VERMONT 2018

The Implementation of Act 114:

December 1, 2016-September 30, 2017

Report from the Commissioner of Mental Health
to the General Assembly

January 22, 2018

VERMONT

Department of Mental Health
AGENCY OF HUMAN SERVICES
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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 nonemergency involuntary psychiatric medication in inpatient settings for people on orders of hospitalization
- The administration of nonemergency involuntary psychiatric medication for adults on orders of nonhospitalization (community commitments), and
- Continuation of ninety-day orders of nonhospitalization

The statute allows for orders of nonhospitalization, 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 nonemergency involuntary medication with judicial hearings in family court. When the statute was passed in 1998, it permitted the administration of involuntary psychiatric medication in nonemergency situations to patients committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in the community in addition to the state-operated Vermont State Hospital (VSH) in Waterbury. Until August 29, 2011, when Tropical Storm Irene forced the evacuation of the State Hospital, nonemergency involuntary psychiatric medications were given only at VSH. Now that the new Waterbury State Office Complex has replaced some of the buildings where VSH and other departments of state government were located, Vermont has seven designated hospitals where involuntary psychiatric medications in nonemergency situations might be administered:

- The University of Vermont Medical Center (UVMMC), in Burlington
- Rutland Regional Medical Center (RRMC)
- The Brattleboro Retreat (BR)
- Central Vermont Medical Center (CVMC), in Berlin
- The Windham Center (WC), in Bellows Falls
- The Vermont Psychiatric Care Hospital (VPCH), the new state-run facility in Berlin that began operations in July 2014
- The Veterans Administration Hospital (VA) in White River Junction

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

Act 114 requires two annual reports on the implementation of Act 114, one from the Commissioner of Mental Health and one from an independent research entity. Over the years, it has become abundantly clear that much of the material in these reports is duplicative and, therefore, redundant, inefficient, and a questionable use of taxpayers' money. DMH recommends, again, that only one comprehensive, independent report be required in the future.

INTRODUCTION

This annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health (DMH). The time period covered by this report is different from most earlier reports because of changes made last year in data collection and reporting for Act 114 patients. This report covers October 1, 2016-September 30, 2017.

The state filed seventy-eight petitions for involuntary medication under Act 114 during that twelve-month time period. Thirteen of those petitions were withdrawn or dismissed before a court hearing. Three other petitions were denied from October 1, 2016, through September 30, 2017, while none were pending at the end of September 2017. The courts granted the state's requests in the remaining sixty-two petitions and issued orders for involuntary medication of those individuals.

Through November 30, 2017, DMH received responses from seven people to the Commissioner's questionnaire about their experiences being involuntarily medicated under the Act 114 process during the time period covered by this report. The remaining individuals who were under orders for involuntary psychiatric medications from October 1, 2016, through the end of September 2017 did not respond to the Commissioner's questionnaire this year.

Among the stakeholders who receive annual requests to respond to the Commissioner's questionnaire about their perspectives on Act 114, Vermont Legal Aid, Disability Rights—Vermont (DRVT), the Vermont Chapter of the National Alliance on Mental Illness (NAMI—VT), and family members, peers, and friends who wish to remain anonymous sent written responses to the Department of Mental Health for this 2017 report. Please see the section on "Input from Individuals and Organizations as Required by Act 114."

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

PROBLEMS WITH IMPLEMENTATION

The Department of Mental Health is implementing Act 114 in accordance with existing state law and addresses what is not working well on pp. 33-34 of this report. Problems from other perspectives appear throughout this report as responses to the question "Which steps [of the Act 114 protocol] pose problems? Why?"

TRIAL COURT OR SUPREME COURT DECISIONS, ORDERS, OR ADMINISTRATIVE RULES INTERPRETING §4 OF ACT 114

In re N. C. interprets 18 V.S.A. § 7626(a) and what constitutes a valid advance directive under 18 V.S.A. § 9700 et seq.

In re P. K. interprets V.R.F.P. 12(a)(2) and (d)(2)(B)(i) in the context of recent amendments removing the provision for automatic stays of involuntary medication orders pending appeal to the Vermont Supreme Court. The Supreme Court concluded that the patient's reliance on policy arguments (which would be applicable to any patient ordered involuntarily medicated), rather than arguments based on facts specific to the patient, had been considered and rejected by the Legislature when it amended the Rules for Family Proceedings to do away with automatic stays. As such, the Court ruled that the trial court's denial of the patient's request for a stay pending appeal was proper.

In re D. P. interprets 18 V.S.A. § 7615(a)(2). In re D. P. concerned a controversy over a Motion to Expedite an Application for Involuntary Treatment (i.e. thereby allowing an Application for Involuntary Medication, 18 V.S.A. § 7624, to be filed). The patient claimed that various serious medical risks described in the affidavit supporting the motion were not sufficiently "emergent" or "imminent" enough to justify expediting the AIT and allowing its consolidation with an AIM for a speedier decision. DMH responded by pointing out that the statute only required a showing of "substantial risk" without any suggestion of required imminence. There was no dispute that the serious bodily injury was at stake, and the remedy sought was only to alter the timing of the hearings with no real prejudice to the patient. The court found there was "substantial risk" and granted the motion. While the court did not expressly adopt DMH's arguments, there is a strong suggestion the arguments were considered persuasive: the court stated it would delay ruling until DMH had responded to the patient's opposition, and it ruled in DMH's favor until DMH had presented arguments against the patient's position. After litigation, the court found there was "substantial risk" and the motion for expedited hearing was granted.

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.

Additionally, the statute requires input from individuals who received psychiatric medication involuntarily under Act 114 at the state's designated hospitals. DMH received seven responses to the Commissioner's questionnaire from patients who were involuntarily medicated at those hospitals October 1, 2016-September 30, 2017.

DMH solicited input from physicians, nurses, social workers, and mental health and recovery specialists at hospitals around the state in three different ways:

- ❖ In writing
- ❖ Through telephone interviews
- ❖ Through onsite interviews

The staff input presented in the following pages came from four of Vermont's designated hospitals for administering psychiatric medications under Act 114:

- The Brattleboro Retreat
- Rutland Regional Medical Center
- The University of Vermont Medical Center
- Vermont Psychiatric Care Hospital

INPUT FROM PSYCHIATRISTS, NURSES, AND OTHER HOSPITAL STAFF IN VERMONT

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

Again this year, as in past years, hospital staff were in general agreement that the time required under Act 114 to get to the point at which they can administer psychiatric medication to individuals who are refusing it is too long from the clinical perspective. Additional thoughts and observations included:

- The process generally works well to establish the judiciary's oversight, but it is bad for patients because it takes so long and patients suffer tremendously—and needlessly—because of the delay.
- People with psychoses should get treated on the first day of hospitalization.
- It is a violation of the rights of the patient to be hospitalized involuntarily without treatment.
- "The therapeutic relationship is pretty well exhausted by the time we go to court."
- There is "much evidence that medications are effective[;] mental illness is a disease [and] not a social ill or excuse to lock any person up indefinitely" and deny treatment.
- The slowness of the process "poses an ethical question in regard to holding a patient involuntarily but not treating their [sic] mental illness. This could be considered inhumane."
- Psychiatric illnesses that go untreated can affect overall health and have a harmful impact on other medical conditions, thus causing increased suffering and possibly lasting damage to both mental and physical health

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

The length of time to allow judicial processes to unfold, ranging from weeks to months, from admissions to commitment hearings and thence, most of the time, to petitions for involuntary medications and the judge's decision, then, finally, to administration of medication(s) has both advantages and disadvantages. Hospital staff noted the following advantages:

- The final step in the process is good; patients finally receive the medication they need and can begin rebuilding their lives.
- The process has a high degree of transparency.
- The twenty-four-hour period from court order to administration of medication allows medical staff more time to meet with patients and explain the whole process. It also gives the patient time to consent to the medication.
- Allowing more time for hospital staff to accommodate the patient's desires to the extent possible
- The working relationship with the Department of Mental Health's Legal Unit is "pretty good" from the point of view of hospital staff.

- From the beginning, patients know that they can take oral medications.
- Combined commitment and medication hearings work better now than in the past.
- "Involving a court to determine the mental capacity of a patient to refuse medications can help to ensure [that] psychiatrists do not abuse their authority to prescribe."

3. Which steps pose problems? Why?

- The whole process is too slow from the clinical point of view, and the circumstances that allow expedited hearings are finite
- Patients can sustain permanent health damage physically as well as mentally from delays in medications for their mental health
- Patients tend to remain dangerous to themselves and others longer, thus limiting their ability to make progress through other means of engaging them in meaningful relationships through a variety of therapeutic activities
- Patients become more symptomatic and are frequently violent too, so much so that restraint is necessary
- Patients who become violent because they are not taking psychiatric medication(s) that they need may become vulnerable to retaliatory violence from other patients
- Patients can take longer to get back to their baseline and may never be as well as they were before
- Patients become (or remain) too sick to have visits with family and/or friends or to engage in activities or therapy while they are waiting for medication orders
- Weekly reviews of involuntary medications are "incredibly burdensome and redundant" and reduce the time available for patient care
- Hospital staff perceived several problems with judges and judicial processes:
  - Holding separate hearings for commitment and for medication
  - Judicial interference with types and dosages of psychiatric medications
  - Judicially imposed limitations on the time during which medication can be given
  - Limiting the medications that hospital staff can offer
  - Inconsistency from one court to another
  - Limiting medication orders to ninety days
  - The varying experience and belief systems of different judges

4. What did you do to try to get these Act 114 patients to take psychiatric medications voluntarily before deciding to go the involuntary route through the courts?

Hospital staff mentioned an abundant variety of strategies to try to help patients understand the necessity of psychiatric medication:

- "Everything!"
- "Just about everything"
- Creating rapport/therapeutic alliance between patient and staff (but this is difficult when patients are too psychotic or paranoid to respond)

- ✪ Education about mental illness and the challenges presented by acute symptomatology
- ✪ Communication about the efficacy of medications and ways in which they can lead to improvements in functioning, feeling, and understanding
- ✪ Sometimes daily meetings to explain an individual's diagnosis and how medications can be helpful
- ✪ Conversations with family members, outpatient teams, outside doctors, even other patients who could reinforce the message that psychiatric medications can reduce symptoms of mental illness
- ✪ Offering medications at different times throughout the day
- ✪ Being flexible about when and where medications might be administered
- ✪ Emphasizing the opportunity to become well enough to leave the hospital and resume one's life among family and friends in the community
- ✪ Offering any clinical interventions that do not involve medication (examples include activities of various sorts, providing structure for the patient's day, making patients feel welcome, reducing sensory stresses)
- ✪ Interventions individually rather than in groups (examples include a massage chair, music, going outside, and time in the library)
- ✪ Trying to understand the patient's concerns about medications
- ✪ Introduction of Open Dialogue, a new and more inclusive, holistic approach to dealing with mental health/mental illness issues
- ✪ Use of Six Core Strategies

5. How long did you work with these patients before deciding to go through the courts?

It is usually weeks and sometimes months before an application for involuntary medication (AIM) can be filed. Staff at one of Vermont's designated hospitals estimated three to six weeks on average, while staff at another hospital mentioned an extreme case that went on for more than a year. The time involved can vary greatly, depending on factors unique from one individual to another. The delay in treatment is especially difficult when patients become violent as a result of not getting the medication(s) they need.

6. How helpful or unhelpful was it to be able to give the medications when you did? In what ways?

Hospital staff are overwhelmingly in agreement that medications are helpful to individuals in need of treatment for mental illness. Adverse reactions are quite rare, they say. One hospital staff person remarked that he/she hasn't heard anyone say, "I wish you hadn't medicated me; I prefer to stay psychotic." Many hospital staff expressed their opinion that it is inhumane to prolong the suffering of patients with mental illness by withholding the medications that can reduce symptoms and lead toward recovery.

Other treatment modalities along with therapy and additional activities complementary to medication can also be helpful in bringing about improvements such as:

- ✓ Reductions in psychosis and other symptoms of acute mental illness
- ✓ Restored ability to engage in meaningful conversations and to make decisions
- ✓ "No longer drinking their own urine or eating their feces"
- ✓ Paranoia and fear go away
- ✓ Working on activities of daily living
- ✓ Ability to regain composure and sound thinking
- ✓ Ability to have a good night's sleep
- ✓ Recognizing the severity of their illness and re-engaging with their families and rebuilding their lives
- ✓ The realization that they do need medications, leading to the decision to take them voluntarily once discharged from the hospital
- ✓ Decreases in assaultive behavior
- ✓ Less impulsive behavior
- ✓ Increased safety for patients, staff, and others
- ✓ Improvements in the patient's overall health, both mental and physical
- ✓ Increased ability to take care of their own needs
- ✓ Overall, the outcome is that discharge back to the community allows people to resume their lives, with the myriad meanings that phrase may have for each individual

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

The worst possible outcome mentioned by hospital staff for individuals was death. Short of death, staff views of possible outcomes for individuals without medications were bleak, including:

- ❖ Longer hospitalization
- ❖ Continued deterioration and suffering
- ❖ Continued dangerousness to self and others
- ❖ Impossibility of achieving recovery
- ❖ Loss of ability to communicate with loved ones and others
- ❖ Damaged relationships with family and friends
- ❖ Loss of rights and liberty
- ❖ Loss of employment/employability
- ❖ Loss of dignity over time
- ❖ Worsening of physical health
- ❖ Shorter lives
- ❖ Incarceration
- ❖ Loss of ability to regain baseline functionality
- ❖ Loss of infrastructure to support independence
- ❖ Increase in stigma

8. Do you have any recommendations for changes in Act 114? If so, what are they?

Again this year, as in reports from previous years, the recommendation repeated most often by hospital staff is shortening the length of time between hospital admission and administration of psychiatric medications. Some hospital staff suggested that there is a right to treatment for mental illness just as there is for other illnesses and that commitment orders should always include treatment as well. Others saw the need to begin medication(s) within twenty-four or forty-eight hours of admission to a psychiatric hospital. Some hospital staff noted that Vermont's law on involuntary medication is different from similar laws in most other states, where administration of psychiatric medication can often begin more quickly and without court involvement.

Other recommendations for changes in Act 114 included:

- Combine commitment and medication hearings
- Reduce continuances
- Allocate more funding to the judiciary so that more judges will be available to hear cases involving psychiatric medications
- Create/implement a mechanism for involuntary treatment in the community
- Offer more training in mental illness and associated issues for judges
- Restore trust in physicians and the medical profession to make sound decisions on psychiatric medications and treatment of mental illness in general
- Expand criteria for expedited medication orders
- Make it possible for all Act 114 patients to have expedited medication hearings
- Discontinue weekly court-ordered medication reviews; make them monthly instead
- Make it easier for prescribing doctors to have their medication plans implemented
- Bar judges from practicing medicine from the bench

For more information relevant to the Act 114 process and additional input from hospital staff, see also the Appendix to this report: Vermont Department of Mental Health, Agency of Human Services, *Reforming Vermont's Mental Health System: Reporrt to the Legislature on the Implementation of Act 82. Section 5: Involuntary Treatment and Medication Review*. December 15, 2017.

INPUT FROM ADVOCACY ORGANIZATIONS AND INDIVIDUALS

The questionnaires to which organizations and individuals responded 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?

Input in this section comes from:

- Ed Paquin, Executive Director, Disability Rights Vermont (DRVT)
- John J. McCulloughIII, Vermont Legal Aid, Inc. (Mental Health Law Project)
- Laurie Emerson, Executive Director, National Alliance on Mental Illness of Vermont (NAMI—VT)
- Family Members, Peers, and Friends Who Wish to Remain Anonymous

Letter from Ed Paquin, Executive Director
Disability Rights Vermont (DRVT)

DRVT's answers to the Commissioner's questionnaire were as follows:

1. **Were you directly involved with any individuals involuntarily medicated under Act 114 in 2016?**

Yes, DRVT staff that monitor inpatient psychiatric units regularly had contact with and provided advocacy services to patients subject to non-emergency involuntary medication.

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

Yes. Again in 2017 DRVT staff witnessed and/or reviewed medical records of many episodes of non-emergent forced medication injections on psychiatric units around Vermont and regularly heard complaints from patients both about the fact of being forcibly medicated and about the fact that protections and procedures, such as the right to have a support person present during forced injections, were not followed. See

http://mentalhealth.vermont.gov/sites/dmh/files/misc/Rules-Regs/Rules%20Implementig%20the%Act%20Relating%20to%20Involuntary%20Medication%20f%20Mental%20Health%20Patients.pdf.

In those cases, DRVT staff continued to intervene to inform all involved about these regulations and secured the patients' rights in these areas.

The most glaring problem with the Act 114 process implementation remains that often episodes of forced non-emergent medications were accompanied by traumatic uses of force to implement the [o]rders. Again, DRVT's experience has been that several patients under forced medication orders continued to struggle and object to the injections for weeks after they began.

Overall in 2017, DRVT did not see significant progress towards the statutory goal of working toward a system that does not rely upon forced medication and coercion (18 V.S.A. §7629). DRVT's experience has been that people who are subjected to forced medication orders sometimes do not improve quickly and stay on the unit for long periods of time even after the orders are implemented. We continue to hear that patients are genuinely afraid of being subjected to forced medication orders and the disruption which that causes in their relationship with their treatment providers. People tell us that they do not seek voluntary treatment because of this fear. Unfortunately, there remains a perception in our community that patients receiving mental health inpatient care will be subjected to involuntary medication that they do not want, that they believe causes them harm, and which they will discontinue at the earliest opportunity. This situation is at odds with the legislative mandate to move to a non-coercive mental health system.

A recent patient subject to a forced medication order gave DRVT permission to share with the Department the following statements about his experience:

- *"I've been backed into corners all of my life and this [forced, non-emergency medication] is no different—I want to get restraining orders against all these evil oppressors" (referring to hospital staff).*
- *"I feel like I'm caught in a nightmare, even when I'm awake" due to taking the medications.*
- *"I don't want anybody to go through what I've been through ever again" regarding being forced to take medications the patient did not want.*

In addition to this patient's statements, DRVT participated in the Brattleboro Retreat's Consumer Advisory Committee meeting in July 2017 during which members engaged in a robust dialogue about non-emergency involuntary medication recommendations/ orders by physicians and the negative impacts those petitions have on building rapport between patients and their providers; the need for shared decision making; and the lack of availability of alternative treatment options.

DRVT remains concerned that, despite legitimate concerns about the long-term impact on patients of these Act 114 [o]rders, DMH has yet to follow through on commencing a study to determine the outcome for patients forcibly medicated going out five years, a plan that has been universally accepted as appropriate and necessary in order to have an effective and informed policy on this practice. DRVT urges DMH to follow up on this suggestion and promptly implement such a study.

3. What worked well regarding the process?

DRVT's understanding from colleagues at the MHLP [Mental Health Law Project] is that Court's [sic] regularly modify DMH requests for Act 114 orders based on MHLP attorney and expert-witness testimony, and DRVT believes that having a robust legal representation for patients subject to Act 114 proceedings is crucial and is a positive aspect of the current system.

4. What did not work well regarding the process?

As noted above, a lack of alternatives to forced medication, in part due to overreliance on highly marketed medications, and in part due to lack of adequate capacity in the overall mental health system resulting in patients being held in inpatient units unnecessarily, remains a significant problem with our mental health system. In addition, as noted above, often hospital staff do not know or do not implement patient protections and preferences during the forced medication administration. Also, the continuing lack of a five[-]year study of outcomes for people subjected to these forced medication orders is an aspect of the process that has not worked well over the last year. Overall, the Department's fixation on increasing the use of coercion in the system, in terms of speeding up medication orders, increasing the number of locked, non-inpatient facilities, and relying more on ONHs requiring medication compliance, instead of putting more resources into peer supports, step[-]down facilities, one[-]on[-]one community

supports, and alternatives to involuntary placements, appears to be a major cause for the problems DRVT staff and our clients have identified.

5. In your opinion, was the outcome beneficial?

DRVT staff have found some patients for [whom] Act 114 [o]rders result in a prompt improvement of their presentation, but as often as not, patients subject to these orders do not stabilize and improve quickly, and feel extremely disempowered, humiliated and victimized by the [o]rders. It is DRVT's opinion based on our experience that in many cases, the outcome of forced medications is not favorable in terms of short[-] or long[-]term improvement, but often effective simply to sedate the patient in order to support discharge into community. The long[-]term benefits to the patients, anecdotally, are also questionable as many DRVT clients attempt to get off the medications when out [of] the hospital and perseverate for years afterward about the trauma of being forced[-]medicated.

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

DRVT recommends that the law be amended to require the Department to implement a robust outcome study of the impact of these orders on people. We also recommend that the Department make stronger efforts to limit the number, as opposed to the recent trend of large increase in the numbers, of the uses of these forced medication orders, at least until the above-recommended outcome study demonstrates that no more harm than good is resulting from these proceedings. DRVT also suggests that the Department advocate for more funding for MHLP to hire additional staff and expert witnesses in order to avoid the appearance that, due to the increase in forced medication petitions and the lack of similar increases in MHLP funding, the ability of MHLP to adequately represent their clients is at risk of significant decline. DRVT suggests again that the goal of more prompt forced medication orders held by the Department and the [h]ospitals can 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.

Providers continue to claim that individuals involuntarily medicated often express thanks or at least relief that they received involuntary treatment. This has not been the experience of DRVT staff who work with these clients. We would agree with the Chair of the House Health Care Committee who asked, upon hearing similar testimony, whether those patients are then offered the option of creating an Advance Directive with a Ulysses clause. DRVT believes that if the Department is to follow the statutory policy of working towards a system free of coercion, then patients should be offered the tools to consent to medical intervention *if that is in fact what they really desire* [italics in the original] when they have the capacity to express their consent.

Thank you again for this opportunity to share our perspective on Act 114 implementation in 2017 and please contact me if you wish additional information or clarification.

Sincerely,

[signature]

Ed Paquin
Executive Director

Letter from John J. McCullough III, Vermont Legal Aid, Inc.
Mental Health Law Project

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

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

As of today's date [the date of the letter is December 8, 2017], our records show that the Department of Mental Health has filed seventy-seven involuntary medication cases in calendar year 2017 to date, putting us on a pace to reach or exceed eighty-two, which would equal the all-time record set in 2016. This continues the pattern of continuous increases in involuntary medication since 2008, as this table demonstrates. Since 2008 the number of involuntary medication cases filed by the State has more than tripled, and it has more than doubled since 2011, the year the State Hospital closed.

YEAR	INVOLUNTARY MEDICATION CASES FILED
2008	23
2009	30
2010	31
2011	39
2012	45
2013	64
2014	77
2015	79
2016	82
2017	77 (to date) [that is, until December 8, 2017]

1. Were you directly involved with any individuals involuntarily medicated under Act 114 in 2016?

The Mental Health Law Project was appointed by the Superior Court to represent the respondents in all of these cases. To my knowledge there were no cases in which the respondent was either represented by outside counsel or pro se.

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

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

While the statute allows for a continuance for good cause, the Department routinely opposes nearly 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 almost all requested continuances evidences the Department's disregard for the patients' right to a vigorous and well-prepared defense.

3. What worked well regarding the process?

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

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

4. What did not work well regarding the process?

In the past year we have noticed a trend for the State to routinely request authorization to involuntarily administer long-acting medications. A few years ago when the statute was changed to raise the legal standard for long-acting medications we observed that courts took the mandate of the law seriously and were less likely to approve these applications; as a result it appeared that the state became more selective concerning the cases in which it requested long-acting medications. The tide seems to have turned, though, and the state seems to be relying more frequently on this extremely intrusive measure with no more substantial basis than the patient's history of "noncompliance."

Since "noncompliance," or refusal of prescribed medications, must be present whenever there is an application for involuntary medications, basing an application on this is the opposite of the individualized showing the statute requires. As I note below, this practice demonstrates the general hostility on the part of the State and the State's psychiatrists toward patient autonomy and self-determination, which is inimical to the values of patient rights and voluntary treatment embodied in the statutes.

5. In your opinion, was the outcome beneficial?

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

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

It is well established that the great majority of patients who receive antipsychotic medications eventually discontinue their use, either because of intolerable side effects or other unacceptable results. This means that every case of involuntary medication must be viewed as no more than a temporary resolution. Unless the State can demonstrate that there are significant and long-lasting benefits in 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 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. § 76259(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.

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

Involuntary medication is an affront to the human dignity and natural autonomy of persons in the State's custody, and it should be used only as a last resort. As written and as applied, the current statute makes it unreasonably difficult for patients to present an effective defense, and eliminating the provision of 18 V.S.A. § 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 basic rights and wishes respected.

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

Very truly yours,

[signature]

John J. McCullough III
Project Director

Letter from Laurie Emerson, Executive Director
National Alliance on Mental Illness of Vermont

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

When families are in crisis and need education and support, they contact NAMI Vermont's 800 Resource Referral Line. We would like to share information about one family's experience who has gone through the involuntary court-ordered treatment process.

1. Were you directly involved with any individuals involuntarily medicated under Act 114 in 2016?

In August 2017, NAMI Vermont was contacted by a father whose adult son was awaiting the involuntary treatment process. The son had stopped medicinal treatment and became very ill in the community—requiring hospitalization due to his inability to care for his basic needs with no eating, no sleep, no hygiene, including defecating on himself. He was unable to communicate, make decisions, and risked his life by not understanding how to even cross a street. He became a danger to himself.

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

This family was very distraught when they learned their son needed to wait five weeks before he could be seen by a Judge who would then determine if he needed/required treatment through the involuntary process. The father reported that five weeks was an expedited process for the court system that ruled on both the involuntary commitment and treatment at the same time.

3. What worked well regarding the process?

The hospital immediately began to administer medicine after the court approved the request. The father reported that 36 hours after his first treatment, he started to eat. Before this time, he refused food. He is now able to form sentences, however speaks in a very different tone of voice and is not back to himself. It took four weeks after administering medicine before he understood how to use the toilet again.

4. What did not work well regarding the process?

The long wait for their loved one to receive medicine was extremely troubling to see him suffer day-after-day. Unfortunately, the son was in denial that he needed treatment. Although in the community with medication, he was able to manage their symptoms, remained well, and lived independently. The father reported that his son required medicine to continue to maintain his wellness—due to his history. The family felt their son was being harmed by the Vermont State Law by delaying the medication.

5. In your opinion, was the outcome beneficial?

Once he received medicine, he began to respond to the treatment—however it should not have taken 5 weeks. His health and functioning began to decompensate after 5 days in the hospital without medicine. He slowly lost all functioning. Because of the decompensation, it is taking much longer to regain his wellness. His health suffered significantly. Doctors reported that he would have bounced back quicker if he did not decompensate so quickly and have to wait five weeks for treatment. As of this writing [November 17, 2017], he is still in the hospital and making very slow progress.

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

This father suggests that a panel of psychiatrists should make the decision to order medicine, not a judge. The family's primary psychiatrist had no input in the process who had seen him since he was a teenager. This should be a medical decision.

The father believes that if he had not advocated for his son, this process would have taken much longer. If the state or legislature would like to speak to this family, NAMI Vermont has permission to share their [contact] information with you.

On behalf of our organization, NAMI Vermont would like to offer the following suggestions for improvement:

1. Provide more opportunities to provide input on Act 114 throughout the year—not just 3 weeks' notice to collect data from organizations and individuals.
    a. It is important to collect more data on the process from the patient perspective—6 individual responses [are] not enough data to make fact[-]based decisions.
        i. Provide the Act 114 questions to every patient (who was involuntarily medicated) <u>as they get released</u> from the hospital to respond with a self-addressed and stamped envelope.
        ii. Create a discharge plan that includes a debrief session with the patient by having an advocate/non-hospital person meet with the patient before they are discharged and ask the Act 114 questions to ensure <u>every patient</u> provides input.
        iii. Since it may be very difficult for a patient to respond to these questions after the traumatic experience of their crisis/illness, send a follow[-]up 6 months later with the same questions—comments and insight may change as the person has been in recovery for a while.
2. Involve family members in the process—when a patient is admitted and they have a supportive family, provide them with the same questions when the patient is released. Additionally send a follow[-]up 6 months later with the same questions. Families also experience trauma with being involved with the experience of their loved one. NAMI Vermont is able to send out

the questions to our membership, however there are many more families that have been involved with the process that we are unable to reach.

3. Allow opportunity for comments for previous years if patient/family is unable to meet the deadline by November 17.
4. Continuously make improvements to the process through fact-based decision making so that patients receive the right care at the right time and in the right place to experience lives of resiliency, recovery, and inclusion.

Thank you.

Laurie Emerson, Executive Director
NAMI Vermont

Letter from Family Members, Peers, and Friends Who Wish to Remain Anonymous

Our thanks to you for including our comments (names withheld) in the annual Department of Mental Health Report: Vermont 2018, The Implementation of Act 114, The Administration of Involuntary Non-emergency Medication. Report from the Commissioner of Mental Health to the General Assembly. Our thanks to NAMI Vermont for notifying us and providing the questions regarding the Act 114 VT DMH annual survey.

We did not know, in years past, that the opportunity was available. We believe we should have been informed by the many providers and professionals we met.

Our comments rise from our individual experiences as family members and peers, and from our collective experience as friends of an incredible person who suffered from the adverse effects of prescribed medication. At first, our friend experienced the benefits of voluntary medication prescribed in cautious, low doses. In recent years, with new doctors who prescribed excessive dosages and insisted on a variety of medications, our friend finally experienced involuntary non-emergency court-ordered medication, as well as involuntary emergency medication. At first, our friend experienced voluntary hospitalization. In recent years, our friend experienced involuntary hospitalizations in the custody of the Commissioner(s) of the Department of Mental Health, as well as placement in a step-down facility rather than the family home.

During fifteen years of independent living and employment in VT, our friend included us in Wellness Recovery Action Plans (WRAPs), taught Family-to-Family classes with some of us, and led support groups with others. We were welcomed, when needed, at WRAP Team meetings. We visited during hospitalizations, signed in at RRMC, completed visitor's forms at Brattleboro Retreat. At times of crisis, we even emailed mental health providers and professionals regarding our friend's care and placement. Despite our friend's requests, we were never included on hospital Treatment Teams or in Discharge Planning. Again, we were never asked to comment on Act 114.

Though two weeks' notice is short notice, we can share these comments:

1. Were you directly involved with any individuals involuntarily medicated under Act 114 in 2017?

We were not involved in 2017. We were directly involved in 2014, 2015, 2016.

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

Yes:

   a. We are aware of psychiatrists and nurses who do not "listen", who disregard the patient's prior experiences and adverse reactions to certain medications, who overlook the patient's family history, trauma, and preferences.

b. The time between doctor's petition for court-ordered medication and the Mental Health Court's decision is vital. That time should be used to engage the patient and supportive family/friends in Open Dialogue; in education regarding medication listed in the doctor's petition; in education regarding involuntary and court-ordered processes; for access to Alternative programs; and practice in Cognitive Therapies known to help restore stability and reduce, hopefully eliminate, the need for medication.

c. The time during and after Care in the Custody of the Commissioner of the Department of Mental Health deserves/demands continuity, communication, and better oversight.

3. What worked well regarding the process?

According to our loved one, Disability Rights Vermont (DRVT) staff was patient, persistent, and supportive throughout difficult times and trying behaviors.

4. What did not work well regarding the process?

Involuntary non-emergency medication and the inept prescription of antidepressants ignited and sustained harmful mania.

5. In your opinion, was the outcome beneficial?

No.

The implementation of non-emergency and later, emergency medication was not beneficial. Too often, during periods of medication compliance and/or coercion while in the Commissioners' custody, abrupt changes of medications caused adverse reactions. Longer-lasting effects of recently withdrawn medications conflicted with newly administered medications. Excessive dosages and bi-directional medication were detrimental. The prolonged course of prescribed medication caused highs and may have caused desperate lows. The prolonged course of restrictions while in the care and custody of the Commissioner(s) of Mental Health caused desperation. Early Discharge from the last hospitalization was unfortunate. Adequate support at the assigned residence, a step-down facility, was not available.

Earlier, during the first involuntary hospitalization at RRMC, two friends visited our loved one. Staff there welcomed them and offered ice water and ginger ale. Staff and other patients sat around and could listen to their shared conversation. Our loved one wore a waistband torn from a clean but old hospital garment. Our loved one wore the waistband around the head and then the neck. One of the two visitors made eye contact with each staff person. The visitor nodded to each individual staff person to direct each one's gaze toward our loved one. Later, as the visitor left the unit, she asked a staff person to dispose of the potential ligature. The staff person smiled and asked politely, But what is a ligature?

Following the final hospitalization at Brattleboro Retreat and placement in a nearby step-down facility, our loved one left the facility and committed suicide. Death by hanging. Death by ligature.

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

   Yes. Changes in the law and procedures must be made. Please:

   a. Provide training for SAMHSA's SIX CORE STRATEGIES, annually. Train New Hires, immediately. Provide refresher workshops for Senior Staff, regularly. Provide 6CS Training for all psychiatric care personnel, hospitals, residential facilities.

   b. Provide Training for OPEN DIALOGUE, annually. Train New Hires, immediately. Provide OPEN DIALOGUE Training for all psychiatric care personnel, hospitals, and all residential facilities.

   c. Correct the misperception that "Judges prescribe medication." Please know that we are thankful for Mental Health Court Judges who are watchful and uphold U.S. Food and Drug Administration (FDA) regulations. We are thankful that MH Court Judges will deny doctors' prescriptions, will decrease dosages that exceed FDA guidelines, and will not allow administration of medication that are not approved by the FDA.

   d. Give thanks for the MH Court Judge who denied a UVMMC psychiatrist's petition to administer antidepressants daily through naso-gastric intubation.

   e. Provide continuity of care. Include the person's preferred psychiatrist and/or prescribing primary care physician in court-ordered decision-making. Include the patient's preferred doctor on the hospital's Treatment Teams.

   f. Involve the person's preferred family members/friends on the hospital's Treatment Team. Involve them in Discharge planning.

   g. Protect Confidentiality. Delete personal identification and initials. Regrettably, two annual Reports prepared and presented by the Department of Mental Health identify persons involved in the Act 114 process. VT DMH published the initials of several persons. Thankfully, the independent Reports by Flint Springs Associates did not divulge identity and did not include identifying initials.

   h. Communicate, educate, and invite family members, friends, and frequent visitors to participate in the Act 114 survey at Visitation Sign-Out, before and following Discharge from the hospital, and from the step-down facility.

i. Correct the misperception that family members and friends must have their loved one's permission to respond to the Act 114 survey. Promote family/friends' participation. Provide anonymity for all involved. Withhold names to protect confidentiality.

Thank you.

INPUT FROM VERMONT JUDICIARY

For the 2018 Commissioner's Report to the General Assembly on Act 114, Chief Superior Judge Brian J. Grearson submitted responses from three Vermont judges "who regularly presided over the largest number [of] Involuntary Medication requests" in calendar year 2017. Those judges were:

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

1. Were you directly involved with any individuals involuntarily medicated under Act 114 in 2017?

All three judges answered this question in the affirmative.

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

Judge Corsones: No.

Judge Teachout offered a single statement in answer to questions 2-5: Yes. One issue that is a continuing concern relates to those individuals for whom probable cause has been found and are in custody in need of treatment but are required to remain in jail or in a community hospital before they finally get transferred to VPCH where treatment, often including medication[,] can get started. I know it is a resources problem, but I am expecting that any day we might get a habeas petition from someone who says "*you are holding me because there has been an ex-parte preliminary finding that I need treatment, but I am being held against my will without a hearing and no treatment is being provided.*" [Italics in the original.]

Judge Hayes stated that she concurs in the responses filed by Judge Teachout.

3. What worked well regarding the process?

Judge Corsones: The attorneys had a good understanding of the law and worked cooperatively to ensure appropriate deadlines and procedures were complied with.

4. What did not work well regarding the process?

Judge Corsones: Unsure.

5. In your opinion, was the outcome beneficial?

Judge Corsones changed the question to "was the process helpful?" and answered yes.

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

Judge Corsones: None at this time.
Judge Teachout: We should consider a pretrial status hearing within X days [number of days unspecified] of the finding of probable cause to make sure that something meaningful is happening with the patient.

INPUT FROM INDIVIDUALS INVOLUNTARILY MEDICATED UNDER ACT 114

Seven patients who were involuntarily medicated between October 1, 2016, and September 30, 2017, responded to the Commissioner's questionnaire about their experiences during their hospitalization for psychiatric care. Data on Act 114 medications from October 1 through December 31, 2016, will not be available until late January 2018.

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: 3
No: 4

Two of the respondents who answered yes to this question offered no additional comments. The third respondent added that the process was "somewhat not fair because I was not suppose [sic] to be represent[ed] [in court] by someone who does not know what I was going through with my life and medication."

The four individuals who answered no to this question offered the following additional comments:

After checking "no" for an answer, one respondent added "I felt the Dr. lied in court [and] the Dr. kept changing his story [in the hospital]."

On being in court, the second respondent who answered no to feelings about the fairness of the process wrote: "My wittness [sic] against me judge[d] me unfairly and [I] was labeled mentle [sic], bipolar, manic and many more. They stood up all and swore with right hand on heart swore to tell the truth and nothing but the truth in front of God our Lord and savior who is the judge over all. My rights were violated. And trown [sic] in prison. They do not know the mind or Christ in us. My problems are physical one[s]." This respondent went on to name two doctors in the hospital who "ran my sugars so high and [did] not give me my proper doses [as prescribed by?] my Doctor at Home. I was getting reading[s] between 75-120 all meals. I would get laugh[ed] at by [doctor] for not running them right.

The third respondent who answered no to this question added that "the doctor lied [in court]. The judge stated that he would not accept conflicting reports. Massive amounts of false evidence were presented and accepted. I was not allowed to represent myself or have a jury trial. The lawyer assigned to me was incompetent and put in little effort. There were no witnesses besides the doctor and me. The evidence was a joke. The judge made statements of obvious falsehood [and] wouldn't allow himself to be corrected. On appeal, a stay would not be granted. I was more incompetent on account of being on drugs at the time." In the hospital, "I was in constant torment. I read the doctor's notes and he never made a statement about me being unable to make

a decision. Despite 'not showing any symptoms,' the doctor would not let me try not taking the medication. Everybody at the hospital said that the court would not let them change the medication."

The fourth respondent who answered no to this question added two lines of mostly illegible commentary and ended her statement with "I do not feel that way."

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: 4
No: 2

Three of the respondents who answered yes to this question offered no further commentary. The fourth respondent who answered yes added that "I let them know I was on syck [psychiatric?] meds since 1990. So many. Jan. 2016 my pathologist did a biopsy on a legon [lesion?] from sever[e] itching. He found out it was from Drugs I had been on for a Long Time. Now with the c[h]emical drug they have me on is causing itching. This [is] the reason I don't like [psychiatric] drugs."

Of the two respondents who answered no to this question, only one offered commentary that was legible: "I had to do almost all my own research on the medications. The doctor would deny the side effects I got from it. The entire basis on which the doctor prescribed the medication was rediculous [sic]."

The seventh respondent, who answered neither yes nor no to this question, commented as follows: "Somewhat clear at some point but if I have to be forced to take medication against my life, that's not fair."

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

The six respondents to the Commissioner's questionnaire this year offered varying comments on their decisions not to take psychiatric medications:

- "I am taking them for not [now?] but not for life because they have horrible sight [sic] effect[s]."
- "I had no problem that the medications could hope to help with. The medications had horrible effects. Even the symptoms the doctors accused me of having were compleatly [sic] fictional."
- "Probably because I didn't have it explained to me."
- "Thought I felt better without them."
- "I was afraid of the side effects"
- "Because [of] my sensitive body & skin. Hello/I've been taking them like it or not. . . ." This respondent goes on to mention a specific psychiatric medication and a mental-health program where she lives.
- "Calm + poised in my [illegible]. I felt [I] can't use this treatment."

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

   Yes: 3
   No: 2

Two respondents did not answer this question. One respondent who answered no did not elaborate further, while the second one remarked that "I am the same person my mom gave birth too [sic]."

Two of the three respondents who answered yes, they did notice differences between the times they are taking their medication(s) and the times they are not, had this to say:

- "I feel better with them."
- "I have been confuse[d] or suspicious because of lack of adequate clear communication from psychiatric doctors."

The third respondent who answered yes to this question described distinctly negative experiences with psychiatric medications: "The medications are severely impairing. They are tortorous [sic] to be on. They are painful, make it so I can't think, drive me crazy, cause me to feel like doing dangerous things, cause conflict in relationships, cause health problems, incapacitate me. If I stay on them, I expect that I may not be able to be sufficiently functional to do much of anything."

Only six of the respondents to the Commissioner's questionnaire answered question nos. 5 and 6.

5. **Was anyone particularly helpful? Anyone could include staff at a designated hospital or a community mental health center, a family member or friend, a neighbor, an advocate, someone else who is in the same hospital you are/were—really, anyone. In what ways was he/she helpful?**

   Yes: 3
   No: 2

The two respondents who answered no to this question did not elaborate further. The three who answered yes wrote as follows:

- "Some of the staff was very helpful. They were somebody to talk to."
- "Mental Health workers and group facilitator and Dr." They "gave me positive support."
- "All of them [were" supotive [sic] to my life struggle and taking good care of my life at the hospital."
- "My granddaughter . . ., who loves me and know[s] the love and helps I have for others. I am a Christian." This respondent's granddaughter helped by "be[ing] there for me, phone calls[,] came and visited when she could . . . I've been here 2 months and two weeks. Caged like a[n] animal."

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

Yes: 3
No: 3

One respondent did not answer this question, while another respondent answered both yes and no and added that "I would like to take my medication if they are working and not giving me sight [sic] efffect [sic]."

The second respondent who had suggestions to offer wrote as follows: "Stop force medicating people. Give better attention to the statutory requirement of somebody not being able to make a decision (this is essentially ignored, as the doctors say that nobody can make a decision). Allow people to make their own legal defence [sic] and have sufficient opportunity to prepair [sic] for trial. Give more chances to contest medication. Allow medication besides injections."

The third respondent who answered yes to this question wrote about serious physical health problems that she has been having lately and criticized a community health center for "stick[ing] their noses in when your [sic] suffering heartache and sorrow." She suggested talking to people about the "person[s] that know them" and ended with complaints that "psychiatrist[s] twist what you say to fit there [sic] need" and "when family came they wouldn't give me a pass to go out with them."

CONCLUSIONS

What Is Working Well

Input from Act 114 Patients, Hospital Staff, Families, Advocates, Judiciary, 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 the Vermont Psychiatric Care Hospital in Berlin.

Positive Effects of Medications. Hospital staff—usually doctors, nurses, and social workers or recovery specialists—who participated in the interviews for this report were unanimous in seeing positive outcomes for individuals after medication. That has been the case every year that this report has been written for the General Assembly

Hospital Staff. Three out of the five Act 114 patients who responded to the Commissioner's question about anyone who was helpful during the Act 114 process mentioned hospital staff. One of them appreciated being able to talk to staff, the second noticed the "positive support" that staff gave, while the third praised "all of them" as being supportive "to my life struggle and taking good care of my life at the hospital."

What Is Not Working Well

Length of the Process. Hospital staff who administer psychiatric medications under the provisions of Act 114 are unanimous in their perceptions that the process is too long. On the other hand, Vermont Legal Aid adamantly asserts that the process is too short. As parts of a decentralized system of care, acute-care hospitals participating in Level 1 care services remain obligated by accreditation or certification bodies to offer active treatment to their patients and to ameliorate the symptomatology of psychiatric distress. The time frame of the legal processes at present may place inpatient facilities at risk from a regulatory standpoint if they are unable to provide timely and effective treatment interventions.

Psychiatric Medications and Their Side Effects. Four of the six Act 114 respondents to the Commissioner's question about psychiatric medications answered yes, the pros and cons of the medications had been explained clearly enough to allow them to make decisions about whether or not to take the medications, but two respondents answered no and only one of them explained why. This respondent complained that "I had to do almost all my own research on the medications. The doctor would deny the side effects I got from it. The entire basis on which the doctor prescribed the medication was rediculous [sic]."

Family members and friends who wrote a letter in response to the Commissioner's questionnaire also registered their distress over the adverse reactions they had seen caused by "abrupt changes of medications." The letter went on to say that "longer-lasting effects of recently withdrawn medications conflicted with newly administered medications. Excessive dosages and bi-directional medication were detrimental. The prolonged course of prescribed medication caused highs and may have caused desperate lows."

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

Opportunities for Improvement

Recommendations Presented in Report on Act 82

See Appendix, pp. 37ff, for recommendations already made in Section 5 of the report.

Focus on Recovery

For many years Vermont's Department of Mental Health has emphasized the concept of recovery as invaluable both for providers and for recipients of mental-health services. Recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[1]

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

- Health
- Home
- Purpose
- Community

The ten guiding principles of recovery are:

- Recovery emerges from hope for a better future

[1]Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery* PEP12-RECDEF (Rockville, Maryland: 2012), p. 3.

- ✪ Recovery is person-driven, based on foundations of self-determination and self-direction
- ✪ Recovery occurs via many pathways that are highly personalized for each individual
- ✪ Recovery is holistic, encompassing an individual's whole life
- ✪ Recovery is supported by peers and allies
- ✪ Recovery is supported through relationships and social networks
- ✪ Recovery is culturally-based and -influenced
- ✪ Recovery is supported by addressing trauma
- ✪ Recovery involves individual, family, and community strengths and responsibility
- ✪ Recovery is based on respect[2]

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

Maximizing Individual Preference and Systemic Resources

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

- ➢ Expanded mobile crisis capacities all over the state,
- ➢ Hospital diversion and step-down,
- ➢ Peer-supported alternatives such as Alyssum and Soteria House
- ➢ The Vermont Psychiatric Care Hospital in Berlin
- ➢ Continued emphasis on least-restrictive transport
- ➢ Support for training in the Six Core Strategies for reducing seclusion and restraint
- ➢ Efforts to identify the most effective ways to support individuals experiencing early-episode psychosis (for example, Open Dialogue and the additional requirement for Mental Health Block Grant funding to use 10% of the state's allocation to explore approaches to the onset of early severe mental illness)
- ➢ Team Two training for collaboration between mental health providers and law enforcement, looking toward more individualized responses to people in emergency situations
- ➢ Working toward making orders of nonhospitalization more effective as treatment tools in the community through technical assistance

[2]*Working Definition of Recovery*, pp. 4-6.

- Potential opportunities to collaborate with the Vermont Ethics Network in facilitating stakeholder discussions regarding community-driven priorities for mental-health system change, treatment intervention, and individual engagement strategies, and accountability tools that would improve individual and system outcomes
- Expansion of Warm Line hours

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

In Closing

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

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

- Better support best practices for active treatment of individuals experiencing mental illness in psychiatric inpatient care,
- Affirm expectations for restoration of capacity when possible during psychiatric hospitalization, and
- Endorse community-based treatment approaches and service models that proactively promote psychiatric stability and community participation

APPENDIX

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 82

Section 5: Involuntary Treatment and Medication Review

December 15, 2017

Table of Contents

Summary of Report Expectations

On or before December 15, 2017, the Secretary of Human Services, in collaboration with the Commissioner of Mental Health and the Chief Superior Judge, shall analyze and submit a report to the Senate Committee on Health and Welfare and the House Committee on Health Care regarding the role that involuntary treatment and psychiatric medication play in inpatient emergency department wait times, including any concerns arising from judicial timelines and processes.

The analysis shall examine gaps and shortcomings in the mental health system, including:

1. Adequacy of housing and community resources available to divert patients from involuntary hospitalization;
2. Treatment modalities, including involuntary medication and non-medication alternatives available to address the needs of patients in psychiatric crises; and
3. Other characteristics of the mental health system that contribute to prolonged stays in hospital emergency departments and inpatient psychiatric units.

The analysis shall also examine the interplay between the rights of staff and patients' rights and the use of involuntary treatment and medication.

Involuntary Treatment and Medication Review

Gaps and Shortcomings in the Mental Health System

1. Adequacy of housing and community resources available to divert patients from involuntary hospitalization;

This information is included in the Act 82 Sections 3 and 4 report due December 15, 2017.

2. Treatment modalities, including involuntary medication and non-medication alternatives available to address the needs of patients in psychiatric crises;

Non-Medication Alternatives

There are several non-medication alternatives that have been shown to address the needs of individuals in psychiatric crisis:

Crisis Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified Crisis Services as one of the most beneficial and cost-effective methods for meeting the needs of individuals in psychiatric crisis. This array of services can include:

- Mobile crisis services
- 24/7 crisis hotlines
- 23-hour crisis stabilization/observation beds
- Short-term crisis residential services and crisis stabilization beds
- Collaborative mental health and law enforcement response
- Pre-crisis telephone support lines (i.e. "warmlines")
- Peer crisis services

SAMHSA states that there is strong evidence that crisis services can "divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing [psychiatric] crisis."[1] In addition, crisis services have been shown to be highly cost effective. SAMSHA states: "…. a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes."[2] Reduced use of hospitalization and diversion from emergency rooms, coupled with an appropriate level of community-based services, leads to lower costs.

While Vermont has a long history of utilizing crisis services to address the needs of individuals in psychiatric crisis, including an expansion of these services through Act 79 in 2012, we believe additional expansion of this continuum of services would further help to address the needs of these individuals and reduce the need for involuntary interventions. **Additional analysis of how existing crisis services could be used to avoid the need for involuntary treatment may also be warranted.**

[1] https://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf

[2] https://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf

Soteria

The Soteria model was originally founded in 1971 by psychiatrist Loren Mosher in San Jose, California as an alternative community-based, non-medical approach to traditional hospitalization for people diagnosed with schizophrenia.[3] The approach emphasizes the following principles:

- A small, community-based, residential treatment environment with strong use of peer and para-professional staffing rather than clinical staff;
- A focus on empowerment, peer support, social networks, and mutual responsibility and reciprocity between residents staying at the program and staff;
- Minimal use of psychotropic medication based on personal choice of the resident.[4]

While some members of the psychiatric community have been, and continue to be, critical of approaches that minimize or avoid the use of psychotropic medication during the first phases of psychosis[5], there has been a strong push among peers and mental health advocates nationally and in Vermont to increase access to this type of support. In addition, systematic reviews of research on this model suggest that it can offer an effective non-medication alternative to individuals in psychiatric crisis. In a 2007 meta-analysis of the Soteria model published in *Schizophrenia Bulletin*, the authors state that while further research is needed, current studies suggest that the Soteria model "yields equal, and in certain specific areas, better results in the treatment of people diagnosed with first- or second-episode schizophrenia spectrum disorders (achieving this with considerably lower use of medication) when compared with conventional, medication-based approaches."[6]

Vermont currently supports a 5-bed Soteria House in Burlington, as well as an 8-bed program, Hilltop, in southeast Vermont that is informed by the Soteria model. Given the research that suggests that the Soteria model can be as effective as traditional treatment while offering a non-medication alternative, **further analysis may be warranted to assess how Vermont's future support and implementation of the Soteria model can reduce the need for involuntary medication for individuals experiencing a psychiatric crisis.**

Six Core Strategies for the Reduction of Seclusion and Restraint

When an individual is hospitalized or being treated in a hospital emergency room for a psychiatric crisis, there are times when hospital staff may be required to use seclusion and restraint (S/R),

[3] https://en.wikipedia.org/wiki/Soteria_(psychiatric_treatment)

[4] ibid; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2632384/

[5] https://mentalillnesspolicy.org/medical/involuntary-medication.html

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2632384/

including the administration of involuntary, short-acting medication, if an individual is presenting an immediate threat to harm themselves or someone else. While necessary to ensure immediate safety, these interventions have been shown to have both short-term and long-term negative effects on both patients and the staff performing the intervention. SAMHSA states, "Studies have shown that the use of seclusion and restraint can result in psychological harm, physical injuries, and death to both the people subjected to and the staff applying these techniques."[7]

To address this issue, SAMHSA has supported the development and promotion of the *Six Core Strategies for Reduction of Seclusion and Restraint*. This approach focuses on organizational training and consultation focused on changing the organization' s culture, management, and policies and procedures to prevent the need for S/R. The six strategies address:

1) Leadership support
2) Debriefing after the use of seclusion or restraint
3) Using data to inform organizational improvements
4) Workforce development and training for all staff
5) Specific tools for S/R reduction (e.g. Sensory Modulation)
6) Inclusion of former patients and their family members in planning and implementation of the strategies

This approach has been found to be effective in reducing the percentage of patients secluded and the proportion of patients restrained, as well as the number of hours that patients spent in seclusion or restraint.[8]

Vermont has supported the implementation of the *Six Core Strategies for the Reduction of Seclusion and Restraint* in both the Vermont Psychiatric Care Hospital (VPCH) and the Designated Level I Hospitals, and several of these inpatient programs have experienced significant success in reducing their use of S/R. **DMH recommends that Vermont continue to support implementation of these strategies and consider expansion of the approach in other hospital inpatient units and emergency rooms that are experiencing a significant level of S/R.**

Sensory Modulation

Sensory Modulation is a therapeutic intervention that provides opportunity for the care provider to help the patient deescalate safely when they are in Phase II of the Assault Cycle. Sensory Modulation includes a number of therapeutic interventions such as a variety of colored lenses, varying types of music, board games, card games, or coloring books. It can also be a time when lighting or noise is reduced or increased. These are all methods that are hoped will distract the patient from thoughts

[7] https://www.samhsa.gov/trauma-violence/seclusion

[8] https://www.psychiatry.org/newsroom/news-releases/evidence-based-package-of-strategies-reduces-use-of-seclusion-and-restraint

of assaultive or aggressive behavior(s). These therapeutic methods can also help to deescalate the patient and help them to maintain a mood of calmness once the patient is returning to their level of baseline behavior or maintaining it. While the goal of Sensory Modulation is to help them return to their baseline of behavior and maintain that level while paying strict attention that the patient care staff is maintaining a necessary level of safety.

About two years ago Tina Champange, a leading expert in this county on Sensory Modulation, gave a two-day workshop on Training Modulation at VPCH. Her workshop was well attended and well received. She was available for talks with staff that were well used by these attendees. She also provided displays of tools that could be used in the provision of Sensory Modulation by staff to our patients. The provision of Sensory Modulation by our staff to patients was met with great enthusiasm by staff for the first 3 or 4 months, mostly by Recovery Staff and Social Workers, but also by some Nurses. Unfortunately, it became difficult to maintain a continuous, regularly scheduled provision of these sessions and soon they ended.

During February of 2018, Tina Champaign will return to VPCH to provide us with two days of training in Sensory Modulation. What will be different about these two days of her workshop is that she will provide us with a Train-The-Trainer program for our staff. **This provides us with strong plans that will help us to keep Sensory Modulation as a viable, ongoing program on a regularly scheduled basis.**

<u>Collaborative Networks Approach</u>

The Collaborative Networks Approach is a Vermont-based initiative that aims to train practitioners in the Vermont mental healthcare system in therapeutic practices originating from Open Dialogue, other needs-adapted approaches, and reflecting processes. This is an intensive, 100-hour training course that takes place over a span of nine months. The primary learning modalities include interactive processes such as role-play and reflective process consultations, as well as didactic presentation and review of relevant literature.

In this model, psychotic reactions are attempts to make sense of one's experience, and to cope with experiences so difficult that it has not been possible to construct a rational spoken narrative about them. Hence, symptoms are treated as meaningful attempts to communicate, and practitioners "join with" patients to create a shared understanding of the problem. Patients are encouraged to participate in all discussions about their care, and are included in every level of decision making. Regular meetings are held with patients whether they are receiving medications or not, so that practitioners can be as flexible as possible in responding to the changing needs of patients throughout their care.

In parts of Europe where similar approaches have been used, this way of working has been shown to have significant benefits for individuals and the communities in which they reside. Outcome research has demonstrated that this approach is associated with decreased reliance on antipsychotic

medication, decreased need for hospitalization, and decreased incidence of new cases of schizophrenia. In one study of patients experiencing first-episode psychosis, it was found that after two years, 83% of patients were working or job-seeking, and 77% did not have residual psychotic symptoms, despite the fact that only 27% of patients were using antipsychotic medications.

Although it is impossible to transplant an entire system of care from Europe to Vermont, the Collaborative Networks Approach has begun to adapt fundamental aspects of Open Dialogue and similar approaches to our own mental healthcare system. Last year, which was the inaugural year of the program, approximately 25 mental healthcare workers from across the state were trained in dialogic and reflective practices. The Vermont Psychiatric Care Hospital sent three full-time nurses and two attending psychiatrists to this training. This year, six new people are being sent and several of the trainees from last year are returning to complete an advanced course. Part of the focus for this more advanced training will be on teaching related principles and practice methods to others at the hospital so that this model can spread throughout the care delivery system. **Plans for implementing ongoing consultation and supervision of people trained in this work are currently being formulated.**

3. Other characteristics of the mental health system that contribute to prolonged stays in hospital emergency departments and inpatient psychiatric units

TAC Report

In early 2016, in response to an upcoming SAMHSA grant opportunity for funding to States to examine existing state laws and potentially develop more robust Assisted Outpatient Treatment "AOT" policies, DMH engaged in preliminary discussion with SAMHSA regarding eligibility and fit for Vermont. Through these discussions it was determined that existing mental health statutory language would render Vermont ineligible to benefit from grant funds as intended in the current round of applications. SAMHSA, however, recommended that free technical assistance was available to states and recommended outreach to the Treatment Advocacy Center (TAC) for follow-up discussions. The TAC organization is not without controversy, as it is a staunch advocate for effective treatment services (including medication). Some advocates and individuals living with a mental illness view these as forms of coercion and antithetical to self-directed, person-centered treatment.

In efforts to capture all perspectives, in late 2016, Brian Stettin of TAC traveled to Vermont to review our statutes and to meet with and hear from a wide range of stakeholders including state agency program and legal representatives, judges, inpatient and outpatient treatment providers, advocates, and self-identified peers and/or individuals with lived mental health system experience. A final report was issued in October 2017. It included findings and potential remedies intended to assist

Vermont in operationalizing existing statutes into practices that would improve mental health treatment services and individual outcomes.

Specific to Vermont, the report outlines a number of high level observations:

1. Current Orders of Non-hospitalization (ONH) practices have very limited influence on only a small percentage of eligible individuals.
2. The courts play no vital role in monitoring progress during the period of the order.
3. An ONH issued by the Criminal Court, for criminal defendants who typically have been found incompetent to stand trial, serves the State's Attorney as a means of disposing of the criminal matter without input of mental health professionals or having to wait indefinitely for competence to be restored.
4. Many ONHs are the result of stipulation without court hearing and patient or treatment team full understanding of their mutual responsibilities.
5. The ONH revocation process requires fresh evidentiary showing that the individual is a "person in need of treatment" rather than retain the status throughout the period of the ONH. It appears no easier to secure hospital care for non-adherent individuals on an ONH.
6. Despite statutory language conveying authority to medicate individuals on ONH, who were previously on an Order of Hospitalization (OH) and over their objection when clinically indicated, the practice remains limited to hospitals in Vermont.
7. Decentralized involuntary hospitalization and annual rotation of judiciary contributes to variability in process in the state and the basic tenets of the AOT model.

Recommendations flow from the above observations and include:

1. Piloting a city or county with buy-in of one assigned Judge and the local Designated Mental Health Agency in the tenets of the AOT Model.
2. Exclusion of individuals under ONH by Criminal Court.
3. Involvement of Court in the ONH process and monitoring of progress.
4. Dedicated inpatient beds if individuals require hospitalization.
5. Recognition that status as "a patient in need of further treatment" is retained throughout the period of ONH.
6. Data collection and evaluation of outcomes of changes.

The TAC report, *"Reimagining ONH: A Report to the Vermont Department of Mental Health"* is an addendum to this Act 82 report update.

4. Interplay between the rights of staff and patients' rights and the use of involuntary treatment and medication.

Given the complexities of this question, DMH felt the best way to answer this would be to seek input directly from direct care staff members. DMH solicited input from the VSEA's VPCH chapter, the Vermont Association of Hospitals and Healthcare Systems (VAHHS), the Vermont Medical Society, and Vermont Care Partners. As of the writing of this report we have received input from the VSEA VPCH chapter and VAHHS.

Several staff members at VPCH submitted comments. What quickly became evident is that while we asked staff to discuss the interplay between the rights of staff and patients' rights, and they did touch on that, by far their biggest concern was for the welfare of their patients. The suffering they witness day in and day out is what weighs on them most heavily and has motivated them to ask the legislature to consider changes.

This is clearly a controversial issue. While of course patient autonomy is very important, there are very real consequences to staff when patients remain untreated when medication is what their psychiatrist feels is what they need to treat their illness. There needs to be a balance between the rights of both groups. Currently, it often takes weeks or months for someone to be involuntarily medicated. DMH believes this period of time is too long and results in increased risk of harm to staff members who are caring for these patients. It is important to remember that it is a very small percentage of people involuntarily committed who need involuntary medication, 11% (51 of 465), but these are often the most acute patients and thus those that can be the most assaultive to staff. They are also the patients that are suffering the most from remaining untreated.

An analysis done by VPCH Quality showed that in FY 2017, 17 patients at VPCH received court ordered medication. Ten of those had emergency involuntary procedures (EIPs) prior to their medication order. As indicated in the analysis below, most of these untreated patients had several EIPs before they started on involuntary medications.

Number of court orders for non-emergency medication	17
Individuals with one or more EIP prior to granting of court order	10
Individuals with no EIPs prior to granting of court order	7

	Emergency Involuntary Procedures	
Patient A	8 seclusions 6 mechanical restraints	9 included manual restraint
Patient B	1 seclusion 3 mechanical restraints	All included manual restraint
Patient C	4 seclusions	4 included manual restraint

	4 mechanical restraints	
Patient D	2 seclusions	Both included manual restraint
Patient E	1 seclusion 1 mechanical restraint	
Patients F and G	1 mechanical restraint	Included manual restraint
Patient H	1 seclusion	5 manual restraints
Patient I	1 seclusion	Included manual restraint
Patient J		1 manual restraint
7 Patients	No EIPs	

It is the opinion of the clinical team that a large majority of these EIPs could have been avoided if these patients had received the clinically determined appropriate treatment in a timelier fashion. EIPs can be incredibly traumatic for patients. No matter how mindful staff are, the experience for patients often replicates a painful and frightening history. EIPs violate the sense of safety and compassion patients expect when hospitalized. A repetition of interpersonal violence (no matter how sensitively delivered) increases an adversarial and self-protective response. Collaboration becomes much more difficult for people who have experienced the fear and pain associated with an intervention that counters patient expectations and providers' desire to provide a positive mental health experience.

Taking EIPs out of the equation increases the likelihood of focused treatment delivered from a positive behavior support paradigm. Relationships are maintained in a mutually respectful way, thus helping to reduce lengths of stay and demonstrating to patients that caregivers can be trusted members in an overall recovery plan. Being able to cut down on these numbers by allowing psychiatrists to treat their patients with the treatment they deem, in their clinical judgment, to be the most appropriate for their illness would improve the patient's experience and create a safer environment for the patient, other patients, and staff.

This is also a very timely subject of discussion given the recent VOSHA investigations at VPCH and the Brattleboro Retreat. Some staff at VPCH clearly conveyed to VOSHA that they felt there were too many assaults by patients resulting in an unsafe environment. Discussions with staff revealed the same themes as the statements below: in addition to other factors, staff believe there are too many untreated acute patients on the units and that in turn creates an unsafe environment for patients and staff.

Input from VPCH

Scott Brumenschenkel, Psychiatric Nurse III

My name is Scott Brumenschenkel and I am an RN working at VPCH as a day shift charge nurse and occasional nursing supervisor. In these roles I am charged with the safety and management Vermont's most acutely ill psychiatric patients and the staff who care for them. Below I have outlined my perspectives on Vermont's shortcomings in the treatment of these individuals, the impact on those who care for them, and suggestions for improvements that could improve safety for all.

Delayed Pharmacological Treatment:

Vermont is unique in withholding the ability of psychiatrists and nurses to treat individuals pharmacologically in a timely manner even though they have been involuntarily hospitalized because of an acute psychiatric need. An exception to this are the patients who take medication voluntarily, or receive emergency medications given when presenting with an imminent risk of harm to themselves or others.

The state suspends the individual's liberty and then denies the ability of clinical staff to provide the accepted standard of care. These lapses in treatment exacerbate the individuals long and short- term prognosis, delay recovery, postpone their liberty, endanger other patients and staff, and incur unnecessary costs to the taxpayers.

I do not profess that medication is a panacea for all individuals. I do believe it is often the first step in recovery for the majority of individuals who are admitted to our facility. It is particularly troubling to care for individuals who are acutely ill, and who have a documented history of recovery with pharmacological treatments, and yet goes without while we wait on the often-lengthy delays of our court system. I would ask our legislators and citizens, what would you like us to do with these folks who are suffering under the weight of their psychosis if we cannot treat them?

VPCH is blessed with a therapeutic environment, adequate staff minimums, and active initiatives to eliminate the use of seclusion and restraints. However, there is a limit to the effectiveness of these interventions in curbing assaults when individuals are actively psychotic. Psychosis is a break with reality that often suspends the individual's ability to actively engage in communications around their needs and emotions. Individuals in this state often act out of fear, or are motivated by delusional beliefs. Patients and staff are particularly vulnerable to assault during the exacerbation of these episodes, which can occur without warning or precipitating events.

Our staff accept that there is some inherent danger in working in a psychiatric hospital, but our patients should not be subjected to acts of violence during hospitalization while there are pharmacological treatments available to help mitigate the risk. Timely pharmacological

treatment of individuals who are actively psychotic will improve safety, patient recovery, and shorten the length and associated costs of prolonged hospitalization.

I have cared for acutely psychotic, and manic patients who went untreated for months due to delays in adjudication. Moreover, our psychiatrist's recommendations for pharmacological treatments are often modified by judges who are not trained in psychiatry, or who impart limits on dosages that result in under-treatment. These hindrances to adequate treatment increase the risk of assault for everyone interacting with the patient and impair the recovery of others sharing the milieu through increased acuity on the units.

Appropriate Placement:

Presumably because of funding, we currently hospitalize individuals accused of murder and other violent crimes with geriatric psychiatric patients and young adults who have are experiencing their first acute psychiatric hospitalization. Individuals who have been exposed to life in corrections require a higher level of security than most of our civilian population. The hospital has a limited ability to blend these forensic patients amongst the different units to avoid conflicts that can result in patient to patient assault. Civilian patients through no fault of their own are then vulnerable to individuals with violent histories exhibiting antic-social behaviors for which there is little to no successful treatment.

Forensic patients are often sent to VPCH from corrections to be treated so that they can regain competency to stand trial for violent crimes. Some of these individuals will likely never regain competency and remain hospitalized for years. The state seems to have no clear guidelines on the limits of these attempted treatments to regain competency, and there by subjects a rotating civilian population to an ongoing potential of assault.

Some forensic patients improve from an acute state but not to the point of competency. It was not the intended purpose of VPCH to be a long-term care facility for psychiatric patients. The state should address this costly use of acute care beds with a forensic psychiatric facility, such as most states have, and explore the funding of community based care for individuals who need a higher level of supervision but are no longer in need of acute care in a locked facility.

Continuity of Treatment:

Patients who refuse voluntary pharmacological treatment and are then ordered to engage in pharmacological treatment receive court ordered medications while hospitalized. When they are ready to reenter the community they typically agree to an order of non-hospitalization or ONH. These contracts vary with the individual but are generally focused around continuing pharmacological treatment and outpatient appointments with a psychiatrist, community,

agencies, and therapist. If the ONH is violated the individual may be re-hospitalized, however the enforcement of the ONH is sporadic and many individuals fall through the cracks and are not seen again until they are arrested for dangerous behaviors or end up in an emergency room to start the process of hospitalization and court ordered medication all over again.

The irony is that the state of Vermont has legislation on the books to implement court medications in the community through ACT 114 but they have failed to do so. Invoking this legislation would close a loop hole in the care of our most acutely ill citizens, keeping them safe in the community saving the taxpayers millions and freeing up more acute care beds.

About half of individuals with a diagnosis of schizophrenia never have insight into their illness, and do not believe they are ill. This creates a pattern of medication non-compliance exacerbating the illness, impairing overall quality of life and creating a revolving door of hospitalization. We should give individuals the freedom to live their lives as they see fit, but when they repeatedly threaten harm to themselves or others then it is the responsibility of the state to override the rights of the individual to insure the rights of the majority to public safety.

Conclusion:

I acknowledge that pharmacological treatments for psychiatric illnesses do not have the accuracy of medications for hypertension or other medical conditions and they are not they are only one facet of what should be a multi-pronged approach, however for individuals who have a history of recovery with pharmacological treatments we must act to expedite their return to wellness and the community through more timely treatment and judicial review. Patients hospitalized against their will have a right to safety, and it is the State of Vermont's responsibility to insure their safety through appropriate placement of extremely dangerous individuals in forensic units detached from the civilian population. The judiciary needs to provide clear expectations and limitations when ordering treatment to regain competency for individuals. Expanding our community placement options for geriatric and low risk individuals who are no longer in need of acute care in a locked facility would save money and give increased oversight as people transition to the community. Continuing treatment in the community and corrections by invoking ACT 114 would stop the cycle of medication non-compliance and improve the long-term prognosis for individuals and save money.

Curtis Karr, Associate Mental Health Specialist

I'm writing this testimonial regarding my advocacy for greater alacrity in the process for administering involuntary medications. This is my third stint working as floor staff at the Vermont State Hospital; twice at the old hospital in Waterbury and now three (3) plus years at our new facility in Berlin, the Vermont Psychiatric Care Hospital.

To clarify the driving force behind my advocacy, it is first and above all, out of the wellbeing of my patients. This is closely followed by my concern for my co-worker's safety. However, my motivation for my advocacy is not to put all my patients in a "chemical straightjacket" a soon as possible to make managing my patients easier. As noted my chief concern is for my patient's welfare and wellbeing.

I have lost count over the course of my career in this occupation how many patients have been able to again move on with their lives once their medication is reintroduced and they are able to stabilize sufficiently to move on to a community facility or even home. So many times, I have personally witnessed my patients suffering the ravages of their illness for months on end because of the snail's pace with which a Med Application moves through the court system.

To be absolutely clear, I am not advocating for a system where we medicate first and ask questions later. Fortunately, there are patient advocacy groups that fight for a patient's right to refuse medication and indeed, this is a necessary tension in the dialectical process between involuntary medications and voluntary medications.

However, it seems that the pendulum has swung too far in the opposite direction of involuntary medication. What I'm hoping will come to pass is that legislation will coax the pendulum back to the middle. This is because when a patient goes off their medication, they seem to lose the ability to realize that the medication is in their best interest. Unfortunately, so many mental illnesses are illnesses that tell you that you don't have an illness. Hence, the revolving door. A patient is discharged, goes off their medication, and end up back at the hospital, often with more legal charges against them for their behavior unchecked by medication.

In closing, if someone with a mental illness is not a danger to themselves or others, then I support their right to decide for themselves whether medication is warranted or not. But, if they do pose danger to themselves or others and are readmitted to the hospital, it seems inhumane to allow them to suffer for so long because of a court system that seems to have only two speeds: really slow, and agonizingly slow.

Rhett Williams, Psychiatric Nurse II

The laws that enable psychiatric patients to receive the medications they need are inadequate in the state of Vermont. It is more difficult than it should be to administer involuntary medications for patients in level 1 psychiatric facilities. It takes far too long for the legal system to give doctors, nurses and other care providers the ability to effectively treat the symptoms our patients experience.

The most important effect of the prolonged process of obtaining the right to administer involuntary medications is patients suffer incredibly and unduly. VPCH can

provide treatment for our patients in a variety of forms. Our patients are at the highest rating scale, Level 1, and reflect inpatients at the highest level of acuity in need of constant observation and/or requiring significant staff resources that may include emergency involuntary interventions. The most effective treatment for our patients are medications. Every day our patients cannot get the most effective treatment is another day they have to endure debilitating symptoms that include extreme paranoia, fear, anxiety and suicidal depression. It is inhumane to let these people suffer acute stages of illness for prolonged periods of time.

The second reason our state needs to speed up the process of obtaining a court order to administer medications is that often as patients remain in protracted acute stages of illness their symptoms are more difficult to treat once the order to administer medications involuntarily has been obtained. As we inhumanely allow them to remain in an acute stage of illness we make it more difficult to assist them in their recovery. We are allowing people to remain in an acute stage of psychosis when we do not treat them with the most effective treatment we have, medications. The longer people remain in an acute stage of psychosis the more likely their new baseline, once treated adequately, will be at a lower level of functioning. In addition, people who return to a baseline that reflects a lower level of functioning will be more likely to have a relapse in symptoms. This cycle causes a revolving door at our facility whereby people become sick, are treated, and then become sick again, ad infinitum.

The third reason Vermont needs to accelerate our ability to adequately treat our most acutely mentally ill people is the danger inadequately treated patients pose to staff at VPCH and elsewhere. While many of our patients go through long waits to determine their competency before they can even be legally hospitalized at our facility they assault staff over, and over again. Corrections officers can take measures to protect themselves from people who have been deemed competent. Some of the people we work with are by far the most dangerous people in our state. They walk amongst us and we wait to be assaulted trying our best to maintain safety, always treating them with the utmost respect and dignity all people deserve. That is more than can be said for a legal system that allows them to remain untreated suffering with the most acute symptoms of psychosis of anyone in this state.

Barb Lowe, Associate Mental Health Specialist

I work at the Vermont Psychiatric Care Hospital. Often when patients are admitted they are psychotic, and can be assaultive. The majority of these patients have not been taking medications consistently, or have been underdiagnosed. After their admission we frequently have to wait for weeks, even months to get them to court for commitment. Often times, many weeks after commitment, they have court for

medication(s). Usually, shortly after this medication is granted. From my observation, I see how ill these patients are and how long they wait for court ordered medication, and I believe this is detrimental to the patient and is abusive to their needs. I have seen how medication has greatly improved a patient's well-being. It would be great if the time it takes to grant court-ordered medication would be greatly shortened.

Sarai Richardson, Mental Health Specialist

I've been here for five years. Prior to becoming a Mental Health Specialist, I was a Guardian for my mother-whom suffered from mental illness and later in life other medical complications on top of her mental health. My experience being her guardian was during the last six years of her life.

The current mental health system needs major changes. One of those changes I'd like to address is the length of time a person in crisis must wait for the proper treatment, not limited to but included, court-ordered medication. The current process when someone comes into our facility takes an unnecessary amount of time to get the patients court-ordered medication, even if it's a current medication the patient has for treatment.

This is causing great harm to the patient. This process almost always causes the patients to be admitted for a stay of six (6) months or more. During those months, not only does the patient lose their housing, but jobs and/or connections that they had in the outside world. It's also causing unjust pain and suffering to the patient. It's forcing them to live with whatever illness that is affecting them, in an acute state, without any relief.

I have personally seen these damaging effects happen over and over. I have personally witnessed events such as this happen to my biological mother. After getting my mother on a healthy treatment plan and getting her life back in order, a result that was needed after her 18 months stay at Fletcher Allen Baird 4, I made sure that her care was of utmost importance and her treatment followed to the letter. After becoming her guardian, I would never allow such a gap in treatment. She needed to be stabilized before she would lose her housing—which was only ten (10) days.

From what I see, the mental health system currently causes the constant mental health crisis that Vermont is facing. The system causes patients greater harm and risk of failure in the outside world. The system causes a housing crisis because the patient loses their housing and possibly homeless, and trapped in the system while a place is found. It causes the patient to lose so much, adding more trauma to their lives and creating a higher risk of being readmitted. Not to mention that the longer period of time without treatment, the greater the health risks occur.

I implore you. Please help fix this system. It would be more beneficial to patients and their lives, and/or families. Fixing the system means establishing a better quality of life for the patient. It would be more efficient and effective for the state to speed up the process of court ordered medication.

Janet Isham, Psychiatric Nurse II

Patients are sent here involuntary Level 1. Their treatment is delayed along with court ordered medication, which keeps them from returning to their lives sooner. They are robbed out of time.

Patients who are getting treatment can be delay with their own when sharing a unit with a very disruptive patient who scream all day. This is not therapeutic for anyone involved.

Our goal should be in and out, not waiting months to receive involuntary medication. Look at the number of patients who have to wait weeks in the Emergency rooms.

The longer patients are without medication, the longer it takes them to get well.

Input from VAHHS

Provider #1

Most direct care staff dealing with certain patients get hurt, but staff suffers much more seeing patients in intense discomfort (fear, rage, panic, delusions etc.) for inhumanly long periods of time due to Vermont's law regarding involuntary medication. Most patients see relief shortly after the hospital receives the court order to allow treatment. It's particularly distressing to see patients with bipolar disorder suffering for months, then seeing them quickly recover, but only after several months of being hospitalized, which on an intensive care psych ward amounts to a form of torture. And the cost to the State is significant, not only in dollars, but in a misused resource that could benefit so many more people if treatment could be sped up. It's exhausting seeing such an obvious fix being unutilized due to the objections of patients not capable of making rational decisions.

Provider #2

Staff are truly saddened by our patient's suffering. The term "compassion fatigue" is a well-known term in the nursing field, and something all of our staff experience at one time because of their compassion for those we care for. Our patients who decline treatment are often one of the greatest contributors to this compassion fatigue. Imagine watching an individual lie in bed

staring at the wall for months, refusing all interventions and interactions. Imagine caring for an individual who has constant hallucinations of people trying to harm them, and will hit and threaten staff unprovoked. Imagine seeing the signs of gradual neuropathy, vision decline, and permanent cardiovascular decline as a patient continues to refuse all medication and treatments due to their paranoia.

What is most painful for staff is knowing that these patients have suffered unnecessarily for so long. It is amazing to see a patient after a few weeks of medication making plans with their family, laughing with staff, and cheering for their favorite football team. Seeing a patient who is no longer fearful of everyone in their environment, and smiles while staff give them a manicure or style their hair. Seeing a patient no longer constantly grimacing from their headaches or nausea that accompanied their refusal of medication for a medical condition they were to paranoid to accept treatment for.

Often these same patients return within the year, and the process begins again. Staff are again hit and threatened on a daily basis by an individual who is having hallucinations that people are attacking her. Overtime, this wears away at some staff as they begin to feel personal failure, fear, and a lack of confidence in the care they are providing to the patient. Sometimes a staff member gets seriously hurt. Unresolvable compassion fatigue sets in and those individuals often choose a different field of healthcare, decrease their hours, retire early, leave healthcare completely, or cannot return at all because of an injury.

Provider #3

I've worked at the hospital for about 7 years, and truly, the most challenging aspect of this work is witnessing patients suffering needlessly. By suffering, I mean the unrelenting anguish of a patient who has a delusional belief that they have murdered their entire family, whose horror and grief is real because their symptomology is so powerful. Patients who are endlessly plagued by cruel voices that tell them that if they take medication they or their loved ones will be killed. Patients who are violent without effective treatment, impacting the treatment of others.

As a hospital clinician, it can be so difficult to sit with the knowledge that our teams each have highly trained doctors who have spent a substantial part of their lives learning and practicing psychiatric medicine, skilled nurses who can effectively administer medication and monitor effects, responsive mental health workers who can offer in-the-moment support, and compassionate social workers to engage in therapy and discharge planning. We have a pharmacy stocked with potential opportunities for wellness. And so often, we just have to wait. Wait and witness the suffering, do what we can to help someone find comfort or safety until the order for involuntary medication is granted. It's better than it used to be, but it's still a wait, and for many patients, that wait is a delay in return to functioning, which is a delay in

returning to family, community, and home. Our goal as a treatment team is to help people return to their communities able to live their lives in a healthiest way possible. I respect that that concept can look very different for a lot of people, and I don't carry the belief that everyone needs to be symptom free to live a full life. However, some of our patients are not able to connect with reality in a way that leaves any room for comfort, contentment, or safety without medication. It can feel difficult to know that relief is available, and that the symptoms of the illness that needs to be treated are what is preventing effective care.

Options

The discussions around involuntary treatment include a vast spectrum of opinions but, without a doubt, a common theme for all is the goal of providing treatment to individuals who require interventions to keep themselves or others safe. DMH believes we must consider the full treatment array including community based, social determinants, therapies, and emergency services to name just a few, to have an effective goal-driven discussion regarding involuntary treatment.

During the process of working on the different sections of the Act 82 reports involuntary treatment has been discussed (including at a DMH-hosted public forum focused on involuntary medication). We know this is a topic we will not achieve agreement on every aspect, but below we will present some ideas or areas of focus we think deserve further discussion. We believe it is important to hear from individuals who have different opinions through a more formal legislative process. We also recognize statutory changes were made in 2014 and that it was a trying process for all involved. However, despite these changes, not all issues were addressed. Some of the continued challenges may be because of statutory requirements but also may be because of human behavior or clinical opinion in response to the statutes.

The first area we would recommend exploring is specific to the forensic population. VT Psychiatric Care Hospital, Rutland Regional Medical Center, Brattleboro Retreat, and Department of Corrections are all experiencing an increase in population of individuals with mental health challenges and criminal offenses. Some of these individuals are found incompetent to stand trial while others are still in the process of a competency determination pursuant to a criminal court orders. And while we can provide treatment to an extent and address some of their mental health issues, we are often challenged by not being able to provide the full extent of treatment options.

Mandate to Treat

Vermont does not have a statutory requirement to restore competency and we were asked to consider this. We are not exploring a restoration to competency statute (although pursuant to your specific request, information about this is included later in this report) but would like to explore a mandate to treat. Below are some options to consider:

1. Reduce timeline for Applications for Involuntary Medications (AIM) in Forensic cases

Patients who are hospitalized through criminal court orders for competency and/or sanity exams (commonly referred to as "forensic patients") often have longer judicial timelines than those hospitalized through family court. Resolving their competency and/or sanity issues can take months. In almost all instances, involuntary medications cannot be requested until the person has been involuntarily hospitalized by order of either the criminal or family court. Resolution of the competency and sanity issues must occur before a hospitalization order is issued. This results in forensic patients, who are often accused of very serious offenses, remaining untreated for months.

DMH believes there are a few ways to try and help this issue.

- Allow AIMs to be filed in family court while competency and sanity is still being determined in criminal court.
- Allow DMH to have party status in criminal court, and then provide a mechanism for the department to seek an expedited hospitalization hearing while the competency and sanity determination continues on a separate track.

The goals of these changes would be to reduce the duration of untreated illness for forensic patients, reduce the rates of seclusion, restraint and staff and patient injuries, and to reduce hospital length of stays. As it would reduce length of stays, it would reduce the wait-time for hospital beds in EDs and DOC.

2. Support DOC in implementing 18 V.S.A. § 7624

   This statutory provision allows DOC to medicate convicted felons in correctional institutions. While we appreciate this would be new and challenging to implement, DMH would commit to working with DOC to address their concerns to allow individuals to continue their medication in correctional settings. This would potentially prevent some inmates from decompensating and requiring repeated inpatient care.

3. Determine a temporary setting for forensic individuals. More information regarding this will be in Secretary Gobeille' s Facilities Report due January 15, 2018.

4. Opening the Forensic Unit within DOC as set forth in language from Act 78 would also support this flow continuum.

Other ideas to explore include:

5. Allow private guardians to consent to psychiatric medications

   Unlike some other states, for example New Hampshire, Vermont guardianship statutes do not allow guardians to consent to psychotropic medications. VPCH has treated several individuals that could be transferred to a more appropriate, less restrictive, level of care more quickly if this consent had been allowed. DMH believes it would be helpful to amend Title 14 to allow a

private guardian to consent to the use of involuntary psychiatric medications by petitioning the court for this specific power. While this is arguably a small group of people, it is an important group.

6. Amend current statutory language regarding expedited motions
   A few years ago, there were modifications made to the involuntary hospitalization and medication statutes that allowed for an expedited motion to be filed 7615(a)(2)(i) if the court finds "that the person demonstrates a significant risk of causing the person or others serious bodily injury as defined in 13 V.S.A. § 1021 even while hospitalized, and clinical interventions have failed to address the risk of harm to the person or others". However, this has been interpreted by courts to be an incredibly high standard needing an actual injury to meet the threshold. This means that a staff member or other patient has likely been harmed and the patient themselves probably received at least one EIP resulting from the incident. It would helpful to clarify this language and make it clear that the provision can be used not just when a patient has become violent, but when there is a clear potential for violence. It is not good treatment nor is it fair to the patient, other patients, and/or staff to wait until there is an actual assault before being allowed to treat the person in the way in which their doctor believes is clinically appropriate.

7. Administrative Option

   Some states, such as New Jersey and Connecticut, approach involuntary medications not through the court system but through an administrative approach. The idea is that independent physicians are making the medical decision around whether someone would benefit clinically from involuntary medications rather than the court. DMH's new director of nursing moved from CT and has shared her experiences with this process. DMH believes this is an area worth exploring given that it assures physicians trained to prescribe medications are making clinical decisions and it results in patients being treated much more quickly when that is the clinically appropriate prescribed course of treatment.

Statutory Directive

To provide the General Assembly with a wide variety of options, the analysis shall examine the legal implications, rationale or disincentives, and a cost-benefit analysis for a statutory directive to the Department of Mental Health to prioritize the restoration of competency where possible for all forensic patients committed to the care of the Commissioner. To provide the General Assembly with a wide variety of options, the analysis shall examine the legal implications, rationale or disincentives, and a cost-benefit analysis for enabling applications for involuntary treatment and applications for

involuntary medication to be filed simultaneously or at any point that a psychiatrist believes joint filing is necessary for the restoration of the individual's competency.

The request in this section contemplates changing statute to add the concept of competency restoration. Competency/sanity evaluations are quite common in Vermont. While historically VPCH had about 30% forensic cases, we have been over 50% for several months and there are no indications this will lessen any time soon. Other facilities also are experiencing an increase in forensics. As discussed above, the judicial timelines for these patients are generally much longer than those committed through the civil process.

In many cases, if someone is found incompetent due to psychosis they are unlikely to resume competency without antipsychotic medication. In 2003 the United States Supreme Court heard a case on this subject, *Sell v. US*.[9] That case established four factors that must be considered when a court is contemplating ordering involuntary medications to an incompetent pretrial detainee. 1) Did the defendant commit a serious crime? 2) Is there a substantial likelihood that involuntary medication will restore the defendant's competence and do so without causing side effects that will significantly interfere with the defendant's ability to assist counsel? 3) is the involuntary medication the least intrusive treatment for the restoration of competency? 4) Is the proposed treatment medically appropriate?

One study did a retrospective record review of all incompetent defendants in the entire U.S. federal court system (N: 132) involuntarily treated under *Sell* over a 6-year period (June 2003-December 2009). Results indicated the majority (79%) of treated defendants suffering from a psychotic related illness were sufficiently improved to be rendered competent to stand trial. The study also found high rates of treatment responsiveness were found across all diagnoses.[10]

One study, from 2016, reviewed various competency restoration programs and outlined a model for best practice competency restoration program.[11] The article listed several elements:

1. Systematic Competence Assessment

   Defendants, upon admission, would undergo a comprehensive assessment to determine the specific reasons for the incompetence, be they psychotic and confused thinking, limited intelligence, mood fluctuations, or brain impairment.

2. Individualized Treatment Program

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[9] 539 U.S. 166 (2003).

[10] Robert E. Cochrane, Bryon L. Herbel, Maureen L. Reardon, and Kristina P. Lloyd, *The Sell Effect: Involuntary Medication Treatment Is a "Clear and Convincing" Success*, Law and Human Behavior,107–116 (2013).

[11] Lenore E.A. Walker, ET. AL., *Best Practices for the Mentally Ill in the Criminal Justice System*, Springer Briefs in Psychology: Behavioral Criminology, 51, 51-54 (2016)

Each defendant would have treatment program tailored to her or his specific needs. Deficits identified in the initial assessment would be addressed by specific treatment modalities.

3. Education

A didactic component consisting of education surrounding charges, sentencing, plea bargaining, roles of courtroom personnel, the trial process, and understanding evidence.

4. Anxiety Reduction

Defendants would be taught anxiety reducing techniques to help them deal with the stress of court proceedings.

5. Additional Education for Defendants with Limited Intelligence

If incompetence stems from intellectual deficits, a specific intervention based on the results of an intellectual assessment at the outset would be used. Didactic material may be reviewed a number of subsequent times in individual sessions to address aspects of the group program that were not well understood by the defendant.

6. Periodic Reassessment

Each defendant would be reassessed on at least two occasions, focusing on the individualized treatment modules to see whether progress is being made.

7. Medication

For those defendants whose incompetence is based on psychosis or mood disorders, appropriate medications would be prescribed and regularly monitored. Medication reassessment would coincide with the periodic reassessment of competence to see if the pharmacotherapy needs to be altered.

8. Assessments of Capacity

A procedure would be created to set in place for the assessment of competency to make treatment decisions, especially when medication is involved.

9. Risk Assessment

Because some defendants who are un-restorable need to be evaluated for involuntary commitment, there needs to be a standard protocol for assessing risk of future violence using empirically based instruments.

DMH's General Counsel and Medical Director have reached out to forensic psychiatrists and attorneys in the neighboring states of MA and CT to better understand how they developed and now administer competency restoration programs in their states. DMH is happy to provide an update on these discussions during testimony on this section.

As for the cost-benefit analysis requirement we understand the intent to better recognize the impact of statutory changes on the cost of services delivered, however we have not viewed this as a financial discussion but about appropriate treatment. We are interested in that outcome of a cost-benefit analysis, but first and foremost we are committed to assuring appropriate and effective treatment, therefore if there were savings we would propose redirecting those resources to other evidence based and effective treatment options for people to reduction or eliminate the need for involuntary treatment. Furthermore, to do an accurate cost benefit analysis we would need more time and consultation from experts in analyzing claims, reviewing service level data, doing time studies with other entities such as courts and gather other important factors to draw any conclusions regarding savings.

Request for Information

On or before November 15, 2017 the Department shall issue a request for information (RFI) for a longitudinal study comparing the outcomes of patients who received court-ordered medications while hospitalized with those of patients who did not receive court-ordered medication while hospitalized, including both patients who voluntarily received medication and those who received no medication, for a period from 1998 to the present. The request for information shall specify that the study examine the following measures:

(A)the length of an individual's involuntary hospitalization;

(B) the time spent by an individual in inpatient and outpatient settings;

(C) the number of an individual's hospital admissions, including both voluntary and involuntary admissions;

(D) the number of and length of time of an individual's residential placements;

(E) an individual's success in different types of residential settings;

(F) any employment or other vocational and educational activities after hospital discharge;

(G) any criminal charges after hospital discharge; and

(H) other parameters determined in consultation with representatives of inpatient and community treatment providers and advocates for the rights of psychiatric patients.

Request for information proposals shall include estimated costs, time frames for conducting the work, and any other necessary information.

DMH has received three responses to the RFI: one from Hornby Zeller Associates from Troy, NY; one from ICF Macro, Inc. from Fairfax, VA; and one from Flint Springs from Hinesburg, Vermont.

Reimagining ONH:

A Report to the Vermont Department of Mental Health

By Brian Stettin, Esq.
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October 5, 2017

Introduction:

The Order of Non-Hospitalization (ONH) (18 V.S.A § 7618) is Vermont's version of a legal mechanism currently authorized in 46 states and the District of Columbia. Known by a variety of terms across the country, but most widely as "assisted outpatient treatment" (AOT), the core concept is civil commitment to outpatient care for individuals with severe mental illness who are considered unlikely to adhere to necessary treatment on a voluntary basis.

In recent years there has been growing recognition of studies indicating that AOT can substantially improve outcomes for individuals trapped in the "revolving doors" of the mental health and criminal justice systems by improving rates of adherence to mental health treatment and thereby reducing frequency and duration of hospitalization, arrests, incarceration, and acts of self-harm and violence[i] – all while allowing treatment systems to substantially reduce the extreme costs associated with providing care to "high utilizers."[ii] The federal government has been particularly active in drawing attention to these studies and promoting wider implementation of AOT, as reflected in the 2015 addition of AOT to the National Registry of Evidence-based Programs and Practices (NREPP) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA)[iii]; the 2012 rating of AOT as an effective crime reduction strategy by the National Institute of Justice (NIJ)[iv]; and federal legislation enacted in 2014 and implemented in 2016 to create a grant fund within SAMHSA to support the launch of new state and local AOT programs.[v]

However, these endorsements of AOT in academic literature and federal policy may ring hollow to those who have observed or participated in Vermont's ONH practice. While Orders of Non-Hospitalization have been employed routinely in the state for decades, the consensus among the mental health professionals consulted in the preparation of this report is that they are largely ineffective in helping patients maintain treatment adherence and avoid the pitfalls of repeat hospitalization and arrest.

To reconcile this disenchantment in Vermont with the rising enthusiasm for AOT elsewhere, it must first be understood that beyond the core concept stated above, there are great

variations in how AOT is practiced from one jurisdiction to the next. Some of these variances are dictated by differences in states' AOT laws; others by policy choices that local AOT programs have made in interpreting and implementing those laws. The purpose of this report is to identify any key differences between Vermont's ONH practice and the basic elements of the national "AOT Model" which may explain the discrepancy in results, and to make recommendations for reform arising from this analysis.

Dissatisfaction with ONH:

From the conversations conducted for this report with professionals involved in various facets of Vermont's ONH process, there appear to be three common points of dissatisfaction:

(1) In most cases, professionals see scant evidence of the "black robe effect" touted in other states, i.e., the notion that the being placed under court order has a meaningful impact on the patient's mindset and helps motivate the patient to maintain treatment engagement. While some noted that the court order did seem to influence those patients who were by nature highly deferential to authority, there is consensus that a greater number of ONH patients are decidedly unmoved by the knowledge of the court order.

(2) There is widespread frustration with the legal process that transpires when a patient fails to adhere to the terms of the ONH and the treatment team deems it appropriate to seek revocation of the order. In this situation, a DMH attorney files a Motion to Revoke the ONH with the court, and the court holds a revocation hearing. However, it is the sense of the professionals who take part in such hearings that the court will typically not revoke the ONH and return the patient to the hospital without a fresh evidentiary showing that the patient is a "person in need of treatment." This, of course, is the legal standard which would be applicable in the absence of an ONH. In other words, the ONH makes it no easier than it would otherwise be to return the patient to the hospital and seems to have no bearing on the court's decision-making.

(3) An ONH may be issued by either the Family Court or the Criminal Court. Patients who are identified by DMH as clinically appropriate for ONH are processed through the Family Court; those placed in the program by the Criminal Court are criminal defendants with mental illness who have typically been found incompetent to stand trial, for whom the District Attorney seeks ONH placement as a means to responsibly dispose of the criminal matter without having to wait indefinitely for competence to be restored. While DMH and the Designated Agencies are equally responsible for the monitoring and treatment of all ONH patients regardless of how they enter the system, there is a strong sense that Criminal Court-ordered patients are rarely individuals who would have been identified by mental health professionals as ONH-appropriate, and are especially unlikely to take the ONH seriously.

The Potential Remedy of Court-Ordered Medication:

In light of these perceived shortcomings of the current ONH practice, it is not surprising that many of the professionals consulted in the preparation of this report see an obvious solution

in integrating the use of Vermont's involuntary medication law (18 V.S.A. § 7624). Among other circumstances, the law empowers DMH to "commence an action for the involuntary medication of a person who is refusing to accept psychiatric medication and … has previously received treatment under an order of hospitalization and is currently under an order of nonhospitalization[.]"

Despite this clear statutory authority to medicate ONH patients over objection if clinically indicated, DMH's current practice is to limit this practice to the hospital setting. Those who advocate a broader implementation of the statute envision a system in which DMH would secure a court order authorizing the temporary removal of a non-medication-compliant ONH patient to an appropriate medical facility, administer medication, and return the stabilized patient to the community, thereby eliminating the need for revocation of the patient's ONH.

Whatever conclusion DMH leadership may reach about the merits of such a policy shift, it should be understood that it would make Vermont's ONH practice *less* like AOT programs elsewhere – not more. Court-ordered medication is not typically an element of the AOT Model. Indeed, many of the most successful programs operate in states where involuntary medication of non-adherent AOT patients is expicitly prohibited by law.[vi]

Vermont ONH vs. the AOT Model

While the lack of court-ordered medication is a point of commonality between Vermont's ONH practice and the national AOT Model, there are several highly consequential differences:

Key Difference #1: AOT programs leverage the "black robe effect" to motivate patients; Vermont's ONH practice forgoes any "black robe effect" by minimizing interaction between the patient and the court.

The "black robe effect" lies at the heart of all successful AOT programs. The premise is simply that the experience of visiting a courtroom, taking part in a hearing with both sides represented by counsel, and (most importantly) receiving direct, personal instructions from a judge, makes a profound impression upon the patient. It relies upon the inclination of most of us to hear the voice of authority in words delivered from the bench. The impact of this is heightened when the judge makes a concerted effort to connect with the patient in a manner that conveys compassion and respect, yet firmness of expectations.

When conveyed effectively, the "black robe effect" is not about scaring the patient into submission. On the contrary, the best AOT judges seize every opportunity to give *positive* reinforcement. It typically starts with impressing upon the patient that the reason he or she has been recommended for hospital release is that the treatment team and the judge are convinced of his or her ability to thrive in the community, but that it will take a team effort to make it happen; that everyone is on the same side, with mutual responsibilities to one another (for the patient's part, that means following the agreed-upon treatment plan, showing up for appointments, etc.); and that the patient also has a right to expect high quality care, and must let the judge know if it isn't delivered.

If indeed this black robe effect is the key ingredient in AOT -- and practitioners across the nation are convinced that it is -- it is fair to question whether Vermont's ONH practice is really AOT at all. In Vermont, ONH orders are almost always issued by the court upon

stipulation, without any hearing. The patient receives a copy of the court order and is informed by treatment personnel of what it means, but will never actually meet the judge unless things go poorly and it becomes necessary to appear at a revocation or modification hearing.

From a purely legal perspective, the stipulated ONH is perfectly sensible. If the patient welcomes the ONH application as a "ticket out" of the hospital and does not wish to contest it, a lawyer or judge might reasonably wonder what purpose is served by holding a hearing. The answer is that while an AOT hearing is unquestionably a legal exercise, it is also something else. Once the appropriateness of civil commitment to outpatient care is conclusively established, the AOT judge must embrace his or her function as the primary motivator of treatment adherence, which can only be performed by forging a personal connection with the patient.

It is typical of AOT programs that most applications are uncontested. As with ONH in Vermont, AOT is most often imposed upon discharge from a hospital stay, at a point when the patient is in stable condition and may have restored (if tenuous) recognition of his or her need for regular mental health treatment. In these situations, some AOT programs require any stipulations to take place in court, at the hearing. Stipulations allow the judge to move quickly through the first phase of the hearing, in which the appropriateness of AOT is considered, and onto the second phase, in which the judge imparts motivation and assures that both the patient and the treatment team fully understand their mutual responsibilities under the court order. Other programs allow the patient to reach a settlement agreement with the treatment team in advance of the hearing. But critically, these settlement agreements are certified by the court at a hearing, in the presence of the parties.

Key Difference #2: AOT courts play a vital role in monitoring patient progress during the period of the order. Vermont's ONH courts do not.

The best AOT programs reinforce the black robe effect throughout the AOT period, with regular "check-in" hearings or status conferences. These tend to occur more frequently at the beginning of the AOT period and less frequently as things settle into a smooth routine. Judges use the progress hearings as opportunities to make sure that any service gaps are quickly addressed, and to praise patients (building self-esteem) for their efforts and small victories. The patient's constant awareness that another progress hearing is approaching helps the treatment team keep the patient on track from day to day.

Nothing like this occurs under Vermont's ONH practice. Once the ONH is issued, the judge maintains no oversight unless and until a Motion to Modify or Motion to Revoke is made.

Key Difference #3: AOT programs have procedures to ease the process of re-hospitalizing a patient who is not adhering to treatment as directed. In Vermont, it is no easier to secure hospital care for a non-adherent ONH patient than it would be in the absence of an ONH.

For good reason, the AOT Model eschews the threat of punishment (i.e., contempt of court) which courts ordinarily rely upon to ensure compliance with their orders. (It would, after all, undermine the purpose of AOT if the court order were to ultimately create a new pathway *into* jail.) But that is not to say that an AOT patient should ever have reason to think that

violation of the court order will have no particular *consequence*. It is critical that AOT patients maintain a sense that their treatment adherence is being closely monitored and that a material violation of the court order is likely to result in re-hospitalization.

Again, it must be emphasized that this does not mean *automatic* re-hospitalization of an individual who does not currently meet hospital commitment criteria, simply because the court order has been disobeyed; such a practice would be plainly unconstitutional. Ultimately, recommitment to the hospital must only occur upon both *clinical and judicial* determinations that the patient meets inpatient criteria. In every state, meeting inpatient criteria is a matter of *both*:

- *status* (being deemed a current danger to self or others, however broadly or narrowly that may be defined under state law); and
- *current clinical needs* (requiring hospitalization as the least restrictive appropriate alternative treatment setting).

In states like Vermont with a shared set of criteria for both inpatient and outpatient commitment, moving a non-adherent AOT patient back to the hospital does not require a new judicial finding that the patient has the appropriate status for inpatient commitment. That finding was already made at the time AOT was ordered, and remains in effect until the court order expires or is vacated. The only question a court must decide upon a motion to revoke AOT is whether to accept the treatment team's finding that the outpatient setting is no longer the least restrictive appropriate alternative to meet the patient's current clinical needs. This empowers a treatment team that knows its patient to be non-adherent and taking the first steps down a familiar tragic path to intervene *now*, rather than defer action until the patient engages in behavior serious enough to convince the court of danger. It is generally understood that an AOT patient can and should be removed from the community at an earlier point in the cycle of decompensation than might be considered appropriate for a patient who does not currently have the status of a "person in need of treatment" (or whatever status terminology is used in that state). All parties accept the common-sense notion that the hospital is the appropriate treatment setting for "a person in need of treatment" who is not adhering to court-ordered treatment.

This should be no less true in Vermont. Under state law there is no difference in *status* between a hospital-committed patient and an ONH patient. When a patient moves from an inpatient commitment to an ONH -- or vice versa -- he or she retains the status of "a person in need of treatment" or "a person in need of further treatment." All that changes is the finding as to what is the least restrictive appropriate treatment setting.

According to the professionals consulted for this report, Vermont courts do not typically take this posture when considering a Motion to Revoke an ONH. Instead, these professionals say that Vermont judges demand new, current evidence that the ONH patient has the status of "a person in need of treatment" – essentially, asking DMH to litigate an issue that should not be in controversy. This makes the ONH revocation hearing indistinguishable from a hearing to impose a new civil commitment and renders the ONH itself irrelevant to the court's inquiry. For patients who have already been through the system a time or two, this only adds to the sense that the ONH is not to be taken seriously.

Key Difference #4: In AOT programs, the mental health professionals who operate the program also determine, subject to court approval, whom the program serves. In Vermont, providers are expected to serve many ONH patients who enter via order of the Criminal

Court, upon application of a District Attorney, without input from mental health professionals.

In typical AOT programs, the consideration of whether an individual is an appropriate candidate for AOT (i.e., whether the individual is capable of surviving safely in the community with treatment but is currently unprepared to make voluntary treatment decisions and is likely to benefit from court-ordered care) takes place in a purely clinical context. Treatment professionals conduct a clinical review of the person's needs and decide whether it is appropriate to file an AOT petition in the court with jurisdiction over civil commitments generally.

This also describes the process for roughly half of the patients placed under ONH in Vermont, who enter through the Family Court. However, the remainder of ONH patients enter the program without any input from the treatment system as to whether the ONH is the best means of serving their clinical needs. These are the patients placed under ONH by the Criminal Court, upon the petitions of District Attorneys.

Vermont is certainly not alone in needing alternatives to incarceration for lower-risk mentally ill criminal defendants. Other states employ a variety of mechanisms to provide offenders with supervised treatment in the community, including specialized mental health diversion courts and mandated treatment through probation and parole. But Vermont is highly unusual in permitting a criminal court to directly place a defendant under civil commitment -- with the usual responsibilities of treatment and oversight that imposes upon DMH and the Designated Agencies -- without regard to whether that defendant meets the same clinical standards of appropriateness that would normally be applied before DMH seeks an ONH from the Family Court.

While there appears to be no available data comparing ONH outcomes for Criminal Court vs. Family Court patients, the consensus among the professionals consulted for this report is that Criminal Court patients are often individuals that DMH staff would not have identified as good ONH candidates, and tend to be much more difficult for the Designated Agencies to engage in treatment.

Reimagining ONH: A Pilot Program Proposal

The Treatment Advocacy Center believes Vermont would achieve far greater results in helping its most vulnerable citizens with severe mental illness maintain wellness and stability in the community by transforming its ONH practice to follow the basic elements of the AOT Model. While this reform may seem a daunting challenge when considered on a statewide level, our recommendation is to limit any action for the time being to the establishment of a modest, two-year pilot program in a single city or county. We believe this program could be initiated without any need to amend state law. If the pilot program were to meet expectations in improving outcomes for participants, it would generate momentum for expansion of the AOT Model across Vermont.

Elements of the proposed pilot would include:

- Selection of a single city or county for the program to serve, with the local Designated Agency fully engaged as a partner.

- Assignment of a single Family Court judge, prepared to embrace the basic tenets of the AOT Model, to preside for the duration of the pilot. (This would require the agreement of the judiciary to suspend the usual practice of annually rotating judicial assignments.)
- Setting a maximum number of patients to be served by the pilot program at any time, based on the clinical and judicial resources that are realistically available to devote to the program;
- Exclusion from the program all patients placed under ONH by the Criminal Court. (Such patients would continue to be served by the Designated Agency under the current ONH process.)
- Integration with DMH's discharge planning process for patients transitioning from "Level I" inpatient care, such that Level I inpatients who reside in the pilot program locale and are deemed appropriate for ONH upon discharge may be placed in the pilot program as capacity permits.
- Establishment of a process to ensure that each participant in the pilot program, represented by counsel, receives a hearing before the court at the initiation of the ONH, which shall include the court's review of the treatment plan and follow the AOT model in maximizing the "black robe effect." (This need not preclude having willing participants sign voluntary settlement agreements prior to the hearing, so long as such settlements are approved by the court at a hearing with the parties present.)
- Status conferences during the period of each ONH, at which the judge shall convene the parties to the ONH with counsel to review the patient's progress and the treatment team's success in delivering services.
- Dedication of hospital beds within VPCH or other appropriate psychiatric hospital, adequate in number to ensure that an immediate bed will be available for any program participant whom the treatment team believes has come to require a more restrictive treatment setting.
- Recognition that the patient retains the status of "a person in need of treatment" throughout the period of the ONH, such that the only issue before the court upon a Motion to Revoke or a Motion to Modify is whether the hospital has become the least restrictive appropriate treatment setting for the patient;
- Holding a court hearing upon the expiration of each ONH, at which the court shall either consider any Motion to Renew the ONH or, in the absence of any such motion, shall commend the patient for his or her successful completion of the program and seek to ensure that appropriate voluntary services have been made available to the patient to allow him or her to continue to maintain stability in the community.
- Integration of a data collection component to track and compare outcomes for both pilot program participants and comparable individuals treated in the same city or county under the longstanding ONH practices.

The Treatment Advocacy Center, with experience in the development and launch of AOT programs across the U.S. and relationships with a broad array of current AOT practitioners, stands ready to provide technical assistance to Vermont in the development of such a pilot program. This would include facilitation of contacts (ideally including field visits) with public agencies, providers, judges and attorneys involved with highly successful AOT programs across the US. Many of these programs were established through legislative and judicial efforts to reform prior outpatient commitment practices regarded as ineffective or overly cumbersome.[vii]

[i] See e.g., Swartz MS, Swanson JW, Steadman HJ, Robbins PC, Monahan J. New York State assisted outpatient treatment evaluation. 2009; Munetz MR, Grande T, Kleist J, Peterson GA. The effectiveness of outpatient civil commitment. Psychiatr Serv. 1996;47(11); Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum R. Can involuntary outpatient commitment reduce hospital recidivism?: findings from a randomized trial with severely mentally ill individuals. Am J Psychiatry. 1999;156(12); 1968-75.

[ii] See e.g., Swanson JW, Van Dorn RA, Swartz MA, Robbins PC, Steadman HJ, McGuire TJ, Monahan J. The Cost of Assisted Outpatient Treatment: Can It Save States Money? Am J Psychiatry. 2013; 170:1423–1432; Quanbeck C, Tsai G, Szabo K. Cost-effectiveness analysis of Assisted Outpatient Treatment implementation in California's civil sector.

[iii] Substance Abuse and Mental Health Services Administration, National Registry of Evidence-Based Programs and Practices. Assisted Outpatient Treatment, accessed March 10, 2017.

[iv] National Institute of Justice, Office of Justice Programs. Program Profile: Assisted Outpatient Treatment, accessed March 10, 2017.

[v] Substance Abuse and Mental Health Services Administration. Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness, accessed March 10, 2017.

[vi] *See e.g.,* N.Y. MHY § 9.60(n); Calif. Welf. & Inst. Code § 5346(f); Tex. Health & Safety § 574.034(c-4).

[vii] Examples include Summit County, Ohio; Butler County, Ohio; Bexar County, Texas; Tarrant County, Texas; Seminole County, Florida; Nevada County, California; and Orange County, California.