2014 Acts and Resolves No. 192, Sec. 23:
Sec. 23. LEGISLATIVE INTENT; EMERGENCY INVOLUNTARY PROCEDURES

The Mental Health Oversight Committee shall identify and include in its 2014 annual report a list of policies that may require clarification of legislative intent in order for the Department of Mental Health to proceed with rulemaking pursuant to 2012 Acts and Resolves No.79, Sec. 33a. The Committee shall also make recommendations as to any legislation needed to clarify legislative intent for those policies identified by the Committee.

Emergency Involuntary Procedures (EIPs) vs. Involuntary Medication

EIPs	Involuntary Medication
Covers: • Seclusion • Restraint, including chemical restraint (i.e. emergency medication)	Covers: • Medication
Used in response to an emergency situation on a short-term basis	Used therapeutically for the length of a court order
Does *not* require a court order	Requires a court order
Applies to all persons receiving medical treatment, not only those having psychiatric illnesses	Applies only to persons receiving treatment for psychiatric illnesses

2012 Acts and Resolves No. 79, Sec. 33a:
Sec. 33a. RULEMAKING

On or before September 1, 2012, the commissioner of mental health shall initiate a rulemaking process that establishes standards *that meet or exceed and are consistent with standards set by the Centers for Medicare and Medicaid Services and the Joint Commission* for the use and reporting of the emergency involuntary procedures of seclusion or restraint on *individuals within the custody of the commissioner* and that require the personnel performing emergency involuntary procedures to receive training and certification on the use of these procedures. Standards established by rule shall be consistent with the recommendations made pursuant to Sec. 33(a)(1) and (3) of this act.

2012 Acts and Resolves No. 79, Sec. 33:

Sec. 33. REPORTS

(a) On or before January 15, 2013, the department of mental health shall report to the senate committee on health and welfare and the house committees on human services and on judiciary on issues and protections relating to decentralizing high intensity inpatient mental health care. The commissioner of mental health shall:

(1) Recommend whether any statutory changes are needed to preserve the rights afforded to patients in the Vermont State Hospital. In so doing, the commissioner shall consider 18 V.S.A. §§ 7705 and 7707, the Vermont Hospital Patient Bill of Rights as provided in 18 V.S.A. § 1852, the settlement order in Doe, et al. v. Miller, et al., docket number S-142-82-Wnc dated May 1984, and other state and federal regulatory and accreditation requirements related to patient rights.

* * *

(3) Develop consistent definitions and measurement specifications for measures relating to seclusion and restraint and other key indicators, in collaboration with the designated hospitals. The commissioner shall *prioritize the use of measures developed by national organizations such as the Joint Commission and the Centers for Medicare and Medicaid Services*.

* * *

18 V.S.A. § 7251(9):

§ 7251. PRINCIPLES FOR MENTAL HEALTH CARE REFORM

The general assembly adopts the following principles as a framework for reforming the mental health care system in Vermont:

* * *

(9) 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*.

Letter from LCAR to Secretary of State James Condos (dated Dec. 6, 2013) stated that the Department of Mental Health's proposed rule is arbitrary and contrary to the intent of the General Assembly with regard to the following topics:

- Examination and evaluation of a person under an order for seclusion or restraint and issuance of prescriptions for emergency involuntary medication
    - CMS allows a physician or licensed independent practitioner to issue the order for seclusion or restraint. (42 CFR § 482.13(e)(5)).
    - 18 V.S.A. § 7251(9) requires that "[i]ndividuals 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… shall be afforded at least the same rights and protections as those individuals cared for at the former Vermont State Hospital". Only physicians could order seclusion and restraint at the Vermont State Hospital.
- Application of rule to all persons within the custody of the Commissioner of Mental Health
    - 2012 Acts and Resolves No. 79, Sec. 33a directs rules on the use/reporting of seclusion and restraint on "individuals within the custody of the commissioner"
    - Children can be in the custody of the Commissioner, but were not contemplated by DMH's rule. Likewise, involuntary patients waiting for a psychiatric bed on a medical unit or in an emergency department were not contemplated by the rule. What seclusion and restraint rules should apply to these groups?

C/O LEGISLATIVE COUNCIL
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STATE OF VERMONT
GENERAL ASSEMBLY

Legislative Committee on Administrative Rules

December 6, 2013

The Honorable James C. Condos
Secretary of State
26 Terrace Street, Drawer 9
Montpelier, VT 05609-1101

Dear Secretary Condos:

On November 14, 2013, the Joint Legislative Committee on Administrative Rules voted to object to the Agency of Human Services, Department of Mental Health's final proposal 13-P01, Regulations Establishing Standards for Emergency Involuntary Procedures. On December 6, 2013, the committee considered the Department's response to the objection and, pursuant to 3 V.S.A. § 842, voted to file its objection in certified form with the Secretary of State.

The committee objects that the rule is arbitrary and is contrary to the intent of the legislature under 18 V.S.A. § 7251(9) and 2012 Acts and Resolves No. 79, Secs. 33(a)(1) and 33a because, with respect to examination and evaluation by a physician and the issuance of prescriptions for involuntary medication, the rule does not afford patients at least the same rights and protections as were afforded to patients at the Vermont State Hospital and because the rule does not apply to all individuals within the custody of the Commissioner of Mental Health.

The committee requests that your office inform any interested party that its objection has legal effect under 3 V.S.A § 842(b) of the Administrative Procedure Act. That section provides in part: "to the extent that the objection covers a rule or a portion of a rule, the burden of proof shall thereafter be on the agency in any action for judicial review or for enforcement of the rule to establish that the part objected to is within the authority delegated to the agency, is consistent with the intent of the legislature, is not arbitrary, and the agency did adhere to the strategy for maximizing public input prescribed by the interagency committee on administrative rules."

Sincerely,

Sen. Mark MacDonald, Chair
Legislative Committee on Administrative Rules

cc: Members, Legislative Committee on Administrative Rules
Paul Dupre, Commissioner, Department of Mental Health
Dena Monahan, Department of Mental Health
Louise Corliss, APA Clerk, Office of the Secretary of State

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Except from the VSH's Emergency Involuntary Procedures Policy

(Sec. B (Patient Care), Page 3, pertaining specifically to emergency involuntary medication)

No individual who has not been found by a court to be subject to an order for non-emergency involuntary medication pursuant to 18 VSA §7627 shall be involuntarily medicated except in an emergency. If involuntary medication has been ordered as a result of a finding that an emergency exists, the patient shall be offered oral medication, but may be given an injection if oral medication is declined or is impossible to administer. When it becomes necessary to administer involuntary medication by injection in emergency situations, a non-depot medication that is consistent with current American Psychiatric Association practice guidelines will be used. Depot medications shall not be used to involuntarily medicate any person unless pursuant to an order for non-emergency involuntary medication pursuant to 18 VSA §7627. All phases of an involuntary medication procedure shall be properly documented.

A. If, on the basis of personal observation, any VSH staff member believes an emergency exists with respect to a patient, a physician shall be consulted immediately.

B. The physician shall personally examine the patient.

C. The physician shall determine whether such facts exist with regard to the patient which necessitates his/her emergency involuntary medication. (The required facts are specified in the "Certificate of Need" form (*PN-04-05*).

D. If, after personal observation of the patient, and only if emergency medication is found to be necessary, the physician may order the involuntary administration of medication, as set forth in I, above. Orders for emergency medication shall not be written as a PRN, telephone or standing order.

E. A physician shall assess the patient within one hour of the administration of the emergency involuntary psychotropic medication.

F. A physician shall report the emergency involuntary medication of the patient to the Medical Director or physician designated to receive such reports on weekends or holidays, within twenty-four (24) hours.

G. Whenever three episodes of emergency involuntary psychotropic medication occur within a four-week period, the patient's treatment team shall, within three business days, conduct a review of the individual's treatment plan, and, in a clinically-justifiable