DISABILITY RIGHTS VERMONT

formerly Vermont Protection & Advocacy
(800) 834-7890 (Toll Free)
(802) 229-1355 (Voice)
(802) 229-2603 (TTY)
(802) 229-1359 (Fax)
141 Main Street, Suite # 7, Montpelier, VT 05602

Date: October 2, 2014
From: Ed Paquin, Executive Director, DRVT
To: Mental Health Oversight Committee
In re.: Consistency of proposed EIP rules with Act 79

DRVT feels it is important to point out that many aspects of the statewide EIP standards proposed by DMH two years ago were very appropriate and supported by DRVT and we hope that when the new version of the rule is promulgated, those aspects remain unchanged.

There were three points that led to DRVT, and eventually LCAR, to conclude that the DMH EIP proposal violated 18 V.S.A. § 7251(9), PRINCIPLES FOR MENTAL HEALTH CARE REFORM:

> "Individuals with a mental health condition who are in the custody of the Commissioner of Mental Health and who receive treatment in an acute inpatient hospital, intensive residential recovery facility, or a secure residential facility **shall be afforded at least the same rights and protections as those individuals cared for at the former Vermont State Hospital**"

And potentially 18 V.S.A. §7629(c):

> "It is the policy of the general assembly to **work towards a mental health system that does not require coercion or the use of involuntary medication**."

The first point was DMH's failure to have the EIP rule apply to all individuals in its custody who are placed in a hospital or other treatment facility, as required by §7251(9). Instead DMH proposed that individuals held in DMH custody for evaluation or treatment be afforded the protections of these

statewide standards, but did not include the patients held in emergency departments or prisons due to lack of capacity in psychiatric units. DRVT suggests that the clear intent of this law was to assure that any person being held for evaluation or treatment in DMH custody would be protected by these standards. This position is a real problem given the fact that the reason people are being held in ED's and prisons when they should be placed in a psychiatric unit is due to a failure to provide sufficient capacity. DRVT suggests that individuals should not be allowed to be subjected to uses of force without the protections afforded by statewide EIP standards simply because of the location in which they are being detained. Rather, anyone held in DMH custody for evaluation and treatment should have the same rights and protections as were applied at VSH.

The second issue involved the DMH proposal to change the Vermont State Hospital Policy requiring that only a licensed physician could order the use of force against a patient. Instead, DMH has proposed to allow individuals with less training and qualifications than a licensed medical doctor to make those orders. After VSH closed, Vermont's inpatient system was knowingly decentralized. The Legislature wisely enacted law that specifically referenced protective standards present at VSH instead of minimums, such as Joint Commission and CMS standards, already in effect at community hospitals. It is one thing for an individual to voluntarily accept treatment from a "licensed independent practitioner." It is very different, and a lessening of rights, to subject them to uses of force authorized by a potentially drastically increased range of providers. We see this in the context of the training received in previous efforts to reduce seclusion and restraint at VSH in which seclusion and restraint were to be seen as "failures of treatment". If more people can order the use of force, and there is no additional motivation to try to resolve the situation while the input of a licensed physician is sought, the numbers of these procedures is unlikely to decrease, violating our mandate to work towards a non-coercive mental health system.

In addition, the standard at VSH required that an order for a use of force should not be made without personal observation of the patient by the individual ordering the EIP. Under VSH policy **telephone orders for EIMs were specifically and clearly prohibited.** See VSH EIP Policy Section I. D. DRVT provided LCAR with the attached article by Dr. Janice LeBel of the Massachusetts Department of Mental Health entitled*, Regulatory Change: A Pathway to Eliminating Seclusion and Restraint or "Regulatory Scotoma"* from ps.psychiatryonline.org, February 2008 Vol. 59 No. 2, as an example of how another State determined that requiring the most qualified and authoritative professionals, physicians, to be personally involved in the use of force was not just appropriate but critical to the overall goal of reducing the use of force against patients with mental health concerns.

DRVT has noted some omissions in the DMH responses that were provided to the committee's questions found in the email from Katie McLinn on September 30, 2014. In 2010 DRVT reached a settlement agreement with VSH regarding two important points: 1) requiring nursing assessments at the time of admission to identify what the patient's preference for EIP would be and what can help deescalate them, and requiring that that information be available and utilized when possible prior to initiating EIPS, and 2) requiring the use of specific questions on CON forms in order to highlight the prohibition against using force in combination unnecessarily. These protections should help bring the patient into the conversation about EIPs something that is recognized as important in reducing the trauma of and need for uses of force. (That agreement is attached.) DRVT would also note that there has for decades been a definition of "emergency" in force at VSH: "Emergency: a significant change in patient's condition or past behavior resulting in the imminent threat of serious bodily harm to the patient or others, so that some action is immediately necessary to protect the patient or others and it is impracticable to first obtain consent." Doe v. Miller Settlement II.D. And although CMS has approved VPCH's policies, the DMH response does not address how CMS's policies are different from those previously found at VSH.

In summary, the Legislature made a commitment to patients held in DMH custody but treated at locations around the state, often in private hospitals, that they would be protected from unnecessary uses of force and provided with the rights equal to those held by patients at the Vermont State Hospital. DRVT believes that this promise was not undertaken lightly, but was made knowing that our mental health system was moving to a less centralized, more privatized reality. This commitment is not easy or without costs. However, to deprive future patients of those same rights and protections would violate the promise made to patients in a more decentralized and privatized system. DRVT hopes that statewide standards for EIP use can be devised that comply with or exceed those in place at VSH. Such a standard does not conflict with CMS standards as those clearly provide a minimum and recognize that when a state enacts higher standards, they must be met.

Thank you for considering our comments.