and increasing the danger of harm to patients, staff, and others. Additional comments on Vermont's statutorily mandated process included the following:

- If patients are committed to the care and custody of the Commissioner before admission to an inpatient psychiatric unit, then the process can go somewhat faster
- Movement of legal proceedings from criminal court to family court takes extra time and lengthens the process
- It is too early to tell how the changes that went into effect in November are going, but it is an improvement to have one less step in the process for recertification
- The changes are "a baby step" in the right direction
- The report card on Vermont issued by Mental Health America, a national advocacy organization, gives the state a D in interpretation of the law and an F in implementation
- In other states, it is possible to obtain medication orders within one to three days after admission
- Having to wait so long for treatment, patients become "tormented," even "terrified"
- Patients are left ill, psychotic and in distress for too long
- With long waiting times, the potential is higher for patients to decompensate further, becoming dangerous and assaultive
- The process is traumatic for patients, staff, everybody involved
- The length of time required is inhumane
- Patients' rights could still be protected under a shorter process

2. **Which of the steps are particularly good? Why?**

Hospital staff offered the following ideas in answer to this question:

- ✪ The ability to administer medication within twenty-four hours without having to wait thirty days while a patient might appeal a medication order is seen as a big improvement.
- ✪ Less paperwork for recertifications now makes for a better process.
- ✪ Combined hearings for commitment and medications are seen as big improvements as well.
- ✪ On-site judges make the process within the hospital better because hospital staff and security can escort the patient to the courtroom, obviating the need for shackles and police escorts.
- ✪ Timely responses from judges (usually within one to two days after a hearing) are very helpful.
- ✪ From the perspective of hospital staff, Act 114 protects patients' rights at the expense of staff and the hospital's ability to provide a therapeutic milieu for other patients.
- ✪ As to rights, there is mounting evidence that an untreated mental illness causes irreversible brain damage, thus negating the supposedly protective nature of the law as it now stands.

3. Which steps pose problems?

The amount of time from hospital admission to medication is still too long. Other factors that add to difficulties and delays throughout the process include:

- ♦ Extraneous continuances on the part of defense lawyers
- ♦ Nurses who administer the medications must document every dose given (typically, doses are daily), thus resulting in more work for no perceived value
- ♦ Doctors must document continuing need for medication every week instead of every thirty days, as was previously required
- ♦ In court, judges end up making medical decisions which should be left to doctors to make
- ♦ Untimely responses from judges are not helpful
- ♦ Delays between second certifications and a court hearing sometimes take as long as a month, again lengthening a process that is already to lengthy
- ♦ The initial discussion about involuntary medication with the patient is frequently difficult, along with filling out the required form; actively psychotic patients are just not able to participate meaningfully in the conversation, which only increases their anxiety and agitation together with the risk that they might harm themselves or others
- ♦ After patients are discharged from the hospital on medications under an order for nonhospitalization and then stop taking the medications, Act 114 requires that patients decompensate to the point of meeting emergency-examination criteria for readmission before returning to the hospital to resume treatment. Thus, it is almost like starting all over again. Instead, case managers should be able to identify patients who are noncompliant earlier, so that they can enter

treatment again without decompensating so much and giving up the improvements that they have made while on medication

- The protocol's provision allowing patients to have a support person present becomes problematic when the support person cannot be at the hospital at the time the medication is scheduled
- Breakdowns in communication between the Department of Mental Health's Legal Unit and hospital staff sometimes allows very little time for hospital staff to prepare for hearings

4. <u>What did you do to try to get these patients to take psychiatric medications voluntarily before deciding to go the involuntary route through the courts?</u>

Staff mentioned numerous kinds of approaches, noting that medication is not the first course of action in all cases and that Act 114 patients have access to all therapeutic inpatient services that any other patients at the hospital have as long as their behavior does not pose risks for themselves or other patients and hospital staff:

- Formation of a therapeutic alliance with individual patients
- Building a trusting rapport by getting something to eat or drink together
- Listening to what patients say about what kind of medication has worked in the past
- Using lowest possible doses of medication at the beginning
- Education about mental illness and the pros and cons of psychiatric medications
- Involving family members and/or staff from designated agencies and advocates
- Reminding patients of how well they have done in the past when they have been on medications
- Use of breathing exercises for anxiety
- Engaging patients in thinking about future plans
- Additional contacts with family, friends, outpatient providers, and other community contacts or people patients can trust
- Review of medical records
- Offering options in regard to medications, for example, the place where they might be administered or the time of day, or even the kinds of medications prescribed based on treatment history and response
- Offering medications at numerous times throughout the day
- Use of medications along with other therapies to treat symptoms

5. <u>How long did you work with them before deciding to go through the courts?</u>

The length of time can vary considerably from individual to individual depending on any number of circumstances—acuteness of illness, past experiences of hospitalization, legal status, and the like. For a patient known to the hospital and known to have responded well to medication in the past, the length of time could be only a few days. For others, it can require weeks or months. The process becomes more complicated with patients who may take medication sporadically, starting and stopping and starting

again. And court time lines complicate the complications and lengthen the amount of time required.

6. <u>How helpful or unhelpful was it to be able to give the medications when you did? In what way(s)?</u>

Hospital staff are unanimous in their opinion that medication almost invariably helps patients get better, some of them almost to the point of restoration of their previous quality of life. They start eating again, sleeping again. They become responsive to staff and others, stop hallucinating, become less paranoid, and generally participate more effectively in their own treatment and recovery. They also become more compliant with treatment for physical conditions that they may have along with the mental illness, thus improving their overall health and prospects for returning to the community. The use of seclusion and restraint declines significantly or is eliminated once a person starts taking psychiatric medications.

7. <u>What do you think the outcome(s) would have been for the patients who were medicated if they had not received these medications?</u>

Responses to this question ranged from the general to the specific, such as:

- Longer suffering/greater suffering
- Longer hospitalization and loss of freedom
- Continuing or rising threat of harm to themselves or others much longer
- Increased brain dysfunction in addition to compromised medical condition(s)
- Impaired sleep
- Damage to reputation
- Damage to relationships/alienation from families, friends, and others
- Trouble with the law, resulting in prison or jail
- Not being able to set and meet personal goals
- Lost jobs
- Lost housing
- Ruined lives
- Suicide/attempted suicide
- Death from co-morbid conditions such as diabetes or hypertension

8. <u>Do you have any recommendations for changes in Act 114?</u>

- ♦ Expedite the legal process
- ♦ Limit the number of continuances by defense attorneys
- ♦ Have set court dates for Act 114 patients every week or so, so that access to courts is assured to secure timelier treatment
- ♦ Applications for involuntary medications should be reviewed by another psychiatrist not connected to the hospital to assure that the proposed treatment meets clinical standards
- ♦ Give doctors more control over medications; judges should trust the clinical judgment of medical professionals

- Lengthen the duration of medication orders so that they last at least as long as the hospitalization of the patients concerned, thus making it necessary most times to start the whole process all over again
- Streamline the documentation process; get rid of duplicative/redundant paperwork
- Replace paper documentation with testimony by medical professionals
- Give involuntary medications in outpatient settings, perhaps in designated agencies or family home—other states allow this; It increases the options available for patients
- Combine commitment and medication hearings or at least hold them on the same day
- Scrap Act 114 and start over with other states' models as a template

CONCLUSIONS

What Is Working Well

Input from Act 114 patients, hospital staff, families, advocates, and others. For a number of years, DMH has asked for input about what is working well and what is not from a wide range of people involved in the Act 114 process and other stakeholders. This approach has provided valuable information in the past; DMH feels that it has continuing merit and will plan to use it going forward. It is important to note that one of the suggestions from the 2013 report, holding court hearings in the hospital setting, has been introduced at the UVM Medical Center, Rutland Regional Medical Center, and Vermont Psychiatric Care Hospital in Berlin:

Education about side effects of psychiatric medications. Six of the nine respondents thought that the advantages and disadvantages of taking medications were explained clearly enough to help them make a decision about whether or not to take them.

Positive effects of medications. Seven of the nine patients who discerned a difference in their condition before and after medication noted positive effects of the medication: "I feel better than before!" exclaimed one respondent. Another said simply, "I am myself again with the medication . . ." Similarly, a third commented that "I'm more myself, more talkative, making more sense," adding that his/her friends notice the difference too. Moreover, the hospital staff—usually doctors, nurses, and social workers—who participated in the interviews for this report were unanimous in seeing positive outcomes for individuals after medication.

Hospital staff. Six of the nine Act 114 patient respondents saw hospital staff in a positive light after going through the Act 114 process. They even mentioned some particularly helpful staff members by name.

What Is Not Working Well

Going through the Act 114 process. Eight of the respondents answering the question about fairness had numerous complaints about the way things went in the courtroom and in the inpatient setting as well:

- A judge who did not look at the patient in court
- Lack of time in court
- Doctors not taking care of the patient in the courtroom
- Perception that hospital staff are "mean" before a patient takes medication
- Being so sick as to be incapable of doing anything but lie in bed in the hospital
- Being "forced on medication was like torture. It was unfair and took away my human rights"
- Strong feeling that no one should ever be involuntarily medicated "under any circumstances ever"

Length of the process. Hospital staff at all five hospitals that administer psychiatric medications under the provisions of Act 114 were unanimous in their perceptions that the process is too long.

Perceived fairness of the Act 114 process. Excluding the one respondent who answered both yes and no to the question about fairness, only four respondents saw themselves unequivocally as having been treated fairly even though an involuntary procedure was involved.

Opportunities for Improvement

Focus on Recovery

Vermont's Department of Mental Health continues to emphasize the concept of recovery as invaluable both for providers and for recipients of mental-health services.

> "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."[1]

Here again, the process of seeking input from patients themselves about their experiences with involuntary medication may be seen as part of the healing process that leads to recovery.

The National Consensus Statement on Mental Health Recovery from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), which has appeared in these reports in previous years, still reminds us that we should keep our focus on recovery as the "single most important goal" for the mental-health services delivery system.[2] The ten components and concepts fundamental to recovery are:

- Self-direction
- Individualized and person-centered supports and services
- Empowerment
- A holistic approach to recovery
- A non-linear process in working toward recovery
- Strengths-based interactions
- Peer support/mutual support
- Respect
- Responsibility
- Hope

[1]http:mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

[2]Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, DDHHS Pub. No. SMA-05-4060 (Rockville, Maryland: 2005), p. 4.

Maximizing Individual Choice

The Department of Mental Health's opportunities for improvement, specific to the implementation of Act 114, lie within exploring ways to maximize individual choice whenever possible. Since the evacuation of the Vermont State Hospital in Waterbury at the end of August 2011, after Tropical Storm Irene, the new community capacities for crisis services, hospital diversion and step-down, peer-supported alternatives such as Alyssum (already open) and Soteria House (scheduled to open early in 2015), and plans for a new, state-of-the-art inpatient facility that opened in Berlin in the summer of 2014 are the most important ways in which the redesign of public mental health here in Vermont has emphasized individual choice among a range of options for treatment and support. In addition, hospital staff repeatedly noted their attempts to maximize patient choice even in an involuntary situation: choosing the place and timing of medication, for example, and numerous attempts to persuade patients to take prescribed medication voluntarily.

In Closing

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