INDEPENDENT STUDY OF THE ADMINISTRATION OF INVOLUNTARY NON-EMERGENCY MEDICATIONS UNDER ACT 114

(18 V.S.A. 7624 et seq.)

July 1, 2024 - June 30, 2025

Report to the Vermont General Assembly
Submitted to:
Senate Committees on Judiciary/Health and Welfare
House Committees on Judiciary/Health Care

Prepared by: Amy Guidice and Amanda Forbes

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Vermont Statute 18 V.S.A. §7624 et seq. (Act 114) governs the administration of involuntary, non-emergency psychiatric medication to individuals committed to the care and custody of the Commissioner of the Department of Mental Health (DMH). This report is the independent assessment that summarizes the implementation of Act 114 during FY25 (July 1, 2024 to June 30, 2025) and evaluates steps taken to achieve a non-coercive mental health system.

In FY25, DMH reported that 81 petitions were filed, for 68 individuals, requesting orders for involuntary, non-emergency psychiatric medication under the provisions of Act 114. These petitions were filed by physicians from four of the seven hospitals designated to administer involuntary medications, including Brattleboro Retreat (BR), Rutland Regional Medical Center (RRMC), University of Vermont Medical Center (UVMC), and the Vermont Psychiatric Care Hospital (VPCH). There were three hospitals that did not file petitions: White River Junction Veterans Affairs Medical Center (VA), Windham Center at Springfield Hospital (WC), and Central Vermont Medical Center (CVMC). CVMC's psychiatric inpatient unit closed in January 2025 and there were no petitions filed between July 1, 2024 and the closing of the unit.

In compliance with statutory requirements for the annual independent review, this report summarizes information analyzed to (1) evaluate and critique the performance of the institutions and staff of those institutions that are implementing the provisions of this act, (2) including interviews with persons subject to proceedings under 18 V.S.A. § 7624, regardless of whether involuntarily medicated, and their families on the outcome and effects of the order, (3) the steps taken by the Department to achieve a mental health system free of coercion; and (4) provide any recommendations to change current practices or statutes.

Review of Previous (FY24) Recommendations:

Based on the results of the FY24 independent review, the following recommendations are noted, along with the outcome of each:

FY24 Recommendation: Develop Uniform Policies, Processes, and Documentation
Outcome: Following this recommendation, evaluators requested Act 114 Nonemergency Involuntary Medication Policies and Procedures from each of the Designated Hospitals to determine whether hospitals followed DMH protocol[1]. The documents were compared to the Rules for the Administration of Nonemergency Involuntary Psychiatric Medications. These *Rules for the Administration of*

[1] Vermont Statute 18 V.S.A. §7628 says "The Department of Mental Health shall develop and adopt by rule a strict protocol to ensure the health, safety, dignity, and respect of patients subject to administration of involuntary psychiatric medications in any designated hospital."

Nonemergency Involuntary Psychiatric Medications[2] and *VPCH Policy and Procedure for Nonemergency Involuntary Medications*[3] were updated and have effective dates of January 2025 and December 2024, respectively.

FY24 Recommendation: Enhance availability of patient support
Outcome: Evaluators met with Mad Freedom Patient Representatives to learn about their process. While no changes were made regarding availability of patient support, a recommendation has been included to continue this work in this next fiscal year.

FY24 Recommendation: Process improvement to obtain more feedback
Outcome: Evaluators requested that the Mental Health Law Project (MHLP) consider mailing individual surveys twice a year rather than once a year, in the hopes to reach people sooner in relation to the date of medication. The option was declined by the MHLP as being too cumbersome administratively. In addition, to obtain more feedback from individuals, evaluators modified the survey to make the questions less cumbersome. And finally, evaluators considered offering surveys online as well as on paper but the technical restrictions to create and maintain online surveys, and manage responses, were considered too great to implement in FY25. DMH and the independent contractor can continue these discussions to determine if an online survey platform hosted by DMH would meet the needs in FY26.

FY25 Findings and Recommendations:

Finding 1: Evaluators recognize an ongoing opportunity to enhance patient support. Hospital policies provided are based on the DMH Rule that states that a patient has the right to identify a support person. The patient identifies a support person upon intake. The support person is made aware of the medication schedule and absence of that support person will not impede the administration of the medication. In reference to Mad Freedom's experience found below in Section 4.4, the Rule is being interpreted by hospital staff as the support person is listed at intake and cannot be substituted with another representative at the time of administration of medication, despite patient agreement.

> **Recommendation 1:** Build rapport to enhance patient support
> Hospital staff and patient representatives should continue to work together to build rapport and develop procedures for the benefit of enhancing patient emotional support. In addition, hospitals should review the Rule and policies/procedures to see if there is flexibility in the current practices regarding support person substitutions and modifications.

Finding 2: In reviewing individual hospital policies in connection with The *Rules for the Administration of Nonemergency Involuntary Psychiatric Medication,* evaluators found an opportunity for the

---

2 https://mentalhealth.vermont.gov/sites/mentalhealth/files/documents/Administration_of_Nonemergency_Involuntary_Psychiatric_Medications.pdf

3 https://mentalhealth.vermont.gov/sites/mentalhealth/files/documents/VPCH_Non-Emergency_Involuntary_Medication_Policy.pdf

Brattleboro Retreat (BR) to develop their policy more comprehensively to enhance patient support. In the current policy, evaluators were unable to find reference to the patient having the right to name a support person, the right to having the medical staff person administering the medication to be accompanied by at least one health professional of the gender of the patient's choice, the right to be observed long enough to ensure there are no adverse side effects, and the right to be offered emotional support.

> **Recommendation 2:** Develop Uniform Policies, Processes, and Documentation
> All Designated Hospitals should continue to ensure uniform policies by reviewing the updated *Rules for the Administration of Nonemergency Involuntary Psychiatric Medication*. Brattleboro Retreat should develop their policy more comprehensively to enhance patient support.

Finding 3: While evaluating the Perspective of Persons Who Received Involuntary Medication and their Families, including surveys and interviews of patients and their families, we found that the response rate was very low (7%) and the responses submitted showed a largely negative experience to receiving involuntary medication. In the current process, the Mental Health Law Project sends surveys annually to individuals who have had petitions filed in the previous year. This results in surveys sent to a range of individuals, from those currently receiving the medication to those who received them up to a year prior to receiving the survey.

> **Recommendation 3**: Process improvement to obtain more feedback
> It is recommended that DMH and contracted independent evaluators continue to develop processes to obtain more feedback from a variety of perspectives and to expand reach to gather more rounded responses.

SCOPE AND METHODOLOGY

1. Evaluate Performance of Institutions and Staff in Implementing Act 114

To evaluate the performance of institutions and staff, we reviewed data provided by DMH and policies submitted by Designated Hospitals that administered involuntary medication, as well as completed interviews and a survey of hospital staff involved in the implementation of Act 114.

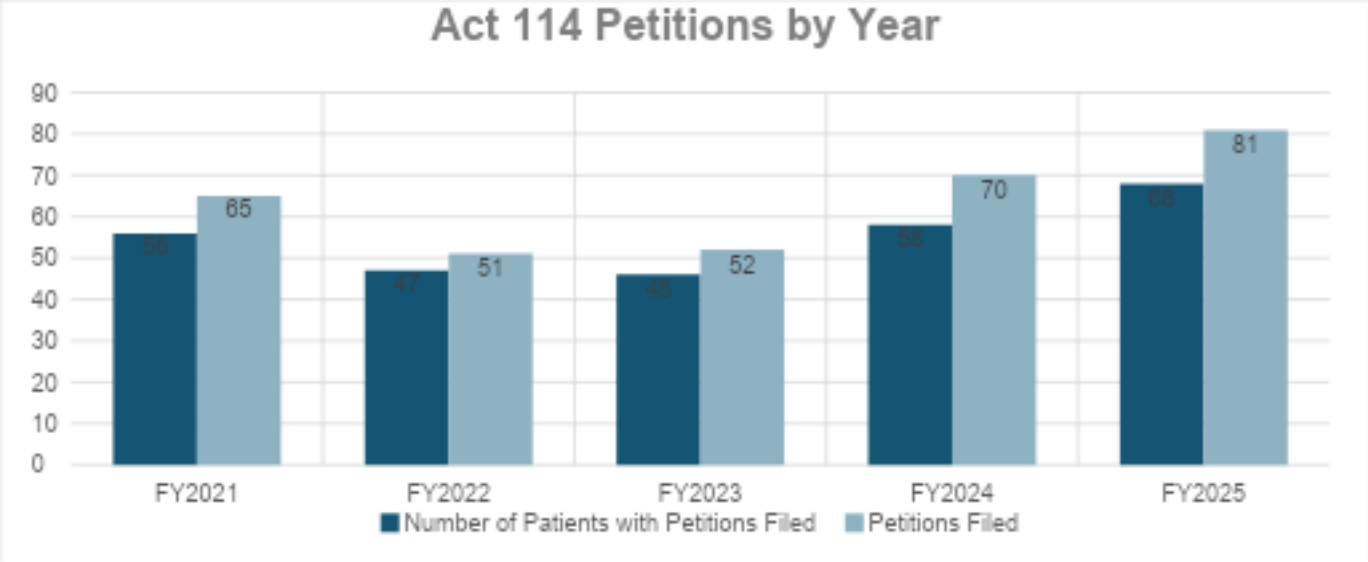
1.1 Department of Mental Health Outcome Data for FY25

DMH provided data for four of the seven hospitals designated to administer Act 114 medication: BR, RRMC, UVMC and VPCH. The VA, CVMC and WC did not report any data as they did not administer Act 114 medication in this period. This data was reviewed to determine the average time between Application for Involuntary Treatment to the time of filing for involuntary medication. The FY24 report, and survey results of hospital staff, indicate concern related to the timeline between the Application for Involuntary Treatment (AIT/Admission) and the Application for Involuntary Medicaid (AIM). Per statute,

the minimum time between the filing of AIT and the filing AIM must be 26 days[4]. In FY25 we asked DMH for more data around this timeline and the results are as follows:

- The average time between Application for Involuntary Treatment and the Application for Involuntary Medication was 30 days.[5] This is not significantly different from the year prior (29 days).
- The average time between the Application for Involuntary Medication and the Hearing date was 9 days.
- No individuals received non-emergency involuntary medication in the community setting, *i.e.* outside of a hospital setting.

Hospital[6]	Psychiatric Patients Served	Patients with Petitions Filed	Percent of Patients with Petitions Filed to Psychiatric Patient Served	Petitions Filed	Petitions Granted	Petitions Dismissed	Petitions Denied	Petitions Filed- Closed/ OH
BR*	314	33	10.5%	40	29	8	1	2
RRMC*	74	14	18.9%	16	15	1	0	0
UVMC	56	2	3.6%	4	3	1	0	0
VPCH*	114	19	16.7%	21	18	3	0	0
Total:	568	68	11.9%	81	65	13	1	2



[4] https://legislature.vermont.gov/statutes/section/18/181/07624

[5] Time Ranges between 0-10 days and >64 days were considered atypical data points and excluded from the analysis. Including these data points recalculates the average to 39 days.

[6] Three hospitals (BR, RRMC, and VPCH) have State Level 1 Units, which are contracted to have higher staffing ratios to provide treatment to individuals with more acute needs.

FY25 data, as compared to previous years, illustrate an increase in the number of patients for whom petitions were filed and the number of petitions filed. Evaluators did not find evidence that this is due to a change in the performance of institutions and staff or the Department of Mental Health. While this increase is concerning, more data will be required to assess whether this is a trend.

1.2 Hospitals and Hospital Staff

This report evaluates the performance of hospitals in implementing Act 114 by reviewing hospital policies and procedures and seeks hospital staff input through a survey. In prior years, an audit of redacted patient documentation was completed. It is not included in this year's study, due to a miscommunication of responsibilities with DMH. Further consideration will be had regarding resuming the practice for future studies.

Assessment of Hospital Policies for Implementing Act 114 Provisions

VPCH, RRMC, and BR submitted policies for review. The VA and UVMMC did not submit policies. The VA does not have a policy as they don't generally administer nonemergency involuntary medication and, due to the infrequency, they rely on partnership with DMH when the situation arises. They stated they are proactively working with DMH to put a policy in place. At the time of the interview, UVMMC did not have a policy to share as they were working to update it. Evaluators received a copy of the policy later for review and it references VPCH's policy directly.

In FY24, evaluators recommended that procedures be updated to ensure information is collected from patients regarding the requested support persons and requested gender of attending health professionals administering the medication and that all responses are documented. The policies submitted generally follow the guidelines. The exception to this is that the Brattleboro Retreat's policy does not follow the *Rules for the Administration of Nonemergency Involuntary Psychiatric Medication* as the following components are missing from the policy materials provided: The patient having the option of naming a support person; that a medical personnel administering the medication shall be accompanied by at least one health professional of the gender chosen by the patient; and the patient has the right to be personally observed long enough to ensure there are no adverse side effects and be offered emotional support.

Survey Summary from Hospital Staff

A survey was provided to all Designated Hospitals to assess staff knowledge of Act 114 provisions, the challenges they face with implementing them, and staff recommendations for improvement. Survey responses were submitted from three hospitals – VPCH, BR, and RRMC – by the following staff: two physicians/psychiatrists/psychologists, 15 nurses, four social workers, three psychiatric technicians and three others for a total of **27 respondents**[7].

Regarding formal training: 18 have undergone formal training while three have received informal training from other staff members, two learned through the completion of forms, and two staff

[7] Survey responses from hospitals were reduced by half compared to the previous year. UVMMC did not submit any responses and CVMC closed their unit, resulting in no surveys being distributed.

members have not received any training. When asked whether they were aware of any written hospital policies related to the administration of medication under Act 114, 25 responded “yes”, one responded “no”, and one did not reply.

Steps staff take to ensure patients understand the process and their rights when they are court-ordered to receive psychiatric medication under Act 114: Respondents replied that team members meet with patients. Staff review alternatives for care and treatment with patients, they provide written information to patients, and they offer patients contact information for attorneys. Additionally, patients are encouraged to contact their attorneys and are given the opportunity to choose a support person to be present when medication is administered.

Current alternatives to involuntary, non-emergency medication are offered to patients: Respondents described a broad range of alternatives to involuntary non-emergency medication, emphasizing patient autonomy, collaboration, and therapeutic engagement. Many noted that patients are offered voluntary medications first, with input on the type, timing, and method of administration, including oral or injectable options if necessary. Education about the need for treatment, ongoing discussions with the care team, and involvement in treatment planning were highlighted as key strategies to support informed decision-making. Therapeutic approaches were commonly cited, including individual and group therapy, coping skills development, mindfulness, relaxation techniques, and structured activities. Environmental and activity-based supports such as yard time, music, large spaces for de-escalation, and access to preferred activities were also used to help patients manage agitation or distress. Staff report they frequently employ crisis communication, redirection, giving space, and one-on-one support to prevent escalation, and outpatient connections or multidisciplinary team involvement (psychiatry, psychology, social work) were emphasized to maintain continuity of care. Collectively, these alternatives reflect a focus on non-coercive, patient-centered strategies that prioritize engagement, de-escalation, and therapeutic support before considering involuntary medication.

To provide more extensive alternatives to involuntary, non-emergency medication, hospital staff identified: Respondents identified several factors that could support more extensive alternatives to involuntary non-emergency medication, though some were uncertain or felt alternatives may not always be possible. Key themes included the need for additional resources, such as increased staffing, safety personnel, funding, and time to allow for individualized care and engagement. Enhancements to therapeutic programming, including more individual and group therapy (e.g., CBT/DBT), outpatient team involvement, and structured activities were highlighted as important. Improving environmental and recreational opportunities, such as better outdoor spaces and unit layouts, was also noted. Some responses emphasized administrative or procedural factors, like timely medication, clearer court orders, and flexibility in implementation. Overall, respondents indicated that expanding alternatives would require a combination of more staff, resources, structured programming, and individualized patient engagement to reduce reliance on involuntary medication.

To improve Act 114, staff recommend: Respondents primarily recommended speeding up the process for implementing court-ordered medications under Act 114 to reduce patient suffering and improve safety for both patients and staff. Many emphasized that the mandated 26-day timeline between the AIT and AIM leave patients untreated during acute episodes, sometimes leading to sleep deprivation, trauma, psychosis, or violent behaviors, which can result in serious injuries to staff and peers. Specific suggestions included shorter timeframes for filing and ruling on court orders, implementing

medications within the first week of admission, and allowing corrections facilities to initiate medications before hospital transfer[8]. Additional recommendations included better continuity of care for patients reentering the hospital, education for staff, and expanded outpatient support to prevent hospitalization.

Physician Input

In the FY24 report, a physician at a Designated Hospital detailed concerns about the lengthy process for obtaining court-ordered involuntary medication for individuals with severe mental illness (which was echoed by many providers). Since there have been no changes to the process timeline, this information is still relevant. The physician wrote that the 26-day wait from filing an Application for Involuntary Treatment (AIT) to filing an Application for Involuntary Medication (AIM) is considered too long, as it is rare for patients who refuse medication for longer than 1-2 weeks to voluntarily begin treatment. Expedited court procedures, though available, have a high threshold, requiring severe behaviors such as bodily harm, and even once the criteria are met, scheduling a hearing can take another 1-2 weeks. This means the process can take 1.5 months or longer. The physician stressed that prolonged untreated mental illness increases the risks of worsening symptoms, treatment resistance, and future recurrence.

The physician also highlighted challenges in cases where individuals have criminal charges and are being held in the hospital under a criminal court order for inpatient competency evaluation versus an Application for Involuntary Treatment in civil court, meaning that a different legal process needs to occur before an individual is eligible for involuntary medications – a process that could take many months. The physician advocated for improvements in the mental health and legal systems to support timely, person-centered, and non-coercive treatment for individuals in need of involuntary care.

2. Perspective of Persons Who Received Involuntary Medication and their Families[9].

To assess how well hospitals are following the guidance for implementation of Act 114, individuals who had Act 114 medication orders during the study year are surveyed, either through phone interviews or paper survey forms. Evaluators worked with the Vermont Legal Aid Mental Health Law Project (MHLP) to contact individuals with Act 114 medication orders. The individuals had the option to do a survey, and/or include family members in the discussion. The individuals were offered a $50 honorarium for their response.

Survey Summary from Individuals and Families

MHLP reported 71 clients in FY25 and 66 of those with known addresses received the survey. Of the 66 surveys mailed, 17 were mailed to an inpatient/secure residential setting, one was mailed to a correctional facility, and the remaining 48 surveys were mailed to community addresses. Nine surveys

[8] DMH states that Act 114 does apply to incarcerated individuals, per statute, following the same process as inpatient facilities.

[9] In 2014, Act 192 changed the statute to include the view of persons for whom an Act 114 application was filed but did not result in a court order. While fourteen individuals had one or more petitions filed that were either dismissed or denied, there were no responses to the survey from those individuals.

were returned by individuals. One survey was blank with a number for a family member and attempts to reach that individual were unsuccessful. Eight remaining surveys were used in our analysis.

Regarding whether they felt like they got better from the experience of receiving non-emergency involuntary medication: Two individuals responded "yes", three responded "no", two responded "I do not know", and one responded with both "no" and "I do not know." When asked in what ways they felt receiving the medication was beneficial, one noted that it "calmed me down". Others replied "Receiving medications makes staff more comfortable. Being weakened by medications creates a lag time in emotional reactions" and "Understanding the benefits of these prescription/over the counter medications".

Prior to receiving involuntary medication, did staff work with you to identify strategies that might minimize or avoid the use of non-emergency involuntary procedures: Two individuals responded "yes," three responded "no," and three responded "I do not know".

Regarding their experience with the court process: (Respondents were prompted to select all that apply): Two people indicated that they felt they were treated fairly. As for being informed about the court hearing time and location, two individuals felt well informed. Two others responded that they were informed of the necessity for seeking court-ordered medication. While they were asked to check all that apply, each only checked one. Two did not check any option.

In response to whether they were informed of their right to have a support person present and their right to receive information regarding the medication: One person checked that they were informed of their right to have a support person present and three people checked that they were provided with information regarding the medication received. Four did not respond.

Regarding while they were receiving medication: (Respondents were prompted to select all that apply): One person indicated that they had the opportunity to have a support person present. Four confirmed that they were able to receive the medication in an area of the hospital that provided privacy. Three were able to choose between oral medication or an injection. Three received the medication through injection and were physically restrained. Individuals were also asked whether they were monitored for adverse effects: two responded they were, and one also indicated they were offered emotional support by a staff member. No responses were given on whether they were offered a choice on the gender of the health professionals administering the medication.

In sharing their views surrounding their experience or receiving non-emergency involuntary medications, individuals responded that: Responses included they were against it and did not want to take the medication. They felt it was an invasion of their body and the process was inhumane.

3. Identify Steps Taken to Achieve a Mental Health System Free of Coercion

DMH staff who are involved in efforts to create a mental health system free of coercion provided input to identify steps taken by the Department to expand mental health services. DMH has launched several initiatives to discourage coercive practices and protect individuals' rights to the least restrictive

treatment. Designated Hospitals accepting involuntary clients undergo biennial reviews led by DMH's Nurse Quality Management Specialist and Medical Directors to ensure compliance and quality, with corrective actions implemented when needed.

Three key committees focused on emergency involuntary procedures, adult mental health, and child and adolescent mental health regularly convene and include individuals with lived experience to promote system improvements and reduce seclusion and restraint. One example is the EIP Review Committee, whose goal is to support hospitals in reducing seclusion and restraint through implementing quality improvement in line with the evidence based Six Core Strategies.

DMH has also advanced community-based care, with two agencies adopting the Certified Community Behavioral Health Clinic (CCBHC) model in July 2025, offering coordinated, evidence-based, trauma-informed, and recovery-oriented services accessible to all. Expansions in mobile crisis services, Alternative to Emergency Department programs such as mental health urgent cares and Living Room model programs, and a new Medicaid-billable peer certification program further strengthen non-coercive, person-centered care. Oversight mechanisms have also been enhanced through reforms to critical incident reporting, hospital designation surveys, and updates to the Administrative Rules governing agency designation and nonemergency involuntary medications, ensuring greater accountability, transparency, and alignment with best practices. For DMH's full description of efforts see Appendix A.

4. Perspective of Judges, Lawyers, and Patient Representatives

Evaluators requested the perspectives and recommendations of legal and patient representative interested parties who have a role to play in Act 114 legal proceedings and/or with patients receiving medication through Act 114 court orders. The questions presented include identifying what is working well, the challenges encountered throughout the process, and recommendations from the perspective of judges, lawyers, and patient representatives.

4.1 Members of the Judiciary

No judicial input was submitted this year.

4.2 Vermont Legal Aid Mental Health Law Project (MHLP)

The Mental Health Law Project (MHLP) reported that it represented seventy-one[10] patients in eighty-three involuntary medication cases in fiscal year 2025, and MHLP was appointed to represent each of the individuals for whom involuntary medication cases had been filed. It was noted that this is a high number compared to previous years.

The Project Director of the MHLP stated that the Act 114 court process is generally manageable through cooperation with the Department of Mental Health, he continues to raise concerns that involuntary medication contradicts Vermont's goal of a mental health system free from coercion by overriding patients' rights to refuse treatment, potentially eroding trust, and discouraging alternative,

[10] Noted as a discrepancy from the DMH data that reports sixty-eight individuals. This may be caused by differing methods of data reporting by DMH and MHLP. MHLP explained a potential cause of this discrepancy as having received an application from the state and opened a case in their database, but the application was not filed.

non-medication-based approaches. They believe that the "substituted judgment" standard should replace the current "best interests" standard in these cases and expressed concern over increased reliance on nurse practitioners rather than psychiatrists for treatment and testimony.

While acknowledging that Act 114 offers more procedural protections than prior systems, MHLP urged greater respect for patient autonomy and a continued move toward a less coercive mental health framework. For Attorney John McCullough's full response see Appendix B.

4.3 Disability Rights of Vermont

The Executive Director of Disability Rights Vermont (DRVT), provided feedback on the implementation of Act 114, emphasizing her continued concerns about the law's impacts on individuals subjected to involuntary medication orders. DRVT reported active involvement with individuals receiving involuntary medication under Act 114 through hospital monitoring, review of Certificates of Need, and advocacy services.

DRVT identified ongoing challenges with the implementation of Act 114. They outline that some patients may show short-term improvement in presentation due to sedation effects but they continue to experience lasting distress or little functional progress. DRVT expressed concern that fear of involuntary medication discourages some individuals from seeking voluntary mental health care and that limited staffing and resources restrict the use of less coercive alternatives. Positive elements include strong legal representation for patients and judicial oversight of medication orders.

DRVT highlighted that they believe there is a lack of identifying alternatives to involuntary medication and what they perceive as an over-reliance on pharmaceutical treatments. This, combined with what they believe is insufficient mental health system capacity, contributes to ongoing problems. DRVT recommends implementing a comprehensive study to assess the long-term effects of involuntary medication as well as improve resources for non-coercive treatments, peer support, and community-based care options. For Attorney Lindsey Owen's full response see Appendix C.

4.4 Patient Representatives

Evaluators met with patient representatives from Mad Freedom to discuss their role as advocates. Patient representatives explained that they are individuals who have lived experience and who provide peer-to-peer support to help patients understand their rights, navigate grievances, and connect with legal resources such as Disability Rights Vermont (DRVT). They meet with patients weekly in person, are available by phone between visits, and attend treatment team meetings when requested. They report confusion over when they can step into the role of support person if a named support person is unavailable.

Patient representatives believe that patients do not consistently receive informed consent regarding medication side effects and requests for specific providers are not always accommodated. Some patients fear overmedication and want greater choice in providers, and current policies limit this flexibility. They feel that more comprehensive awareness of Act 114 could help hospital staff better support patient rights.

While Mad Freedom reported that they currently have no written policies or formal training specific to Act 114, they provide general rights information to individuals and their approach primarily promotes self-advocacy and empowerment. Representatives continue to meet regularly to coordinate advocacy efforts and review strategies to support patients.

CONCLUSION

In conclusion, the implementation of Vermont Statute 18 V.S.A. §7624 (Act 114) during FY25 highlights a continued desire to improve the administration of involuntary, non-emergency psychiatric medication. While the Department of Mental Health and the hospitals continue to work toward creating a more structured and non-coercive mental health system, areas for improvement include standardizing documentation, ensuring patient support, and gathering comprehensive feedback from those affected by involuntary medication orders. The findings underscore the importance of refining policies, enhancing communication, and prioritizing patient choice and support to improve the overall process. With continued attention to these areas, Vermont can further strengthen its mental health system, ensuring it aligns with its goals of reducing coercion and fostering a more respectful, patient-centered approach.

APPENDIX A: DMH STAFF INPUT TO ACHIEVE A MENTAL HEALTH SYSTEM FREE OF COERCION

DMH believes that reducing coercive treatment requires creative quality improvement projects, broad system of care reforms, and ongoing monitoring practices to ensure continuous progress that is sustained over time. To that end, there are a number of initiatives launched in the last year to discourage coercive practices and protect the right to the least restrictive treatment necessary:

Every two years, DMH staff, led by the Nurse Quality Management Specialist and Medical Director(s), review hospitals currently designated to accept involuntary clients to ensure they are continuing to meet quality and compliance standards. Three of the six Designated Hospitals were re-designated within the last year following designation surveys. Critical Incident Reports from DHs and DAs as well as Hospital EIP Reports are reviewed as they are submitted to check for concerning trends, ensure providers followed expectations, and assign corrective action if indicated.

There are three recurring committees where discussions about ways to reduce coercion and ways to better structure our system of care often occur, all of which have members which include individuals with lived experience receiving services, and/or family members. These are the quarterly Emergency Involuntary Procedure Review Committee, the monthly Adult Mental Health State Program Standing Committee, and the monthly Child and Adolescent Mental Health State Program Standing Committee. All these meetings are open to the public. The EIP Review Committee's goal is specifically to support hospitals in reducing seclusion and restraint through implementing quality improvement in line with the evidence based Six Core Strategies.

Since the last Act 114 survey, there have been many quality improvements implemented and expanded on that bolster community mental health in Vermont. On July 1st, 2025, the first two designated agencies went live with the CCBHC model, designed to ensure access to coordinated and comprehensive behavioral health care. CCBHCs serve anyone who requests care for mental health or substance use, regardless of their ability to pay or other factors. This model aims to increase access to and improve the quality of behavioral health services. CCBHCs focus on integrated, evidence-based, trauma-informed, and recovery-oriented care. Part of the CCBHC model includes mobile crisis services, which went live in 2024 and has been expanded on over the past year. Several alternatives to emergency department programs have also gone live in the past year to provide an emergency department alternative for those experiencing an acute mental health crisis. There is now a peer certification program run by the State whose services within a DA or SSA can be billed to Medicaid. Certified peer support providers use their lived experience of mental health challenges in combination with specialized training to build genuine, mutual relationships that support individuals to live self-determined lives of their own choosing. To ensure that oversight of Designated Agencies meets the most current best practices and standards of care, the Administrative Rule on Agency Designation was updated in April of 2025.

Since the last Act 114 survey, there have also been many quality improvements implemented and expanded on that bolster DMH oversight of designated hospitals and support a non-coercive culture. Both the critical incident reporting procedure and the hospital designation survey have undergone extensive quality improvement reforms in the last year. These reforms for critical incident reporting also extend to designated agencies. Improvements related to review, tracking, and follow up of findings

have greatly enhanced the quality of DMH's oversight and the entity's resolution to issues identified. A review of policies and procedures for implementation and the administration of nonemergency involuntary medications has been added to the hospital designation process to ensure compliance with the Act 114 Administrative Rule. DMH has also re-educated and re-established expectations for all submitted emergency involuntary procedure reports to ensure compete compliance with the EIP Administrative Rule as well as timely submissions. Finally, the administrative rule on nonemergency involuntary medications was updated within the past year.

APPENDIX B: MENTAL HEALTH LAW PROJECT (MHLP) INPUT

Thank you for the opportunity to comment on the Act 114 involuntary medication process. The Mental Health Law Project takes its obligation to represent clients in Act 114 proceedings very seriously, and we would hope that our comments will improve the process and, more importantly, the overall outlook and approach to involuntary mental health treatment in Vermont.

A review of our database indicates that we represented seventy-one patients in eighty-three involuntary medication cases during fiscal year 2025, all of them receiving inpatient treatment at one of the psychiatric hospitals in the state. This continues to be a historically high rate of involuntary medication cases compared to previous years. The Mental Health Law Project was appointed to represent, and did represent, each of the individuals against whom involuntary medication cases have been filed.

What is going well in relation to implementation of Act 114?

Because we regularly participate in involuntary treatment cases in the Family Court, we found that the process for handling these cases was manageable. Over the years we have found that the Department of Mental Health often does not push for a hearing on involuntary medication as soon as absolutely possible, preferring to wait until the passage of time has made it possible to litigate the involuntary medication application at the same time as the trial of the application for involuntary treatment. When this happens, assuming it is acceptable to our client, it enables us to manage the timing of the hearing and the impact of these cases on our ability to manage our other hearing schedules. There have been cases in which the Department has found it necessary to pursue a more expedited schedule, and when that happens we work with counsel for the Department to make sure we can conduct the hearing while maintaining our ability to defend our clients' rights.

What challenges, if any, exist in relation to implementation of Act 114?

The most important thing to keep in mind is that the Legislature has declared that the policy of the State of Vermont is to move toward a mental health system that is free of coercion. In every case in which involuntary medication has been ordered, the outcome was the rejection of the patient's wishes and right to refuse treatment. In addition, forced drugging undermines trust and consequently harms the client's long-term willingness to seek treatment voluntarily. The pursuit of involuntary medication is an endeavor in which the hospital seeks to break the patient's will to resist so that the patient will be

compliant with the treatment the hospital seeks to impose. While this may make things easier for the hospital in the short run, it raises questions about whether it harms patients in the long run.

It appears to us that the ability to seek involuntary medication encourages hospitals to hold patients longer than would be considered appropriate if it were not possible to do so. Furthermore, the use of involuntary medication may reduce the hospitals' interest in seeking other, non-medication-based means of addressing the needs of the patients.

What challenges, if any, exist in relation to implementation of Act 114?

If it is decided to continue with the authority to involuntarily medicate detained patients, we strongly advocate that the proper standard for such a process is that of substituted judgment, rather than the "best interests" standard currently embodied in the statute. At a more basic level, we encourage the State to reconsider the extent to which involuntary commitment and involuntary medication are pursued.

In addition, we have seen an increase in reliance on advance practice registered nurses or nurse practitioners instead of physicians not only to provide direct treatment but also to represent the state's push for involuntary medications. There is no question that the training that an APRN or NP receives is nowhere near that of a physician, and their testimony consequently lacks the credibility and expertise of a psychiatrist. While they probably meet the low standards required to qualify to testify as an expert witness, we do not believe that they can provide the level of expertise or treatment that the people who present the most challenging conditions need. I understand that this is the result of shortages of trained medical professionals, we do not believe shortchanging the needs of the patients is the right way to address this challenge. We believe that psychiatric treatment should be provided by psychiatrists, and that expert testimony in cases that put patients' liberty interests at risk should also be provided by psychiatrists, not less-trained and less-qualified personnel.

In conclusion, it has been our impression that the process has worked pretty much as expected. The process itself is more protective of the rights of patients than the former administrative review process under the *J.L.* consent judgment was. Nevertheless, we continue to argue that substituted judgment, the legal standard applied in other cases relating to refusal of medical treatment, even where the life of the patient is at risk, is the appropriate standard. Furthermore, we would urge the Department to become more responsive to patients' rights, including the right to refuse treatment, and to make stronger efforts to move toward a system free of coercion, consistent with State policy.

Thank you.

John J. McCullough III
Project Director
Mental Health Law Project
Vermont Legal Aid, Inc.
56 College St.
Montpelier, Vt. 05602

APPENDIX C: DISABILITY RIGHTS OF VERMONT INPUT

DRVT thanks you both for reaching out again to DRVT this year for comments and input regarding our experience working with people subject to the Act 114 Non-Emergency Involuntary Medication process. We appreciate the law's requirement that an independent research firm conduct an evaluation of how this law is being followed. Upon review of DRVT's prior comments on this subject, dating back to 2020, our comments have not changed to any significant degree, which is a concerning fact on its own. As you know, Disability Rights Vermont (DRVT) is the federally authorized disability protection and advocacy system (P&A) in Vermont pursuant to 42 U.S.C. 10801 et seq., as well as being the Mental Health Care Ombudsman (MHCO) for the State of Vermont pursuant to 18 V.S. A. §7259. The following are responses to the specific questions presented to DRVT in our virtual meeting last year, October 2, 2024. DRVT wishes to highlight the significance, again, of the fact that our comments remain unchanged, year after year, with the same observations both in our monitoring as the P&A, and in our review as the MHCO of emergency involuntary procedures (EIPs), many EIPs stem from orders for non-emergency medication orders. The alarming status quo of the impacts of this questionable and traumatic practice is evidenced by the fact that DRVT merely updated the dates and ensured the citations and links were still accurate from its 2020 comments but otherwise made minimal edits.

1.Please identify your direct involvement with any individuals involuntarily medicated under Act 114.
DRVT staff monitored all inpatient psychiatric units regularly and had contact with, and provided advocacy services to, many patients subject to non-emergency involuntary medication. DRVT staff also reviewed all Certificates of Need (CON's) provided by DMH pursuant to statute and that review includes many instances of the use of force to accomplish Court-Ordered Involuntary, non-emergency, medication.

2.Are you aware of any problems encountered in the implementation of this process?
Yes. As DRVT has reported each year since these surveys started, DRVT staff have identified problems with Act 114 implementation through both first-hand witnessing and/or from review of medical records and discussions with impacted patients. DRVT continues to identify that subject to Act 114 often require the use of force to administer the injection, often perseverate afterwards about the indignity and trauma of the experience, and, at times, DO NOT make significant improvements in functioning or discharge readiness. DRVT has identified instances again this year where protections and procedures, such as the right to have a support person present during forced injections, were not followed. See https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/Nonemergency_Involuntary_Psychiatric_Medications.pdf

Still, in 2025, the most glaring problem with the Act 114 process remains the failure to identify and implement reasonable alternatives to forced medication, often limited by staffing and funding. Episodes of forced non-emergency medications continue to be accompanied by traumatic uses of force to implement the Orders. Please see DRVT's first Annual Mental Health Care Ombudsman Report for the year 2024, submitted to the General Assembly on January 31, 2025, https://disabilityrightsvt.org/wp-content/uploads/2025/04/2024-MHCO-Annual-Report.pdf. As you will see, DRVT received 1,280 discrete Certificates of Need (CONs) from designated hospitals throughout the state in 2024. These CON reports document the use of Emergency Involuntary Procedures (EIPs), including restraints, seclusions, and involuntary medications, across Vermont's psychiatric facilities.

There were 463 reports of manual restraints. For future Annual Reports, DRVT intends to try to capture how many of those were justified by having to enforce an Order for Involuntary Medication. DRVT's experience has been that several patients under forced medication orders continued to struggle and object to the injections for weeks after they began.

The failure to substantially reduce the use of forced medication orders is a sign that Vermont's mental health system is failing to live up to the stated mandate to move towards a less coercive mental health treatment system. See 18 V.S. A. §7629. Another sign is the expansion of the number of inpatient facilities where involuntary treatments are permitted.

During the relevant period DRVT continued to hear from people with mental health conditions who are genuinely afraid of being subjected to forced medication orders and the disruption that it causes in their lives, in particular with their relationship to treatment providers. People continue to report that they do not seek voluntary treatment because of this fear.

Unfortunately, there remains a perception in our community that patients receiving mental health inpatient care will be subjected to involuntary medication, a situation that is at odds with the legislative mandate to move to a non-coercive mental health system and one that DRVT urges DMH to effectively confront. DRVT asserts that Act 114 is doing far more harm than good, and is in fact one of the reasons DMH, and some members of the community, feel that more inpatient beds are needed. However, people are afraid to access care when they need it out of fear of being involuntarily and forcibly "treated," so
they don't access needed care, and, ultimately, they deteriorate resulting in the need for a higher level of care at a hospital that could have been avoided.

DRVT reiterates what a 2017 patient who was subject to a forced medication order told DRVT. They gave DRVT permission to share their story about their experience with the Department and which remains relevant today: "I've been backed into corners all of my life and this [forced, non-emergency medication] is no different – I want to get restraining orders against all these evil oppressors" (referring to hospital staff)."I don't want anybody to go through what I've been through ever again" regarding being forced to take medications the patient did not want.

Another significant and unmet problem with the implementation of Act 114 is the failure of DMH and the Legislature to commence a study to determine the outcome and overall health impact for patients forcibly medicated over short, midrange and longer time periods. Despite universal recognition that such a study is appropriate and necessary to have an effective and informed policy on this practice, no progress has been made to accomplish this necessary action.

3.What worked well regarding the process?

DRVT refers to Vermont Legal Aid's Mental Health Law Project to respond to how the actual legal process was administered during this reporting period. DRVT understands that courts regularly modify DMH requests for Act 114 orders based on MHLP attorney and expert witness testimony, and DRVT continues to adamantly believe that robust legal representation for patients subject to Act 114 proceedings is crucial and is a positive aspect of the current system. DRVT again points to the Vermont Supreme Court decision in In Re G.G., vacating the trial court's Order of involuntary medication over the patient's Advance Directive mandates, as a positive development in terms of empowering people

with mental health conditions to avoid involuntary medication when it is their decision to do so. DRVT continues to urge the Department to pursue robust public and professional educational efforts to inform about how using Advance Directives can improve outcomes for people with mental health conditions, including the ability to prevent unwanted forced, non-emergency medications.

4.What did not work well?
As noted above and for many years, DRVT identified a lack of alternatives to forced medication, in no small part due to overreliance on highly marketed medications, and in part due to lack of adequate capacity in the overall mental health system resulting in patients being held in inpatient units unnecessarily, as a significant problem with our mental health system. In addition, as noted above, the continuing lack of a study of outcomes for people subjected to these forced medications orders is an aspect of the process that is not working. To the extent that the use of coercion in the system, in terms of the numbers and time periods for Act 114 Orders, is a key warning that the Act 114 process as a part of our overall mental health system is not working well. Increases in medication orders, increases in the number of locked, non-inpatient and inpatient facilities, and reliance on ONH's requiring medication compliance, rather than allocating many more resources to peer supports, step down facilities, one-on-one community support, and alternatives to involuntary placements, appears to be a major cause for the problems DRVT staff and our clients have identified.

5.In your opinion was the outcome favorable?
DRVT acknowledges that some patients subject to Act 114 Orders experience a prompt improvement of their presentation, but as often as not, patients subject to these orders do not stabilize and improve quickly, and feel extremely disempowered, humiliated and victimized by the Orders. In many cases, the outcome of forced medications is not favorable in terms of short- or long-term improvement, but rather often work to simply sedate the patient in order to support discharge into community. The long-term benefits to the patients, anecdotally, are also questionable as many DRVT clients report efforts to discontinue the medications when out of the hospital and perseverate for years afterward about the trauma of being forced medicated.

6.Do you have any changes to recommend in the law or procedures?
Similarly to our comments in past years, DRVT recommends that the law be amended to require the Department to implement a robust outcome study of the impact of these orders on people. We also recommend that the Department be required to demonstrate quantifiable progress in reducing the number of Act 114 and other involuntary, coercive aspects of mental health treatment in Vermont or identify what additional resources are needed to obtain those reductions. DRVT recommends adequately responding to any requests for funding or other resources made by Vermont Legal Aid's Mental Health Law Project in order to assure appropriate due process for people subject to Act 114. Thank you again for this opportunity to share our perspective on Act 114 implementation. Please contact me if you would like additional information or clarification.

Respectfully,

Lindsey Owen, Esq.
Executive Director
Cc: Jack McCullough, MHLP