1 S.309

2 Introduced by Senator Snelling

3 Referred to Committee on

4 Date:

5 Subject: Mental health; emergency involuntary procedures

6 Statement of purpose of bill as introduced: This bill proposes to require that a
7 psychiatrist order emergency involuntary procedures in psychiatric hospital
8 units and in some circumstances at the secure residential recovery facility. It
9 also requires the Department of Mental Health to establish protocols for
10 individuals received in an emergency department during a mental health crisis.

11 An act relating to emergency involuntary procedures

12 It is hereby enacted by the General Assembly of the State of Vermont:

13 Sec. 1. LEGISLATIVE INTENT

14 It is the intent of the General Assembly that high quality, patient-centric
15 mental health care be standardized across the State to ensure that treatment
16 received in geographically diverse locations share the same level of excellence.
17 The General Assembly further intends that therapeutic supports be used in lieu
18 of emergency involuntary procedures whenever feasible.

1 Sec. 2. 18 V.S.A. § 7260 is added to read:
2 § 7260. EMERGENCY DEPARTMENT PROTOCOLS
3 (a) The Department of Mental Health shall develop a protocol for use by
4 hospitals, as defined in section 1851 of this title, for receiving individuals in
5 mental health crisis in emergency departments. The protocol shall provide for
6 the use of therapeutic supports, peer counseling, and a quiet room, as clinically
7 appropriate. The protocol shall emphasize that whenever feasible, therapeutic
8 responses should be favored over emergency involuntary procedures. When
9 emergency involuntary procedures are necessary, they shall be used in
10 accordance with chapter 184 of this title.
11 (b) The Department shall distribute the protocol and any subsequent
12 changes to all hospitals, the Vermont Sheriffs' Association, and the Vermont
13 Association of Chiefs of Police.
14 (c) Hospitals shall collaborate with the Department of Mental Health, the
15 Vermont Sheriffs' Association, and the Vermont Association of Chiefs of
16 Police to implement the protocol in emergency departments.
17 Sec. 3. 18 V.S.A. § 7703 is amended to read:
18 § 7703. TREATMENT
19 (a) Outpatient or partial hospitalization shall be preferred to inpatient
20 treatment. Emergency involuntary treatment shall be undertaken only when

1 clearly necessary. Involuntary treatment shall be ~~utilized~~ <u>used</u> only if
2 voluntary treatment is not possible.
3 (b) The ~~department~~ <u>Department</u> shall establish minimum standards for
4 adequate treatment as provided in this section, including requirements that,
5 when possible, psychiatric unit staff be used as the primary source to
6 implement emergency involuntary procedures such as seclusion and restraint.
7 <u>(c) The Vermont Psychiatric Care Hospital and all participating hospitals</u>
8 <u>providing acute inpatient treatment shall maintain a psychiatrist on hospital</u>
9 <u>premises at all times.</u>
10 Sec. 4. 18 V.S.A. § 7704 is amended to read:
11 § 7704. MECHANICAL RESTRAINTS
12 Mechanical restraints shall not be applied to a patient unless it is determined
13 by ~~the head of the hospital or his or her designee~~ <u>a psychiatrist</u> to be required
14 by the medical needs of the patient or the hospital. Every use of a mechanical
15 restraint and the reasons therefor shall be made a part of the clinical record of
16 the patient under the signature of ~~the head of the hospital or his or her designee~~
17 <u>a psychiatrist</u>.
18 Sec. 5. 18 V.S.A. chapter 184 is added to read:
19 <u>CHAPTER 184. EMERGENCY INVOLUNTARY PROCEDURES</u>
20 <u>§ 7751. DEFINITIONS</u>
21 <u>As used in this chapter:</u>

1 (1) “Advanced practice registered nurse” means a registered nurse
2 licensed pursuant to 26 V.S.A. chapter 28, subchapter 3 as a nurse practitioner
3 in psychiatric or mental health nursing, or both.
4 (2) “Depot medication” means a chemical form of certain antipsychotic
5 medication that is injected intramuscularly and allows the active medication to
6 be released over an extended period of time.
7 (3) “Emergency” means an imminent risk of serious bodily injury to the
8 person or others.
9 (4) “Emergency involuntary medication” means one or more
10 medications administered against a person’s wishes without a court order.
11 (5) “Emergency involuntary procedure” means seclusion, restraint, or
12 emergency involuntary medication.
13 (6) “Hospital” means any hospital providing psychiatric treatment,
14 including designated hospitals and the Vermont Psychiatric Care Hospital.
15 (7) “Licensed independent practitioner” means a physician, an advanced
16 practice registered nurse, or a physician assistant.
17 (8) “Nonphysical intervention skills” means strategies and techniques of
18 communication or interaction that do not involve physical contact, such as
19 active listening, conversation, and recognition of a person’s personal and
20 physical space, including a willingness to make adjustments for the
21 person’s needs.

1 (9) "Person" means an individual who is either a patient receiving
2 psychiatric treatment in a hospital or a resident of a secure residential
3 recovery facility.
4 (10) "Physician assistant" means an individual qualified by education
5 and training and licensed by the Vermont Board of Medical Practice pursuant
6 to 26 V.S.A. chapter 31.
7 (11) "Psychiatrist" means a person licensed to practice medicine
8 pursuant to 26 V.S.A. chapter 23 who specializes in the practice of psychiatry.
9 (12) "Restraint" means any manual method, physical or mechanical
10 device, material, or equipment that immobilizes or reduces the ability of a
11 person to move his or her arms, legs, body, or head freely.
12 (13) "Seclusion" means the involuntary confinement of a person alone
13 in a room or area from which the person is physically or otherwise prevented
14 from leaving.
15 (14) "Serious bodily injury" means the same as in section 1912 of
16 this title.
17 (15) "Specially trained registered nurse" means a registered nurse who
18 has been trained to conduct an assessment of a person for whom one or more
19 emergency involuntary procedures have been ordered.

1 § 7752. PATIENT RIGHTS
2 (a)(1) All persons in the custody of the Commissioner of Mental Health
3 have the right to be free from physical or mental abuse, including
4 corporal punishment.
5 (2) All persons in the custody of the Commissioner of Mental Health
6 have the right to be free from emergency involuntary procedures imposed as a
7 means of coercion, discipline, convenience, as part of a behavioral
8 intervention, or as retaliation by staff in a hospital or secure residential
9 recovery facility.
10 (3) All persons in the custody of the Commissioner of Mental Health
11 have the right to trauma-informed care.
12 (b)(1) Upon the person's admission to a hospital or secure residential
13 recovery facility or at the earliest reasonable time and with the person's
14 permission, staff shall work with the person and his or her family, caregivers,
15 and agent or agents pursuant to chapter 231 of this title, if any, to identify
16 strategies that may minimize or avoid the use of emergency involuntary
17 procedures. Staff shall obtain written permission from the person before
18 contacting the person's family. The permission form shall state that the person
19 may refuse to give staff permission to speak with family members.
20 (2) Staff shall discuss with the person, his or her family, caregivers, and
21 agent or agents, if any, the person's preferences regarding the use of

1 emergency involuntary procedures should they become necessary. The
2 hospital or secure residential recovery facility is not required to follow the
3 person's preferences, but the person's preferences shall be considered when
4 determining the least intrusive and least restrictive emergency involuntary
5 procedure to use to address an imminent risk of harm. The information about
6 the person's preferences shall be accessible to direct care staff for reference
7 when the person is exhibiting signs of escalation.
8 (3) Staff shall inquire about the existence of an advance directive
9 pursuant to chapter 231 of this title with the person or his or her guardian and
10 shall also access the Advance Directive Registry. If an advance directive
11 exists, a copy shall be placed in the person's medical record and staff shall
12 reference it with regard to emergency involuntary procedures, if applicable.
13 (c)(1) Upon admission to a hospital or secure residential recovery facility, a
14 person shall be specifically informed that he or she has the right to have
15 anyone notified, including an attorney, when an emergency involuntary
16 procedure is used.
17 (2) The person's court-appointed guardian or agent or agents, if any, and
18 with the person's consent, any individual identified by the person, shall be
19 notified of each emergency involuntary procedure as soon as practicable but
20 within 24 hours of each use.

1 (d) A person shall not be made to ingest oral medications as a condition of
2 release from seclusion or restraint.
3 § 7753. POLICIES AND PROCEDURES
4 (a) The use of emergency involuntary procedures shall be implemented in
5 accordance with any written modification to the person's plan of care and with
6 safe and appropriate techniques as described in this chapter.
7 (b) Emergency involuntary procedures shall only be used to prevent the
8 imminent risk of serious bodily injury to the person or others and shall be
9 discontinued at the earliest possible time based on an individualized
10 assessment of the person and reevaluation. When feasible, the person shall be
11 offered an opportunity to cooperate prior to and during an emergency
12 involuntary procedure.
13 (c) The decision to use emergency involuntary procedures shall not be
14 driven by diagnosis, but by a comprehensive, individualized assessment of
15 the person.
16 (d) Emergency involuntary procedures shall only be used when:
17 (1) alternative interventions have been attempted unsuccessfully;
18 (2) alternative interventions have been considered and determined
19 ineffective; or
20 (3) the person is attempting to cause or is in the process of causing
21 serious bodily injury to self or others and immediate action is necessary.

1 (e)(1) In a hospital, the use of emergency involuntary procedures shall only
2 be ordered by a psychiatrist who has personally observed the emergency.
3 (2) In a secure residential recovery facility, a psychiatrist, if present,
4 shall order the use of seclusion or restraint. If a psychiatrist is not present at a
5 secure residential recovery facility, a licensed independent practitioner in
6 consultation with a psychiatrist via telephone shall order the use of seclusion
7 or restraint.
8 (f) The use of emergency involuntary procedures shall be documented
9 pursuant to section 7756 of this title. The documentation shall include a
10 description of the specific behaviors justifying the use of the emergency
11 involuntary procedures.
12 (g) Each hospital and secure residential recovery facility shall submit
13 reports of the use of emergency involuntary procedures to the Department of
14 Mental Health on a monthly basis.
15 (h) Every effort shall be made to avoid the use of uniformed security
16 guards when implementing emergency involuntary procedures. When security
17 guards are used, documentation shall substantiate the need for this response
18 after the initial staff response is assessed insufficient to prevent the imminent
19 risk of serious bodily injury to the person or others.
20 (i) Hospitals and the secure residential recovery facility shall not use law
21 enforcement officers to implement emergency involuntary procedures.

1 Firearms, electronic control devices, pepper spray, mace, batons, and other
2 similar law enforcement devices shall not be used to implement emergency
3 involuntary procedures.
4 § 7754. ORDERS
5 (a) If, on the basis of personal observation, any trained staff member
6 believes an emergency exists, a psychiatrist shall be consulted immediately. A
7 psychiatrist at a hospital, and if available at a secure residential recovery
8 facility, shall personally observe the person prior to writing an order for an
9 emergency involuntary procedure. If a psychiatrist is not available for
10 personal observation at a secure residential recovery facility, he or she may be
11 consulted by a licensed independent practitioner via telephone.
12 (b) The use of any emergency involuntary procedure in a hospital or the
13 use of seclusion and restraint in a secure residential recovery facility shall be
14 implemented in accordance with the order of a psychiatrist, or licensed
15 independent practitioner as needed in a secure residential recovery facility,
16 who is responsible for the care of the person and is authorized by the hospital
17 or secure residential recovery facility to order the procedure.
18 (c) A hospital or secure residential recovery facility protocol shall not serve
19 as a substitute for obtaining a psychiatrist's order, or the order of a licensed
20 independent practitioner as needed in a secure residential recovery facility, for
21 each use of emergency involuntary procedures.

1 (d) An order for the use of emergency involuntary procedures shall not be
2 written as a standing order or on an as-needed basis.
3 § 7755. OBSERVATION AND ASSESSMENT
4 (a)(1) The condition of a person who is subject to an emergency
5 involuntary procedure shall be assessed by a licensed independent practitioner
6 or specially trained registered nurse at an interval determined by the
7 psychiatrist ordering the procedure, but no less frequently than every
8 15 minutes. If a psychiatrist is not available at the secure residential recovery
9 facility, a licensed independent practitioner shall determine the frequency of
10 the assessment.
11 (2) In addition, the psychiatrist shall monitor the person periodically to
12 determine whether there is a continued need for the emergency involuntary
13 procedure. If a psychiatrist is not available at the secure residential recovery
14 facility, a licensed independent practitioner shall monitor the person.
15 (b) Each hospital and secure residential recovery facility shall develop a
16 policy to guide staff in determining appropriate intervals for assessment and
17 monitoring based on the individual needs of the person, the person's condition,
18 and the type of emergency involuntary procedure used. Each designated
19 hospital's policy shall be reviewed as part of the hospital designation process.

1 (c)(1) Each hospital and secure residential recovery facility shall
2 debrief staff following each incident involving the use of emergency
3 involuntary procedures.
4 (2) A hospital and a secure residential recovery facility shall also give
5 persons involved in each incident opportunities to discuss the incident with
6 staff within 24 hours of the incident's resolution.
7 § 7756. DOCUMENTATION
8 (a) The use of any emergency involuntary procedure, including
9 combination procedures used pursuant to section 7760 of this title, shall be
10 documented in the person's medical record in accordance with standards
11 established in 42 C.F.R. § 482.13 by the Centers for Medicare and Medicaid
12 Services' Conditions of Participation.
13 (b) Appropriate documentation shall ensure that an independent qualified
14 mental health professional can readily verify the factual basis for and medical
15 necessity of the prescribed action, as well as its involuntary administration.
16 Elements that will enable the reviewer to determine whether the prescribed
17 action complied with relevant standards, policies, and rules include:
18 (1) the necessity of the action taken to control the emergency;
19 (2) the expected or desired result of the action on the person's behavior
20 or condition;

1 (3) whether alternatives were considered or used, and why they were
2 ineffective to prevent the imminent risk of serious bodily injury;
3 (4) the risks of adverse side effects; and
4 (5) if used in combination, the basis for the determination by the
5 psychiatrist that the use of a single emergency involuntary procedure would
6 have been ineffective to prevent the imminent risk of serious bodily injury.
7 § 7757. EMERGENCY INVOLUNTARY MEDICATION
8 (a) Emergency involuntary medication shall be ordered by a psychiatrist
9 prior to its use.
10 (b) Emergency involuntary medication shall be used on a time-limited,
11 short-term basis and not as a substitute for adequate treatment of the
12 underlying cause of the person's distress. Emergency involuntary medication
13 shall be used in a hospital only, and not a secure residential recovery facility.
14 (c) When an emergency situation renders it necessary to administer
15 emergency involuntary medication by injection, a nondepot medication that is
16 consistent with current American Psychiatric Association practice guidelines
17 shall be used.
18 (d) When the use of emergency involuntary medication has been ordered,
19 the person shall be offered oral medication prior to the implementation of
20 the order.

1 (e) If possible and where clinically appropriate, the hospital shall give the
2 person a choice of injection sites and shall follow that preference if medically
3 safe to do so.
4 (f) A person who has received emergency involuntary medication shall be
5 monitored for adverse effects by a licensed independent practitioner or
6 specially trained registered nurse at an interval determined by the psychiatrist
7 ordering the procedure, but no less frequently than every 15 minutes as
8 clinically indicated following its administration. Each observation shall be
9 documented in the person's medical record.
10 (g) Within one hour of the initiation of the procedure, the psychiatrist
11 ordering the emergency involuntary medication shall complete an assessment.
12 The assessment must occur face-to-face and shall include an assessment of:
13 (1) the person's physical and psychological status;
14 (2) the person's behavior;
15 (3) the appropriateness of the intervention measures; and
16 (4) any complications resulting from the intervention.
17 § 7758. SECLUSION
18 (a) The placement of a person in seclusion and the duration of its use shall
19 be kept to a minimum, consistent with the safe and effective care for a person.
20 The use of seclusion shall adequately accommodate a person's physical and
21 environmental needs without undue violation of his or her personal dignity.

1 (b) If a person is restricted to a room alone and staff are physically
2 intervening to prevent the person from leaving the room or giving the
3 perception the person will be threatened with physical intervention if the
4 person attempts to leave the room, the room is considered locked, whether the
5 door is actually locked or not.
6 (c) An order for seclusion shall be obtained either during the emergency
7 application of the seclusion or immediately after its use.
8 (d)(1) Only a psychiatrist shall order the seclusion of a person in a hospital.
9 (2) If a psychiatrist is present at a secure residential recovery facility, he
10 or she shall order the use of seclusion. If a psychiatrist is not present at a
11 secure residential recovery facility, a licensed independent practitioner in
12 consultation with a psychiatrist via telephone shall order the use of seclusion.
13 (e) A person in seclusion shall be assessed by a licensed independent
14 practitioner or specially trained registered nurse at regular intervals pursuant to
15 subdivision 7755(a)(1) of this chapter.
16 (f)(1) Within one hour of the initiation of the procedure, the psychiatrist or
17 licensed independent practitioner ordering the seclusion shall complete an
18 assessment. The assessment must occur face-to-face and shall include an
19 assessment of:
20 (A) the person's physical and psychological status;
21 (B) the person's behavior;

1 (C) the appropriateness of the intervention measures;
2 (D) any complications resulting from the intervention; and
3 (E) whether the person is aware of what is required to be released
4 from seclusion.
5 (2) If a licensed independent practitioner completes the face-to-face
6 assessment, he or she shall consult with a psychiatrist via telephone as soon as
7 possible after completion of the assessment.
8 (g) At least hourly thereafter, the psychiatrist or licensed independent
9 practitioner ordering the seclusion shall monitor the continued need for the
10 emergency seclusion intervention and document the ongoing need for the
11 intervention pursuant to subdivision 7755(a)(2) of this chapter.
12 (h) The seclusion shall end at the earliest possible moment that the person
13 is no longer considered an imminent risk of serious bodily injury.
14 (i) An additional order for seclusion shall be required at the conclusion of
15 two hours if continued use of seclusion is deemed necessary based on an
16 individualized assessment of the person at that time. Each order of seclusion
17 shall not exceed two hours.
18 § 7759. RESTRAINT
19 (a) The involuntary placement of a person in restraints shall occur only in
20 emergency circumstances.

(b) An order for restraint shall be obtained either during the emergency application of restraint or immediately after its use.

(c) Restraints are to be applied in the least intrusive and least restrictive manner, providing for padding and protection of all parts of the body where pressure areas might occur by friction from mechanical restraints.

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

(e) Mechanical restraints shall not be used when the person is in a prone position.

(f)(1) Only a psychiatrist shall order the restraint of a person in a hospital.

(2) If a psychiatrist is present at a secure residential recovery facility, he or she shall order the use of restraint. If a psychiatrist is not present at a secure residential recovery facility, a licensed independent practitioner in consultation with a psychiatrist via telephone shall order the use of restraint.

(g) A person in restraints shall be assessed by a licensed independent practitioner or specially trained registered nurse at regular intervals pursuant to subdivision 7755(a)(1) of this chapter.

(h)(1) Within one hour of the initiation of the procedure, the psychiatrist or licensed independent practitioner ordering the restraint shall complete an

1 assessment. The assessment must occur face-to-face and shall include an
2 assessment of:
3 (A) the person's physical and psychological status;
4 (B) the person's behavior;
5 (C) the appropriateness of the intervention measures;
6 (D) any complications resulting from the intervention; and
7 (E) whether the person is aware of what is required to be released
8 from restraints.
9 (2) If a licensed independent practitioner completes the face-to-face
10 assessment, he or she shall consult with a psychiatrist via telephone as soon as
11 possible after completion of the assessment.
12 (i) At least hourly thereafter, the psychiatrist or licensed independent
13 practitioner ordering the restraints shall monitor the continued need for the
14 emergency restraint intervention and document the ongoing need for the
15 intervention pursuant to subdivision 7755(a)(2) of this chapter.
16 (j) The restraint shall end at the earliest possible moment that the person is
17 no longer considered an imminent risk of serious bodily injury.
18 (k) An additional order for restraint shall be required at the conclusion of
19 two hours if continued use of restraint is deemed necessary based on an
20 individualized assessment of the person at that time. Each order of restraint
21 shall not exceed two hours.

1 § 7760. USE OF EMERGENCY INVOLUNTARY PROCEDURES IN
2 COMBINATION
3 (a) Emergency involuntary procedures shall only be used in combination
4 when a single emergency involuntary procedure is determined in the clinical
5 judgment of a psychiatrist to be ineffective to protect the person or others from
6 imminent risk of serious bodily injury.
7 (b) Prior to ordering a combination of emergency involuntary procedures, a
8 psychiatrist shall conduct a comprehensive assessment of the person to
9 determine that the risks associated with the use of combined emergency
10 involuntary procedures are outweighed by the risk of not using a combination
11 of emergency involuntary procedures.
12 (c) The use of restraint for the purpose of administering court-ordered
13 involuntary medication shall not be considered the use of combined emergency
14 involuntary procedures.
15 § 7761. STAFF TRAINING
16 (a) A person has a right to safely implemented emergency involuntary
17 procedures by hospital and secure residential recovery facility staff.
18 (b) Each hospital and secure residential recovery facility shall provide
19 trauma-informed training to staff who may be involved with emergency
20 involuntary procedures.

1 (c) As part of orientation and regularly thereafter, any staff members
2 participating in emergency involuntary procedures shall receive training and be
3 able to demonstrate competency in the implementation of seclusion,
4 application of restraints, and monitoring, assessment, and care for a person
5 receiving an emergency involuntary procedure prior to performing any of the
6 actions specified in this chapter. Staff members shall perform only those
7 emergency involuntary procedures for which they have been found competent.
8 (d) A hospital or secure residential recovery facility shall require staff who
9 may be involved in emergency involuntary procedures to receive education
10 and facility-specific training and also to have demonstrated knowledge based
11 on the specific needs of the hospital or facility population served in at least the
12 following manners:
13 (1) the use of nonphysical intervention skills;
14 (2) the ability to perform trauma-informed care for a person with a
15 history of sexual or physical assault or incest;
16 (3) the ability to choose the least restrictive intervention based on an
17 individualized assessment of the person's medical or behavioral status
18 or condition;
19 (4) the safe use of all types of emergency involuntary procedures used in
20 the hospital or secure residential recovery facility, including training in how to

1 identify behaviors, events, and environments that may trigger circumstances
2 that require the use of emergency involuntary procedures;
3 (5) the clinical identification of specific behavioral changes that indicate
4 emergency involuntary procedures are no longer necessary;
5 (6) the monitoring of the physical and psychological well-being of the
6 person who is receiving an emergency involuntary procedure, including
7 respiratory and circulatory status, skin integrity, vital signs, and any special
8 requirements specified in the policy of the hospital or secure residential
9 recovery facility;
10 (7) the use of first aid techniques and certification in the use of
11 cardiopulmonary resuscitation, including required periodic recertification;
12 (8) the use of staff trainers who are qualified as evidenced by education,
13 training, and experience in interventions used to address escalating
14 behaviors; and
15 (9) documentation in hospital or secure residential recovery facility staff
16 personnel records that the training and demonstration of competency were
17 successfully completed.
18 (e) Training for a licensed independent practitioner to conduct the one-hour
19 face-to-face evaluation in a secure residential recovery facility when a
20 psychiatrist is not present pursuant to subsections 7758(f) and 7759(h) of this
21 chapter shall include all of the training requirements in this section as well as

1 instruction on evaluating the person's immediate situation, the person's
2 reaction to the intervention, the person's medical and behavioral condition, and
3 the need to continue or terminate the emergency involuntary procedure. An
4 assessment of the person's medical condition shall include a complete system
5 and behavioral assessment review, including review and assessment of the
6 person's history, medications, and most recent laboratory results.
7 (f) The Department of Mental Health shall review the competency and
8 training records of each designated hospital as part of the hospital
9 designation process.
10 § 7762. HOSPITAL AND FACILITY DUTIES
11 (a) Hospital and secure residential recovery facility responsibilities.
12 (1) Hospital and secure residential recovery facility leadership shall
13 ensure that systems and processes are developed, implemented, and evaluated
14 to support a person's rights and that eliminate the inappropriate use of
15 emergency involuntary procedures.
16 (2) Each hospital and secure residential recovery facility shall report to
17 the Department of Mental Health on the use of emergency involuntary
18 procedures using standardized forms made available on the
19 Department's website.
20 (3) Each hospital and secure residential recovery facility shall establish
21 an internal performance improvement process for regularly meeting and

1 reviewing its training, documentation, and practice trends pertaining to
2 emergency involuntary procedures with its local quality advisory body.
3 Information generated shall be used to inform the Emergency Involuntary
4 Procedures Advisory Panel quarterly meetings.
5 (4) As part of its quality assurance performance improvement program,
6 each hospital and secure residential recovery facility shall review and assess its
7 use of emergency involuntary procedures to ensure that:
8 (A) persons are cared for as individuals;
9 (B) each person's condition, needs, strengths, weaknesses, and
10 preferences are considered;
11 (C) emergency involuntary procedures are used only to address the
12 imminent risk of serious bodily injury to the person and others;
13 (D) emergency involuntary procedures are discontinued at the earliest
14 possible time, regardless of the length of the order; and
15 (E) emergency involuntary procedures are used only after
16 deescalation interventions were ineffective to protect the person or others
17 from harm.
18 (b) Medical director review.
19 (1) As soon as practicable but within two working days following an
20 order for an emergency involuntary procedure, the hospital or secure

1 residential recovery facility's medical director, or his or her designee, shall
2 review the incident.
3 (2) The Medical Director of the Department of Mental Health, or his or
4 her designee, shall review all orders of emergency involuntary procedures in
5 hospitals and the secure residential recovery facility at least once
6 every 30 days.
7 (c) Reports of death.
8 (1) Each hospital and secure residential recovery facility shall report
9 deaths associated with the use of emergency involuntary procedures to the
10 Commissioner of Mental Health and the Centers for Medicare and Medicaid
11 Services by telephone no later than the close of business on the next business
12 day following the hospital or facility staff's knowledge of the person's death.
13 (2) Staff must document in the person's medical record the date and
14 time the death was reported.
15 (3) The hospital and secure residential recovery facility shall report the
16 following information:
17 (A) each death that occurs while a person is receiving an emergency
18 involuntary procedure;
19 (B) each death that occurs within 24 hours after the person has
20 received an emergency involuntary procedure;

1 (C) each death known to the hospital or secure residential recovery
2 facility that occurs within one week after an emergency involuntary procedure
3 where it is reasonable to assume that use of the emergency involuntary
4 procedure contributed directly or indirectly to the person's death.
5 § 7763. EMERGENCY INVOLUNTARY PROCEDURES
6 ADVISORY PANEL
7 (a) Creation. There is created an Emergency Involuntary Procedures
8 Advisory Panel to review compliance with the procedures required by this
9 chapter, whether the rights, dignity, and interests of persons have been
10 considered and protected, and the appropriateness of clinical decisions,
11 including the prescribed medication, its dosage, and the use and duration of
12 seclusion and restraint.
13 (b) Membership. The Advisory Panel shall be composed of the
14 following members:
15 (1) the Commissioner of Mental Health or a designee who shall serve
16 as chair;
17 (2) the Commissioner of Disabilities, Aging, and Independent Living or
18 a designee;
19 (3) a representative from the clinical staff of each designated hospital;
20 (4) a representative from the clinical staff of a designated agency that
21 provides services to persons who have been hospitalized;

1 (5) a peer; and
2 (6) a person with either a personal or familial lived mental
3 health experience.
4 (c) Powers and duties.
5 (1)(A) The Advisory Panel shall receive aggregate data that have been
6 prepared by the clinical leadership teams of the hospitals and secure residential
7 recovery facility regarding all orders of emergency involuntary procedures.
8 The aggregate data shall be sent to the Department of Mental Health's Quality
9 Management Director in monthly reports.
10 (B) The Advisory Panel shall meet quarterly to review the aggregate
11 data reports submitted by the hospitals and secure residential recovery facility.
12 (C) The Advisory Panel may request the attendance at its quarterly
13 meetings of any individual it deems helpful to the review process, including
14 hospital staff, persons receiving treatment, their attorneys, outside qualified
15 mental health professionals, or other chosen support individuals.
16 (2) The Advisory Panel shall review adherence to the requirements of
17 this chapter and the appropriateness of the decisions to use emergency
18 involuntary procedures.
19 (3) The Advisory Panel shall make suggestions and recommendations to
20 the Commissioner of Mental Health or the Department of Mental Health's
21 Quality Management Director or Medical Director.

1 (4)(A) If a person wishes to present a grievance or a complaint
2 regarding the use of an emergency involuntary procedure, he or she may
3 request the opportunity to appear before the Advisory Panel with regard to
4 specific issues for consideration. A person presenting a grievance or complaint
5 to the Advisory Panel may be accompanied by an individual or individuals of
6 his or her own choosing. The person's complaint and the resolution of that
7 complaint by the Advisory Panel are confidential and are exempt from public
8 inspection and copying under the Public Records Act.
9 (B) Representatives of a hospital or facility with a specific case under
10 review may participate in the discussion, but shall take no role in the Advisory
11 Panel's conclusions or recommendations.
12 (d) Assistance. The Advisory Panel shall have the administrative,
13 technical, and legal assistance of the Department of Mental Health.
14 (e) Meetings.
15 (1) A majority of the members of the Advisory Panel shall be physically
16 present at the same location to constitute a quorum.
17 (2) A member may vote only if physically present at the
18 meeting location.
19 (3) Action shall be taken only if there is both a quorum and a majority
20 vote of the members physically present and voting.

1 (f) Reimbursement. Members of the Advisory Panel who are not
2 employees of the State of Vermont and who are not otherwise compensated or
3 reimbursed for their attendance shall be entitled to per diem compensation
4 pursuant to 32 V.S.A. § 1010 for no more than four meetings each year.
5 (g) To the extent permitted by the Health Insurance Portability and
6 Accountability Act of 1996, 42 U.S.C. § 1320d and 45 C.F.R. §§ 160–164, the
7 Advisory Panel shall have access to all relevant records or other information
8 needed to perform its reviews.
9 Sec. 6. EFFECTIVE DATE
10 This act shall take effect on July 1, 2014.