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MEMORANDUM

TO: **The Senate Committee on Health and Welfare**
The Senate Committee on Judiciary
The House Committee on Health Care
The House Committee on Judiciary

FROM: **Emily Hawes, Commissioner, Department of Mental Health**

DATE: **January 14, 2025**

RE: **Independent Study of The Administration of Involuntary Non-Emergency Medications Under Act 114**

The Department of Mental Health (Department) appreciates the time and work of the independent evaluator of the implementation of Act 114 (Vermont Statute 18 V.S.A. §7624) during FY24, as well as that of each individual who provided feedback on their personal or professional experience with Act 114. The annual independent evaluation provides a valuable tool for the Department as it works to continually assess and improve processes. The independent evaluation, completed with the assistance of community partners, enhances transparency, a core value that the Department upholds to ensure accountability and maintain trust with the communities it serves. The Department summarizes its responses to the three overall recommendations from the report below:

Recommendation 1: Develop Uniform Policies, Processes, and Documentation
The Department does not recommend standardizing procedures, documentation or policies across hospitals. Although all Designated Hospitals must comply with the Department's reporting requirements, requiring a standard form across all hospitals could create an unnecessary financial and technological burden in modifying their electronic medical records. It is not clear to the Department how an inter-hospital standard reporting form, procedure, or policy would impact patient experience or outcomes. The Department is also aware that the process of creating standard policies, procedures, and polices across all Designated Hospitals could be time- and labor-intensive, again without a clear purpose. Although establishing a basic level of care is critical, individual hospital settings must take into account a variety of factors: unique physical spaces, differences in EHR systems, and the specific skill sets of their staff. Because of this, the Department cannot support a statewide mandate for standardization at this time. However, the Department is willing to provide testimony on this topic if there are further questions.
The Department recommends that hospital leadership ensure that staff receive specific guidance in talking with patients about whether they would like a support person present during administration of court-ordered medications and/or if they have a preference on gender for the staff administering the medications. The Department agrees with the recommendation that each hospital have a policy around

the administration of medications via Act 114, though it does not see necessity for all hospitals to have the same one. The existing VPCH Policy and Procedure for Nonemergency Involuntary Medication could certainly be provided as a useful template for other hospitals in developing their own.

Recommendation 2: Enhance availability of patient support
The independent evaluator recommends collaborating with patient representatives in Designated Hospitals to be available as support people when requested by a patient receiving involuntary medications under Act 114. The Department values the presence on hospital units of patient representatives, and of patients having access to support people when receiving involuntary medication. The Department, however, recognizes that it would be a significant increase and change in scope of duties for the contracted patient representative entity to provide support person services across all Designated Hospitals seven days a week. As the most immediately accessible option to ensure that this support can be offered to patients, the Department recommends that Designated Hospitals identify internal processes in identifying support people and making them available to patients when needed.

Recommendation 3: Process improvement to obtain more feedback
The Department agrees with the importance of receiving as much feedback as possible from those who had direct experience with the implementation of Act 114, specifically patients and their families. The Department also recognizes that the decision to provide feedback, and the nature of the information shared, is very personal. The Department will collaborate each year with the independent evaluator of the report to identify additional strategies that could be used to increase survey participation, and would also want to partner with the Vermont Legal Aid Mental Health Law Project, who mails the surveys.

Reference Legislation and Report History

Reference Legislation: Act 192 (2013)

Sec. 26. 1998 Acts and Resolves No. 114, Sec. 6 is amended to read:

Sec. 6. STUDY AND REPORT

(a) An annual independent study shall be commissioned by the Department of Mental Health which shall:

> *(1) evaluate and critique the performance of the institutions and staff of those institutions that are implementing the provisions of this act;*
>
> *(2) include 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) include the steps taken by the Department to achieve a mental health system free of coercion; and*
>
> *(4) include any recommendations to change current practices or statutes.*

(b) The person who performs the study shall prepare a report of the results of the study, which shall be filed with the General Assembly and the Department annually on or before January 15.

(c) Interviews with patients pursuant to this section may be conducted with the assistance of the mental health patient representative established in 18 V.S.A. § 7253.

History of Act 114 Reporting Requirements:

Act 114 (1998) established procedures for the application for administration of involuntary medication (in 18 VSA § 7624) and included reporting requirements for both an independent evaluator (Sec. 6) and the Department of Mental Health (Sec. 5). The requirements for independent evaluation were then amended by Act 192 (2013).

The Department of Mental Health reporting requirement originally mandated in Act 114 was repealed by Sec. 20 of Act 137 (2024).

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

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

July 1, 2023 - June 30, 2024

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

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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 FY24 (July 1, 2023 to June 30, 2024) and evaluates steps taken to achieve a non-coercive mental health system.

In FY24, DMH reported that 70 petitions were filed, for 58 individuals, requesting orders for involuntary, non-emergency psychiatric medication under the provisions of Act 114. These petitions were filed by physicians from five of the seven hospitals designated to administer involuntary medications. The five hospitals that filed petitions include Brattleboro Retreat (BR), Central Vermont Medical Center (CVMC), Rutland Regional Medical Center (RRMC), University of Vermont Medical Center (UVMMC), and the Vermont Psychiatric Care Hospital (VPCH). The two hospitals that did not file petitions are the White River Junction Veterans Affairs Medical Center (VA) and Windham Center at Springfield Hospital (WC).

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.

Key Findings and Recommendations

Based on the results of the independent review, the following key findings and recommendations are noted:

Finding 1: While evaluating DMH data and hospital documentation, we found that staff were generally aware of the provisions of Act 114 and the documentation was generally complete, though not standard throughout all hospitals. Information regarding requested support persons or gender of attending health professionals administering the medication were often left blank, resulting in an unknown as to whether to question was asked or not answered. There were some inconsistencies in the documentation collected from hospitals that indicate a recommendation to standardize, policies, procedures, and documentation across all hospitals administering nonemergency involuntary medications.

Recommendations: Develop Uniform Policies, Processes, and Documentation

1. It is recommended that procedures be updated to ensure information is collected regarding the requested support persons or gender of attending health professionals administering the medication and that all responses are noted.

2. It is recommended that all hospitals follow the DMH protocol[1] when administering involuntary, non-emergency psychiatric medications and make every effort to standardize policies, procedures, and documentation across all designated hospitals. Though evaluators did not request and review policies from all hospitals, we did note that VPCH maintains a Policy and Procedure for Nonemergency Involuntary Medications that is clear and comprehensive and could be used as a template for other facilities, ensuring that all policies meet state standards. In future evaluations, written policies and procedures should be requested and reviewed for each hospital.
3. It is recommended, through an effort of continued quality improvement, that DMH continue to review and revise the following documents:
    - *Rules for the Administration of Nonemergency Involuntary Psychiatric Medications*, Effective Date: August 18, 1999. When asked about the timeline for these Rules, DMH provided the following information: Review of Rules for the Administration of Nonemergency Involuntary Psychiatric Medications was legislatively mandated in Act 27 (2023) and then additional changes request in Act 137 (2024). DMH is in the process of updating this rule. The rule was approved by the Legislative Committee on Administrative Rules (LCAR) on December 5th, 2024 and there is an anticipated effective date of January 15th, 2025.
    - *VPCH Policy and Procedure for Nonemergency Involuntary Medications*, effective April 2014, revised March 2023, and due for review March 2025. This policy is on schedule for review in March 2025.

Finding 2: Out of 53 patient files reviewed, only one indicated a request for a support person to be present when involuntary, non-emergency psychiatric medication was administered. DMH recognizes the need to work toward a mental health system free of coercion and "the importance of the voices of those with lived experience in advocacy, innovation, communication, and as patient representatives (advocates) inside hospitals".

> **Recommendation**: Enhance availability of patient support
> It is recommended that DMH, or entity granted to do this, work with patient representatives in the hospitals to ensure support persons are available when an individual requests one be present while medications are administered.

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 (14%) and the responses submitted showed a largely negative experience to receiving involuntary medication. Responses highlight a lack of information and communication and they call for greater respect for patient choice.

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

[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."

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 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 FY24

DMH provided data for five of the seven hospitals designated to administer Act 114 medication. The VA 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 hospital admission to the time of filing for involuntary medication, average length of hospital stay, length of community stay and readmission rates.

- The average time between hospital admission to the date of filing for involuntary medication was 29 days.[2]
- The average length of a hospital stay was 126 days[3].
- No individuals received non-emergency involuntary medication in the community setting, *i.e.* outside of a hospital setting.
- The readmission rate[4] was 19%. Out of 58 patients, 11 were readmitted and 3 of those were readmitted a total of two times during the study period.

Hospital[5]	Psychiatric Patients Served	Patients with Petitions Filed	Percent Patients with Petitions Filed to Psychiatric Patient Served	Petitions Filed	Petitions Granted	Petitions Dismissed	Petitions Denied	Petitions Filed- No Results Provided
BR*	299	32	10.7%	36	31	4	1	1
CVMC	19	1	5.2%	1	1			
RRMC*	89	10	11.2%	14	9	3		
UVMC	65	2	3.0%	2	2			
VPCH*	70	13	18.6%	17	16	2		
Total:	542	58	10.7%	70	59	9	1	1

[2] 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.

[3] In cases where the patient was still admitted as of the end of the study period the date of 6/30/24 was used as the discharge date.

[4] Readmissions are counted as individuals with multiple admissions during the fiscal year (and only after an admission associated with an Act 114 petition)

[5] Three hospitals (BR, RRMS, and VPCH) have Level 1 Units. State Level 1 Units are facilities that are contracted to have higher staffing ratios due to higher acuity.

1.2 Hospitals and Hospital Staff

This report evaluates the performance of hospitals in implementing Act 114 by reviewing patient documentation and seeks hospital staff input through a survey. This is a summary review and not intended to be a thorough audit of patient documents, which is done by DMH during bi-annual quality reviews.

Assessment of Hospital Documentation in Implementing Act 114 Provisions

The hospitals designated to administer involuntary, non-emergency psychiatric medication under Act 114 were requested to submit the following redacted documents for review:

1. Patient Information Form
2. Implementation of Court-Ordered Involuntary Medication
3. 7 Day Review of Nonemergency Involuntary Medications by Treating Physician
4. Certificate of Need (CON) packet
5. Support Person Letter

Upon request, hospitals submitted a total of 53 patient files: VPCH (14), RRMC (8), BR (28), UVMMC (2) and CVMC (1). Overall, the review of the files found that the dates of the order, Patient Information Forms, and first medication administration aligned with the intended procedural order. The documents provided show that hospitals and staff are generally aware of the procedural and documentation requirements. However, there were some inconsistencies were noted in the review. For example, hospitals used a variety of forms and methods of documentation, including handwritten documentation. In some cases, the dates were consistently incorrect on the 7-day reviews, or progress notes were used in their place. Also, questions regarding requested support persons or gender of attending health professionals administering the medication were often left blank, resulting in an unknown as to whether to question was not asked, or not answered. It is noted that only one person was named specifically by a patient as a support person.

Survey Summary from Hospital Staff

A survey was provided to all seven 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 each of the hospitals (except the VA) by the following staff: 7 physicians/psychiatrists, 36 nurses, 2 social workers, 5 psychiatric technicians and 6 others for a total of 56 respondents.

Regarding formal training: 26 have undergone formal training, 12 have received informal training from other staff members, 4 learned through the completion of forms and 8 staff members have not received any training.

Staff members describe various steps they take to ensure patients understand the process and their rights when they are court-ordered to receive psychiatric medication under Act 114: 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: These alternatives emphasize the opportunity for voluntary approaches via individualized care and include working with a psychiatric provider to come to agreement on voluntary medications, daily therapy sessions (group, individual, and specialized), music, art, journaling, and mindfulness practices. When distressed, patients are encouraged to engage in various coping strategies such as walking, quiet time, fidgeting, and using sensory rooms. The multidisciplinary treatment team collaborates closely with patients to develop tailored care plans that respect their preferences and past treatment successes. Patients are also provided with opportunities for physical activities like gym use, and resources such as puzzles, crafts, and relaxation techniques to help manage their symptoms. The hospital staff notes emphasizing patient autonomy by offering voluntary medications and non-pharmaceutical therapies, aiming to prevent the escalation to going to court to seek involuntary medications. Additionally, patients are supported through discussions about their treatment options and are encouraged to participate in decisions about their care.

To provide more extensive alternatives to involuntary, non-emergency medication, hospital staff identified: It would be important to have additional resources allocated to them to meet a variety of goals. Hospital staff would like to have more space, facilities, and access to outdoor areas for physical activity. Increased staffing, particularly more social workers, licensed therapists, and trained staff in therapeutic modalities, would help enhance care. Expanding support systems, such as robust case management, housing resources, and community partnerships, is also essential. The care environment of the hospitals would benefit from a layout that supports therapeutic activities and patient engagement, along with stronger family involvement and advocacy. Ongoing staff education and training in effective treatment strategies are necessary, as well as more diversionary activities and 1:1 time with patients. Additionally, quicker processes for court-ordered non-involuntary medications and preventive care options could help manage challenging cases more effectively.

To improve Act 114, staff recommend: Shortening the legislatively mandated current 26-day waiting period before the provider can go to court to request involuntary medications, as this length of time is seen as detrimental to both patient well-being and staff safety. Suggestions include reducing the wait to 14 days, expediting the process, and allowing more discretion for treatment teams in making medication decisions. Some propose that medical providers, rather than judges, should decide on medication administration, especially in acute cases. Additionally, there is support for providing more funding for alternative resources and therapeutic modalities to reduce reliance on involuntary medications. Expedited court hearings, case-by-case assessments, and quicker medication initiation are also suggested to prevent prolonged suffering, brain damage, and delays in care. The goal is to balance the legal processes with timely and effective treatment to improve patient outcomes and staff safety.

Physician Input

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). The provider believed 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 an order for inpatient evaluation versus an application for involuntary treatment, 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[6].

Surveys were conducted to assess the perspective of individuals who received involuntary, non-emergency medication, as well as their families. Phone interviews were conducted by request.

Survey Summary from Individuals and Families

In accordance with the desire of the legislature to assess how well hospitals are following the guidance for implementation of Act 114, persons hospitalized who had Act 114 medication orders during the study year are asked questions, either through phone interviews or paper survey. 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 written survey, a phone interview and/or include family members in the discussion. The individuals were offered a $50 honorarium for their response. MHLP had 64 clients in FY24 and 59 of those with known addresses received the survey. Eight surveys were returned by individuals and used in our analysis. An additional phone conversation with a family member is also noted.

Regarding how informed individuals were about the hospital's application to the court: One person felt well informed, while seven felt they were not. As for being informed about the court hearing time and location, three individuals felt well informed, one was somewhat informed, and four were not well informed. Comments on this question included one person stating they were notified by a letter from Legal Aid, another saying it was easy to attend the hearing, and a third mentioning that they were only notified on the day of the hearing and experienced difficulties getting a hearing while in Brattleboro.

In response to whether they were informed of their right to have a support person present to offer emotional support when the medication was administered: One person said yes, they were informed of their right to have a support person present, while six said no. Regarding whether they were able to

[6] 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. This is addressed by the first two questions on the survey, noting whether they were informed of both the court filing and the hearing. While 8 individuals had one or more petitions filed that were either dismissed or denied, there were no responses to the survey from those individuals.

choose between oral medication or an injection, four people were given the choice and were willing to take the tablet orally and two said they were not given a choice. Also asked was whether the injection was given at their requested site, two people confirmed they had a choice and that the injection was administered where they requested and three people said they were not given a choice.

In response to what they found the least and the most helpful surrounding the experience of receiving court-ordered non-emergency involuntary medication: Generally, individuals noted very few helpful aspects about their experience and felt the overall experience was traumatic and abusive. They believe they and others should have the right to choose their treatment. They were critical of the lack of communication with their primary healthcare team and hospitals' reliance on temporary staff. Some described the process unnecessary and overkill given their existing mental health support team.

To improve Act 114, individuals responded that: Their personal preferences should be prioritized by keeping an open mind to what they feel is best for their treatment, allowing patients to choose whether to take medication, and ending coercive treatment. They noted the importance of ensuring patients' rights in all hospitalizations, whether voluntary or involuntary, and recommend involving a patient's primary psychiatrist, offering counseling, and providing legal representation during these processes.

When asked for input, a family member responded: They did not feel that their loved one was fairly treated nor that they were well informed about the court process. They felt that the problem was medical rather than psychiatric and their input was ignored. Prior to their family member's hospitalization, the family had sought help for a year without success. This family member raises concern that there are limited resources for families, and they ask for laws to be changed to allow families to help loved ones.

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. The Vermont Department of Mental Health (DMH) is actively enhancing mental health services through various initiatives. These include routine quality reviews of designated hospitals, regular assessments of emergency involuntary procedures as required by administrative rule, and discussions in committees aimed at reducing coercion with input from individuals with lived experience and family members. Key developments include the statewide rollout of Enhanced Mobile Crisis for quicker community responses, alternative crisis spaces, and the expansion of the 988 mental health hotline. Vermont was awarded demonstration status for Certified Community-Based Integrated Health Centers and continues implementing evidence-based practices like the Six Core Strategies to reduce involuntary procedures. Additionally, new facilities, such as the River Valley Therapeutic Residence, have opened, and the Vermont Psychiatric Care Hospital is improving patient outcomes through its Health Equity Committee. 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 Judicial Input

Chief Superior Court Judge Thomas Zonay provided feedback summarizing input from multiple judges on the implementation of Act 114. Judges perceive that the process is functioning well overall, with apparent effective collaboration between counsel and increased participation from respondents, particularly due to remote proceedings. Some judges suggest a change to the law to allow of prior involuntary medication orders issued for individuals to be presented when a new application is presented to the court to streamline the process and reduce delays. Additionally, some judges recommend allowing involuntary medication orders in cases involving non-hospitalization orders (ONH), which could reduce hospitalization rates and better serve individuals. Despite these suggestions, challenges remain in balancing legal rights with the need for consistent and timely care. For Chief Superior Court Judge Thomas Zonay's full response, see Appendix B.

4.2 Vermont Legal Aid Mental Health Law Project (MHLP) Input

The MHLP reported representing individuals in seventy-nine involuntary, non-emergency medication cases during FY24, with each patient receiving inpatient treatment at one of the designated hospitals in the state. It was noted that this is historically high compared to previous years. MHLP was appointed to represent each of the sixty-four[7] individuals for whom involuntary medication cases had been filed.

The Project Director of the MHLP, responded that in relation to the implementation of Act 114, the process has been manageable, with DMH often allowing hearings on involuntary medication to be scheduled alongside involuntary treatment applications, which helps manage case timing effectively. However, he believes significant challenges persist. While the state's policy aims to create a mental health system free of coercion, he believes that involuntary medication orders reject patients' rights to refuse treatment, leading to concerns about trust and long-term treatment engagement. He also worried that the ability to seek involuntary medication may lead to prolonged hospital stays and diminish efforts to explore non-medication alternatives. He noted that he thinks the standard should be changed from "best interests" to "substituted judgment". He also questioned whether providers such as nurse practitioners were as well-qualified to handle involuntary medication cases. He noted in conclusion that the process is more protective of patient rights than in the past, but he would still like to see DMH be more responsive to requests to refuse treatment and for the state to move toward a less coercive mental health system. For Attorney John McCullough's full response see Appendix C.

[7] Noted as a discrepancy from the DMH data that reports fifty-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.

4.3 Disability Rights of Vermont Input

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 has observed that many patients experience involuntary injections which they feel is traumatic and a perception of a lack of improvement in their condition.

DRVT highlighted that they believe not identifying alternatives to involuntary medication and what they perceive as an over-reliance on pharmaceutical treatments, combined with what they believe is insufficient mental health system capacity, contributes to ongoing problems. DRVT also criticizes the absence of a comprehensive study to assess the long-term effects of involuntary medication. DRVT would like to see a study on the health impacts of involuntary medication and a stronger push to reduce coercive practices. She also recommends improving resources for non-coercive treatments, peer support, and community-based care options as well as funding for Vermont Legal Aid's Mental Health Law Project to provide due process for those people for whom involuntary medication petitions have been filed. For Attorney Lindsey Owen's full response see Appendix D.

CONCLUSION

In conclusion, the implementation of Vermont Statute 18 V.S.A. §7624 (Act 114) during FY24 highlights both progress and areas for improvement in the administration of involuntary 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 recently launched or ongoing to turn-the-curve on coercive practices:

- 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. Every day, DMH reviews reporting of critical incidents from inpatient and outpatient settings to check for concerning trends, ensure providers followed expectations, and assign corrective action if indicated. Every two weeks, the Nurse Quality Manager, Utilization review team, and care management teams receive detailed information about Emergency Involuntary Procedures that have occurred in Designated Hospitals, and review for compliance and quality, often leading to further discussions with hospitals about best practice.

- 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.

- On January 1, 2024, the state officially launched Enhanced Mobile Crisis statewide. The mobile crisis program ensures faster response times and more community-based responses during times of crisis. It also introduces a two-person response team for crisis situations. In addition, five agencies have been awarded grants to open alternative spaces to emergency departments for individuals in need of crisis-level support. All these services are client-focused, and the client defines the crisis. Some of these spaces focus on youth, while others focus on adults, and most follow a 'living room' model. Furthermore, the national lifeline for mental health crises, 988, has seen expanded use over the last year due to growing awareness about its services. Vermont offers multiple avenues for people to call during a crisis, including the Pathways Vermont Support Line and individual crisis lines at designated agencies in each region.

- Vermont applied this year and was awarded demonstration status in the national model of Certified Community-Based integrated Health Centers (CCBHC – referred to nationally as the Certified Community Behavioral Health Clinics). This model boasts intentional integration with substance use and mental health services, expanded services such as peer services, greater focus on customization to community needs, and a funding model that better reflects the cost of providing services.

- Recognizing the importance of the voices of those with lived experience in advocacy, innovation, communication, and as patient representatives (advocates) inside hospitals, DMH posted a Request for Grant Application (RFGA) to non-profit organizations to apply for our annual grant supporting this work. We have selected a new vendor, MadFreedom Advocates, Inc. (MFA) to deliver these services to the community. MFA is a statewide peer-run organization dedicated to providing leadership, education, and advocacy for individuals with lived experience of mental health challenges. Their mission is "to ensure equal rights and protections, eliminate discrimination and coercion, and improve mental health services and supports to enable individuals to thrive and live self-determined lives". Their board membership is composed of the executive director or designee of each Vermont, peer-led organization as well as two, at-large members.

- DMH is working with Vermont Designated Hospitals to continue implementation of the evidence-based practice (EBP), Six Core Strategies. This EBP focuses on a comprehensive approach to reduce emergency involuntary procedures within hospital-based care settings. DMH is working with nationally recognized experts to implement and sustain Six Core Strategies throughout the Vermont inpatient system of care.

- Since the newly located, expanded location for River Valley Therapeutic Residence opened its doors in May of 2023, there have been efforts to build the staff capacity to support as many clients as possible. We are proud to share that RVTR now has the capacity to support 12 residents.

- Vermont Psychiatric Care Hospital (VPCH) is committed to enhancing patient experiences and improving outcomes through the newly established Health Equity Committee. This initiative focuses on fostering intentional conversations and implementing practice changes. VPCH has successfully integrated the CMS Social Needs Screening into their Electronic Medical Records (EMR) system. This screening tool utilizes social drivers of health to identify hospitalized individuals whose safety may be at risk in the community. By incorporating these factors into treatment plan goals and reviews, VPCH aims to track progress, assist with discharge planning, ensure successful community transitions, and potentially reduce readmission rates.

APPENDIX B: JUDICIAL INPUT

Judges have been asked to weigh in on Act 114. Notably, there is no singular position or view on behalf of all judges. Set forth below are some views and perceptions of the judges who responded to the inquiry. Some views are those expressed by a single judge, while others may be by several judges.

The judges were asked to weigh in on the following three questions:

1. What is going well in relation to implementation of Act 114?
2. What could be done to improve the implementation of Act 114?
3. What challenges, if any, exist in relation to implementation of Act 114?

Act 114 provides a framework designed to provide a consistent process across all counties and medical facilities in Vermont governing administration of involuntary nonemergency psychiatric medications to clients of the public mental health system committed to the care and custody of the Commissioner. The process is one which must also protect the legal rights of the individuals who are involved within it.

It is reported that implementation has been going well for the most part. There is a perception that counsel involved in these cases work together well to resolve many cases or reduce the areas of conflict. It is also the view that the availability of remote proceedings, has increased participation of respondents and functioned well overall.

Judges addressing IM cases must only consider the evidence which is brought before them under the statutes and rules governing the proceedings. There are times where an individual may have had a prior order for involuntary medication. It has been suggested that consideration should be given to having such prior orders incorporated into the law relative to an application for a new order. This could streamline the process and potentially remove delay.

Currently, IM orders cannot be issued for persons who are on orders of non-hospitalization. It has been suggested that consideration should be given to allowing IM orders to be issued in connection with ONH orders. This could potentially reduce the number of hospitalization orders, thereby benefitting the individual.

Thomas A. Zonay
Chief Superior Judge
State of Vermont

APPENDIX C: 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 patients in seventy-nine involuntary medication cases during fiscal year 2024, 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 each of the fourteen 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 works 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.

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APPENDIX D: DISABILITY RIGHTS OF VERMONT INPUT

DRVT thanks you both for reaching out 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. According to the Department of Mental Health's website, and having served as the Executive Director since May of 2021, I do not recall being contacted for feedback since our comments that were published in "Act 114 The Implementation FY2020" (p. 12) , are incorporated almost verbatim in the 2021 Legislative Report.

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 on October 2, 2024. DRVT wishes to highlight the significance 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, 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 that 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 patients 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 2024, 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. 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 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 feel like I'm caught in a nightmare, even when I'm awake" due to taking the medications.

"I don't want anybody to go through what I've been through ever again" regarding being forced to take medications the patient did not want.

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

5.In your opinion was the outcome favorably?

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
Disability Rights Vermont