An Independent Study of the Administration of Involuntary Non-Emergency Medications Under Act 114 (18 V.S.A. 7624 et seq.) During FY 2017

Report to the Vermont General Assembly

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EXECUTIVE SUMMARY

The Vermont statute governing administration of involuntary nonemergency psychiatric medications to clients of the public mental health system committed to the care and custody of the Commissioner is 18 V.S.A. 7624 et seq. – referred to in this report as Act 114. The statute requires two annual assessments of the Act's implementation, one conducted by the Department of Mental Health (DMH) and a second conducted by an independent reviewer. The following report summarizes Flint Springs Associates' independent assessment, providing a review of implementation during FY17 (July 1, 2016, through June 30, 2017).

This report examines implementation of Act 114 at designated hospitals responsible for administering involuntary psychiatric medications under Act 114 during FY17.

During FY17, DMH reported that 67 petitions were filed requesting orders for nonemergency involuntary medication under the provisions of Act 114 for 61 different individuals. Petitions were sought by physicians at four of the hospitals designated to administer the medications and sent through the Attorney General's DMH office to the court. Of those 67 petitions, 55 (82%) were granted and 12 (18%) were dismissed. Hospitals involved included: Brattleboro Retreat, Rutland Regional Medical Center, University of Vermont Medical Center, and the Vermont Psychiatric Care Hospital.

In compliance with statutory requirements for the annual independent assessment, this report provides information on:

- Implementation of Act 114
- Outcomes associated with implementation of the statute
- Steps taken by the Department of Mental Health to achieve a mental health system free of coercion
- Recommendations for changes

Key Findings

Among the findings presented in this report, this year's assessment found that:

- Based on documentation review, staff at UVMMC demonstrated full implementation of the provisions of Act 114 in the administration of involuntary nonemergency psychiatric medication. Staff at RRMC generally completed needed Patient Information and Implementation forms indicating that protocols were followed. However, RRMC physicians used Progress Notes rather than a 7-Day Review form resulting in omission of information in 82% of the files reviewed. Files at VPCH included required forms, but half of the Patient Information Forms were missing information, and needed Administration of Medication forms were missing from three files (17%). VPCH physicians fully completed all needed 7-Day Review forms. Taken together, VPCH documentation suggests implementation of Act 114 protocols. The Retreat continues to work on documentation. Half of the files at the Retreat had completed Patient Information Forms; 31% were missing some or all of the Administration of Medication forms; and six (38%) files were missing completed 7-Day Review forms. This documentation does not provide sufficient evidence that the protocols were consistently and fully followed.

- Hospital staff feel that the process leading to involuntary medication should move as quickly as possible. They believe that individuals for whom Act 114 petitions are filed suffer on many levels when not receiving psychiatric medication as soon as possible.

- As in past years, Vermont Psychiatric Patient Representatives and lawyers from Legal Aid/Mental Health Law Project (MHLP) and Disability Rights Vermont (DR-VT) believe that applications for involuntary, nonemergency court-ordered medication are filed too quickly, reflecting a reliance on the use of medication as the first line of treatment. From their perspective, hospital staff should prioritize efforts to build a therapeutic relationship with the patient by taking more time initially to explore and employ a wider range of approaches that respect patients' concerns and lead to their recovery.

- Fewer individuals had petitions for medication under Act 114 filed in FY17 (n = 61) than in past years. In addition, petitions were filed sooner after admission in FY17 than in past years: 39% were filed within 30 days and 34% within 30-60 days of admission, or, on average, 51 days from admission to petition filing. Once the petition was filed, a decision was recached within an average of 11 days, also faster than in past years. The average time from admission to an Act 114 order was 62 days, or about two months – overall, a decrease in time from previous years.

- On average, patients under Act 114 orders in FY17 were discharged from psychiatric inpatient care about two months after the Act 114 order for medication was issued. In FY16, it was on average three months between the order and discharge.

- Responses from individuals who received medication under Act 114 and agreed to be interviewed for this annual assessment were mixed in terms of how they perceived the experience of receiving involuntary medication. The majority, however, described the experience as coercive.

- The majority of individuals interviewed who were hospitalized during FY17 reported that they were not offered a support person. No one hospitalized in FY 17 reported that staff provided emotional support or the opportunity to debrief regarding their experience of receiving involuntary court-ordered medication. Some of the individuals who were interviewed reported they knew the name of the medication that was ordered, but all said they did not receive information about the dosage or possible side effects.

- In terms of the degree of control people felt they had, two of the eight persons interviewed who received medication under Act 114 during FY17 said they were able to negotiate when and how medication was given.

- Sixteen individuals interviewed who received Act 114 orders continue to take medication and remain involved either with community or private mental health services. The majority of individuals reports that their current medication helps them function better in the community.

Recommendations

Flint Springs Associates offers the following recommendations:

Hospital Practices

FSA recommends that staff at hospitals administering Act 114 medication continue efforts to help patients understand the reasoning behind the decision to seek an order for involuntary medication and to invest time in talking with patients about the process and available options.

Beginning with the years in which the patient representatives employed by Vermont Psychiatric Survivors (VPS) have been interviewed, the report has included a recommendation that, with consent of the patient, patient representatives be included in treatment team meetings. As patient representatives bring the unique perspective of persons with lived experience, their inclusion could support both the interests of patients and the efforts of hospital staff seeking to help patients achieve recovery in the least-coercive manner.

To complement the prior recommendation, FSA also recommends that patient representatives be able to access information as to where people are located in the system and whether they are receiving Act 114 medication or applications have been filed under Act 114. This would help patient representatives reach out to more people.

In order to maintain clear records for documenting implementation of Act 114 in accordance with provisions of the statute, FSA recommends that each hospital maintain an electronic file or section within the electronic file for persons receiving medication under Act 114. This file should contain:

- Copy of court order
- Copy of Patient Information Form
- Copies of every Implementation of Court-Ordered Medication Form
- Copy of 7-day reviews – Hospitals should use a specific 7-day review form, rather than progress notes, to ensure that three specific issues are addressed: continued need for involuntary medication, effectiveness of medication, and side effects of the medication.
- Copies of Support Person Letter, if used
- Copies of certificate of need (CON) or other documentation of emergency procedure, if needed
- Summary of medications based on court order
- Specific time line of court order based on language of court order

Annual Act 114 Assessment

FSA recommends that the following steps continue to be used in future assessments of Act 114:

- The annual assessment should expand to include these additional outcomes for persons receiving medication under Act 114l:
    - Perceived treatment in hospital after receiving medication
    - Continued use of medication after discharge
    - Engagement with community services
    - Quality-of life-measures such as achievement of individually defined wellness; independent living in community
    - Readmission rates and reasons for readmission

- Provide a financial incentive for the participation of individuals who have received court-ordered medication.

- Request input from individuals through extensive outreach efforts to any person who received medication under Act 114 in previous years, not just the year under review, in order to learn about longer-term outcomes including individuals' engagement in treatment and their lives in the community as well as experiences receiving medication under Act 114 orders.

- Ask persons interviewed if they would like any family members to be interviewed and pursue these as permitted.

- Use the same reporting period for both the Commissioner's assessment of Act 114 implementation and the independent assessment.

INTRODUCTION

The Vermont statute governing administration of involuntary nonemergency psychiatric medications to clients of the public mental health system committed to the care and custody of the Commissioner is 18 V.S.A. 7624 et seq. The statute requires two annual assessments of the act's implementation, one conducted by the Department of Mental Health (DMH) and a second conducted by an independent reviewer. This report will refer to the statute as Act 114. Implementation of Act 114 commenced in late 2002.

This independent assessment report provides a review of implementation during FY17 (July 1, 2016, through June 30, 2017). The report also summarizes feedback from:

- sixteen individuals who chose to be interviewed and who received medication under Act 114 between January 2003 and June 30, 2017
- one person on whom an application was filed but denied by the court in FY17
- one mother of an individual who received an Act 114 order in FY 17.

As a result of the petitions filed during FY17, court orders for administration of involuntary nonemergency psychiatric medication under the provisions of Act 114 were issued for 52 individuals.

Prior to August 2011, all persons receiving involuntary nonemergency psychiatric medication were hospitalized at the Vermont State Hospital (VSH) at the time of the court order and receipt of medication. On August 28 of that year, Tropical Storm Irene flooded the Waterbury State Office Complex that housed VSH and other departments of state government. For most of FY12 through FY14, patients with acute needs who otherwise would have been referred to VSH, now designated as Level I patients, were served by the University of Vermont (UVM) Medical Center (previously Fletcher Allen Health Care), the Brattleboro Retreat and Rutland Regional Medical Center (RRMC). In FY13, the Department of Mental Health (DMH) opened the Green Mountain Psychiatric Care Center (GMPCC) in Morrisville to serve patients while the new psychiatric hospital was under construction; GMPCC became the Vermont Psychiatric Care Hospital (VPCH) and moved to its permanent location in Berlin in July 2014. At that time UVM Medical Center stopped serving Level 1 patients but continued to provide medication under Act 114. During FY15, Central Vermont Medical Center (CVMC) was designated to administer medications under Act 114. The Commissioner of Mental Health has thus designated these five hospitals responsible for administering involuntary psychiatric medications under Act 114 through FY17. During FY17, four of the five hospitals actually administered medication under Act 114, CVMC was the one hospital that did not.

This report, in compliance with statutory requirements for the annual independent assessment, provides the following information:

Section 1: The performance of hospitals in the implementation of Act 114 provisions, including interviews with staff, interviews with judges, lawyers and peers, review of documentation, and interviews with persons involuntarily medicated under provisions of Act 114.
Section 2: Outcomes associated with implementation of Act 114.
Section 3: Steps taken by the Department of Mental Health to achieve a mental health system free of coercion.
Section 4: Recommendations for changes in current practices and/or statutes.

Flint Springs Associates (FSA), a Vermont-based firm advancing human-services policy and

practice through research, planning and technical assistance, conducted this assessment. Flint Springs' Senior Partners, Joy Livingston, Ph.D., and Donna Reback, MSW, LICSW, gathered the required information, analyzed the data, and developed recommendations reported here.

Section 1: Performance Implementing Provisions of Act 114

During FY17, DMH reported that 67 petitions were filed requesting orders for nonemergency involuntary medication under the provisions of Act 114 for 61 different individuals. Petitions were sought by physicians at four of the five hospitals designated to administer the medications and sent through the Attorney General's DMH office to court. Of those 67 petitions, 55 (82%) were granted and 12 (18%) were dismissed. Hospitals involved included: Brattleboro Retreat, Rutland Regional Medical Center, University of Vermont Medical Center, and the Vermont Psychiatric Care Hospital.

Table 1 provides information on the number of petitions for court orders that were granted, denied or withdrawn over the last five fiscal years of Act 114 implementation. "Other" court decisions include dismissal of the case, discharge of the patient by the court, or appeals brought by patients. In most years, courts granted the vast majority of petitions; during FY13, more petitions were withdrawn, primarily because individuals began to take medication voluntarily, thus bringing down the proportion of granted petitions. The number of petitions and individuals affected by Act 114 rose noticeably in FY14, and continued to rise into FY16; in FY17 the number of petitions filed decreased.

Table 1: Court Decisions for Cases Filed during Last Five Fiscal Years

Court Decision	FY of Petition Filing Date (7/1 to 6/30)									
	FY13		FY14		FY15		FY16		FY17	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Granted	32	76%	55	80%	56	74%	66	75%	55	82%
Denied	2	5%	2	3%	6	8%	6	7%	0	0%
Withdrawn	8	19%	11	16%	6	8%	16	18%	0	0%
Other	0	0%	1	1%	8	11%	0	0%	12	18%
Total	42	100%	69	100%	76	100%	88	100	67	100%

Updates on Hospitals' Structure and Policies Related to Act 114

FSA senior partners, Joy Livingston and Donna Reback, conducted site visits at each of the designated hospitals responsible for and actually administering involuntary nonemergency psychiatric medication under Act 114 in FY17. During those site visits, interviews were conducted with leaders to identify any changes in hospital facilities, staffing, and procedures relative to implementation of Act 114. In addition, leaders were asked to identify outcomes they expect to result from administration of medication under Act 114. Results from these initial interviews are summarized below.

Brattleboro Retreat

During FY17, the Retreat enhanced its electronic medical records (EMR) to include documentation for Act 114. This allows administrative staff to track completion of needed documentation and provide physicians with reminders. The use of EMRs for Act 114 documentation and a new physician on staff contributed to less than 100% compliance with documentation, the leadership reported. Continued efforts are underway to improve documentation.

When asked about desired outcomes for patients receiving medication under Act 114, Retreat leaders identified the following measures:

- Rehospitalization rates
    - Continued use of medication as evidenced by filling/refilling prescription
- Engagement in community services as evidenced by:
    - Follow-up appointments with health care providers within 90 days of discharge
    - Level of engagement with CRT
- ONH followed after patient is released on ONH

The Retreat has limited capacity to follow up with patients once they have returned to the community. The hospital is, however, currently working with Dartmouth/Hitchcock Medical Center to use a telehealth device to allow follow-up with patients for 30 days post-discharge. The plan is to begin a pilot study during FY18 with 30 to 50 patients who volunteer to participate.

Rutland Regional Medical Center

RRMC continues to implement the Six Core Strategies for reducing the use of seclusion and restraint, including staff training in trauma-informed care. Leaders note that staff "do a good job of giving people space to vent – this impacts on other patients, the other patients don't feel safe, they end up wanting to be in their own room. Patients who want to engage in therapeutic environment are now staying away because someone is out of control." This is a challenge for staff and for providing trauma-informed care to all patients. "People with trauma history are now being exposed to loud, triggering behavior daily, even all day. We have limited spaces to give people a place to go, to get out of the yelling – it is hard for patients to live in this environment. For a person who is acutely psychotic, that period is also traumatizing."

RRMC leaders identified several outcome measures they felt would be useful in understanding the impact of receiving medication under Act 114:

- Length of stay in hospital after receiving medication
- Remaining on ONH in community
- Readmission reasons (e.g., no longer taking medication)
- Use of medication
- Engagement with outpatient treatment through CRT
- Living independently
    - Return to work
    - Participate in community
    - Maintain and/or re-establish relationships with family and friends

RRMC can track readmission for an individual, as well as the time between admission and receipt of medication, and between receipt of medication and release. The other data are not available through RRMC.

UVM Medical Center

During FY17m UVMMC made several changes to the space for psychiatric patients. These changes included:

- A new porch that provides patients with access to the outdoors
- Addition of an exercise room
- Introduction of an exercise program provided by UVM Rehab and Exercise Department students under supervision of the group therapist – patients receive exercise programs they can do at home without having to join a gym
- Addition of new sensory modulation tools and access to the sensory modulation room

As with other hospitals, UVMMC doesn't have the capacity to follow up with patients once they

leave the hospital. If it were possible to do so, however, outcome measures identified by staff would include:

- Patient knowledge about medications (how to take them, how to incorporate medications into lifestyle)
- Use of medication(s)
- Perception of care received in hospital
- Achievement of individually defined wellness

Vermont Psychiatric Care Hospital

During FY17, there were no changes in VPCH policies or practices that would impact administration of Act 114. There were significant changes in leadership, however.

VPCH leaders identified the following outcome measures they would like to see tracked:

- Treatment in hospital after receiving medication under Act 114
    - Quality of relationship with treatment team
    - Access to treatment
    - Length of stay
- Treatment in the community:
    - Stability in community
    - Use of medication
    - Readmission rates
    - Ability to find providers who will take someone who has refused to take medication
- Number of Act 114 applications for one person, number denied/accepted
- Quality-of-life measures such as ability to live in the community

Staff Feedback on Implementing Act 114 Protocol

In past years, interviews were conducted with staff members during each hospital site visit. This year, in order to gather input from a wider range of staff members, an online survey was developed. Each hospital was responsible for distributing the survey link to staff involved in administering medication under Act 114.

As shown in Table 1, 77 staff members, 51% of whom were nurses, responded to the survey. RRMC and UVMMC were the most frequently represented among respondents, Brattleboro Retreat least represented.

Table 1: Act 114 Survey Respondents

Position at Hospital	**All Respondents**		**By Hospital**			
	Frequency	Percent	Retreat	RRMC	UVMMC	VPCH
Physician/Psychiatrist	10	13%	0	1	8	1
Nurse	39	51%	2	11	18	8
Social Worker	5	6%	3	0	2	0
Psychiatric technician/assistant	19	25%	0	11	5	3
Other	4	5%	0	2	1	1
Total	77	100%	5	25	34	13

Act 114 Implementation Training

Nurses were the only staff members to report that they received at least some training on Act 114, most often formal training (see Table 2). Past assessments found that Act 114 is regularly included in annual training for nurses. About half of the physicians responding had received formal training. Psychiatric assistants most often received formal training while social workers responding most frequently reported no training at all.

Table 2: Training Staff Receive on Protocols for Administering Medication under Act 114 By Position at Hospital

Training on Protocols for administering medication under Act 114	**Position at hospital**				
	Doctor	Nurse	SW	Psych Tech	Other
No training at all	1	0	3	4	1
Informal training through other staff members	3	9	1	4	1
Learn through completion of required forms	2	3	0	1	0
Formal training through orientation or another program	4	27	1	9	2
Total	10	39	5	18	4

Patients' Rights

Staff were presented a list of steps taken to ensure that patients understand the process under Act 114 and are fully informed of their rights. These steps have been reported by staff in previous assessment interviews.

As shown in Table 3, nearly all staff at the Retreat, RRMC and VPCH report that most of these steps are utilized. Patient advocates were reportedly involved most often at RRMC and the Retreat. Staff from UVMMC provided a number of "other" responses, including six respondents who were not sure.

Table 3: Steps Taken to Ensure that Patients Understand Process and Rights under Act 114

Steps taken	All Respondents		By Hospital			
	Frequency	Percent	Retreat (n=5)	RRMC (n=24)	UVMMC (n=34)	VPCH (n=14)
Patients receive contact information for advocates, including attorneys	68	87%	5	23	27	13
Members of the treatment team review the above information with the patient	65	83%	4	23	26	12
Physician meets with patient to review all of the above	63	81%	5	20	26	12
Written information is provided to patients	60	77%	3	23	22	12
Patients are encouraged to contact their attorney	58	74%	4	21	22	11
Patient advocates are asked to explain the process, reasons, rights, and consequences	43	55%	3	19	13	8
Other (please specify)	14	18%	1	3	9	1

Staff, in past years' interviews, have often identified a number of challenges that arise when they attempt to provide patients with information about the Act 114 process. Thus, the survey asked, "How do you, and the others on the treatment team, respond to challenges that arise when providing patients with information about their rights and the Act 114 process?"

Staff often (n = 17) described ongoing efforts to engage with the patient, for example staff quotes include:

- *If the first attempt to provide patients with the necessary info is unsuccessful, more attempts are made. If the patient agrees, family support and guidance is also helpful in getting info to patients*
- *Listening, providing information, and patience*
- *To be as supportive as needed when navigating this process. A relationship needs to be built between staff and patient, and the talk about treatment and medications is happening*

before court-ordered meds are even brought up. If/when they are needed to be brought up, staff and the patient already have a knowing, working relationship around medications and treatment.

- *Use patience to try and help the patient understand the process and reasoning behind the request. Attempt on multiple occasions with different staff members if necessary.*
- *We repeatedly attempt to inform the patient verbally and in writing, trying to catch the moment when he/she may be more receptive or capable of having a dialogue.*
- *We try our best to be compassionate, patient, and reassuring. We make sure that patients have a voice in the decision and try our best to accommodate their terms of the agreement (such as asking them what time they'd like the medication, or if they'd like to come to the med window for them or have them brought down to their room; would they like a staff member whom they have good rapport with to be there for support? etc...)*
- *We work on establishing a rapport with the patient. Even if only one staff member is able to connect with the patient we will use that avenue to make sure the patient listens to the important information. We also consistently repeat the same information to the patient, all members of the treatment team and on all shifts.*

Another frequent response (n = 17) was to encourage patients to speak with their advocates. Examples of quotes from staff include:

- *Encourage communication with community supports, peer advocates and legal advocates.*
- *Have the patient contact legal aid, their lawyer or direct them to talk to their MD.*
- *Let them know they are able to call and speak to their attorney, I let them know there is a phone here and get them the phone number*
- *Refer to attorney, offer information about the involuntary admission process, communicate with the social worker and MD re: patient questions/concerns*
- *Trying at different times of day with different staff, asking an advocate to talk with patient*
- *Encourage them to ask questions and provide resources as needed.*

A number of respondents (n = 14) said that they would refer concerns or challenges to the physician or treatment team. For example, the following quotes from staff:

- *I am not part of the treatment team. Line staff aren't included in treatment team meetings or rounds.*
- *I do not provide information to patients other than directing them to patient advocacy or encourage them to speak to their treatment team.*
- *I let my manager know what's going on so that we can have some guidance with this.*
- *I personally refer them to their nurse or doctor for those questions*
- *Refer to the unit manager*
- *Seek assistance from management*

Three respondents commented on the challenge of providing information to patients who are not able to understand, as demonstrated by these quotes:

- *Patients are usually not in a place in their minds that they are able to understand the whats and whys of Act 114. There may not be any reasoning with patients because of a compromised mental state.*
- *Patients in need of court-ordered medications are frequently disorganized because they are not taking medication*

One respondent offered the following comment:

> *Unfortunately, it seems that there is a divide between the clinical staff at VPCH who are trying to provide treatment to those in need, versus the advocates/lawyers who are there to defend patients. The hospital is seen as the "bad guy" and the lawyers and advocates are the*

"good guys." A more therapeutic/efficient system would include the treatment team working together with advocates/lawyers to help patients fully understand their options while in the hospital. But instead we are split, which causes confusion for patients and an "us vs them" environment. If the treatment team worked together with advocacy and the defense I believe there would be less need for court-ordered medications (as patients would have a better understanding of their circumstance and their options) and hopefully a decrease in length of stay…

Alternatives to Medication

Hospital staff were asked to "describe any alternatives to involuntary psychiatric medication offered to patients." Most frequently (n = 38), staff responded with an array of options as shown in the following quotes from staff respondents:

- *Everything and anything to activities, groups, time spent, enhanced observation, family/outside supports*
- *Additional staff support, one to one or two-to-one. Private garden time, safety planning with patient around triggers, quiet space.*
- *Patients have personal space, quiet spaces and outdoor spaces, groups and recovery services, opportunities to work with psychologists and other therapists, as well as assistance developing and strengthening coping skills.*
- *Processing groups, physical activities, sensory modulation, art therapy, open dialogue, therapeutic environment, and voluntary medications.*
- *Sensory integration, staff support in meeting their needs, to listen, provide warm beverages, music, coping strategies, counseling. A team effort to provide care and encouragement to help the patient feel safe and supported.*
- *De-escalation techniques, quiet room, low stimulation room, head phones, private outdoor time, diversional activities*
- *Emotional regulation via sensory modalities, therapeutic rapport techniques, group activities.*
- *Talking, space as needed, offer to meet basic needs, distraction from psychosis or behavior.*
- *Verbal redirection, coping plan, sensory modulation options, access to activities, access to exercise, access to garden*
- *We work together as a team to try lots of different avenues to decrease the use of involuntary medication*
- *Yard, food, sensory therapy, walking, art, music and fitness.*
- *Milieu therapy in the form of quiet rooms, music, tablets with headphones, 1:1 staff time, coloring, crafts, exercise, Wii games, having the patient buy in to an agreed-upon voluntary medication regimen that may start to benefit them.*
- *Behavioral plans, Stress and Coping Tools/Plans, Time*
- *Our facility has added more groups and a larger area for patients to be able to calm down and take space in times of crisis.*
- *The team attempts to find a treatment plan that the patient is in agreement with, often discussing which medications the patient might prefer among those they could benefit from and compromising on dosage etc.*
- *Treatment team discussions with a patient to identify any alternatives that the patient would agree to.*

Eight staff said that there were no alternatives to psychiatric medication for some patient. The following quotes offer examples:

- *With severely decompensated and psychotic patients, my experience has been that they*

continue to decline and get worse until the administration of medication and the length of time it takes prior to administration of an anti-psychotic determines the likelihood of their return to baseline (the shorter the time, the more likely they will recover and the episode will resolve).

- *By the time it comes to our recommendations for involuntary medication, all other reasonable options have been exhausted.*
- *On inpatient, we have groups, exercise, good nutrition, phototherapy, and vitamins to offer which we invariably do. These alone, though, are unlikely to address more severe illnesses such as psychosis and the severe end of the spectrum of mood disorders.*
- *Usually if the person is disorganized enough to need involuntary medications, there are not many alternatives. I have never seen a person improve while waiting for involuntary medications.*

The survey asked a forced-choice question: What would be needed to provide more extensive alternatives to involuntary psychiatric medication? As shown in Table 4, slightly more than half of respondents suggested more programs and activities, as well as more private quiet spaces.

Table 4: Needed to Provide more Extensive Alternatives to Involuntary Medication

	Frequency	Percent
More programs and activities	44	56%
More private quiet spaces	41	53%
Outdoor spaces	34	44%
More sensory equipment	34	44%
More staff	31	40%
Other	32	41%

More than 40% of respondents offered other suggestions; 14 of these suggested that there were no viable options to psychiatric medication. The following respondent quotes are examples:

- *All of these would be wonderful alternatives and/or adjunctive treatments. None of these would obviate the need for medical treatment.*
- *Even with all of the above alternatives, there will still be a population of patients that require involuntary medications as their illness is so severe that they have limited insight and judgment*
- *First explain to me how these alternatives will help the patient re-compensate if they have a biologically based psychiatric illness that requires medications, such as schizophrenia or a severe psychotic mania.*
- *When the person has acute psychosis, there is often no other alternative than antipsychotic medications... that is the history about how they gained freedom. When the person has trauma-related symptoms, other methods can work.*
- *By the time that Act 114 is being sought all of these alternatives have been used.*
- *Suggesting [that] the interventions listed above can effectively treat acute psychosis is like suggesting meditation, exercise and a low sodium diet can effectively treat congestive heart failure. They help but failure to treat acute psychosis or congestive heart failure with medications harms the patient and is inhumane.*

Seven respondents suggested changes in spaces to address the needs of patients; example quotes include:

- *Asylum for individuals who do not wish to take medications but are a danger to themselves or others in the community.*
- *Institutions that are willing to house patients indefinitely. Severe depression with*

psychosis, severe mania with psychosis, and severe psychosis are unlikely to remit with the above listed alternatives.
- *Better soundproofing to help muffle the sound of screaming, swearing, threats, doors slamming, chairs being flipped over, etc. This noise pollution is frightening and causes patients to become anxious or triggered. … Also, the environment is just too cramped, and patients have little to no escape to get away from the alarming behaviors of some of our patients. Having more staffing and more room would allow for staff to safely bring patients to quieter areas away from the patients who are acutely ill and disruptive.*
- *More capacity at level one facilities for patients who are more acute and choose not to take medications.*

Four staff identified a need for additional services in the community; example quotes:
- *There is a strong need for mid-level programs for patients in between home and hospitalization. Currently there are such long waitlists and criteria that patients have to decompensate in the community to the point of needing hospitalization and court-ordered meds instead of intervening sooner because there aren't services for those that fall in between.*
- *More state hospital beds so people don't end up trapped in hospitals on involuntary status but without the necessary medications to treat their very real and disabling mental health condition.*

Benefits of Act 114

The survey presented a list of four possible benefits of Act 114 – drawn from staff responses in previous years. Staff most often felt the benefit of Act 114 was that patients not willing to take medications received them (see Table 5).

Table 5: Benefits of Act 114

Benefits of Act 114	Strongly agree	Somewhat agree	Not sure	Somewhat disagree	Strongly disagree	Total
It provides a consistent process across all hospitals	16 *22%*	22 *30%*	27 *36%*	7 *9%*	2 *3%*	74 *100%*
Patients who are not willing to take medication on their own receive medication	25 *34%*	22 *30%*	9 *12%*	13 *18%*	5 *7%*	74 *100%*
It provides a check on the decision to administer involuntary medication	19 *26%*	31 *42%*	17 *23%*	6 *8%*	1 *1%*	74 *100%*
It protects the legal rights of patients	23 *31%*	27 *36%*	16 *22%*	6 *8%*	2 *3%*	74 *100%*

Additional comments were offered by 13 respondents; most of these comments (n = 9) spoke to the time it takes for patients to receive medication under Act 114. Examples of quotes from respondents include:
- *While it protects the patients' rights, the process takes much too long, and I am not sure the judge is always sufficiently aware of the consequences, despite the legal representation trying to make their case.*
- *Frequently once patients are taking the medications and feeling better they ask why it didn't happen sooner so that they could recover more quickly and "get their lives back."*
- *The check that it provides on the decision to administer involuntary meds serves the patient*

so very poorly; they lose unnecessary days of their lives and livelihoods; and it causes healthcare costs to skyrocket. It may influence the legal rights of patients, but more often than not it dramatically takes away their dignity.

- *The fact is that patients wait too long to be medicated. If the patient could manage in the community with no medications, they would be in the community. … The fact that they have to wait so long is heartbreaking. Come watch a patient who is acutely psychotic by horrific delusions walk up and down the hall screaming and holding their head, day after day, after day.*
- *Patients have the right to treatment when they lack capacity to make medical decisions due to severe brain disease. Patients who are not acutely psychotic can refuse to take medications…*

Two comments focused on the decision-making power of the courts:

- *Judges often decide against involuntary medication or pick and choose what medications should be used, practicing medicine from the bench. The process is not at all consistent.*
- *The process inappropriately allows people who are not medically trained and who have no clinical relationship with the patient to make medical decisions*

Challenges Posed by Act 114

The survey also asked a question about challenges posed by Act 114, again using a forced-choice list developed from previous staff interviews. The primary challenge identified by staff in this survey, and in every previous assessment interview, was the delay between admission and receipt of medication (see Table 6).

Table 6: Challenges posed by Act 114

Challenges	Strongly agree	Somewhat agree	Not sure	Somewhat disagree	Strongly disagree	Total
Results in long delays before patients receive psychiatric medication	59 *81%*	10 *14%*	2 *3%*	1 *1%*	1 *1%*	73 *100%*
Oversight is provided by judges not trained in psychiatry	48 *65%*	14 *19%*	12 *16%*	0 *0%*	0 *0%*	74 *100%*
It creates an adversarial relationship between providers and patients	28 *38%*	22 *30%*	11 *15%*	11 *15%*	2 *3%*	74 *100%*
Court orders are too restrictive to allow adjusting medications	36 *49%*	16 *22%*	18 *24%*	3 *4%*	1 *1%*	74 *100%*

Two comments offered by respondents included more details about the length of time for patients to receive medication, as shown by these two quotes:

- *Clinical trials and reviews of the literature show duration of untreated psychosis is directly related to poor long-term outcomes for patients including more severe positive and negative symptoms, less likelihood of remission and worse social functioning.*
- *The length of time that it takes most patients to receive court-ordered medication places other patients in a toxic, disruptive, non-therapeutic living situation. I strongly believe that the patients who are less ill are negatively impacted by those patients who can't control their behavior but are not medicated until weeks/months after their admission.*

Three quotes focused on concerns with court involvement in decisions about medications:

- *Lots of issues with judges who have no known experience with mental health. Very odd that a judge who has no experience or understanding of this field is able to make the final ruling on someone's health. In many other states (this is reported by travel nurses) judges are REQUIRED to go to the unit to meet patients who refuse to come to court, that way a judge always gets a face-to-face interaction with this person they are ruling on.*
- *The judicial system is too inconsistent. Judges act as pseudo-physicians.*
- *We can still not get a court order for medications like mood stabilizers or Clozaril, which are oftentimes the only options to support an individual in being able to leave the hospital.*

One comment addressed the creation of adversarial relationships:

- *For the adversarial relationship- that is unavoidable and likely was there prior to the court order for medications. Yes, it can get worse but that risk is worth it, given the likely clinical improvement of the patient.*

One Hearing for Commitment and Act 114

The survey asked staff if recent legislation that allows the courts to hold one hearing for both commitment and involuntary non-emergency medication for some patients has reduced the time it takes for many patients to receive medication under Act 114. As shown in Table 7, 46% of staff felt that the option had reduced time for many patients, while 30% felt it had not; 15% of respondents were not sure.

Table 7: The Option for Hearing on Commitment and Act 114 Simultaneously Has Reduced Time for Many Patients to receive Medication

	Frequency	Percent
Strongly agree	15	19%
Somewhat agree	21	27%
Not sure	12	15%
Somewhat disagree	14	18%
Strongly disagree	16	21%
Total	78	100%

Staff Recommendations

The primary recommendation offered by hospital staff was to speed up the legal process so that it takes much less time to obtain an Act 114 order (n = 33). Several of the comments included concerns about patients who wait to start taking medications; the following quotes are examples:

- *Patients who are suffering mentally need to be on medication sooner [rather] than later. Their brain is deteriorating every day that they are not well which can also be dangerous for staff and other patients as well*
- *The longer patients go without meds the longer it takes for patients to come back to a base line, and sometimes are not able to reach the base line they were at previously.*
- *Shorten the length of time the whole process takes. Months of languishing without treatment is unfair, and deepens the psychosis.*
- *Shorten the time span to process the involuntary order. Keeping patients locked up and not providing treatment is cruel and unfair.*
- *If a patient is hospitalized involuntarily, they should also be able to receive necessary*

medications on an involuntary basis. Delaying treatment with meds leads to prolonged hospitalizations and patient's [sic] remaining in active psychosis/mania for far too long often leading to harm to self and others.

Eight respondents offered specific recommendations for shortening the time between admission and receipt of non-emergency involuntary medication. Quotes with suggestions included:

- *To stop delaying help for the patients suffering and become 72 hours like most states to allow involuntary psychiatric medications to help stabilize and give them the quality of life they deserve.*
- *The hearing should be held within the first week of evaluation to expedite patient treatment as it is neurotoxic to withhold treatment as the brain is an organ that sustains damage with each psychotic episode, and/or release patient to open more beds for others who need/want help.*
- *For those patients on an ONH, whom [sic] have gone off their medication, they should be having a court hearing within 2 days to determine if the medication is still needed. If it's determined that it is, then ACT 114 medications should be granted immediately before the patient becomes more ill and has an opportunity to self-harm or assault others.*
- *Allow for physician to make changes to the medication without having to go back to court; look at past admissions and if the patient has been on court-ordered medication in the past this should expedite the process*
- *We need a combined hearing and court order completed for both commitment and medications done within less than 5 days…There is no clinical logic to incarcerate someone in a hospital without the appropriate treatment given. It is a loss to the psychotic patient who end[s] up staying in the hospital longer without treatment, loss to the mental health care system that end[s] up with beds full of patients waiting to start treatment, loss to patients waiting in correction[al] system and emergency rooms for a bed in the hospital.*
- *We need to address the limited slots for court to expedite the process. Consider mood stabilizing medications/Clozaril to be able to be court-ordered.*

Several respondents (n = 14) suggested increasing the decision-making power of physicians and reducing that of judges, for example the following quotes:

- *I really don't have a problem with Act 114, but I do have a problem when some judges make determinations about medications in which they are not trained or licensed to do.*
- *Judges should not be vested with the authority to decide which medications doctors will use to treat patients.*
- *Put more of the decision-making on the MD's who are working with [patients] and experts on this, less with the judges/legal systems. Have a two-MD/Provider check system when deciding there is a need to [file for] court-ordered medications...*
- *Judges need some more education in the mental health field, and/or need to be required to see each patient face to face. Defense lawyers/advocates need to work with physicians/ treatment providers in a neutral manner to help provide patients with more clarity.*
- *Judges [should] have some training on the risks and benefits of medications in this population - based on scientific evidence.*

Four staff spoke to the need for community treatment options, including these example quotes:

- *Create a mechanism to administer medications in the community, including corrections [,] because the majority of our patients are chronically ill.…Not everyone needs to be medicated but those that are repeatedly hospitalized and have a clear history of recovery with pharmacological treatment should not endure the delays or shortcomings of the system while their disease progresses.*
- *Needs to have a community component.*

Three comments focused on providing the legislature with more information about involuntary psychiatric medication:

- *Have legislature be aware of the impact of ACT 114 on the safety, well-being and willingness to do this kind of work of the workforce*
- *For legislature to experience what it's like for patients. It's hard to vote on something that you have not experienced.*
- *Review the literature that shows longer duration of untreated psychosis leads to worse outcomes. Understand that allowing patients to remain untreated with antipsychotic medications means allowing patients to absolutely suffer and is tantamount to cruel and unusual punishment for having a mental illness.*

Interviews with Judges, Legal Services and Patient Representatives

This year, following up from interviews conducted during the prior five studies, two judges, three lawyers representing the Mental Health Law Project (MHLP) and Disability Rights Vermont (DRVT), and three patient representatives from Vermont Psychiatric Survivors (VPS) who work at UVMMC, VPCH and the Brattleboro Retreat were interviewed in order to learn, from their perspectives:

- What is going well in relation to implementation of Act 114?
- What challenges exist in relation to implementation of Act 114?
- What could be done to improve the implementation of Act 114?

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

Attorneys from both organizations note that the legal process through which judgments are made on whether an individual should be forced to receive medication guarantees that due process is followed for each case. The ability to provide information to the court from an independent psychological evaluator stands as an acknowledgement of a patient's civil rights and, at times, has led to a modification of a medication order.

There is an orderly process for conducting hearings which is reflected in:
- the predictability of knowing which judges will be sitting at each of the hospitals
- some degree of predictability for defense attorneys in scheduling hearings.

Finally, this may be the first year in a while that fewer medication orders were granted.

Judges identified multiple aspects related to court processing as going well. Both judges noted that attorneys on both sides are working collaboratively on behalf of patients and agreeing to continuances on the application if a patient is accepting treatment. This has also led to a reduction in the volume of cases judges are hearing.

Doctors are providing information that judges need to issue an order. One judge has asked doctors to explain why, in the case of patients with a known history for a specific medication being effective, additional medication is being requested. This has led to attorneys on both sides asking this question as well and the impact has resulted in doctors revisiting and often revising their request for additional medication in these instances.

In the Berlin court the judge notes the important role that the two guardians ad litem (GAL) play in reaching patients in a way that helps reduce their suspicions and distrust of the system. While one GAL has just left, there is a desire to fill that position so as not to overburden the remaining person in that position.

Finally, doctors are submitting typed, versus handwritten orders making once illegible orders easier for the judge to read and rule on.

The patient representatives continue to hold the perspective that things are going well when an application has not been granted. Minus that, they feel that what works well is time that is taken by hospital staff to work with someone who does not want medication and build a relationship with that person.

What challenges exist in relation to implementation of Act 114?

Concerns identified by defense and advocate lawyers fall into a number of categories. Both organizations feel that the use of involuntary medication, once meant for a small number of instances, has become a trend. Citing the continued increase in orders since the initial implementation of the law, MHLP in particular believes that DMH will propose to speed up the process as a remedy for the lack of beds and back-up of patients in hospital emergency departments. MHLP feels that hospital psychiatric units are holding people who, once on medication, are responding positively and could be released. DRVT lawyers note that the community mental health system lacks adequate capacity to provide community-based services to people in need, which in turn creates individual mental health crises that result in hospitalization.

Lawyers believe that psychiatrists are requesting long-acting medications increasingly as a routine versus exceptional practice, using the argument that the patient's history of refusing medication supports the need for a long-acting agent. Lawyers believe that long-acting medications are extremely intrusive and, if they cause side effects, those effects can't be reversed or stopped as long as the medication is active. Other impacts related to the use of long acting medication negate the obligation for doctors and staff on the units - and in community mental health settings - to work to build a therapeutic relationship with their patients. Again, lawyers say that if Vermont's intend is to move toward a system free of coercion that system should include therapeutic interactions needed to get an individual to the point of voluntarily accepting medication each day. Finally, lawyers believe that the continued underfunding for both community and inpatient mental health services, staff and resources sets up the system to rely on the widespread use of involuntary medication. Knowing that most of the people who go through the mental health system have experienced some form of trauma, use of involuntary medication in its present volume serves to re-traumatize those the system is mandated to serve.

Judges identified two major challenges that Act 114 both faces and creates. One is time. Judges want to hear and rule on applications as quickly as possible. There is a concern about the amount of time, prior to an application receiving a hearing, that an individual transferred from jail and/or another hospital may have spent untreated either with medication or with any form of mental health intervention. In those situations, judges believe that reducing the length of time that elapses before a hearing would help a patient's symptoms abate.

Another challenge to time arises from situations when a a person already under mental health supervision through an ONH stops taking medication and a new case must be filed. The creation of a new case on a person already involved with the mental health system seems unnecessarily time-consuming as it creates more paper work and complicates an already complex court processing system.

Finally, from one judge's point of view, the current mental health system lacks capacity, both in terms of effective medication treatment and hospital bed space, to address the needs of persons with serious mental health issues.

The VPS patient representatives agree that, as one of them stated, *"it's difficult to see anything positive about forced drugging."* Another representative said, *"There is no kind, humane, efficient, effective way to take away someone's right to choose their treatment"* and views the extent of the use of involuntary medication as an indicator that *"something else is not working".*

They cite the Retreat, where group and individual activities including WRAP and Art Therapy have been scaled back due to changes in budget and staffing. In their opinion, these activities can reduce the reliance on the use of medication as the primary treatment modality. They see a correlation between staff-to-patient ratios and reliance on medication, seclusion and restraint. Specifically, when fewer staff are available to deal with difficult incidents on a unit, they feel that medication

comes to be used as a form of chemical restraint. Furthermore, medication orders request dosages that are unnecessarily high which have the potential of being harmful to one's physiology. Additionally, they are concerned about the use of medications such as Ativan to calm people down. Ativan and similar medications are addictive and, as such, increase the potential harm to patients receiving involuntary medication orders.

Overall, as in recent years, patient representatives play a limited role as resources to the patient and to hospital treatment teams. Unless a patient requests their presence at treatment team meetings, they are not included in hospital team efforts to work with patients, present alternatives, and monitor and encourage the use of best practices.

What could be done to improve the implementation of Act 114?

Suggestions from Lawyers:

- Independent evaluations of an individual's capacity to determine one's own medication care should be conducted and routinely provided as information to be considered in Act 114 hearings.

- Commitment hearings should not take place in the same judicial process with hearings on medication orders as they are addressing two different issues, i.e., the former addresses whether to take away one's liberty and the latter makes a determination about one's medical care.

- DRVT lawyers would like doctors to be required to inform and educate patients who are deemed to have capacity and, prior to receiving forced medication, about their right to issue an advance directive as well as the costs and benefits of doing so.

- The mental health system should be identifying and investing in efforts like Housing First that are known to create healing environments for persons with mental health challenges.

- As is happening in other areas of health care, payments for mental health services should be linked, , to the effectiveness of treatment and not just to treatment services provided.

Suggestions from Judges:

- Court proceedings related to Act 114 should be filed in a centralized place for the entire state. This suggestion was made last year and remains relevant this year, as little progress has been made on this point. Centralization of information would address the frequent movement and transfer of individuals from their county of residence to hospitals and community treatment organizations in different locations, and it would also allow the court to have timely access to filings for Act 114. A centralized filing place would:
    - reduce the number of hearings that people would have to attend
    - reduce the amount of time and staff required
    - result in a coordinated docket that would let judges know that an Act 114 application had been filed elsewhere.

- Convene judges, attorneys and mental health providers to discuss challenging cases, provide opportunities for shared education and information on developments in the treatment field.

Suggestions from Patient Representatives

- The mental health system should move away from the assumption that medication is the front-line response, that it is always helpful, and that everyone needs it. Instead, it should

move toward an understanding that whatever state a person presents, s/he has autonomy and can still participate in decision-making. In keeping with this suggestion, shared decision-making between providers and patients should be a goal of the system. Doctors should listen to patients and seek to understand what medications may have worked well or not so well in the past. Clinical staff should be competent in the use of alternative modalities such as Dialectical Behavioral Therapy (DBT) with patients who have cognitive as well as psychiatric issues.

- Professional staff should engage people beyond clinical staff in the treatment team. This would include the involvement of patient representatives. Toward this end, professional staff regularly should remind the patient that s/he can invite representatives to be present in treatment team meetings.

- Patients should be educated in the use of advance directives. Patient representatives believe that advance directives, as a tool for informing the court of an individual's preferences, can empower an individual and can reduce the potential of harm caused by future attempts to administer involuntary court-ordered medication.

Review of Documentation

The Act 114 statute requires the Department of Mental Health to "develop and adopt by rule a strict protocol to insure the health, safety, dignity and respect of patients subjected to administration of involuntary medications." VSH had in place a protocol and set of forms intended to guide its personnel in adhering to the protocol, including written, specific, step-by-step instructions that detailed what forms must be completed, by whom and when, and to whom copies were to be distributed. As other hospitals took on responsibility for administering medication under Act 114, they utilized the forms VSH had developed. Forms included:

1. Patient Information: Implementation of Nonemergency Involuntary Medication – completed once – includes information on the medication, potential side effects and whether patient wishes to have support person present.
2. Implementation of Court-Ordered Involuntary Medication – completed each time involuntary medication is administered in nonemergency situations – includes whether support person was requested and present, type and dosage of medication, and preferences for administration of injectable medications.
3. 7-Day Review of Nonemergency Involuntary Medications by Treating Physician – completed at 7-day intervals – includes information on dose and administration of current medication, effects and benefits, side effects, and whether continued implementation of the court order is needed.
4. Certificate of Need (CON) packet – completed anytime emergency Involuntary procedures (EIP), i.e., seclusion or restraint, are used. This form provides detailed guidelines for assessing and reporting the need for use of emergency involuntary procedures.
5. Support Person Letter – completed if a patient requests that a support person be present at administration of medication.

The VSH protocol included a requirement that each patient on court-ordered medication have a separate file folder maintained in Quality Management including:

1. Copy of court order
2. Copy of Patient Information Form
3. Copies of every Implementation of Court-Ordered Medication Form
4. Copy of reviews
5. Copies of Support Person Letter, if used
6. Copies of CON, if needed
7. Summary of medications based on court order
8. Specific time line of court order based on language of court order

To assess the implementation of the Act 114 protocol, FSA reviewed each hospital's documentation for patients with Act 114 orders for whom the petition had been filed during FY17. This year the hospitals were all using electronic records; staff provided hard copies of Patient Information Forms, Implementation of Court-Ordered Medication Forms, and 7-Day Review Forms (or Progress Notes if review forms were not used), along with any CON documentation for review. Staff at the Retreat provided separate Act 114 files for each patient, along with useful summary sheets built from tracking data.

FSA reviewed forms completed by hospital staff for 49 of the total 52 persons with Act 114 applications filed and granted in FY17 (July 1, 2016 - June 30, 2017). This included patients from Brattleboro Retreat (n = 16), Rutland Regional Medical Center (n = 11), Vermont Psychiatric Care Hospital (n = 18), and UVM Medical Center (n = 4).

Patient Information Form

Patient Information forms were present for 32 of the 49 files (65%) reviewed. Half of the files at the Retreat (8 out of 16) and half of those at VPHC (9 out of 18) had completed Patient Information Forms. At the RRMC and UVMMC all files had the forms, though two of the files at UVMMC had forms completed at VPCH.

Thirty-eight (76%) of the Patient Information Forms that were reviewed were completed fully. Eleven forms (1 at VPCH, 1 at UVMMC, 4 at the Retreat, and 5 at RRMC) left blank the item that asks whether the patient wanted a support person present when the medication was administered. Among the forms that included responses to this item, one at the Retreat indicated that the patient wanted a support person present and named the physician as the desired support person. The remaining forms indicated that the patient either did not want a support person or refused to discuss the issue.

The Patient Information Form also includes space for the patient to sign the form. In most cases patients did not sign the form and the document noted that the patient either refused to sign or was not able to discuss signing the form. Three VPCH patients, one UVM Medical Center patient, one RRMC patient, and two Retreat patients signed the form.

The Patient Information Forms should be completed prior to the first administration of court-ordered nonemergency involuntary medication. This is indicated by the Patient Information form completion date at least one day prior to the date of the first Implementation of Court-Ordered Medication form. All but one of the Patient Information Forms had been completed either a day or two prior to first administration of medication or on the same day as first administration. One form, from the Retreat, was completed 16 months prior to the order issued in FY17 – in this case it appeared that the form was for a previous court order, not the one issued in FY17.

Form for Implementation of Court-Ordered Medication

FSA examined the forms documenting the first three administrations of involuntary medication following the court order, and then the same forms documenting administration of medications at 30-day intervals following the court order. Of the 209 Implementation Forms reviewed, 190 (91%) were complete. At the Retreat two files were missing implementation forms for blocks of time between the first and final administration of medication; and three files did not have any implementation forms. Most missing information from the Retreat files concerned whether or not the patient wanted a support person (7 of 71 forms). VPCH files most often were missing the gender of the person administering injections (6 of 82 forms) or copies of CON forms (4 of 71 forms).

The UVMMC and RRMC forms were all complete.

One patient at the Retreat asked for a support person to be present when medication was given; the form did not indicate whether or not the support person was present.

Review of Nonemergency Involuntary Medications by Treating Physicians

Required review forms (every 7 days after January 1, 2015) were present and complete for all UVMMC and VPCH files.

The Retreat piloted an electronic 7-Day Review Form in FY16 and implemented its use for FY17; prior to this, physicians used Progress Notes rather than a review form. Two of the 16 Retreat files did not include Review Forms; instead these two files had Progress Notes. Four files had some of the required forms, but were missing at least one Review Form (n =1) or three forms (n = 3). Of the 42 Review Forms, three (7%) were missing information on the continued need for medication; three (7%) were missing information on side effects; and four (10%) were missing information on the effectiveness of the medication.

RRMC files did not include Review Forms but, rather, included the information in Progress Notes. Of the 37 Progress Notes reviewed, 23 (62%) did not include information about medication side effects; 17 (46%) did not address the effectiveness of medication; and one (3%) did not speak to the continued need for medication under Act 114.

Certificate of Need (CON) Form

The forms documenting administration of medication include a check box to indicate whether or not a CON form was needed. The check boxes indicated that CON forms were needed 10 times for VPCH patients, six times for RRMC patients, and 18 times for Retreat patients. These CON forms were present and complete three times (30%) for VPHC and in all other cases for the Retreat and RRMC.

Perspective of Persons Receiving Involuntary Medication

Attracting Participants

The 2017 annual assessment invited feedback from persons to whom medication had been administered under an Act 114 court order anytime between 2003 and June 30, 2017, as well as from persons for whom an application for an Act 114 court order had been filed and denied by the court. In our conversation with the Adult Program Standing Committee following submission of our 2007 assessment, members suggested that the study should offer *anyone* who has received Act 114 court-ordered medication the opportunity to reflect on the experience. The suggestion was driven by an interest in knowing if and how individuals' perceptions of their experiences receiving involuntary medication while hospitalized might change over time with changes in their living situation to a community setting. Thus, beginning with the 2008 Annual Assessment, anyone who had been under an Act 114 court order (through June 30th of each year) was invited to participate in an interview. Additionally, in the 2014 legislative session, legislators asked that beginning in the FY 2015 assessment interviews be offered to individuals on whom a petition was filed during the assessment period but NOT granted by the court. Therefore, invitation letters were sent by MHLP both to:

- Individuals for whom an Act 114 application was filed and granted
- Individuals for whom any Act 114 application filed between 2003 and June 30, 2017 had not been granted.

The following steps were used to engage individuals in this study:

- A brochure, intended to inform people and create interest in participating, was written for distribution.
- The Vermont Legal Aid Mental Health Law Project (MHLP) mailed a packet of information to all persons who were involuntarily medicated under an Act 114 court order between January 1, 2003, and June 30, 2017, and for whom they had postal addresses.
- This packet included a letter and the brochure referred to above, which described the study, how one could get more information about the study, and compensation for participation.
- Additionally MHLP mailed a letter inviting feedback to persons on whom applications submitted for Act 114 medication were not granted by the court.
- A toll-free phone number was provided to make it as easy as possible for people interested to learn about and schedule an interview.
- A peer advocate, well known and highly regarded in the peer community, was engaged by the consultant team to talk with individuals interested in learning more about the study, to answer their questions, and to refer interested parties to the consultant conducting interviews.
- Compensation of fifty dollars ($50.00) was offered and paid to those individuals who received the packet from MHLP and chose to be interviewed.

Focus of Interviews

The assessment pursued two lines of questioning: one for persons hospitalized and receiving Act 114 medication orders at some point between July 1, 2016, and June 30, 2017, and another for those discharged from VSH, the Retreat, RRMC, GMPCC or UVM Medical Center at any time prior to July 1, 2016.

The interviews with persons who had been hospitalized and had received Act 114 medication orders during this annual assessment study period sought to understand:

- How the event of receiving court-ordered, nonemergency medication was experienced
- To what extent the protocols identified in the statute were followed, and
- What recommendations individuals might have for improving the experience of receiving Act 114 medication.

Detailed information was sought from them regarding the extent to which provisions of Act 114 had been implemented including:

- Conditions and events leading up to the involuntary medication
- How well individuals were informed regarding how and why they would be receiving involuntary medication
- Whether and how individuals were apprised of their rights to have a support person present and to file a grievance
- Conditions and events related to the actual experience of receiving involuntary medication
- Each individual's view of what was most and least helpful
- Current engagement in treatment and self-care

Persons discharged at any time prior to July 1, 2016, were asked the following:

- How the event of receiving court-ordered medication was experienced on reflection
- What impact receiving court-ordered medication has had on their current life
- What course of treatment they are currently engaged in and how they are caring for themselves
- What recommendations they have for improving the administration of court-ordered, non-emergency, involuntary medication at the UVM Medical Center, Rutland Regional Medical Center, the Brattleboro Retreat, Central Vermont Medical Center and the Vermont Psychiatric Care Hospital

Number of Persons Interviewed

Between 2003, when Act 114 court orders were first granted, and June 30th, 2016 (the end of the FY16 study period), MHLP records indicate that a total of 52 individuals received Act 114 court-ordered medication.

MHLP had correct addresses for and sent letters to 214 individuals. Of those, 191 were persons whose application for Act 114 medication was granted by the court anytime between 2003 and June 30, 2017, and the remaining 23 were persons on whom applications filed were not granted. A total of twelve letters were returned, all of which were sent to persons who received Act 114 medication. As a result, 202 letters sent by MHLP were received by:

- 179 individuals for whom Act 114 medication applications were granted

- 23 individuals for whom applications were not granted by the court between FY 14 and FY 17

The recruitment efforts yielded phone calls from twenty individuals interested in learning more about the project. Ultimately, nineteen persons (including one family member) of the 202 individuals who had received letters provided feedback, which is summarized below.

Of those nineteen persons interviewed:

- Eight had been hospitalized and received Act 114-ordered medication between July 1, 2016, and June 30, 2017.

- One person who responded had been hospitalized during FY 17 and had an application for Act 114 medication denied.

- One person interviewed is the mother of an individual who received court-ordered medication during FY17. Her son did not request an interview.

- Nine had received Act 114 medication before FY 17 and have been living in the community for more than a year prior to the study period.

Table 8: Interview Participants as Proportion of All Persons under Act 114 Orders in Each Study Year

Year of Court Order	**Persons Who Received 114 Court Orders**		
	Number with Orders Issued in Designated Study Period	Number Interviewed Who Received Order in Study Period	Response Rate of Interviews within Same Study Period as Order
2003	14	1	1%
2004	27	6	22%
2005	13	4	31%
2006	22	4	18%
2007	18	2	1%
2008(1/1/08–11/30/09)	12	4	33%
2009 (7/1/08 -6/30/09)	19	3	16%
2010 (7/1/09 -6/30/10)	26	4	15%
2011 (7/1/10 – 6/30/11)	28	4	14%
2012 (7/1/11 – 6/30/12)	28	6	21%
2013 (7/1/12 – 6/30/13	32	4	13%
2014 (7/1/13 - 6/30/14	55	6	11%
2015 (7/1/14 - 6/30/15)	50	6	12%
2016 (7/1/15 - 6/30/16)	62	6	10%
2017 (7/1/16 - 6/30/17)	52	8	15%

Of the eight persons interviewed who received Act 114 medication orders during FY17:

- two received the medication order at the Brattleboro Retreat
- four at the Rutland Regional Medical Center, and
- two at the Vermont Psychiatric Care Hospital (VPCH).

Additionally:

- one individual whose application was denied was committed to VPCH at that time
- the mother who provided feedback regarding her son's treatment noted that he was at VPCH during the study period for this study.

The following summary of responses will reflect feedback from the above ten individuals.

Responses from the ten persons described above regarding FY 17 medication applications and orders.

The reason for refusing to take medication

Five individuals did not believe they needed medication. Different reasons were cited to back up their beliefs. In one case an individual didn't think she was a danger to herself or others. Another person, looking back at the hospitalization, stated that "I just don't think it's necessary when I am in that state".

Unlike previous years, no one interviewed said that negative side effects were their main reason for refusing medication.

Information about the court hearing, the court order, the Act 114 protocols, and the right to file a grievance

Act 114 protocols stipulate that individuals be given information about the upcoming court hearing and the subsequent court order. Two respondents said they could not remember if they had been informed about the initial hearing and a third said no information was given. Five respondents knew about the hearing and had learned about it through either the Mental Health Law Project, staff at the hospital, or prior hospitalizations. In all but one case, people said they were told by hospital staff or legal representation that the court had ordered medication. Reports of receiving or not receiving information about court hearings had no association with any particular hospital.

While Act 114 requires that individuals be given information about the prescribed medication being ordered, including its name, the frequency with which it would be administered and the dosage, only two persons interviewed who received court-ordered medication in FY 17 said comprehensive information regarding the medication ordered was provided to them. The remaining feedback indicated that people's experiences varied from having vague recollections of receiving bits of information to adamantly saying they were given no information and knew nothing about the medication ordered.

Finally, people were asked what they knew about the Act 114 protocols for administering court-ordered involuntary medication and whether they were aware of their right to file a grievance. In three instances people reported knowing something about the protocols for receiving medication and one of these reported having filed an appeal to the court order. All three had been hospitalized at RRMC. One person reported no awareness of the protocols or the right to file a grievance and, among the remaining five individuals, their answers revealed a lack of clarity about the protocols or grievance rights.

Treatment by staff during and after administration of involuntary medication

People were asked to comment on:

- How they felt they were treated in general by staff around, during and after the administration of court-ordered medication
- Concern that staff showed for a patient's interest in being afforded privacy when medication was being administered
- Whether they were asked if they wanted a support person present when receiving medication, as stipulated in the protocols
- Whether they were offered emotional support
- Whether staff offered to help debrief them after administration of court-ordered medication

Responses regarding how people were treated by staff in relation to the administration of the court-ordered medication revealed mixed reactions. None of the six respondents said they had been treated throughout their stays in either a uniformly positive or negative way by all staff. One person said that sometimes staff treatment was fair, other times unfair. Another person said staff treatment could have been more respectful, but did not elaborate. Two female respondents, each of whom had been at different hospitals when receiving medication, described incidents of being restrained as physically forceful and resulting in their being hurt.

Patients receiving Act 114 medication should be asked by staff if they would like a support person present when receiving medication, and should receive offers from staff to debrief the experience of receiving involuntary medication and to receive emotional support. Two respondents said they thought or believed staff had asked if they wanted a support person present when receiving court-ordered medication, while six individuals said they had not been asked. In response to the question "would you have wanted a support person present?" three persons answered in the affirmative, naming, in one case, staff from Disability Rights Vermont (DRVT) and, in two other cases, a specific member of the hospital staff.

When asked whether staff offered to debrief with or provide emotional support to them regarding receiving the medication, all respondents said that no hospital staff had offered to debrief how the experience of receiving court-ordered involuntary medication had impacted them. Two individuals who had received the medication order at RRMC felt that certain staff had been emotionally supportive and described them as:

- "very professional and compassionate" or
- "very supportive…one nurse in particular".

The interviewer asked respondents how, in overall terms, they felt staff at the hospitals demonstrated concern and respect for their dignity, safety and health. Feedback reflected two different perspectives regarding this question. Three individuals stated clearly that they were not treated with any concern or respect for their health, safety or dignity. Comments to that effect included the following:

- "I was treated punitively in a hostile, aggressive manner."
- "[I received] no respect, no attention to health, safety, dignity."

Of these three, two received their medication orders at VPCH and the third at RRMC. However, four individuals, three hospitalized at RRMC and one at VPCH, remember their treatment by hospital staff as respectful.

- “When people gave me the medication they were polite, calm, answered questions if I had them……When you get to RRMC they give you a welcome bag with a squeeze ball for stress….a couple of things and a list of rules of the facility. It was cute.”
- “Some staff gave me compliments on my dress style.”
- “Overall I was treated with respect.”

Regarding the extent of force used to get people to take medication:

The interviewer asked people overall how much force was used to get them to take medication. Three of seven respondents noted that physical restraint and/or verbal threats had been used multiple times to force them to take court-ordered medication during their hospitalizations. Two of these individuals were at VPCH and one at RRMC. The remaining five respondents had a different experience which was reflected, as follows, in their ability to exercise differing degrees of control over what was happening to them:

- “Yes, I negotiated around when to take the medication and who gave it to me”
- “It gives me the opportunity to think about it the next time and the next time…and eventually my mind becomes clear enough that I think the medication is helping me”
- “They really did everything in their power to give me a choice”
- “I was asked what time [I wanted to take] the PRN”

What was most helpful and unhelpful about the experience?

The interviewer asked people what was most unhelpful and/or negative and what was most helpful and/or beneficial about the experience of receiving court-ordered medication. Nine out of ten people interviewed (including the person whose application was not granted and the mother of a former patient) gave various explanations regarding the negative aspects related to receiving court-ordered medication. One person noted that the medication ordered had uncomfortable side effects, including fidgeting, headaches and *“other maladies you have for the rest of your life.”* Two individuals hospitalized at VPCH noted treatment by staff at all levels as detrimental. Another individual said that being locked up in the hospital and having to take more medication than needed was most difficult. The parent of one individual was highly critical of the court process which, due to unforeseen continuances, left her son without medication for more than two months. She disagreed with her son’s unwillingness to take medication as she felt that his condition deteriorated over the delay in getting a court order. The person whose medication application was denied by the court noted the collateral trauma experienced by other patients who, by proximity on a ward or in common areas, witness the restraint and injection of individuals who refuse medication.

When asked what was most helpful or beneficial four people provided feedback. One person said that once she began taking medication family and friends were able to visit, *“which was very nice.”* Another person talked both about the care staff were providing and the ability to engage in activities as follows:

- “I knew they were doing the best care for me.”
- “The longer I was there the more activities I could participate in which helped the time pass.”

Another person who was transferred to UVMMC after the initial court order had been granted at VPCH felt the staff at UVMMC were truly trying to teach her to take better care of herself.

Both positive and negative comments reported immediately above came from persons hospitalized

in different facilities.

The interviewer asked people whether, looking back, they felt the state had made the right decision in giving them involuntary, court-ordered, nonemergency medication. Two persons, one hospitalized at RRMC and the other at VPCH, who believe the state did the right thing offered the following thoughts:

- "I was very unsure about myself and how I would react to taking medication if I did it on my own. I needed their help….I told them I have a mental illness and I needed your help."
- "in the end I'm alive and well and can think clearly. The longer I can think clearly, the more grateful I am…..I don't feel I have to hide the need for medication. If I do go back [to the hospital] I won't be embarrassed [to take the medication]. The hospital is there to help me and they do a really good job at it."

Another respondent noted that the question was a *"tough"* one. Being hospitalized removed her from her life, but on reflection she felt that the thought and emotional process *"I was going through was causing me to get in trouble outside."*

Five people did not think the decision was a good idea and, of those, two believe the medication is permanently damaging their health. One of the five notes that she takes medication on a daily basis, understands its positive effects on her but still disagrees with the state's decision.

Responses from people who had been discharged prior to July 1, 2016, and were living in the community during this study period:

Nine people living in the community completed interviews. Each of these individuals last received a court order for involuntary nonemergency medication prior to July 1, 2016. Respondents gave the following years, to the best of their recollections, in which the last Act 114 court orders had been granted:

- 1 person in 2011 at VSH
- 2 persons in 2012, both at RRMC
- 1 person in 2013 at the Retreat
- 2 persons in 2014, one at RRMC and one at UVMMC (formerly Fletcher Allen Health Care)
- 3 persons in 2015, two at RRMC and one at UVMMC

People living in the community were asked to reflect on the following:

- How the event of receiving court-ordered involuntary, nonemergency medication was experienced
- The impact of receiving medication on their current life
- Their current involvement in self-care and treatment activities

How was the event of receiving court-ordered medication experienced?

Responses to this question were clearly negative or positive. Three individuals noted they had been treated well by staff and felt that they needed the medication as reflected through the following statements:

- "I'm grateful I got the medication and grateful that it was court-ordered. [Without the] court order I wouldn't have taken it and would have lost everything…lost my apartment."
- [At the time] "I didn't understand how medication could be helpful to me…[but I] was treated well by the staff at UVM."
- "I needed the medicine."

Six individuals, however, view the last hospitalization and resulting court order for medication through a negative lens based on their beliefs that they did not need the medication, were treated badly by hospital staff, had a false report made to the court depicting them as violent, were forced to take more medication than they needed, and were deprived of their rights.

- "It was absolutely terrible…my rights were violated, I wasn't violent, didn't put my hands on anyone [but] because I wouldn't take it orally so they restrained me and I got the shot."
- "A caseworker wrote a false report that I attacked her…they thought I was dangerous so that influenced how I was treated. The staff would be aggressive toward me but I would get verbally aggressive and it created a vicious circle.
- "It was a bad experience. I thought the medication was up to me. Whatever concerns I raised weren't attended to…Some of the stuff was so hurtful to go through, psychologically, physically and emotionally it was so damaging - it was very painful."
- "When I was forced and restrained, the coercion was horrifying."

<u>What impact has receiving court-ordered medication had on your current life?</u>

People were asked to describe how their current lives had been affected by receiving medication under the provisions of Act 114. Regardless of differing perceptions of how they were treated while hospitalized, six persons identified positive longer-term benefits gained from receiving Act 114 medication. These included gains in independence and autonomy, clarity of thinking and stability in housing.

- "I needed the medication - I didn't think I needed it but I did. A few days after I began taking it I started feeling better and realized how delusional my thoughts were."
- "If I didn't take medication my life would be in a nursing or group home….I have some independence….I got a dog and live alone with my cat."
- I'm able to live an independent life. There are problems with the medicine. I would gain weight but it's more important to take the medication rather than be a [problem] to society."

Two individuals were left with more negatives impressions of receiving court-ordered medication, pointing out impacts on physical and emotional health. A weight gain of up to seventy pounds, coupled with loss of self-esteem, left one person feeling that *"medication had the effect of making me afraid to go anywhere alone…I didn't want to leave my house."* Those effects, in his words *"took a long time to overcome."* Another individual attributes high cholesterol counts to the results of the medication, even while acknowledging that the medication *"can be positive in a way"*.

<u>What course of treatment they are currently engaged in and how they are caring for themselves:</u>

People were asked to discuss how they are taking care of themselves. Specifically, they were questioned about what activities and events they participate in that they view as beneficial and what, if any, course of treatment they are following.

Each person reports engaging in one or more forms of activity either individually or with others that goes beyond involvement with the formal mental health system. Three people identified different ways in which they interact socially with friends, five people described exercise and wellness routines they try to follow, three individuals follow some form of religious and/or spiritual practice, and five respondents named specific activities/hobbies that give them pleasure.

Social interactions include going shopping with friends, having a long-term stable partner, playing bingo, going to car shows, snowmobiling and riding motorcycles with friends. People who attend to

their physical wellness do that through gym memberships at a gym, daily exercise with home equipment, walks in the out-of-doors, and eating healthily. Two individuals go to church regularly one prays and practices meditation in her home, and five people report that their hobbies include reading, art projects, home decorating, fishing and writing in a journal.

People were asked whether they remained connected to the formal mental health system and if so what course of treatment they were following. Eight persons take medication and, of those, seven receive medication under Orders of Non-Hospitalization (ONH) while one takes medication entirely of her own volition. Some people take medication because they know it helps them.

- I make sure I take my medication daily for the schizophrenia…. I can't let myself slip. I see the difference in myself [between taking and not taking the medication] and it's well worth it."
- "Yes, I will never go off my medication - its' very effective at this point…and I have no side effects or weight gain."

One person takes medication to cooperate with the mental health system and to avoid another hospitalization.

- "I do continue to take medication but I'm doing this because I don't want them to put up roadblocks. If they think it's the best thing then I'm taking it. I want to work with them."

All eight respondents who take medication continue to see a psychiatrist primarily to monitor their medication. Each of the seven on an ONH have case workers affiliated with a local mental health organization, and the majority feel very positively about the concrete help and caring their caseworkers provide. That support comes in the form of being taken on shopping trips for food, providing transportation to activities and church, and making connections and gaining access to vital social and health services. One respondent who is going blind reported that the caseworker made arrangements to get a guide dog. Finally, two respondents participate in support groups run through their mental health agencies.

Two persons who were interviewed live in their own homes, either with family members or with a life partner. One person lives in a group residence and the remaining six live in individual apartments, each of which is supported by their local mental health agencies. One person reports being employed full-time, and another reports taking on part-time jobs.

Table 9: Reported Treatment Participation and Self-Care Activities

Key Responses	**Number of Responses**
Involved in some way with mental health professional services (has caseworker, sees MD, participates in individual and/or group therapy)	8
Currently taking psychiatric medication	8
Lives in independent housing	2
Lives in Community Mental Health residential support setting (apartment, group home)	7
Exercises regularly (exercises, taking walks, etc.)	5
Engages in some form of spiritual practice	3
Works full- or part-time and enjoying it	1
Engages in social activities with others in the community	3

Engages in hobbies	5

Recommendations for improving how court-ordered involuntary medication should be administered at the hospitals and planned new facilities in Vermont

This section describes responses from nineteen people interviewed this year, including:

- 8 people who received Act 114 medication orders in FY 17
- 1 parent of an individual who received an Act 114 medication order in FY 17
- 1 person whose application for medication was denied in FY 17
- 9 persons who received Act 114 medication at least once prior to FY 17.

Consistent with findings in previous years, a number of recommendations focused on the quality of communications between staff and patients, the importance of staff interpersonal skills with patients, and provision of information to patients about the medication. The following represent a sample of recommendations regarding the above:

- In order to reduce or, ideally, to eliminate the force and coercion recipients of Act 114 medication report they experience, staff should engage with patients in more gentle, patient and personable ways.
    - "Give them more emotional and physical support."
    - "Be kinder to patients, compassionate. Don't abuse them."
    - "I would not force medicate and I would treat them with conversation."
    - "Establish a relationship [with someone whom patients can] trust in the hospital, someone to go to with questions."
    - "The most trust I had in involuntary situations was with the people who took the time, the psych techs….so many of those people did such an amazing job to spend time with me, get to know me, walk with me, really see me as a whole person."

Staff should give patients information about the medication including why it is needed, its potential benefits and side effects, address fears and concerns that patients may have.

- Not just say "you have to take this, explain things to let people know about the court order and about possible reactions."
- Doctors don't like to give out the side effects of medicine because people will think they have side effects when they don't. It's important that doctors give out that information….I wasn't told - maybe at the time I wouldn't have listened but later when I felt better it would have been helpful to know [the side effects]".
- Staff should do their best to explain to the patients what, why, where, when and how medications are distributed, especially when the patient is reactive."

Additional recommendations touched a number of issues and included the following:

- Re: activities to structure time and calm emotions within the hospital setting:
    - "Patients should be allowed to work on art projects and art expressions in order to get out their frustrations about being abused.
- Re: need for privacy to reduce trauma to patients receiving and those viewing forced medication:
    - "Injections should be given out of public view. It's traumatizing for the patient [being restrained] receiving the medication, for other patients who are in the areas and for the nurse who has to give the shot….HIPAA doesn't quite seem to exist in a psych ward. Just because people on the outside don't know, doesn't mean it's ok

[that other patients and staff see what treatment is being administered]. There is no privacy from other patients, doctors talk to each other, there is no way to preserve patient dignity."

- Re: need for true confidentiality in the community mental health system to prevent hospitalizations and need for court-ordered medication. Trust is difficult to establish with providers as people don't feel there is true confidentiality:
  - "There are so many people who are falling through the cracks - people who are minimally hooked up with an agency or feel the agency didn't help them. They don't have a steady tie with any of the designated agencies and they're at risk of suicide…[the designated agencies] would build better trust if clients felt their relationship and communications were truly confidential

Re: the need to medicate people more quickly

- "It took too long for me to get court-ordered medication. It took five months - it was stressful because I was kept on a unit with Level 1 high-acuity patients. It was stressful living there…I got into a protective mode. [On that unit] I took off my glasses when I went into the hall in anticipation that someone would punch me."
- "I am hopeful that at some point this system will address the amount of time passing without medication…. he shouldn't have been allowed to be there unmedicated. While waiting [for the court order] he wouldn't participate in counseling…. Staff felt bad they couldn't help him. This is cruel and unusual punishment, to let it go on that amount of time."

Key Findings Emerging from Interviews

It is important to offer the following information about the interviews. First, the people who volunteered to participate in the interviews were self-selected. Therefore, one cannot view the findings as representative of all people who received Act 114 court-ordered involuntary medication between January 1, 2003, and June 30, 2017. Second, in some cases, people chose not to comment, were unable to remember, or were confused and unable to clarify their responses to some of the circumstances surrounding the court order and administration of medication.

In recruiting people who received court-ordered medication over the span of time between 2003 and June 30, 2017, the study aimed to:

- Generate an increased amount of feedback from individuals who received involuntary medication under Act 114
- Gain new information from people now in the community and no longer under an Act 114 court order about:
  - How receiving involuntary medication has impacted their current circumstances
  - Choices they have made regarding whether and how they are currently engaged in any form of (voluntary) treatment

In this year's assessment, two persons were hospitalized at the time interviews were conducted. The overall percentage of people for whom medication applications were granted and who participated in interviews (n = 17) represented 9% of those who received packets sent out by MHLP (n = 179). This represents a decrease from last year's response rate of 10.7%. One person for whom the medication application was denied was interviewed; this represents less than 0.4% of the 23 persons whose applications were denied and who received interview invitation letters from MHLP.

This year, as in years 2009 through 2016, two different sets of questions were posed to study participants, based on whether they were hospitalized at some point during the study period or had been discharged prior to July 1, 2016, and were living in the community.

Responses from the eight individuals who were hospitalized and received involuntary medication through an Act 114 order at some point between July 1, 2016, and June 30, 2017, showed mixed responses in terms of:

- Reports of how the Act 114 protocols were followed. The majority of individuals reported they were not offered a support person, emotional support or the opportunity to debrief after receiving court-ordered medication. Three said they were aware there were Act 114 protocols, and knew they could file a grievance. Some knew what medication(s) they were receiving, but most did not receive information regarding the dosage or frequency of receiving medication. No one said they'd received information about potential risks and side effects from staff.

- Sense that they had some control. Two individuals said they had some ability to negotiate when and how medications would be administered. Five individuals stated they had no control over any aspect of how the medication order was administered.

- Feelings about how they were treated, supported and respected during that experience. Responses from participants indicated mix feelings about how staff treated them.

Regarding the value and benefit that receiving court-ordered medication has had on their current situations, two individuals felt the state did the right thing, and five disagreed with the decision to be medicated.

Of the seventeen individuals who received Act 114 orders, sixteen continue to take medication, with the majority feeling they need it and report ongoing involvement at various levels with community or private mental health services. Living situations for these people vary from private residences to housing supported by community mental health services. One respondent is employed full-time and another takes odd jobs. These finding are similar to those reported in last year's assessment.

As in past years, participants were asked if they would like any family member to be interviewed. All participants who had at one time received Act 114 medication as well as the person whose application was denied refused the offer, however one parent of an adult who received medication under Act 114 but did not request an interview - called and was interviewed.

Finally, those interviewed noted the critical role that the communication and interpersonal skills of hospital staff can and should play in:

- Treating patients with more compassion and sensitivity
- Helping patients understand why medication is being recommended
- Providing patients with the information needed to exercise more choice in their treatment

Section 2: Outcomes from Implementation of Act 114

As part of earlier assessments, stakeholder input was used to identify a set of outcomes that would be expected with successful implementation of Act 114. These outcomes include:

- Hospital staff awareness of Act 114 provisions
- Decreased length of time between hospital admission and filing petition for involuntary medication
- Decreased length of stay at hospital for persons receiving involuntary medication
- Reduced readmission rates and increased length of community stay for persons receiving involuntary medication

In addition, persons currently living in the community were asked to describe the impact that receiving nonemergency involuntary medication had on their current lives and their engagement in treatment.

For FY17, achievement of outcomes was as follows:

- Staff awareness of Act 114: Documentation was not sufficient to conclude that all staff at all four hospitals administering medications under Act 114 in FY17 were aware of the provisions as shown by documentation of adherence to Act 114 provisions. Improvements in documentation are particularly needed at the Retreat and VPCH.
- Time between admission and petition: In FY17, 39% of Act 114 petitions were filed within 30 days of the date of hospital admission; 34% were filed 30-60 days after admission (see Table 10). This finding demonstrates that petitions were filed more quickly in FY17 than in past years.

Table 10: Time (in days) Between Admission to VSH and Filing Act 114 Petition

Time from Admission to Petition	FY of petition filing (7/1 to 6/30)							
	FY2014		FY2015		FY2016		FY2017	
	Freq	Percent	Freq	Percent	Freq	Percent	Freq	Percent
<30 days	18	26%	23	30%	26	30%	24	39%
30-60 days	22	32%	23	30%	23	26%	21	34%
61 - 180 days	18	26%	21	28%	26	30%	11	18%
181 - 365 days	9	13%	4	5%	5	6%	1	2%
>365 days	2	3%	5	7%	8	9%	4	7%
Total	69	100%	76	100%	88	100%	61	100%

In FY17, it took on average 51 days from admission to filing the Act 114 petition (see Table 11). Overall, it took about 62 days from admission to the Act 114 order. This represents a decrease in time from previous years. It took on average 11 days from the date the petition was filed to the date an order was issued. This was also less time than in most previous years.

Table 11: Mean Time Delays between Steps in Act 114 Process
(Excluding cases in which petition filed more than 1 year after admission)

FY of Petition (7/1 t0 6/30)	Time (in days) from:					
	Admission to Filing Petition		**Petition to Order**		**Admission to Order**	
	Mean	*Std. Dev.*	Mean	*Std. Dev.*	Mean	*Std. Dev.*
2012	50.21	*35.07*	14.38	*6.82*	65.67	*35.03*
2013	57.55	*40.91*	13.44	*9.64*	66.71	*39.71*
2014	93.17	*107.36*	16.16	*8.11*	109.33	*109.41*
2015	64.93	*55.89*	15.87	*9.65*	81.13	*61.01*
2016	67.60	*61.37*	12.21	*6.91*	79.63	*63.01*
2017	51.16	*56.16*	10.97	*6.91*	62.12	*57.65*

In past assessments, and again this year, hospital staff reported that time delays in the Act 114 process were often due to legal procedures. The first of these is separation of the commitment and Act 114 hearings. As shown in Table 12, in FY 17, 50% of Act 114 petitions had been filed prior to the commitment orders; 13% were filed within seven days of the commitment date; and, 19% were filed 30 days or more after the commitment. On average, it took 18 days from the commitment date to the date on which Act 114 petitions were filed. Once a petition was filed, it took an average of 11 days in FY17 for an order to be issued (see Table 11).

Table 12: Time between Date of Commitment and Act 114 Petition Filing Date
(Excludes cases in which time was 1 year or more)

Petition filed:	**FY14**		**FY15**		**FY16**		**FY17**	
	Freq	Percent	Freq	Percent	Freq	Percent	Freq	Percent
Before commitment	16	24%	15	22%	25	36%	24	50%
Same day as commitment	10	15%	6	9%	1	1%	0	0%
Within 7 days of commitment	19	28%	13	19%	10	14%	6	13%
8 - 30 days following commitment	12	18%	15	22%	13	19%	9	19%
30+ days after commitment	11	16%	20	29%	20	29%	9	19%
Total	68	100%	69	100%	69	100%	48	100%

- Length of stay: Of the 52 individuals with Act 114 orders in FY17, 46 (88%) were discharged from psychiatric inpatient care, on average, 122 days (approximately four months) after admission, and 69 days (about two months) after the Act 114 order was issued.

Table 7: Length of Stay for Patients under Act 114 Orders Who Were Discharged from Hospital

FY Petition Filing (7/1 t0 6/30)	**Average Length of Stay (in days) from:**			
	Admission to Discharge		**Order to Discharge**	
	Mean	*Std. Dev.*	Mean	*Std. Dev.*
2012 (n=23)	128.09	*67.41*	63.52	*40.48*
2013 (n=21)	123.38	*41.34*	71.00	*38.89*
2014 (n=35)	154.67	*125.92*	85.77	*62.99*
2015 (n=45)	149.60	*87.87*	97.07	*69.56*
2016 (n=41)	152.83	*121.00*	58.93	*49.00*
2017 (n= 46)	122.36	*75.41*	68.90	*47.83*

- Readmission Rates: Of the 46 patients with Act 114 orders who were discharged, seven individuals (15%) had been readmitted by the time of this review.

Future assessments of Act 114 implementation may address additional outcomes identified by hospital leadership during our FY17 interviews. These outcomes include:

- Perceived treatment in hospital after receiving medication under Act 114
  - Quality of relationship with treatment team
  - Access to treatment
  - Length of stay
- Continued use of medication after discharge
- Engagement with community services (e.g., attend follow-up appointments with physical and mental health providers)
- Quality of life measures
  - Access to services
  - Achievement of individually defined wellness
  - Stability in community
  - Independent living
  - Participation in community
  - Maintaining and/or improving relationships with family and friends
- Reasons for readmission along with readmission rate.

Section 3: Steps to Achieve a Noncoercive Mental Health System

The Department of Mental Health (DMH) leadership team, including the Commissioner, met with Flint Springs Associates (FSA) to review steps DMH took during FY17 toward achieving a noncoercive mental health system. These include:

1. In partnership with the Vermont Cooperative for Practice Improvement and Innovation (VCPI), DMH continued to provide assistance and support for the implementation of evidence- based practices, including the Six Core Strategies for reduction of emergency interventions such as seclusion and restraint at designated hospitals as well as the promotion of trauma-informed care, recovery, consumer-driven care and resiliency.

2. DMH continues to fund residential programs and crisis beds to strengthen community-based care.

3. DMH continues to support peer programs, expanded hours for the Peer Warm Line run by Pathways, the Patient Representatives, and the Workforce Wellness Coalition.

4. Multi-stakeholder advisory groups continue to meet and provide DMH with feedback on system-of-care and policy issues, e.g., the State Program Standing Committee for Adult Mental Health and the Community Mental Health Services Block Grant Planning Council.

5. Continued training for police officers and emergency dispatch staff to identify a situation as a mental health crisis and to bring in the designated agency (DA) in the area.

6. In FY15, DMH funded two pilot sites to implement Open Dialogue, a service-delivery model with proven effectiveness in lowering the rates of hospitalization and medication use for persons with schizophrenia. The pilot program included clinical training, implementation of the model, and evaluation of outcomes. The program continues through funding to VCPI to provide training and support more widely than the pilot sites.

7. DMH continues to support the Zero Suicide model. The model includes training in the Collaborative Approach to Managing Suicide (CAMS) for designated agencies and partner agencies, including home health agencies.

8. During FY15, DMH began research with the Department of Health to identify the population of individuals with first-episode psychosis. During FY16, DMH formed a work group to examine models, identify directions, and begin to develop strategies to address the needs of this population. This work continued into FY17.

9. DMH continues to support a telepsychiatry program to bring psychiatry to small hospitals. This allows hospitals without a psychiatrist on staff to obtain the two certifications needed for involuntary hospitalization without requiring the patient to be transported to another hospital.

Flint Springs Associates offers the following recommendations:

Hospital Practices

FSA recommends that staff at hospitals administering Act 114 medication continue efforts to help patients understand the reasoning behind the decision to seek an order for involuntary medication and to invest time in talking with patients about the process and available options.

Beginning with the years in which patient representatives employed by Vermont Psychiatric Survivors (VPS) have been interviewed, the report has included a recommendation that, with consent of the patient, patient representatives be included in treatment team meetings. As patient representatives bring the unique perspective of persons with lived experience, their inclusion could support both the interests of patients and the efforts of hospital staff seeking to help patients achieve recovery in the least-coercive manner.

To complement the prior recommendation, patient representatives should be able to access information as to where people are located in the inpatient hospitals and whether they are receiving Act 114 medication or applications have been filed under Act 114. This information would help patient representatives reach out to more people.

In order to maintain clear records for documenting implementation of Act 114 in accordance with provisions of the statute, FSA recommends that each hospital maintain an electronic file or section within the electronic file for persons receiving medication under Act 114. This file should contain:

- Copy of court order
- Copy of Patient Information Form
- Copies of every Implementation of Court-Ordered Medication Form
- Copy of 7-day reviews – Hospitals should use a specific 7-day review form, rather than progress notes, to ensure that three specific issues are addressed: continued need for involuntary medication, effectiveness of medication, and side effects of the medication.
- Copies of Support Person Letter, if used
- Copies of certificate of need (CON) or other documentation of emergency procedure, if needed
- Summary of medications based on court order
- Specific time line of court order based on language of court order

Annual Act 114 Assessment

FSA recommends that the following steps continue to be used in future assessments of Act 114:

- The annual assessment should expand to include these additional outcomes for persons receiving medication under Act 114l:
    - Perceived treatment in hospital after receiving medication
    - Continued use of medication after discharge
    - Engagement with community services
    - Quality-of life-measures such as achievement of individually defined wellness; independent living in community

- Readmission rates and reasons for readmission

- Provide a financial incentive for the participation of individuals who have received court-ordered medication.

- Request input from individuals through extensive outreach efforts to any person who received medication under Act 114 in previous years, not just the year under review, in order to learn about longer-term outcomes including individuals' engagement in treatment and their lives in the community as well as experiences receiving medication under Act 114 orders.

- Ask persons interviewed if they would like any family members to be interviewed and pursue these as permitted.

- Use the same time period (FY or calendar year) for both the Commissioner's assessment of Act 114 implementation and the independent assessment.