DISABILITY RIGHTS VERMONT

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To: Ann Pugh, Chair
House Committee on Human Services

From: A.J. Ruben, Supervising Attorney

Date: March 11, 2015

Re: H. 241

Dear Chairwoman Pugh,

DRVT understands your Committee will be considering H. 241 on Thursday, March 12, 2015 and we ask that you provide the following comments from DRVT to the Committee and the public for consideration on this important bill.

DRVT is aware that there is a concern about maintaining the current statutory language aimed at assuring that patients in State custody receive the same rights and protections as patients received when placed at the old Vermont State Hospital.

We think the protections and rights that patients at VSH had, obtained through patients filing and settling lawsuits, are important for the committee and the legislature to consider maintaining. The Administration promised us all that if we allowed a decentralized inpatient system that relied more heavily on private hospitals than we had in the past when we ran a larger State Hospital, concerns about patient rights being diluted due to being spread out across the State in private hospitals would be assuaged because the Department would guarantee that anyone in its custody would have the same rights and protections they had at the large, State-run facility. Now the Department is asking to do away with those rights and protections and just let the private hospitals rely on the lowest, national standards; this turn around could be understood as a textbook bait and switch.

What are those rights and protections that patients at VSH had fought for and obtained?

From the Doe v Miller Settlement (MHLP) they include the right to have an M.D., not a lesser paid and less qualified person, make all orders for involuntary medication, see the person before making the order, and see the person within an hour of the injection to check on the patient. The CMS regulations allow for non-M.D.'s to make forced medication orders, to do so without ever seeing the patient and to allow non-M.D.'s to do the one hour assessment. As noted previously, making it easier for uses of force to occur by expanding those who can make the order and relieving them of the need to actually see the patient, will result in more, not less, use of force. This outcomes appears inconsistent with both legislative policy to move towards less use of force in our mental health system and to maintain the highest standards of protections and rights for people in State's custody.

From Doe v. VSH Settlement (DRVT) they include express prohibition against using force in combination when the initial use of force (say seclusion) has eliminated any imminent threat of serious harm. This is important because DRVT has found that often patients in seclusion are subjected to involuntary medication only because they remain agitated and disruptive but are not an actual imminent threat of harm. Connected to that right is the additional right to have a patient express their preference on types of uses of force during the admission process and having that information known and available to unit staff so that if a use of force is needed, the staff can use the patient preference to determine what is the least restrictive (as required by CMS) use of force from the patient's point of view. The CMS regulations do not include these protections but the proposed DMH statewide standards do.

It is worthy to note that the Doe v. Miller agreement created standards in 1986. CMS did not come up with anything nearly as strong till the late 1990s after media focused attention on deaths and abuse in the system. Those standards were very similar to what came out of Doe v. Miller. Under pressure from institutions at the national level the CMS standards were lowered in 2007.

Thank you for considering this information as you work on H. 241.