Vermont Legal Aid, Inc. **MEMORANDUM**
Montpelier, Vermont

TO: House Human Services Committee

FROM: John McCullough III, Project Director

SUBJECT: Emergency Involuntary Procedures

DATE: February 4, 2015

In 2012, after the destruction of the Vermont State Hospital, the Legislature for the first time acted to address the delivery of inpatient mental health care as a system, and it included important language related to the rights of all patients in the custody of the Department of Mental Health, regardless of where they are receiving treatment.

> (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. (Added 2011, No. 79 (Adj. Sess.), § 1a, eff. April 4, 2012.) 18 V.S.A. § 7251(9).

The rights protecting those individuals are set forth not only in the policies of the Vermont State Hospital, but fundamentally in the settlement agreement in *Doe v. Miller*, which the Department agreed to, and which provides in part that when a staff person believes an emergency exists, that staff person shall consult with a physician, and that only a physician is authorized to order involuntary medications.

Unfortunately, ever since the legislation has been enacted, the Department has been engaged in an effort to retreat from the rights provided at the Vermont State Hospital. I believe this is a terrible position for the Department to embrace. Regardless of the merits and failings of the State Hospital and of the hospitals that have come to replace it, it is beyond belief that at this time the Department and the designated hospitals should be arguing that patients in state custody should have even fewer rights than they would have if the State Hospital were still in operation.

The Committee has requested my thoughts on the questions raised at pages 5-6 of the report of the Mental Health Oversight Committee. These questions include to whom do the rules on emergency involuntary procedures apply, who can prescribe

chemical restraint, and whether the prescriber must personally observe the patient prior to prescribing chemical restraint.

The answers are straightforward.

First, the rules should apply to everyone in state custody. This includes adults and minors. This includes people in designated psychiatric hospitals, as well as people held in the emergency department or medical service of a community hospital. All patients, all hospitals.

This is more important than ever as people are admitted to emergency departments and held for ever-increasing periods. In a recent case my Project handled we represented a man involuntarily confined to a hospital emergency department for three weeks without ever seeing a psychiatrist, ordered to take psychiatric medications by a doctor, not a psychiatrist, who rarely if ever saw him. For three weeks his entire world was a tiny room, segregated from other people, guarded by law enforcement, and deprived of any psychiatric care. We regularly see patients confined for shorter periods, days rather than weeks, in emergency departments across the state, often in hospitals without any provision for psychiatric care. These people are in the custody of the Department of Mental Health and they are entitled by law to all the rights that a patient formerly held at the Vermont State Hospital had, yet the Department has proposed to deny them those rights. This is a clear violation of their rights under Act 79.

The same principle means that the rules should apply to all patients, minors as well as adults. In the summer of 2012 I participated in a work group convened by the Department as required by Act 79 to develop and propose rulemaking on emergency involuntary procedures. Throughout that process, one of the arguments that advocates consistently made was that it was essential to extend protections not only to adults, but also to children being involuntarily detained. The Department's position, set forth in its final rule filing, was that "it believes that emergency involuntary procedures for children should be addressed in a separate rule specific to the treatment of children." http://mentalhealth.vermont.gov/sites/dmh/files/CommitteesWorkgroups/EIP_Rule_LCAR/072913_Responses_to_Public_Comments.pdf. This statement was made in its filing of July 29, 2013, yet almost two years later the Department has made no effort to propose rules governing the imposition of involuntary procedures on children. Act 79 is clear that all patients in the Department's custody, adults or children, are entitled to at least the same protections as were provided at the State Hospital. It is essential that the Department adopt protections for children in its custody; in light of the Department's failure to do so the Legislature should require it.

Second, to the extent that chemical restraint may be ordered, it must be limited to prescriptions by physicians. We are aware that advance practice nurses and physicians' assistants are authorized by their licenses to prescribe drugs. It is also clear, however, that even psychiatric nurse practitioners receive nowhere near the

level of psychiatric training that a psychiatrist receives. Regardless of the changes we have seen in ordinary medical practice, the treatment to which involuntary patients can be subjected to without their consent is strikingly different from what a voluntary patient may voluntarily consent to: if this were not the case, these protections would not be needed.

Third, the standard that governed involuntary medication at VSH, as agreed by class counsel and the State, paragraph III(A)(2)(b) requires the physician to personally examine the patient before ordering involuntary medication, whereas the final rules proposed by the department would have allowed involuntary medication to be ordered after the patient's behavior is merely described over the telephone to a physician or licensed independent professional who had not examined the patient or observed his or her behavior. Assessment of behavior on a psychiatric unit by its very nature requires a personal interaction between the patient and the evaluator, and it is far more complicated than reciting vital signs, or other purely objective measures that might give rise to a treatment decision. There are important reasons that involuntary administration of these powerful drugs is strictly regulated, and allowing an order based on secondhand reports is not only bad policy, it violates the protections afforded patients at the Vermont State Hospital.

For these reasons, the Legislative Committee on Administrative Rules was right to object to the proposed rules as written. Provision of clear standards for emergency involuntary procedures is vital, and those standards must preserve the protections enjoyed by the patients of the Vermont State Hospital for decades.