

VERMONT2017

Reforming Vermont's Mental Health System
Report to the Legislature on the Implementation of Act 200, Section 3

December 1, 2018



Department of Mental Health

AGENCY OF HUMAN SERVICES

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I. Summary of Report Expectations: The Mental Health System of Care

Sec. 3. ORDER OF NON-HOSPITALIZATION STUDY COMMITTEE

(a) Creation. There is created the Order of Non-Hospitalization Study Committee to examine the strengths and weaknesses of Vermont's orders of non-hospitalizations for the purpose of improving patient care.

(b) Membership. The Committee shall be composed of the following 12 members:

- (1) the Commissioner of Mental Health or designee;
- (2) the Commissioner of Public Safety or designee;
- (3) the Chief Superior Judge or designee;
- (4) a member appointed by the Vermont Care Partners;
- (5) a member appointed by the Vermont Association of Hospitals and Health Systems;
- (6) a member appointed by Vermont Legal Aid's Mental Health Project;
- (7) a member appointed by the Executive Director of the Department of State's Attorneys and Sheriffs;
- (8) the Vermont Defender General or designee;
- (9) the Executive Director of Vermont Psychiatric Survivors or designee;
- (10) the Mental Health Care Ombudsman designated pursuant to 18 V.S.A. § 7259;
- (11) an individual who was previously under an order of non-hospitalization, appointed by Vermont Psychiatric Survivors; and
- (12) the family member of an individual who is currently or was previously under an order of non-hospitalization, appointed by the Vermont chapter of the National Alliance on Mental Illness.

(c) Powers and duties. The Committee shall examine the strengths and weaknesses of Vermont's orders of non-hospitalization for the purpose of improving patient care and may propose a pilot project that seeks to redress any weaknesses and build upon any existing strengths. The Committee shall:

- (1) review and understand existing laws pertaining to orders of non-hospitalization, including 1998 Acts and Resolves No. 114;
- (2) review existing studies and reports on whether or not outpatient commitment and involuntary treatment orders improve patient outcomes;
- (3) review existing data pertaining to orders of non-hospitalization, including data pertaining to individuals entering the mental health system through both civil and forensic procedures;

(4) if appropriate, propose a pilot project for the purpose of improving the efficacy of orders of non-hospitalization;

(5) if appropriate, recommend any changes necessary to approve the efficacy of orders of non-hospitalization; and

(6) identify statutory changes necessary to implement recommended changes to orders of non-hospitalization, if any.

(e) Report. On or before November 1, 2018*, the Committee shall submit a written report to the House Committee on Health Care and the Senate Committee on Health and Welfare with its findings and any recommendations for legislative action.

*Please see attached DMH memorandum of October 17, 2018 requesting extension for report submission from the ONH Study Committee to December 1, 2018, allowing the committee one additional meeting to complete its work.



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MEMORANDUM

TO: Sen. Claire Ayer, Chair, Senate Committee on Health and Welfare
Rep. William J. Lippert Jr., Chair, House Committee on Health Care

FROM: Melissa Bailey, Commissioner, Department of Mental Health

DATE: October 17, 2018

SUBJECT: Report extension- Act 200 (2018), Section 3, Order of Non-Hospitalization Study Committee

Act 200, Section 3 of the 2018 legislative session requires an Order of Non-Hospitalization Study Committee to submit a written report to the House Committee on Health Care and the Senate Committee on Health and Welfare with its findings and any recommendations for legislative action. The report is due on or before November 1, 2018.

The Department of Mental Health respectfully requests, on behalf of the Order of Non-Hospitalization Study Committee, that the report deadline for any committee findings and recommendations be extended from November 1, 2018, to December 1, 2018.

The committee is requesting this extension so that the group may be convened for one additional meeting on November 15, 2018 in order to review data that was not previously available and to finalize any recommendations that may be made by the committee in the report submission.

II. Executive Summary

This report is in response to directives of Act 200, Section 3, and addresses tasks assigned to this committee that included review and evaluation of existing laws, studies, reports, and data pertinent to Orders of Non-Hospitalization (ONH) and, if applicable, making recommended improvements, efficiencies, or changes to the legislative Committees of Jurisdiction. Over the course of five meetings undertaking these assignments, the Department of Mental Health (DMH) has compiled all reviewed material, including submissions of the committee membership, for the purpose of presenting a balanced overview of perspectives on ONHs and their role in Vermont’s mental health system of care. The perspectives put forward reflect the diversity of opinions of the committee membership with only a few recommendations having majority endorsements and many with no consensus recommendations.

The majority of committee members endorsed that additional system-wide, community-based expenditures that are preventive, non-coercive, and responsive to individual needs/choices are the best return on investment for individuals experiencing mental health stressors in Vermont. Increased availability of responsive mental health delivery systems (crisis, outreach, and mobile response), skilled mental health clinicians, strong peer and/or family involvement, and social determinant supports (housing, employment, advocacy/education) will avert trends toward higher cost and more coercive inpatient and institutional bed demand.

Committee members also endorsed efficiencies recommended in the current ONH revocation process that could result in more timely and individual-focused motions for court action with regard to existing ONH proceedings.

Committee members generally supported the concept of creating an ONH pilot for the purpose of evaluating ONHs and any longer-term outcomes achieved for individuals subject to an ONH. The model proposed would require new, additional resources for more robust service availability for individuals who would otherwise have been on an ONH and dedicated pilot management, meaningful data collection and evaluation to accompany the pilot.

In that same vein, a majority of committee members endorsed a recommendation to have more meaningful and readily available data concerning ONHs and their short and long-term benefits. Much of the committee's examination efforts were thwarted by data storage and retrieval anomalies that prevented review over a multi-year time frame of individuals placed on ONHs.

Multiple other considerations, including the wholesale elimination of ONHs in Vermont, occurred during summer and fall meetings and are included herein, but did not achieve full endorsement by committee membership.

III. Directive - Sec. 3(c)

Examine the strengths and weaknesses of Vermont's orders of non-hospitalization for the purpose of improving patient care and may propose a pilot project that seeks to redress any weaknesses and build upon any existing strengths.

During the course of meetings, a running list of strengths and weaknesses was generated through discussions. The following list is an effort to capture individual/group observations and perspectives but does not fully account for all input in these areas. The list does not suggest committee member consensus with any of the statements made nor any consensus regarding accuracy of the perceptions articulated by committee members. Committee meeting agendas, meeting notes, and individual member submissions may also be referenced and are attachments to this report.

Strengths:

- Current ONH statutes are the only way to resolve a criminal case when individual is incompetent
- There are much longer periods of hospitalizations without ONHs as an option
- One benefit is that ONHs can divert people from the criminal system who need mental health care
- ONH conditions provide an opportunity for those who might be falling off their treatment plan to get them going again.
- ONHs are viewed as a less restrictive alternative to hospitalization, a transition out of the hospital back to community-based treatment with some form of judicial oversight.
- Legally, an ONH can serve a role channeling people charged with a crime into treatment.
- For law enforcement, an ONH is a way to get people into treatment if they need it. While it is completely coercive, it can create good communication with local MH agency; otherwise the person could be charged with disorderly conduct and go into the criminal justice system.
- Medications and ONHs have saved lives; “we need to be careful about making decisions to just scrap something that can help people.”

Weaknesses:

- Some people do not comply with ONHs
- Families don't have a lot of recourse with current ONHs- civil or criminal. Individual has to fail rather than get the help they need, for there to be consequences. The individual may not want ONHs in the form currently offered.
- There is a lack of current statistical or data detail for questions presented by the committee to know about outcomes.
- ONHs don't work, the system is broken the way it is now.
- There can be inconsistent decision-making across the state in family courts
- Lack of diversion, lack of response, lack of funding tied to why ONHs exist
- Individuals coming out on an ONH from criminal court may have no connection with community mental health services and not engage with follow-up services
- Once incompetent, criminal defendants stipulate to an ONH; then there is no further involvement for State's Attorney
- Once criminal defendant found incompetent, no opportunity for victim to be heard and no notice if being released from an ONH.
- Legally, when there is serious criminal conduct, the order of ONH is not functional to deal with risk issues over time.
- Filings, to see an action, can take too much time when there is ONH non-compliance
- There is a big disconnect between criminal and civil ONHs; the goals are seen as different- safety versus treatment.
- “Order” as the focus does not provide for involvement in individual's own recovery.
- “Black robe effect” may not be that effective for ONHs currently
- There probably would be some longer hospitalization if not for the ONH; but if there were an alternative in place, that might not be the case.

IV. Existing laws pertaining to orders of non-hospitalization - Sec. 3(c)(1)

Info found on: <https://mentalhealth.vermont.gov/news/order-non-hospitalization-study-committee>

Mental Health Commitment statutes:

Title 18 §7617 <http://legislature.vermont.gov/statutes/section/18/181/07617>

Title 18 §7617a <https://legislature.vermont.gov/statutes/section/18/181/07617a>

Title 18 §7621 <http://legislature.vermont.gov/statutes/section/18/181/07621>

Vermont Involuntary Medication Statutes:

Title 18 §7624 <https://legislature.vermont.gov/statutes/section/18/181/07624>

Vermont Crimes and Criminal Procedure Statutes:

Title 13 Chapter 157: Insanity as a Defense: <https://legislature.vermont.gov/statutes/chapter/13/157>

Selected Vermont Supreme Court Decisions on Orders of Non-Hospitalization submitted by Legal Aid Mental Health Law Project:

In re J.M.R., 146 Vt. 409 (1985). Indeterminate order of non-hospitalization cannot be extended without a factual finding that the patient was potentially dangerous without treatment.

In re G.K., 147 Vt. 174 (1986). Persons on indeterminate orders of non-hospitalization have a due process right to review of their commitment. Provision for review of commitment only upon request of the patient was unconstitutional.

In re P.S., 167 Vt. 63 (1997). Order of non-hospitalization can be revoked without a showing of present dangerousness.

In re M.L., 167 Vt. 53 (1997). Order of non-hospitalization may not be revoked without a pre-deprivation hearing to establish need for rehospitalization.

State v. J.S., 174 Vt. 619 (2002). In a criminal case the state is not required to prove that there is no less restrictive alternative to hospitalization in order to justify inpatient commitment.

In re E.T., 177 Vt. 405 (2004). In deciding whether to extend an order of non-hospitalization the trial court may consider public safety and the consequences of discontinuing treatment.

In re T.S.S., 2015 Vt 55 (2015). To justify continued order of non-hospitalization state must prove both that the patient's condition is likely to deteriorate and that it will cause him to become a danger to himself or others in the near future without treatment.

Selected Unpublished Supreme Court Entry Orders and Trial Court decisions interpreting Supreme Court decisions regarding Orders of Non-Hospitalization submitted by DMH AAG:

Unpublished Supreme Court Entry Orders regarding Orders of Non-Hospitalization

State v. Koch., No. 98-281 (VT Supreme Court 1999) – Court finds that patient's history of rapid relapse and decompensation with ensuing danger supports a finding he was a "patient in need of further treatment." The Court acknowledges there was no prediction of when the next manic episode might occur and finds the testimony on the record "left little doubt" that the danger would arise in the near future.

In re T.B., No. 2009-238 (VT Supreme Court 2010) – Since the statute does not define "near future" lack of evidence as to a precise time when decompensation would occur to the point of danger did not make court's finding that the danger would arise "in a few months" an error. The Court found testimony that deterioration to danger would "necessarily and inevitably" arise supported the trial court's determination.

In re B.P., No. 94-437 (VT Supreme Court 1995) – The Court found that patient's decompensation with treatment provided, even though the patient mostly refused to participate in that treatment, did not support a finding that he was not receiving "adequate treatment" and therefore should be discharged. The Court therefore rejected the patient's argument he did not meet the definition of being "patient in need of further treatment" because his treatment was inadequate, but also found that even if the patient was correct in claiming his decompensation demonstrated his care was inadequate, "this could not form the basis for a discharge."

Trial Court decisions interpreting Supreme Court decisions re Orders of Non-Hospitalization

In re H.F., No. 154-10-15 Cnmh (Chittenden County) (12/28/15) – The Court concluded a prediction of danger "within months" of ending treatment is not sufficient to establish "the near future." The Court's opinion indicates it construed "the near future" as related to a needed to a need to find there was "imminent danger" though the imminent danger standard is required only for initial commitment. The Supreme Court in *P.S.*, 167 Vt. 167 (1997), held that subsequent commitment does not require showing of imminent danger, but instead a prediction danger will arise later due to a withdrawal of treatment. In a later entry of 4/13/16 the Court refused to change this ruling based on DMH's motion to alter and amend this decision. (Note: In August of 2016, this patient is charged with threatening a family with a knife on Cherry St. in Burlington and charged with the crime – a threat with a knife was the ground for her original commitment.)

In re A.B., No. 52-3-15 Cnmh (Chittenden County) (8/25/15) – The same Court from the *H.F.* case, above, found that decompensation to danger in three to four months satisfies the “the near future” criteria for danger arising from a withdrawal of treatment.

In re A.M., No. 107-7-15 Cnmh (Chittenden County) (7/22/15) – The same Court in *H.F.* and *A.B.*, above, found that “within 6 months” until decompensation to danger arising from a lack of treatment does not satisfy “the near future.” (Note: The patient was hospitalized after assaulting a woman with a cane 2 months later, with an ensuing order of hospitalization being issued by the criminal division within 3 months.)

In re M.L. I, No. 163-11-15 Cnmh (Chittenden County) (2/3/15) – Same Court as *H.F.*, *A.B.* and *A.M.* finds that an estimate of danger without adequate treatment arising “in days” and a danger to others arising in three to four months is within the near future.

In re M.L. II, No. 17-2-17 Cnmh (Chittenden County) (4/15/17)– Same Court as *M.L. I*, above, but a different judge found that that an estimate of danger to self or others within six months’ time without adequate treatment, is within the near future.

In re D.M., No. 25-12-15 Bnmh (Bennington County) (4/15/16) – The Court found that a decompensation in six to twelve months would not satisfy the “near future” criteria, though it also notes that the estimate was not made with great confidence, and there was no evidence available regarding prior decompensations without treatment. The court also suggested treatment had never been withdrawn before, so there could be no “hard” evidence of the effects the State needed to show. (Note: *D.M.* is now hospitalized by an Application for Involuntary Treatment (AIT) in Windham County – arising from threats to neighbors with conduct that is similar to her original commitment.)

In re J.G., No.69-4-16 Rdmh (Rutland County) (10/14/16) – The Court found that a patient would suffer “mental deterioration” in the near future without treatment, but proof did not show the deterioration would be “severe” and so State failed to prove “danger” to patient would arise in near future. (Note: *J.G.* was recently hospitalized and ordered medicated in November 2018.)

V. Existing studies and reports on patient outcomes - Sec. 3(c)(2)

Info found on: <https://mentalhealth.vermont.gov/news/order-non-hospitalization-study-committee>

1. An Assessment of Innovative Models of Peer Support Services In Behavioral Health To Reduce Preventable Acute Hospitalization And Readmissions, Prepared for Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, December 2015, <https://aspe.hhs.gov/system/files/pdf/205411/PeerSupServ.pdf>
2. "A systematic review of the effect of community treatment orders on service use," *Social Psychiatry and Psychiatric Epidemiology*, 2014: <https://www.ncbi.nlm.nih.gov/pubmed/24136002>
3. "Caring Coercion", *Psychiatric News*, September 2005: <https://mentalhealth.vermont.gov/sites/dmh/files/Caring%20Coercion%209-2-05.pdf>
4. "Community treatment orders for patients with psychosis (OCTET): a randomized controlled trial", *The Lancet*, March 2013 <https://mentalhealth.vermont.gov/sites/dmh/files/OCTET%20March%202013.pdf>
5. "Compulsory community and involuntary outpatient treatment for people with severe mental disorders," *Cochrane Database of Systematic Reviews*, 2017: https://www.cochrane.org/CD004408/SCHIZ_compulsory-community-and-involuntary-outpatient-treatment-people-severe-mental-disorders
6. "Effectiveness of Community Treatment Orders: The International Evidence", *The Canadian Journal of Psychiatry*; January 2016: [Effectiveness of Community Treatment Orders: The International Evidence. *Can J Psychiatry*. 2016;61\(1\):15-24.](https://doi.org/10.1177/0898010115601111)
7. "Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State", *Psychiatric Services*, February 2010: <https://mentalhealth.vermont.gov/sites/dmh/files/Effectiveness%20and%20Outcomes%202-2010.pdf>
8. Essential Elements Of Effective Integrated Primary Care And Behavioral Health Teams, https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKewi4-tOo9HcAhWymOAKHQ-4DLsQFjAAegQIABAC&url=https://www.integration.samhsa.gov/workforce/team-members/Essential_Elements_of_an_Integrated_Team.pdf&usg=AOvVaw0mvrBt-NdCyXjlkZESDN0C
9. "Ethics Considerations of Involuntary Outpatient Treatment", *Psychiatric News*, November 2016: <https://mentalhealth.vermont.gov/sites/dmh/files/Mental%20Health%20Court%20and%20Assisted%20Outpatient%20Treatment.pdf>
10. Examining the Relationship between Choice, Therapeutic Alliance and Outcomes in Mental Health Services, Stanhope, et al., <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4251393/>

11. “Five Year Outcomes of Tapering Antipsychotic Drug Does in a Community Mental Health Center”, Foundation for Excellence in Mental Health Care, August 2018:
<https://www.ncbi.nlm.nih.gov/pubmed/30074116>
12. "Life on hold': a qualitative study of patient experiences with outpatient commitment in two Norwegian counties," Issues in Mental Health Nursing, 2015:
<https://www.ncbi.nlm.nih.gov/pubmed/25898132>
13. “Mental Health Court and Assisted Outpatient Treatment: Perceived Coercion, Procedural Justice, and Program Impact”; Psychiatric Services; March 2014:
<https://mentalhealth.vermont.gov/sites/dmh/files/Mental%20Health%20Court%20and%20Assisted%20Outpatient%20Treatment.pdf>
14. Mental Health Court and Assisted Outpatient Treatment: Perceived Coercion, Procedural Justice, and Program Impact, M. Munetz, et al., March 2014,
<https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.002642012>
15. Recovery and Recovery Support, <https://www.samhsa.gov/recovery>
16. Reducing Psychiatric Inpatient Readmissions Using an Organizational Change Model, Connor, et al., June 2016, <https://www.ncbi.nlm.nih.gov/pubmed/27443087>
17. Treatment engagement of individuals experiencing mental illness: review and update, Dixon, et al., World Psychiatry, Feb 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4780300/>
18. Treatment engagement of individuals experiencing mental illness: review and update, Dixon, et al., <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4780300/>

VI. Existing data pertaining to orders of non-hospitalization - Sec. 3(c)(3)

This section of the report provides summary statistics and other information detailing the ONHs issued in Vermont each year, the courts that produced the them, the types of cases that result in ONHs, the duration of the ONHs issued, the case outcomes associated with the ONHs, and the number of community mental health services obtained by individuals who are placed on ONHs. Data analysis is based upon each individual fiscal year’s data and not a multi-year data set for longitudinal analysis.

Data from two Vermont Department of Mental Health (DMH) databases were analyzed to obtain the results presented below. The Law Manager database was used to identify all cases that were litigated by the state of Vermont and which either produced an ONH case outcome or were assigned an ONH matter type during FY17 and FY18. The Law Manager database also provided data elements pertaining to the individuals who were placed on ONHs and the case processing associated with each ONH. Statistical Package for the Social Sciences (SPSS) software was used to link Law Manager data to DMH’s Monthly Service Report (MSR) database in order to establish the number of individuals on and ONH who received community mental health services and to tabulate the number of community mental health services that each individual obtained while on an ONH.

Please note that Law Manger software was adopted and put into use by DMH in FY17. This limits the amount of longitudinal data available for analysis. However, similar archival data was also obtained for FY15 and FY16. However, with DMH’s implementation of Law Manager, DMH began maintaining more data related to ONH case processing and it began a stricter data integrity program in order to maintain higher data quality standards.

Each year the state of Vermont litigates or otherwise oversees an average of 324 cases that produce an order of non-hospitalization outcome. (See Table 1 below for specific annual totals for FY15 though FY18.) Most individuals who receive an ONH only receive one ONH, however, there is a small number of individuals who receive two, three, or sometimes even four ONHs per year. Approximately 85% of the ONHs issued in Vermont come out of civil court (i.e. family court) and the remaining 15% come out of criminal court.

Table 1
ONH Case Outcomes Summary

	FY2015	FY2016	FY2017	FY2018
Number of cases with ONH outcome	321	322	335	319
Unique people with ONH case outcomes	261	253	275	260
Unique people with ONH case outcomes who were involuntarily hospitalized	81	98	108**	97**
Range in Number of ONHs per Person	1 to 3	1 to 3	1 to 4	1 to 3
1 ONH	202	190	225	206
2 ONHs	58	57	42	49
3 ONHs	1	6	6	5
4 ONHs	0	0	2	0
Criminal/Civil Breakdown				
ONHs Issued in Civil (Family) Court	185	191	278	275
ONHs Issued in Criminal Court	32	28	57	44
Unknown	104	103	0	0
Number of Times a Criminal ONH Was Followed by a Civil ONH for the Same Individual	*	*	13	9

* - Missing data (pre-Law Manager)

** - Provisional Data

Tables 2 and 3 break out the number of ONH case outcomes that were issued by the county court and division that issued them.

Table 2

Number and Percent of ONH Case Outcomes by Superior Court Unit (Family Division)

FY17			FY18		
Venue	Frequency	Percent	Venue	Frequency	Percent
Washington Family Unit	44	15.8	Washington Family Unit	57	20.7
Windham Family Unit	44	15.8	Chittenden Family Unit	56	20.4
Rutland Family Unit	39	14	Windham Family Unit	39	14.2
Chittenden Family Unit	39	14	Rutland Family Unit	28	10.2
Windsor Family Unit	27	9.7	Orange Family Unit	15	5.5
Orange Family Unit	19	6.8	Franklin Family Unit	14	5.1
Franklin Family Unit	14	5	Caledonia Family Unit	13	4.7
Bennington Family Unit	13	4.7	Windsor Family Unit	13	4.7
Caledonia Family Unit	13	4.7	Lamoille Family Unit	12	4.4
Lamoille Family Unit	8	2.9	Orleans Family Unit	10	3.6
Addison Family Unit	7	2.5	Bennington Family Unit	9	3.3
Orleans Family Unit	7	2.5	Essex Family Unit	5	1.8
Essex Family Unit	3	1.1	Addison Family Unit	4	1.5
Missing	1	0.4	Total	275	100
Total	278	100			

Table 3

Number and Percent of ONH Case Outcomes by Superior Court Unit (Criminal Division)

FY17			FY18		
Venue	Frequency	Percent	Venue	Frequency	Percent
Chittenden Criminal Unit	24	42.1	Chittenden Criminal Unit	16	36.4
Windham Criminal Unit	10	17.5	Windsor Criminal Unit	7	15.9
Franklin Criminal Unit	5	8.8	Windham Criminal Unit	5	11.4
Washington Criminal Unit	4	7	Franklin Criminal Unit	4	9.1
Windsor Criminal Unit	4	7	Caledonia Criminal Unit	3	6.8
Lamoille Criminal Unit	3	5.3	Addison Criminal Unit	2	4.5
Addison Criminal Unit	2	3.5	Lamoille Criminal Unit	2	4.5
Orange Criminal Unit	2	3.5	Rutland Criminal Unit	2	4.5
Caledonia Criminal Unit	1	1.8	Bennington Criminal Unit	1	2.3
Essex Criminal Unit	1	1.8	Orange Criminal Unit	1	2.3
Rutland Criminal Unit	1	1.8	Orleans Criminal Unit	1	2.3
Total	57	100	Total	44	100

Table 4 presents the number and percent of the matter types that produced ONH case outcomes in FY17 and FY18. All ONHs coming out of criminal courts were produced by forensic evaluations. Civil ONHs were produced by either applications for continued treatment or applications for involuntary treatment.

Table 4
Number and Percent of Matter Types that Produce ONH Case Outcomes

FY17			FY18		
Matter Type	Frequency	Percent	Matter Type	Frequency	Percent
Application for Continued Treatment	232	69.3	Application for Continued Treatment	227	71.2
Application for Involuntary Treatment	43	12.8	Application for Involuntary Treatment	42	13.2
Forensic Evaluation	57	17	Forensic Evaluation	42	13.2
Missing Data	3	0.9	Missing Data	8	2.5
Total	335	100	Total	319	100

Table 5 displays the length of ONH matter types by year. Please note that the number of ONH matter types does not correspond with the number of ONH case outcomes issued in each year. This is due to the number of already existing ONHs that are modified within each year. Almost all criminal ONHs are issued for 90 days, but there is greater variability in the length of the order among civil ONHs.

Table 5
Length of ONH Matter Types by Year

	FY2015	FY2016	FY2017	FY2018
365 Days	78	64	139	122
270 Days	3	4	0	0
180 Days	74	74	80	103
90 Days	62	77	110	86
Other	8	9	31	19
Unknown	96	94	1	2
Total	321	322	361	332

From this point on in the report, the results are drawn from FY17. The choice to focus on one year of data was made so that more detailed analyses could be completed. FY17 was chosen because it was the first year that Law Manager data was available and because enough time had elapsed from the end of the fiscal year to allow for complete clinical data to be pulled from DMH's MSR database (i.e. clinical data that ran through the end of the last ONH that had been opened in FY17).

Table 6 breaks out the outcomes associated with ONH matter types in FY17.

Table 6
Number and Percent of Case Outcomes for ONH Matter Types In FY17

Case Outcome	Frequency	Percent
Application For Continued Treatment	210	58.2
Expired	87	24.1
Closed	4	1.1
Dismissed	3	0.8
Revocation	3	0.8
OH	1	0.3
Missing	53	14.7
Total	361	100

In FY17, there were 296 unique individuals with ONH matter types. In other words, irrespective of the number of ONHs issued in FY17, there were 296 individuals who had an ONH case opened. Of these 296 individuals, 282 were found in the MSR data for FY17 and FY18. (Note that a two-year clinical dataset was used for these analyses because a 365 day ONH was issued on the second to last day of the year in FY17.) This means that 95% of individuals with an ONH matter type that was opened in FY17 received community mental health services in FY17 or FY18. Additionally, 258 (87%) of these individuals received community mental health services during their respective ONHs.

The 296 individuals who had an ONH matter type opened in FY17 received a total of 104,917 community mental health services in FY17 and FY18. However, only 43,729 (42%) of these services were actually obtained while during and ONH. The remaining 61,188 (58.3%) were obtained either before an ONH began or, more likely, after an ONH ended. These findings call into question the notion that ONHs are coercive and do harm to the individuals who receive them.

Table 7 provides a categorical breakout of the number of community mental health services received by individuals while they were on an ONH for cases that were opened during FY17.

Table 7

Number of Community Mental Health Services Received During ONHs Among Individuals With ONH Matter Types Opened In FY17

Service Total	Frequency	Percent
None	24	8.5
1 to 5	17	6
6 to 10	14	5
11 to 25	28	9.9
26 to 50	34	12.1
51 to 100	48	17
100 to 150	27	9.6
151 to 250	35	12.4
250 or more	55	19.5
Total	282	100

VII. Propose a pilot project for the purpose of improving the efficacy of orders of non-hospitalization - Sec. 3(c)(4)

1. Pilot #1 – Alternative Enhanced Voluntary Treatment for individuals who would be placed on an ONH

Disability Rights Vermont and Family Member committee representatives put forward a recommendation that funding be authorized for the creation of two ONH pilot projects in different parts of the state focused on augmented treatment and support services. The pilot projects would use person-centered, recovery-based approaches for individuals who would otherwise be on an ONH in the community. The multi-faceted service package would include:

- (1) Real, active and sensitive outreach

- (2) Mental health services
- (3) Vocational assistance
- (4) Education concerning family issues
- (5) Information to develop wellness skills
- (6) Peer support services, and
- (7) Housing supports

The proposal specifies that these services should be provided by mobile, multidisciplinary teams in the community. As part of evaluation of effectiveness, the proposal was that the pilot projects should be reviewed by a committee of stakeholders identified by the Legislature.

2. Pilot #2 – Deleted. Full text available in the DMH Position Statement

Section VII Pilot Project Proposal:

Pilot #1 will clearly require additional, focused resources for implementation of the project proposal. Committee support/endorsement for Pilot #1 is greatest as there is no element of coercion reflected beyond the continued existence of ONHs. Committee majority recommended that the legislature consider providing the resources necessary to fully implement Pilot #1.

In order to evaluate the efficacy of Pilot #1, the pilot would be expected to have clear expectations for comprehensive data collection and analysis, an unbiased evaluation process, and include regular stakeholder engagement and review of measurable outcomes. The expectation would be that the pilot establish these parameters prior to any new allocated resource expenditures, if approved by the legislature.

VIII. Recommend any changes necessary to approve the efficacy of orders of non-hospitalization - Sec. 3(c)(5)

1. ONH Process Efficiency

One identified and endorsed accomplishment, resulting from the ONH committee meeting discussions, was revision in the ONH communication process with the courts regarding change requests when individuals are not adhering with the conditions outlined in their ONH. A sub-group of the committee worked together to improve the process around ONH revocation and modification proceedings in the Vermont Superior Court Family Division.

The earlier process made no distinction as to whether a revocation or modification was being requested. Also, the process did not specifically ask for one of those things as the filing was titled a “Notice of Non-Compliance,” because that is the language used in the statute. Judicial members on the committee felt re-titling the filings as motions (for revocation or modification) and filing separate motions for a status

conference or hearing would provide court clerks with a better understanding of what was being requested as well as the urgency in getting the matter before a judge.

Going forward in applicable cases, the Commissioner will file a motion specifically requesting the modification or revocation of an individual's ONH. The motion will be accompanied by either a motion for status conference or expedited hearing depending on the circumstances of the case. The court filing will include a certificate completed by a member of the individual's outpatient treatment team outlining the basis for the relief sought. The certificate and filing will provide greater context for the court. DMH anticipates rolling out the new forms, once the designated agencies have been apprised of the changes and the judiciary has been notified, likely by the end of this year.

2. Mental Health representation in Criminal Court Hospitalization Hearings

The Vermont Care Partner (VCP) and Mental Health Law Project Representatives put forward a more ambitious improvement of the existing ONH process. One of the identified issues with Vermont's current ONH structure is the difference between ONHs issued out of family court versus ONHs issued out of criminal court. While ONHs can be issued out of two different courts, the state and the person subject to the order are not represented by the same people in those two different settings.

When an ONH is issued out of family court, the State is represented by Assistant Attorney Generals (AAG) from DMH. These attorneys primarily work with the mental health statutes that govern involuntary commitment. In these cases, the respondent is represented by the Mental Health Law Project by an attorney who primarily works with the same mental health statutes that the AAG is versed in. When an ONH is issued out of criminal court, the State is represented by the State's Attorney and the defendant is represented by, most often, a public defender. Both the prosecutor and the defense attorney handle a variety of criminal cases, not just those with a mental health component.

When ONHs are issued, regardless of what court they come out of, they contain a number of conditions. According to the VCP representative, these conditions typically include "stay in treatment", "take all prescribed medications", "live in approved housing" and other clinically based conditions. Every ONH contains the name of a DA that is tasked with providing treatment as well as oversight of compliance with the conditions within the ONH. While the respondent or defendant is under the care and custody of the Commissioner of the DMH, it is the DA within the county where the defendant resides that provides direct treatment and oversight. If the respondent/defendant is not compliant with the conditions contained in the order, it is the DA that is required to report that non-compliance to DMH. It is the DA that is directly responsible for the respondent/defendant.

The VCP representative asserts that communication with the DA is critical to an ONH being effective. When a person who is potentially subject to an ONH is known to the agency, the agency's input into what types of treatment will be most effective and/or complied with will factor into what conditions are contained within the ONH. It is the person who is not known to the DA that presents the greatest challenge in attempting to fashion an ONH that will provide necessary treatment and be adhered to.

She notes that when ONHs are issued out of family court it is usually the result of a person no longer requiring hospitalization. These individuals are being discharged into the community to be treated by their local DA. This handoff between the hospital and the community is most often a "warm" handoff. The treatment team at the hospital will have had at least one conversation with the person's treatment

team at the DA. Because of these conversations, the DA has input into the conditions of the ONH. She identifies that this is a stark contrast to ONHs that are issued out of criminal court.

She asserts that when ONHs are issued out of criminal court, it is most often because a defendant has been found incompetent or insane and the State's only recourse is to dismiss the criminal charges. When charges have to be dismissed because of incompetency, the source of that incompetency is not always because of a mental illness. A defendant could be incompetent because of an intellectual disability, a traumatic brain injury, or dementia, to name a few alternatives. Some defendants found incompetent can have their competency restored, but this process can take some time. After a finding of incompetency or insanity, a hospitalization hearing will occur in criminal court where a decision is made regarding whether the defendant needs to remain or be in a hospital, be treated in the community on an ONH, or receive no treatment. If the incompetency finding is the result of something other than a mental illness, she asserts that it is not appropriate to place a defendant on an ONH as the involuntary treatment statute specifically excludes persons with an intellectual disability. She notes that not all State's Attorney's and Public Defenders are aware of this statutory requirement.

She remarks that while communication has improved as of late, it is the overall experience of the designated mental health agencies that when a criminal defendant is being considered for an ONH because of either incompetency or insanity, there is no communication or very little communication at all with DA's regarding the efficacy of an ONH with a particular defendant. She reports that defendants found incompetent in criminal court have appeared at mental health agencies, ONH in hand, to be treated according to the conditions of the ONH. The agency providing the treatment may have had absolutely no prior knowledge of this person. The agency often has had no input at all into the conditions of the ONH. She opined that if the DA had been contacted by the attorney handling the case prior to the hospitalization hearing, they would have been able to provide valuable input into the process.

(See Section IX for statutory change considerations.)

3. States Attorney Input on Criminal Court ONH

In contrast, the States Attorney representative offers that there are various stakeholders who observe that ONHs have little influence in helping a person maintain engagement in mental health treatment; that mandating mental health treatment through court order generally is ineffective, and that persons placed on ONHs as a result of criminal proceedings generally do not engage effectively with DA's. Rather than placing criminal defendants who are found incompetent to participate in legal proceedings or are acquitted by reason of insanity on ONHs administered by DA's, the States Attorney representative suggests it would better serve the public interest for this population to be subject to risk assessment, community-based risk management and response supervision, and risk reduction programming, directly administered by a public agency of the State, informed and supported by mental health care and treatment principles.

He notes that a core principle underlying the criminal justice system is that persons who engage in criminal conduct may pose risk to public safety. A primary response as embodied in the criminal law is to subject those who commit offenses to supervision aimed at reducing risk in a manner proportionate to the criminal conduct the offender committed, with the goals, among other things, of protecting public safety and rehabilitating the offender. Like other members of the population,

criminal defendants who are found incompetent to participate in legal proceedings or acquitted by reason of insanity may pose risk to public safety, and it reasonably can be concluded that they too should be subject to risk assessment, supervision, and programming with the goals of protecting public safety and rehabilitation. He asserts that is not the structure established by current Vermont law. Chapter 157 of Title 13 of the Vermont Statutes, titled "Insanity as a Defense," and identifies the circumstances under which a defendant charged in a criminal case is to be found incompetent to participate in legal proceedings or acquitted by reason of insanity. A person is not competent if they do not have a factual or rational understanding of the proceedings and therefore cannot assist counsel with their defense. A finding of insanity is proper when, as a result of mental disease or defect, defendant lacks adequate capacity either to appreciate the criminality of their conduct or to conform their conduct to the requirements of law.

He further notes that under Chapter 157, a defendant who is incompetent or insane and meets the definition of a person in need of treatment or a patient in need of further treatment under 18V.S.A. § 7101(16&17) is admitted to the care and custody of the DMH for treatment for an "indeterminate period" under a commitment order that has the same force and effect as an order issued under 18 V.S.A. § 7611-7622. For the reasons he noted regarding various stakeholders, however, he asserts the treatment paradigm established by this statutory commitment structure has proven ineffective. Similarly, for a series of reasons, he contends the current structure established by Chapter 157 does not adequately address the potential risks to public safety potentially presented by defendants who are found to be incompetent or insane.

Further, he outlines that under the structure established by Chapter 157 applicable to defendants who are found to be incompetent and insane due to mental illness and Chapter 207 of Title 18, DMH delegates administration of its custodial authority under ONHs issued in criminal cases to DA's, which are non-governmental agencies responsible for delivering mental health treatment services to community members. Based on confidentiality laws, Vermont's prosecutors do not have the ability to monitor the ONH care and treatment provided by DA's to defendants who are found to be mentally ill and incompetent or insane. However, he reports it is the experience of Vermont's prosecutors that DA's are not structured or funded in a manner that enables them to mandate and execute effective risk assessments, community-based risk-related supervision, and risk reduction programming for defendants found to be incompetent or insane. The States Attorney representative alleges, as a result, there is a significant rate of criminal recidivism among the population of defendants who are found incompetent or insane and placed in the care and custody of DMH on ONHs.

Additionally, he notes structural defects in Chapter 157 that further weaken its effectiveness. Both as written and applied, Vermont law established by Chapter 157 does not provide for commitment of all offenders who are found to be incompetent or insane to the custody of either DMH or DAIL. Rather, he outlines that Chapter 157 establishes a binary system: Under 13 V.S.A. § 4822, defendants found to be incompetent or insane are committed to DMH custody only if they meet criteria as a person in need of treatment or a patient in need of further treatment pursuant to 18 V.S.A. § 7101(16&17); and, under 13 V.S.A. § 4823, individuals who have a developmental disability as defined by law or traumatic brain injury and are found to be incompetent or insane are committed to DAIL custody under Act 248 only if they have inflicted or attempted to inflict serious bodily injury to another or committed sexual assault or lewd and lascivious conduct against a child, and DAIL is prepared to pay for their programming. See *In re D.C.*, 159 Vt. 314, 320 (1992) (18 V.S.A. § 8839(3) authorizes DAIL to decline based on fiscal considerations to provide custody, care, and habilitation to developmentally disabled person who poses danger of harm to others).

He argues that by its plain language, this binary statutory structure leaves a substantial group of defendants who are found incompetent or insane and do not meet these criteria not subject to any custody, because the categories of person in need of treatment, developmental disability, and traumatic brain injury do not cover all circumstances where persons who are found incompetent or insane. He opines that DMH and DA's generally take the position that defendants who have co-occurring disorders, including autism spectrum, and found ill incompetent or insane, should not be placed on ONHs, and that various cognitive conditions including dementia, Alzheimer's and encephalopathy do not fall within the definition of mental illness. Pursuant to 18 V.S.A. § 8839(1), defendants who have a developmental disability and found to be incompetent or insane are not subject to Act 248 jurisdiction unless they fall at least two standard deviations below the mean with respect to intellectual capacity and adaptive functioning, which leaves a subgroup of persons who have a developmental disabilities who commit crimes subject to no form of State custody, oversight, or involvement. He contends that DMH and DAIL also take the position that persons who commit crimes in Vermont but live outside Vermont are not subject to DMH or DAIL custody.

Overall, he reports that it is the experience of Vermont's prosecutors that these limitations leave a substantial group of defendants who are found to be incompetent or insane without any form of involvement with the State flowing from their criminal conduct, not subject to any form of DMH, DAIL, or other custody. Despite the potential harm to public safety demonstrated by these offenders' criminal behavior, including recidivist criminal behavior, the State Attorney representative repeated his assertion that Vermont law does not provide for risk assessments, supervision, or programming when they are found incompetent or acquitted based on insanity. In these circumstances a crime is committed in Vermont, but Vermont law creates no remedy.

He acknowledges that many mental health conditions wax and wane; and Chapter 157 of Title 13 does not establish any mechanism for informing prosecutors or the court whether a person who has previously been found incompetent may now be competent, and therefore capable of participating in proceedings where criminal responsibility can be determined. Accordingly, he identifies that a finding of incompetency in Vermont often removes a criminal case from the criminal justice system without any mechanism for ensuring its return when defendant is competent. He outlines that the structural inadequacy of the current intersection between the criminal justice and mental health care systems in Vermont is exacerbated by Vermont Supreme Court decisions that highlight the lack of compatibility and weaken the links between these systems.

The State Attorney representative outlines that Chapter 157 provides for commitment of incompetent or insane defendants to DMH care and custody for an indeterminate period, with notice to the prosecutor and the potential for a hearing before discharge from DMH custody pursuant to 13 V.S.A. § 4822(c) if the crime involved violence or a threat thereof. In State v. Mayer, 139 Vt. 176, 178-79 (1980), however, the Supreme Court construed indeterminate commitment to mean an initial 90-day commitment period followed by subsequent commitment orders not exceeding one year. Then, in State v. B.C. & D.H., 2016 VT, the Supreme Court held that the Section 4822(c) discharge hearing requirement only controls when a defendant who is found to be incompetent or insane is being discharged before the expiration of the term of a commitment order.

These decisions effectively sever any ongoing coordination or link between the mental health and criminal justice systems in Vermont after findings of incompetency or insanity. Many criminal defendants who are found to be incompetent or insane do not actively engage with DA's after being placed on ONHs, and little effective interaction may have occurred between a defendant and a DA during the initial 90-day ONH commitment period. Unless the criminal case involved personal injury or threat thereof, Chapter 157 as written does not provide for notice to the prosecution when

an ONH expires, whether after its initial 90-day term or as extended in Family Court proceedings to which the prosecution is not a party. Pursuant to B.C. & D.H., even in cases involving bodily injury or threat thereof: notice to the prosecution is not provided and discharge hearings are not convened if DMH allows an ONH to lapse at the end of its term without seeking its renewal, including at the end of its initial 90-day term.

In summary, he asserts that the practical impact of these statutes and Supreme Court rulings is that DMH is now vested with unreviewable discretion to allow an ONH to lapse when it expires at the end of its initial 90-day term or the end of a such other period for which it was extended by Family Court, without notice to the prosecutor, court oversight, or public review. He further asserts that the system created as a result can ultimately leave a defendant who has a mental illness and found to be incompetent or insane without any form of mandatory State oversight or involvement within a period of just 90 days after commitment to DMH custody, without effective risk assessment, supervision, or programming. Moreover, no mechanism exists to provide notice to the court and the parties in the criminal case that circumstance may warrant re-evaluation of defendant for competency. He reiterates that the system created by Chapter 157 similarly fails to vindicate victim's rights. Under Chapters 165 and 167 of the Title 13 of the Vermont Statutes victims have a wide range of rights, including to receive notice about court proceedings and status of the case, to be present in the courtroom, to restitution for damage directly caused by the crime, and to offer comment on dispositions and potential delays in proceedings. Crimes committed by defendants who are found incompetent and insane can cause injury, including serious injury, to victims. However, victims do not have comprehensive rights under Chapter 157 if the defendant who perpetrated crimes against them is found incompetent or insane, whether placed in DMH or DAIL custody or not. He identifies that victims: do not receive notice of the nature of the interaction between defendant and DMH; are not entitled to notice when the defendant's custodial status is ending, and why; do not have the right to communicate to the court about the impact of these crimes and their positions about dispositions and delays; and finally, do not receive restitution.

(See Section IX for statutory change considerations)

4. Other Considerations Discussed

During meeting discussions, a variety of efficiencies were identified that could be undertaken with modest effort or cost.

- For issues regarding inconsistencies within family courts, the idea of trainings in counties viewed as outliers based on low frequency or number of ONH proceedings was well received by members (Efficiency #1 this section). Opportunities to interact with local courts and personnel and partnering with local DA's was viewed as opportunities for positive communication and cross-pollination of "system glitch" areas for potential problem-solving as they occur.
- Along the training/education options, there was also discussion of more information being made available to individuals about psychiatric advance directives and the completion of these advance directives. Too few individuals take advantage of these legally binding documents that clearly articulate their wishes during periods of psychiatric emergency and hospitalization.
- Resource investment remained an ongoing theme throughout discussions as the more options and alternatives available to individuals for voluntary engagement decreases the need or likelihood for more coercive ONH conditions being imposed. There was support for respite, resources, and

information for individuals who choose to seek medication reduction or non-medication alternatives to be increased. Some committee members felt that any need for an ONH represented a system failure and should be addressed through greater investments in services that individuals wanted to voluntarily engage with and tailored to their individual needs. Some of these considerations are captured in the Pilot Proposal section of this report.

- While not the focus of this committee's discussions, the numbers of individuals with mental health needs who found their way into the correctional system was sometimes seen as one of the only remedies available to promote engagement for individuals who are unwilling to engage treatment services. To that end, members of the committee supported that individuals in corrections with mental health treatment needs, should have comparable access to treatment services and improved treatment practices that meet their needs while incarcerated.
- Members of the Judiciary identified at a new Information Technology initiative was underway and would be statewide within the next three years, addressing some of the data collection challenges identified by the committee.
- There was also interest by some committee members in studying the effectiveness of ONH conditions over time. The committee members felt that all pilots put forward should carry expectations for solid data collection, evaluation, and analysis for both individual and system outcomes over time.

Section VIII Recommendations:

Training for local family courts regarding development of new forms for better communicating the need regarding ONH modifications or changes was supported by committee members. Ongoing dissemination of information regarding psychiatric advance directives was also supported by committee members. There was not consensus by committee members to advance recommendations for the VCP/Legal Aid Mental Health Law Project Proposal or the States Attorney Proposal during the meetings.

It was the recommendation of the majority of the ONH committee members that the Legislature seriously review and consider the VCP/Legal Aid Mental Health Law Project recommendations as there appeared to be only one dissenting opinion, from the Department of States Attorneys and Sheriffs representative, for full member consensus. Further work in this area would need to be undertaken to develop suitable compromise recommendations that appreciate the interests of the constituencies represented. All content taken into account, Section IX addresses some of the statutory changes required for proposals put forward.

IX. Identify statutory changes necessary to implement recommended changes to orders of non-hospitalization - Sec. 3(c)(6)

1. Elimination of ONHs in Vermont

The mission of Vermont Psychiatric Survivors is to provide advocacy and mutual support that

seeks to end psychiatric coercion, oppression and discrimination. Involuntary outpatient commitment is on its face coercive, and the arguments for its use further oppression and discrimination against those marginalized by having received psychiatric labels.

The Vermont legislature has codified its intention “to work toward a mental health system that does not require coercion or the use of involuntary medication.” VPS, therefore, calls on the state to strike from the books legislation that allows for court-ordered outpatient treatment, or orders of non-hospitalization, and join Connecticut, Maryland, Massachusetts, and Tennessee in resisting the punitive and paternalistic model put forth by the Treatment Advocacy Center and other proponents of force.

Our position is based on:

- Research indicating that involuntary outpatient commitment does not improve outcomes compared with voluntary services;
- The harmful effects of long-term neuroleptic use common among outpatient court orders;
- The disruption of the therapeutic alliance with providers and further institutionalization of service users and survivors; and
- The threat to privacy, liberty, and independence, which has been condemned by human rights organizations including the United Nations.

We recommend that the state refocus on providing more and better voluntary supports including housing subsidies, peer-operated crisis respites, support for psychiatric drug withdrawal, and stronger protections for psychiatric advance directives.

Overview

It is agreed in clinical practices that the only effective treatment is engaged in voluntarily with informed consent. Anything else should be referred to not as “treatment” but rather as social control. In this committee, we have heard arguments for engaging in this type of social control based on assumptions of the criminality and dangerousness of those labeled with a mental illness.

For example, the state’s attorney’s office suggests that people found not competent to stand trial or not guilty because of psychiatric disability should be subject to supervision that is at least as onerous as the criminal supervision they would have been under if found guilty. Civil commitment orders are no less punitive than criminal court orders. The vast majority of ONHs represent “treatment” imposed to curtail behaviors that do not break any laws.

Last year, the Vermont legislature found in S.3 (Act 51) that “the overwhelming majority of people diagnosed with mental illness are not more likely to be violent than any other person; the majority of interpersonal violence in the United States is committed by people with no diagnosable mental illness.”

Nevertheless, unlike any other class of person, people with psychiatric labels may be detained, drugged, and/or monitored based on what we *might* do, whereas in the criminal justice system we must be convicted of a crime in order to be punished. A person convicted of a crime may serve a finite sentence based on that conviction, whereas our peers serve indefinite sentences locked in institutions or forced into outpatient psychiatric intervention and surveillance, based on a mere prediction of dangerousness.

Clinicians cannot predict dangerousness, as several studies have shown. One recent study found that standardized risk assessments could not predict violence among discharged forensic

patients. Its authors assert that, even with the development of new risk assessment instruments, there is little evidence they are any better than their predecessors.

When someone chooses not to follow a given treatment plan, it's most often because that plan is not working for them. Rather than force compliance with treatment that is not perceived as helpful, the standard of care should be to improve services so as to make them desirable.

Resorting to coercion means that the system has failed to provide adequate services to begin with.

A few years ago, when the Murphy bill was making its way through Congress, Vermont Congressman Peter Welch joined 19 other House Democrats in a letter opposing provisions of the bill that restricted civil rights, particularly what the TAC calls "assisted outpatient treatment." They wrote, "The use of the court system and law enforcement to force individuals into care is a dramatic departure from how individuals, particularly those who pose no imminent threat to themselves or others, obtain health care services in this country."

In a letter dated Jan 18, 2000, then-DMH Commissioner Rod Copeland wrote about why Vermont's mental health system was not more successful at reducing coercion and its negative impacts: "I believe a major part of the answer lies in the overemphasis, even dependency, in our treatment and rehabilitative practices on power, control, paternalism and, ultimately, coercion." Here we are, almost two decades later.

ONH Benefits and Harm

Studying the current ONH system in terms of "strengths and weaknesses" is a misguided effort. A "strong" ONH system can be a harmful one with few benefits, and a "weak" one does not necessarily require strengthening as much as questioning why it even exists. Instead, we ask whether the current system is beneficial or harmful to those who are subject to it, and in what measures.

Research into the outcomes of coercive treatment is sorely underfunded given that the pharmaceutical industry subsidizes the majority of studies related to psychiatric interventions. Studies showing a benefit to involuntary outpatient treatment have been determined by researchers to have faulty research designs such that the conclusions drawn are not supported by the studies.

A systematic review by the Cochrane Schizophrenia Group published in 2017 of all relevant randomized controlled clinical trials included only three small trials comparing involuntary outpatient commitment with voluntary treatment in the community. Cochrane reports: "Results from the trials showed overall CCT [compulsory community treatment] was no more likely to result in better service use, social functioning, mental state or quality of life compared with standard 'voluntary' care." A 2014 review of 18 randomized and non-randomized studies found a "lack of evidence ... that CTOs [community treatment orders] are associated with or affected by admission rates, number of inpatient days or community service use." So with no added benefit, we need to ask whether involuntary outpatient commitment causes any harm.

Outpatient commitment frequently involves medication with neuroleptics (major tranquilizers also called antipsychotics). For decades now, we have known about the large percentage of patients treated with these drugs that develop tardive dyskinesia, a chronic, often permanent neurologic disorder characterized by loss of voluntary muscle control. There is also ample evidence of damage to the highest centers of the brain, causing dementia and psychosis. They have been shown to cause brain atrophy, Parkinsonian symptoms, akathisia, cognitive impairment, and metabolic disorders, contributing to the reduced average life expectancy of those labeled with mental illness.

Citing a recent Cochrane review on antipsychotic maintenance treatment and a randomized clinical trial by Wunderink and colleagues, Shawn S. Barnes, M.D., and Nicolas Badre, M.D., write in *Psychiatric Services*, “if a clinician is considering compulsory long-term use of these side effect–laden medications against a patient’s will, with the threat of involuntary psychiatric hold if the patient is noncompliant, then it is our opinion that the evidence for the long-term use of these medications should be far stronger than that provided in the current literature.”

Forced outpatient interventions alienate service recipients from care providers and disrupt any possibility of therapeutic alliance. The threat of force deters others from seeking treatment voluntarily.

Very little data have been collected on the experiences of those directly impacted by outpatient commitment orders. A recent study in Norway found that patients subject to these orders felt like their lives were “on hold.” Their compulsory “treatment” got in the way of taking control of their own lives, and the conditions imposed by mental health providers actually reduced their quality of life. In our own experience working with our peers on ONHs, the court orders contribute to feelings of hopelessness, loss of autonomy, an increase in suicidal thoughts, and for some, increased trips to the ER because of these intensified feelings of powerlessness.

From a budget perspective, any forced or coercive interventions—whether inpatient or outpatient—divert resources from those who would access them willingly.

Human Rights Violations

Beyond the question of whether ONHs are effective is whether they constitute a severe threat to the privacy, liberty, and independence of the people subjected to them. Achieving a desired outcome is not a standard by which we measure the ethicality of an intervention.

Globally, involuntary treatment is coming under increasing scrutiny. The United Nations Convention on the Rights of Persons with Disabilities has concluded that “forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law” protected by Article 12; therefore, signatories “must abolish policies and legislative provisions that allow or perpetrate forced treatment.” The UN Special Rapporteur on Torture called on all states to “impose an absolute ban on all forced and non- consensual medical interventions against persons with disabilities, including the non- consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application.”

On the Ground in Vermont

In the absence of formal studies showing ONH outcomes for Vermonters, VPS can offer what we have observed and the first-hand testimonies of those we serve. As the survivor-led, membership-based advocacy organization in the state, we come into regular contact with people subject to ONHs, whether on inpatient units or in the community, and have a unique perspective on how they are impacted by the process.

What we regularly hear is that people involved in this process lack even the most basic information about the ONHs they are placed on. Several individuals have described a bewildering process. When stipulating to an ONH, they don’t feel as if they have a choice. They describe decisions

made for them without their input or knowledge, decisions that are barely explained. Once discharged from the hospital, they seek guidance from case workers or psychiatrists to explain the conditions. Rumors among service users abound: that you can never get off an ONH, that you cannot leave the state, etc. Those who manage to become informed realize that it exists primarily as a threat—something providers can hold over their heads if they don't "comply." One individual stated, "I think my life would've been the same without it [the ONH]. I think if they would've just sat down and talked to me, I would've listened. ... The idea of someone telling me what to do doesn't sit well with me."

The current issue of *Counterpoint* has a telephone poll asking readers whether ONHs are of value to psychiatric survivors. One person responding to the poll via phone commented, "They're useless, and we should just get rid of them." As of this writing, the Facebook poll asking this same question has 41 votes, 98% responding "no."

Recommended Strategies

The practice of involuntary outpatient commitment doesn't need to be replaced by anything. Under the Hippocratic Oath, "first do no harm" is a directive to begin by not engaging in any harmful practice. However, many of us on this committee would presumably like to go beyond simply not doing harm and would like to provide the needed support for people in our communities who are struggling. We have several evidence-based recommendations that the state can implement to help Vermonters achieve their goals of wellness and autonomy.

- VPS has identified lack of affordable housing as a primary driver of distress and instability among our peers. Subsidized housing and basic income have been shown to result in fewer ER visits, inpatient stays, health problems overall, and interactions with law enforcement. One peer we spoke with recently said that his ONH helps ensure that he will be housed, that without it he would likely be without housing. How much better would it be for everyone if he could get the supports he needs without an unnecessary and punitive court order?

- For those for whom psychiatric interventions have been helpful and who want to adhere to a treatment plan, psychiatric advance directives are a way to formalize their wishes for treatment when deemed to lack capacity to make healthcare decisions. In the event that legal capacity is not absent, everyone should retain the right to opt in or out of care and services. Holding regular statewide advance directive clinics could make this practice more widespread, relieving the state from the responsibility for making healthcare decisions on our behalf.

- Data show that most people who take neuroleptics will attempt to stop taking them at some point. Withdrawal can be accompanied by a range of physical, cognitive, and emotional symptoms. Without information and support for coming off psychiatric drugs, many people become caught in a disruptive cycle of stopping their use of drugs they find harmful or unhelpful, experiencing withdrawal, and then being hospitalized and court-ordered to resume taking them. We need community-based supports, from both our peers and providers, for coming off psychiatric drugs in the safest, best informed way possible. Many psychiatrists, including Vermont's own Dr. Sandra Steingard, are looking into the practice of patient-centered de-prescribing as a harm-reduction measure.

- Peer-operated crisis respites provide better outcomes than hospital stays, can be developed rapidly using existing peer-run networks, and cost far less than inpatient care. Vermont currently has only one peer-based crisis respite with two beds, serving 50 individuals per year and

turning away more than half that many because those beds are occupied.⁹ Others have not been able to access this resource because they lack transportation to its remote, low- population location. VPS is proposing to the Agency of Human Services the creation of six additional respites throughout the state where they are needed most and can be accessed most easily.

In the event that the legislature does not immediately retire the ONH statutes, we would like to recommend two measures that would help reduce the harm to those subjected to them:

- Provide for a sunset clause that would allow ONHs to be terminated upon completion. Do not allow them to be renewed indefinitely on the meager grounds that “the patient doesn’t believe they are ill,” as is the current practice.
- Conduct annual surveys of Vermonters subject to ONHs in order to monitor the process and get input from those directly affected. This is best done by contracting with an independent organization conducting interviews using peer advocates.

All citations associated with this position paper are available at the following link:

https://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Vermont_Psychiatric_Survivors_Position_ONH_Statutes.pdf

2. Family and Criminal Court ONH – Section VIII, Efficiency #2

To rectify the inequity between family and criminal court as outlined in the VCP and Legal Aid Mental Health Law Project Proposal in Section VIII, the following statutory amendment/s would be required:

Sec. 1. 13 V.S.A. § 4820 is amended to read:

§ 4820. HEARING REGARDING COMMITMENT

(a) The court before which a person is tried or is to be tried for a criminal offense shall hold a hearing for the purpose of determining whether the person should be committed to the custody of the Commissioner of Mental Health or, as provided in 18 V.S.A. chapter 206, to the Commissioner of Disabilities, Aging, and Independent Living, if the person is charged on information, complaint, or indictment with the offense and:

(1) is reported by the examining psychiatrist following examination pursuant to sections 4814–4816 of this title to have been insane at the time of the alleged offense;

(2) is found upon hearing pursuant to section 4817 of this title to be incompetent to stand trial due to a mental illness, ~~intellectual~~ developmental disability, or traumatic brain injury;

(3) is not indicted upon hearing by grand jury by reason of insanity at the time of the alleged offense, duly certified to the court; or

(4) upon trial by court or jury is acquitted by reason of insanity at the time of the alleged offense.

(b) A person subject to a hearing under subsection (a) of this section may be confined in jail or some other suitable place by order of the court pending hearing for a period not exceeding 15 days.

(c) For a person who is found upon hearing pursuant to section 4817 of this title to be incompetent to stand trial due to mental illness or developmental disability, or insane at the time of the crime, the court

shall appoint co-counsel from the Mental Health Law Project to represent the person who is the subject of the proceedings and from the Office of the Attorney General to represent the Agency of Human Services in the proceedings.

Sec. 2. 13 V.S.A. § 4821 is amended to read:

§ 4821. NOTICE OF HEARING; PROCEDURES The person who is the subject of the proceedings, his or her attorney, the legal guardian, if any, the Commissioner of Mental Health or the Commissioner of Disabilities, Aging, and Independent Living, and the ~~State's Attorney or other prosecuting officer representing~~ counsel appointed pursuant to subsection 4820(c) of this title to represent the State in the case, shall be given notice of the time and place of a hearing under 4820 of this title. Procedures for hearings for persons who are mentally ill shall be as provided in 18 V.S.A. chapter 181. Procedures for hearings for persons who are intellectually disabled or have a traumatic brain injury shall be as provided in 18 V.S.A. chapter 206, subchapter 3.

3. Criminal Court ONH – Section VIII, Efficiency #3

Two considerations are advanced by the States Attorney Representative and are as follows:

Consideration #1: New ONH Structure

- Commit defendants who are found to be incompetent or insane to the custody of a public agency whose role includes direct community supervision and protection of public safety. This public agency would conduct effective risk assessments, engage in community-based supervision under risk response and management models, and provide appropriate risk reduction programming, including anger management, sex offender, batterer's intervention, reparative, and substance abuse treatment groups with accommodations tailored to participants' needs.
- Recommend that this responsibility be within the Department of Corrections (DOC). DOC probation and parole field offices would need additional personnel with experience in delivery of mental health care assigned to support this case load.
- DMH would retain custody and responsibility for criminal defendants requiring hospitalization.
- Mechanisms for referrals from DOC to DA's for additional support, and for ongoing working relationships between DOC and DA's, would need to be established.
- A due process hearing would have to be available before commitment of defendants who have been found to be incompetent or insane to DOC custody to protect defendant's rights:
 - Absent a defendant's consent to DOC supervision, a system should be established that provides for a merits hearing in public in Criminal Division, where the State has the burden to prove commission of the criminal conduct by a preponderance of the evidence.
 - Periodic review would occur thereafter, also in a public proceeding in Criminal Division, including the possibility of ending the supervision early or extending it past the end of the otherwise applicable term of the commitment order if circumstances including the interests of public safety warrant.
 - Notice and periodic review whether defendant may have regained competency would also be addressed in these proceedings.
- The appropriate length of supervision should be determined by reference to the potential sentence assigned by the legislature for the criminal offense, which is a proxy for the extent of the potential harm to the community caused by criminal conduct, rather than an arbitrary 90-day or one-year period.

- Additional provisions should be added to the law allowing victims to communicate to the court about the impact of crimes committed against them by defendants who are found to be incompetent or insane and victim's views on dispositions and delays.
- The rights of victims to receive restitution also should be protected.

Consideration: #2 Existing ONH Structure with Modifications

If current ONH structure is unchanged, Vermont's State's Attorneys recommend a series of statutory amendments to Chapter 157 of Title 13 to make the system more effective.

- Notice provisions should be added to Chapter 157 to ensure that prosecutors and the court are informed whenever the custodial relationship between DMH and a defendant who is found to be mentally ill and incompetent or insane is ending, whether by discharge or on expiration of the term of the ONH. This notice would allow the prosecution to seek renewed evaluation whether defendant is now competent and enable notification of victims about the status of cases.
- Provisions should be added to Chapter 157 clarifying that the discharge hearing requirement under 13 V.S.A. 4822(c) applies not just upon early termination of an ONH, but also when an ONH is expiring.
- Amend Chapter 157 to clarify that the purpose of commitment to DMH custody of criminal defendants who are found to be mentally ill and incompetent or insane includes protection of public safety, and effective risk assessments, programming, and direct community supervision of persons placed in custody under ONHs should be required.
- DMH should be required to report to the court and the parties to the criminal case at periodic intervals and upon termination of the custodial relationship about the progress of a defendant who is found to be mentally ill and incompetent or insane, the risk that person now presents to public safety, and the likelihood the person has become competent. Provisions authorizing release of otherwise confidential information for this purpose should be added to Chapter 157.
- The length of ONHs that originate in criminal cases should be extended either to an indeterminate period or a time commensurate with the maximum potential penalty for the crimes the person is charged with committing, and periodic review should be adopted to protect defendants' due process rights.
- Provisions should be added to the law protecting the rights of victims to notice of all court proceedings involving defendants who are found to be incompetent or insane, including periodic reviews addressing the status of defendants who caused them harm or injury. Victims should be entitled to communicate to the court about the impact of crimes committed against them by these defendants and about their views on dispositions and delays. Victims' rights to receive restitution for injuries also should be protected.
- The current practice applicable to ONHs, which routinely include specific provisions governing the scope of the commitment order, should be codified.

4. Other Considerations

Some members of the committee supported, had no opinion, or disagreed with the following concepts discussed:

- Statutory amendment that permits telephone or teleconferencing testimony by psychiatrists in court proceedings
- Statutory amendment that codifies a time frame for issuing judiciary findings and orders in involuntary hospitalization, applications for involuntary medication, and revocation hearings
- Statutory amendment that requires potential expiration provisions for ONHs
- Statutory amendment that allows for forensic psychologists to be utilized for forensic evaluations in addition to forensic psychiatrists. It was noted by DMH that defense attorneys have utilized appropriately qualified professionals for testimony in legal proceedings already even though not identified in statute currently.
- Amend 13 V.S.A §4822 (a) such that orders of commitment (hospitalization and non-hospitalization) can be for no longer than 90-days (remove “indeterminate period” language to make consistent with initial orders under Title 18. Also, consider elimination of the ability of a Judge in criminal court to require a discharge hearing for someone who is discharged from the DMH Commissioner’s custody.

Section IX Recommendations:

There was no unanimous committee member consensus for any of the proposals or considerations reflected in this section. Individual submissions by representative committee members and/or meeting minutes reflect the extent of disagreement or rationales for disagreement with content of this section.

X. Committee Representative Submissions - ONH Processes

- A. Devon Green – Member appointed by VAHHS - November 9, 2018
<https://mentalhealth.vermont.gov/sites/dmh/files/VAHHS%20Response%20to%20DMH%20ONH%20Memo-%20Updated%2011%209%2018.pdf>
- B. Kristin Chandler – Member appointed by Vermont Care Partners in collaboration with Jack McCullough – Member appointed by Legal Aid, Mental Health Law Project - November 1, 2018:
<https://mentalhealth.vermont.gov/sites/dmh/files/Proposed%20Language%20-%20KC%20and%20JM%2011-1-18.pdf>
- C. David Gartenstein – Member appointed by Department of State’s Attorneys and Sheriffs - July 22, 2018
https://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Memo_VSA_Office_ONH_Related_Issues.pdf

November 12, 2018

<https://mentalhealth.vermont.gov/sites/dmh/files/Memo%20-%20VSA%20Office%20%2011-12-18.pdf>

- D. Calvin Moen – Member Designee for VPS - September 27, 2018
https://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Vermont_Psychiatric_Survivors_Position_ONH_Statutes.pdf
- E. Mary Cox - Member appointed by NAMI - A Vision for Persons with Mental Health Challenges and National Coalition for Mental Health Recovery:
<https://mentalhealth.vermont.gov/sites/dmh/files/ONH%20Outline.pdf> – Involuntary Outpatient Commitment Myths and Facts:
<https://mentalhealth.vermont.gov/sites/dmh/files/documents/news/NCMHR-Fact-Sheet-on-Involuntary-Outpatient-Commitment-4.3.14.pdf>
- F. Phoebe Wagner – Member appointed by VPS – Connecticut Legislature Testimony:
<https://mentalhealth.vermont.gov/sites/dmh/files/CT%20Legislature%20Testimony.pdf>
- G. Frank Reed – Member Designee for DMH – TAC Report:
https://mentalhealth.vermont.gov/sites/dmh/files/documents/news/TAC_Report_Reimagining_ONH.pdf & MH System without Coercion:
https://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Vision_of_DMH_without_Coercion_RCopeland_2000.pdf
DMH Submission addressing elimination of ONHs – November 23, 2018:
<https://mentalhealth.vermont.gov/sites/dmh/files/DMH%20ONH%20Position%20Statement%20112318.doc>
United Nations General Assembly Human Rights Council 28th Session March 5, 2015:
<https://mentalhealth.vermont.gov/sites/dmh/files/UN%20General%20Assembly%203-05-2015.pdf>
American Psychiatric Association, World Psychiatric Association, December 9, 2013:
<https://mentalhealth.vermont.gov/sites/dmh/files/American%20Psychiatric%20Association%20World%20Psychiatric%20Association%2012-9-2013.pdf>
United Nations Human Rights Office of the High Commissioner, January 22, 2014:
<https://mentalhealth.vermont.gov/sites/dmh/files/UN%20Human%20Rights%2001-22-2014.pdf>
- H. Jack McCullough – Member appointed by Legal Aid, Mental Health Law Project – November 1, 2018 Statistics
<https://mentalhealth.vermont.gov/sites/dmh/files/ONHREV%20stats%20Jack%20M%2011-1-18.pdf>
- I. A.J. Ruben – Member designee for Mental Health Care Ombudsman/Disability Rights Vermont – November 1, 2018
<https://mentalhealth.vermont.gov/sites/dmh/files/DVRT%20Memo%2011-1-18.pdf>
- J. Judge Teachout and legal subgroup collaboration on ONH Modification/Revocation Motions:
<https://mentalhealth.vermont.gov/sites/dmh/files/ONH%20Study%20Committee%20Memo%20MV%2010-31-18.pdf>

K. Final ONH Study Committee Draft Report edit requests – November 30, 2018

1. I thought there was overwhelming consensus (unanimous minus one) to recommend that there be a place for AHS (attorney general) and MH project attorneys to be involved in Hospitalization hearings in the criminal division. I did not see this recommendation in the Executive Summary.

DMH Response: Language on page 27 in Section IX (2) (c) was modified to reflect above. The recommendation on page 22 in Section VIII also includes the language discussed that the legislature closely examine this recommendation as there only appeared to be one dissenting opinion among the collective committee. Since this issue was not unanimously endorsed by the collective committee and there was not a request by the collective committee members to place this recommendation in the executive summary, it remains within the body of the report.

2. Suggest that at p 5 in the executive summary we add the following underlined phrase to this sentence:

Committee members generally supported the concept of creating an ONH pilot for the purpose of evaluating ONHs and any longer-term outcomes achieved for individuals subject to an ONH. The model proposed would require new, additional resources for more robust service availability for individuals who would otherwise have been on an ONH and dedicated pilot management, meaningful data collection and evaluation to accompany the pilot.

DMH Response: This is not a substantive change to the committee's discussion or intent. It has been modified.

3. Under the strengths and weaknesses section (p 6) I think the whole section should be deleted because as it stands it is misleading, appearing to identify that there are many more important, substantive strengths than weaknesses in the system, and many of the statements don't make sense or are themselves misleading or just one person's perspective. I suggest scrapping the whole section and instead state that the group identified general dissatisfaction with the current ONH system, some because it was too coercive, some because it wasn't coercive enough, and many because there is a lack of adequate resources in the community to effectively support the most needy people with mental health needs in Vermont subject to ONH's and leave it at that.

DMH Response: As part of the record, the collective committee members addressed this recommendation at their final meeting and the majority members voted to keep this section in the report with agreement that a caveat be made that this section did not represent any agreement or consensus with the individual strengths and weaknesses identified by committee members. Language was inserted to reflect this agreement and appears on Page 6. The section is therefore not deleted.

4. On p 15 at the bottom of the box on data there is a statement that the data supports the notion that ONH folks are high resources users and that they often transition to voluntary services that benefit them...I don't think there is consensus on the latter finding, i.e. that ONH's lead to beneficial voluntary services. In fact, the folks that talked about their experiences with ONHs

implied the use of coercion to obtain compliance actually detracts from people seeking or continuing with voluntary treatment. One data point that is important but missing is how many folks on ONH's with medication requirements continue on the medications when the ONH is over? Without good data on this stuff I'd rather not assert there's agreement in the group that ONH's lead to voluntary tx and patient benefits.

DMH Response: DMH agrees that the collective committee members sought to have any interpretive analysis removed from the current narrative as there was not consensus about its meaning. While this specific edit was not discussed during the committee meeting, this request appears consistent with the collective committee's intent. The analysis generated for this legislative report by DMH research and statistics has been removed.

5. Not sure why we're leaving reference to Pilot 2 in the report if we all agreed we shouldn't recommend it?

DMH Response: Pilot #2 was discussed along with Pilot #1. A majority of the collective members did not support a recommendation to endorse the pilot. The collective committee members also voted to delete Pilot #2 text from the report. The report now only includes "Pilot #2 – Deleted – Full text available in the DMH position statement." While the Treatment Advocacy Center report is attached, text deletion without reference would suggest no review occurred or provide no context of what components of the pilot were discussed. The text was added to the DMH position statement on ONH's in order to provide pilot information as both pilots were presented and discussed.

6. While I appreciate the complete recitation of both VPS' submission and David's on behalf of the State's Atty's and sheriff's, it still appears to me to leave the report weighted in favor of David's positions. David's perspective is not only fully laid out in his recommendations, but also in the text of the report from pages 18 to 21. I'm thinking perhaps the reader can be directed to David's actual written comments that appear after VPS' written comments (p 23) instead of paraphrasing David's positions?

DMH Response: The collective committee members recommended that the full text of the VPS Position Statement be added to the report as a counter balance to the extensive information provided by the State's Attorney. The collective committee members took no consensus action during its final meeting to modify the States Attorney content. As reminder of the collective committee's intent, no change has been made.

7. Also, I would like to see reference in the report to the fact that many, if not a majority, of the committee supported VPS' recommendations in their submission, and no one that I can recall, other than David, supported the positions he was asserting on behalf of the SAS's.

DMH Response: The collective committee members endorsed that there was no consensus recommendation regarding ONHs in in Section IX. Pilot #1 in Section VII was clearly endorsed and included in the Executive Summary. Additionally, the collective committee members requested that recommendation, outlined in response #1, be included to identify that the majority members wanted the legislature to consider the changes proposed in the Section VIII, the VCP and Mental Health Law

Project Legal Aid proposed changes, as the sole committee dissenter to such changes appeared to be the designee of the States Attorney's Office.

8. In addition, in Section V, could we please have the studies listed in alphabetical order in order to avoid weighting some more than others due to order?

DMH Response: This is not a substantive change to the committee's discussion or intent. It has been modified.