STATE OF VERMONT
WASHINGTON COUNTY, SS.

WASHINGTON SUPERIOR COURT

JOHN DOE, on behalf of himself and all others similarly situated, Plaintiffs,	)	
vs.	)	
SUTHERLAND MILLER, Ph.D. individually and in his capacity as Commissioner of Mental Health for the State of Vermont, and	)	DOCKET NO. S-142-82-Wnc
GEORGE BROOKS, individually and in his capacity as Superintendent of the Vermont State Hospital, Defendants.	)	

MOTION FOR ORDER APPROVING STIPULATION OF VOLUNTARY DISMISSAL WITHOUT PREJUDICE

Pursuant to Rules 23(e) and 41(a)(1) the parties move this honorable Court for the entry of an order approving the stipulation of voluntary dismissal without prejudice, under such terms and conditions of notice to the members of the plaintiff class as the court directs.

The parties hereby stipulate as follows:

1. This cause shall be voluntarily dismissed without prejudice to the named Plaintiffs or any member of the class to refile the action if Plaintiffs in good faith believe that the terms of the Rules attached to this motion are not being implemented or complied with by the Defendants or their successors in office.

2. The Rules Governing Involuntary Medication, Seclusion and Mechanical Restraints at the Vermont State Hospital, are made part of this stipulation and motion and shall be promulgated as official policy of the Vermont State Hospital by the Vermont Commissioner of Mental Health, consistent with his powers and duties under 18 V.S.A. §7401.

3. The attached Rules will become effective within seven days of approval of this stipulation. The Commissioner of Mental Health shall assure their implementation according to the following time table and procedures (times referred to below are times elapsed from the date of the final court order of approval of this stipulation):

(a) Rules and required forms and certificates will be printed and distributed to all VSH staff, Vermont Legal Aid, administrative staff of the Department of Mental Health, the Board of Mental Health and other appropriate persons or agencies designated by the Commissioner. - 45 days

(b) Copies of the Rules shall be made available to patients at VSH either upon request or shall be available for review on each unit at VSH. - 45 days

(c) Training and compliance materials for distribution to VSH staff shall be prepared by the Commissioner or his designate, printed and distributed to persons noted in paragraph 3(a). - 60 days

(d) The commissioner shall designate and empanel the Treatment Review Panel and make such agreements concerning costs, administrative and clerical support or other arrangements as may be necessary in the Commissioner's judgment to ensure the effective functioning of the Panel. - 90 days

(e) The Chief of Clinical Services shall be designated by the Commissioner. - 45 days

(f) A detailed plan, timetable and materials for training all appropriate VSH and Department of Mental Health staff shall be developed under the supervision of the Chief of Clinical Services or his/her designate, in order to ensure maximum understanding of an implementation of the Rules. Counsel for the plaintiffs, appropriate representatives of the VSH patient community, and such other persons who may constructively add to the development of the training plan and materials shall be involved in all phases. - 90 days

4. The Commissioner or the Treatment Review Panel shall design a method of studying, monitoring and analyzing the implementation of the Rules in particular and the involuntary medication, seclusion and restraining of VSH patients to aid the Commissioner, the Treatment Review Panel and the Chief of Clinical Services in evaluating the care and treatment provided at VSH. The study shall consider at least but shall not necessarily be limited to the following:

(1) Number of administrations of involuntary treatment or control.

(2) Frequency of emergency treatments or control.

(3) Recurrence of patients who are administered involuntary treatment or control whether or not on an emergency basis.

(4) Nature and duration of the involuntary treatments or controls.

(5) Correlation, if any, between frequency, type and duration of involuntary treatment or control and staffing patterns and experience and training of staff.

(6) Units of VSH and shifts on which involuntary treatments and controls occur (e.g. whether acute short-term, continued (chronic) treatment, security, etc.) and their distribution.

(7) Nature and frequency of factual situations and reasons given for use of involuntary treatment or control, correlated with patient legal status, living unit, treating physician, etc. -90 days

5. The parties agree to jointly prepare a suggested notice to the Court which summarizes the elements of this stipulation and the Rules, to be posted at the Vermont State Hospital in order to provide adequate notice to the class herein under V.R.C.P 23(e), prior to final Court approval of the voluntary dismissal.

6. This stipulation shall not constitute any admission of liability by the Defendants;

rather the actions herein are voluntarily entered into in the interest of precluding further litigation. Nor shall this stipulation be regarded as an adjudication of the merits of any of the claims asserted by the plaintiff class.

7. The parties reserve the right, from time to time, to make mutually agreeable changes in, or adjustments to the timetable for, implementation of this stipulation and the attached Rules, consistent with the general framework and policies set forth herein, and in recognition of plaintiffs' rights to refile their claims in good faith within the time period established in paragraph 1.

8. The parties agree to absorb their own costs incurred in this action.

DATED: _____

William A. Dalton, Esq.
Assistant Attorney General
Attorney for Defendants

Kenneth A. Schatz, Esq.

John D. Shullenberger, Esq.

John R. Durrance, Esq.
Attorneys for Plaintiffs

Rec'd 5-17-84

STATE OF VERMONT
WASHINGTON COUNTY, SS.

WASHINGTON SUPERIOR COURT

JOHN DOE,
on behalf of himself and
all others similarly situated,
Plaintiffs,

vs.

SUTHERLAND MILLER, Ph.D.
individually and in his
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GEORGE BROOKS,
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DOCKET NO. S-142-82-Wnc

'84 MAY 14 PM 5 27
SUPERIOR COURT
WASHINGTON COUNTY

ORDER

Upon the Motion of the parties for approval of Stipulation of Dismissal without Prejudice, pursuant to V.R.C.P. Rules 23(e) and 41(a)(1), this Court being fully advised in the premises

IT IS HEREBY ORDERED:

1. That within seven (7) days the parties shall post in conspicuous places throughout the Vermont State Hospital a summary of the essential elements of the Stipulation of Dismissal and the Rules Governing Involuntary Medication, Seclusion and Mechanical Restraints at the Vermont State Hospital, and shall make available copies of such documents to class members who request to review them.

2. The notice shall explain to class members that they may comment on or be heard on the Stipulation of Dismissal and terms of settlement by submitting their statements in writing to:

Doe, et al v. Miller, et al,
Docket No. S-142-82-Wnc

Settlement Order
Attention: Ms. Josephine Romano, Clerk
Washington Superior Court
P.O. Box 426
Montpelier, Vermont 05602

3. A final hearing on the motion for approval shall be held on Fri, June 8, 1984, at 3:00 ~~A.M.~~/P.M.

Dated: May 14, 1984

Approved as to form:

Attorney for Plaintiffs

Attorney for Defendants

Enter:

Hon. John P. Meaker
Superior Court Judge

Assistant Judge

Assistant Judge

RULES GOVERNING INVOLUNTARY MEDICATION, SECLUSION AND MECHANICAL RESTRAINTS AT THE VERMONT STATE HOSPITAL.

I. GENERAL POLICY

Patients at the Vermont State Hospital have the right to make informed choices concerning their mode of treatment. A person in Vermont State Hospital who has not been found by a court to be a person in need of treatment or a person in need of further treatment and committed to Vermont State Hospital, shall not be treated involuntarily in a non-emergency situation. Treatment can only be provided if the patient has given his or her consent without pressure or coercion. Some patients seriously object to taking psychotropic medication. Many patients are particularly concerned about the adverse effects of psychotropic medication. Such effects include permanent muscular disorders, diminished spontaneity, blurred vision, palpitations, diarrhea or constipation, low blood pressure and fatigue. Consequently, the patient and staff must weigh the possible benefits against the risks of treatment with psychotropic medication.

The only basis for involuntary administration of medication, seclusion or restraints to non-committed patients is in the legitimate exercise of the State's authority to control an emergency and protect patients from themselves or others. When necessary, these measures shall be utilized in the least intrusive and restrictive manner and for the least amount of time consistent with the need to protect patients and others and consistent with good medical practice. These measures shall not be unnecessarily used in combination.

Where possible, written documentation of the use of these measures shall occur prior to their implementation. Staff shall abide by the following policies and procedures.

II. DEFINITIONS

A. "Chief of Clinical Services" - A psychiatrist responsible for supervising the care and treatment of all the patients present in the Vermont State Hospital.

B. "Consent" - Agreement by an individual to undergo a particular course of treatment after receiving an explanation of and evincing an understanding of the nature of the proposed course of treatment, including the potential risks and benefits of that particular mode of treatment. An individual must have the capacity to give consent i.e., s/he has the mental ability to make decisions concerning medical treatment or other basic decisions with respect to managing his/her personal care.

C. "Documentation" - The factual basis for all opinions on the prescribed forms and in other records must be explicit, descriptive, and detailed, not conclusory. The test of the adequacy of documentation is whether an independent, qualified mental health professional could readily verify from such documentation the factual basis for and the medical necessity of the prescribed action; as well as its involuntary administration.

The elements of adequacy shall enable the reviewer to determine:

1. The necessity for the action taken to control the emergency.

2. The expected or desired result of the action on the patient's behavior or condition.

3. Whether the action is an accepted medical practice or is experimental.

4. Whether less intrusive actions were considered.

5. The risks of adverse side effects.

6. The extent of bodily intrusion, pain, or discomfort.

D. "Emergency" - A significant change in the 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.

E. "Involuntary Medication" - The administration of any medication against a person's will.

F. "Involuntary Patient" - A person present at the Vermont State Hospital who has been found by a court to be a person in need of treatment or a patient in need of further treatment pursuant to the statutory definitions found at 18 V.S.A. §§7101 (16) and (17).

G. "Mechanical Restraint" - Any mechanical device which limits freedom of motion by a patient.

H. "Nurse" - A licensed registered nurse on the staff of the Vermont State Hospital.

I. "Physician" - A licensed physician on the staff of the Vermont State Hospital.

J. "Psychologist" - A licensed psychologist on the staff of the Vermont State Hospital.

K. "Qualified Mental Health Professional" - Psychiatrist, physician, psychologist, social worker, nurse, or ward supervisor, who by training and experience can identify mental illness and recognize behavior which would constitute an emergency.

L. "Regular Working Hours" - The usual daytime working hours are 8:00 a.m. to 4:00 p.m.

M. "Seclusion" - Confinement of a patient alone in a locked room. During prescribed sleeping hours on the male maximum security ward, patients may be locked into their sleeping quarters in order to ensure the safety of patients and staff. Hospital staff shall be careful to provide adequately for individual patient care and comfort during these hours.

N. "Staff" - Nurses, physicians, psychologists, psychiatrists, social workers and aides who are employed by the Vermont State Hospital to provide care and treatment for patients.

O. "Treatment Review Panel" - An interdisciplinary panel appointed by the Commissioner consisting of at least a psychiatrist, psychologist, social worker and nurse none of whom are affiliated with the Vermont State Hospital.

III. EMERGENCY PROCEDURES.

A. Involuntary Medication

1. General Policy

No individual who has not been found by a court to be a

person in need of treatment or a patient in need of further treatment 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 rapid-acting major tranquilizer will be used. Long acting medications shall not be used to involuntarily medicate any person who has not been found by a court to be a person in need of treatment or a patient in need of further treatment.

All phases of an involuntary medication procedure shall be properly documented.

2. Procedure

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 necessitate his/her involuntary medication (The required facts are specified in the "Certificate of Need for Emergency Involuntary Administration of Medication".).

d. If, after personal observation of the patient, and only if found to be necessary, the physician may order the involuntary administration of medication, as set forth in A.

e. The physician shall certify the need for the emergency involuntary administration of medication at the time s/he observes or soon as practicable after observing the patient, and shall provide required documentation.

f. A physician shall report the involuntary medication of the patient to the Chief of clinical services (or physician designated to receive such reports on weekends and holidays, within 24 hours).

g. When, in the opinion of the physician, based upon personal observation or facts reliably reported to him by one who has personally observed the patient, the emergency ceases to exist, administration of involuntary medication shall be terminated immediately.

h. By the end of 24 hours, the Chief of clinical services (or physician designated to receive such reports on weekends and holidays, within 24 hours) shall determine whether the emergency continues to exist and the need for continuing medication because of the emergency. If the medical record and certificate of need for emergency involuntary medication do not adequately document the necessity for medication or if alternative less intrusive modes of control have not been carefully considered or attempted, the Chief of clinical services shall disapprove continuing the administration of involuntary medication, unless he or she has made a personal and independent clinical determination consistent with paragraphs a-e of this section.

i. If the emergency continues for more than 24 hours, an independent review by the Chief of clinical services shall occur

within the next 24 hours. The Chief of clinical services shall review the situation on each working day thereafter until the emergency ceases to exist.

j. If the emergency continues for more than 3 days, the Chief of clinical services may initiate appropriate legal proceedings to determine the competency of the patient, to refuse involuntary medication.

k. Counsel for the patient and nearest relative or guardian of the patient with the patient's consent shall be notified of emergency involuntary administration of medication within 24 hours. Counsel shall be provided with a copy of the Certificate of Need for Emergency Involuntary Medication.

B. Seclusion

1. General Policy

Secluding a patient is a valid procedure that may be used only in emergency circumstances. Seclusion, properly used, can provide containment, isolation and decreased sensory input for the patient with such needs. Its usefulness in reducing symptoms in the drug refusing patient may be especially important.

Placement of a patient in seclusion and the duration of its use shall be kept to a minimum, consistent with the safe and effective care of patients, and shall adequately accommodate a patient's physical and environmental needs without undue violation of his or her personal dignity. No order for seclusion shall extend beyond two hours and the patient shall be observed at least every 15 minutes, by a qualified mental health professional.

All phases of seclusion of a patient shall be properly documented.

2. Procedure

a. The seclusion of a patient may be ordered only after personal observation of emergency circumstances by a physician; or in the physician's absence, a nurse or Unit/Area supervisor. A certification of need for emergency seclusion shall be entered in the patient's record that documents emergency circumstances requiring the use of seclusion.

b. If the seclusion of a patient occurs during regular working hours without prior personal observation by a physician, the patient shall be seen by a nurse within 30 minutes and a physician within 30 minutes thereafter. The physician shall either order this patient out of seclusion or certify the need for continuing an emergency seclusion, beyond that point in time.

c. If the seclusion of a patient occurs outside regular working hours without personal observation by a physician, the patient shall be seen by a nurse within 30 minutes and a physician shall be consulted within 30 minutes thereafter, who shall either order the patient out of seclusion or certify the need for continuing an emergency seclusion, beyond that point in time. In such instances, the physician may authorize additional seclusions, up to 2 hours each, which may be administered consecutively without consultation with the physician, but only after the nurse reviews each seclusion and documents the continuing emergency necessity for an additional time period. No more than 3 consecutive

seclusions may be ordered without consultation with or personal observation by the physician.

d. On the next working day following an order of seclusion, the Chief of clinical services or his designee shall review any orders for seclusion of the patient. If a patient is secluded for more than 10 hours in any 24 hour period or for more than 24 hours in any 5 day period, the staff shall report the case at the next patient-oriented crisis meeting and submit a written report to the Chief of clinical services and the commissioner of mental health, who shall review the Certificate of Need and other documentation for adequacy.

e. Counsel for the patient and, with the patient's consent, nearest relative or guardian shall be notified of seclusion within 24 hours. Counsel shall be provided with a copy of the Certificate of Need for Seclusion.

C. Mechanical Restraints

A. General Policy

Involuntary placment of a patient in mechanical restraints is a valid procedure that may be used only in emergency circumstances.

The use of mechanical restraints shall be kept to a minimum consistent with the safe and effective care of patients. No order for the use of mechanical restraints shall extend beyond 2 hours and the patient shall be observed every 15 minutes, by a qualified mental health professional.

Restraints are to be applied in a manner which provides for

padding and protection of all parts of the body where pressure areas might occur by friction and shall:

1) Be adjusted to eliminate the danger of gangrene, sores and paralysis;

2) Allow room for healthy breathing; and

3) Allow the patient as much freedom as possible under the circumstances.

Patients in restraints shall be encouraged to take liquids, be allowed reasonable opportunity for toileting, and shall be provided appropriate food, lighting, ventilation and clothing or covering.

Geriatric chairs and posey belts may be employed as therapeutic tools when incorporated into a treatment plan that has been set forth in a behavioral contract which has been voluntarily signed by the patient and entered into with the consent of the patient and the staff. The voluntariness of the contract shall be documented. All such contracts shall be reviewed at least once every thirty days by the Clinical Director. The patient shall have the right to revoke his/her consent to the use of geriatric chairs and posey belts and a behavioral contract at any time.

There may be circumstances in which it is necessary in order to protect the physical well-being of certain patients, such as the seriously physically disabled, when the use of geriatric chairs or posey belts may be indicated. Where such circumstances are documented, and there is documented, voluntary consent by the patient or patient's guardian, the use of geriatric chairs and

posey belts may be approved by a physician. Such approvals must be reviewed every 30 days by the physician and redocumented.

2. Procedure

a. The involuntary restraint of a patient by any means may be ordered only after personal observation of emergency circumstances by a physician; or in the physician's absence, a nursing staff supervisor. A certificate of need for emergency restraint shall be entered in the patient's record that documents emergency circumstances requiring the use of restraints.

b. If the restraining of a patient occurs during regular working hours without prior personal observation by a physician, the patient shall be seen by a physician within 30 minutes. The physician shall either order this patient out of restraints or enter the need for continuing an emergency restraint beyond that point in time.

c. If the restraining of a patient occurs outside regular working hours without personal observation by a physician, the patient shall be seen by a nurse within 30 minutes, and a physician shall be consulted within 30 minutes thereafter, who shall either order the patient out of restraints or certify the need for continuing an emergency restraint beyond that point in time.

In such instances, the physician may authorize additional restraints up to 2 hours each, which may be administered consecutively without consultation with the physician, but only after the nurse reviews each restraint and documents the continuing emergency necessity for an additional time period. No

more than 3 consecutive restraints may be ordered without consultation with or personal observation by the physician.

d. On the next working day following an order of restraint the Chief of clinical services or his/her designee shall review any orders for restraint of the patient. If a patient is restrained for more than 10 hours in any 24 hour period or for more than 24 hours in any 5 day period, the staff shall report the case at the next patient oriented crisis meeting and submit a written report to the Chief of clinical services and the Commissioner of mental health, who shall review the Certificate of Need and other documentation for adequacy.

e. Counsel for the patient and, with the patient's consent, nearest relative or guardian of the patient shall be notified of emergency involuntary administration of restraints within 24 hours. Counsel shall be provided with a copy of the Certificate of Need for Emergency Involuntary Restraint.

IV. AUTOMATIC REVIEW

A. General Policy

All instances of emergency involuntary administration of medication, seclusions and mechanical restraints, should be automatically, independently and regularly reviewed. Review shall focus upon whether each factual situation actually constituted an emergency, whether the action taken was appropriate or whether less intrusive means could have been considered or tried and whether the documentation was adequate. The reviews should result in continuing evaluation of VSH

practices and policies and concrete recommendations to the Chief of clinical services on ways to improve services to patients at VSH and on alternative ways of handling emergency situations.

1. Factors to be considered in any review of emergency administration of involuntary medication, seclusion or restraint shall include:

a. Evaluation of the existence of an emergency.

b. The appropriateness of the medication and its dosage; of the use and duration of seclusion or restraint.

c. Whether alternatives were available.

d. Whether alternatives were available and attempted.

e. Whether the patient had an opportunity to cooperate.

f. Whether the required documentation is complete and in descriptive, non-conclusory terms.

g. The legal status of the patient.

h. Compliance with the procedural requirements of these rules.

B. Nature and Frequency of Reviews

1. The Chief of clinical services shall review all orders of emergency involuntary medication, seclusion and restraint at least once every 30 days and shall prepare a report to the Commissioner of Mental Health and the Treatment Review Panel.

2. The Treatment Review Panel shall meet at least once every 90 days to review the medication,

seclusion and restraint practices at the Vermont State Hospital.

3. The Review Panel shall consider VSH compliance with the requirements of these rules, the appropriateness of the clinical decisions themselves, and make any recommendations or suggestions it deems helpful to the staff, the Chief of clinical services and the Commissioner of Mental Health.

4. The Treatment Review Panel may request the attendance of any person it deems helpful to its review process, including VSH staff, patients, their attorneys, or outside qualified mental health professionals. If a patient wishes to appear before the Panel, s/he may request the opportunity to appear and specify which issues s/he wishes the Panel to consider.

5. The Treatment Review Panel shall have access to all relevant forms, documents, files or other information needed to perform its reviews, and in determining whether required procedures have been followed and whether the rights, dignity and interests of patients have been considered and protected.

6. The Treatment Review Panel shall annually prepare a report summarizing its reviews; the frequency of administrations of emergency

involuntary medication, seclusion and restraint; its findings and recommendations relative to adequacy of compliance with procedures, need for changes in practices or policies, staff training and other relevant matters. A copy of the report shall be provided to the Chief of clinical services, the Head of VSH, the Commissioner of Mental Health and the Board of Mental Health.