

**REPORT OF
AN INVESTIGATION INTO THE TRANSPORT BY LAW
ENFORCEMENT PERSONNEL AND THE USE OF METAL SHACKLES
ON A CHILD WITH DISABILITIES FOR PURPOSES OF HOSPITAL TO
HOSPITAL TRANSFER ON NOVEMBER 3, 2006**

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I. INTRODUCTION

Vermont Protection & Advocacy, Inc. (VP&A) is a private, independent, not-for-profit agency mandated by federal law to provide advocacy services on behalf of people with disabilities to ensure their rights are protected.¹ Under our federal mandates, VP&A has the duty and authority to investigate allegations of abuse and/or neglect involving people with disabilities if the incident is reported to VP&A or if VP&A determines there is probable cause that an incident of abuse and/or neglect occurred. VP&A is Vermont's designated protection and advocacy system and is a member of the National Disability Rights Network (NDRN).

This report presents the results of an investigation conducted by VP&A into the circumstances surrounding the secure transport of a seven year old child with disabilities from one hospital setting to another for inpatient psychiatric evaluation and treatment. For purposes of this investigation secure transport is defined as the mechanical restraint (use of metal handcuffs and shackles) and transportation of an individual by law enforcement personnel. VP&A's investigation into this matter was completed at the request of the involved juvenile's legal guardian and with the juvenile's consent.

VP&A wishes to emphasize that the facts discussed herein relate to the secure transport of a child that occurred in November of 2006. Although we appreciate that the transport decisions made by the involved professionals were done with great concern for potential safety issues, VP&A concludes that hospital to hospital transfers necessitating safety precautions such as mechanical restraint fall under the scope of the federal Emergency Medical Treatment and Active Labor Act (EMTALA).² VP&A's investigation identifies that the use of secure transport by law enforcement personnel as a means to protect patients from potentially dangerous behavior during a transfer from one hospital to another for purposes of psychiatric evaluation and treatment is a violation of EMTALA.

VP&A is aware and supportive of ongoing efforts by the State of Vermont to continually review and improve the situation facing psychiatric patients who require transportation between hospitals for treatment purposes. These ongoing efforts should be intensified, both in terms of funding and quality assurance, to ensure that hospital to hospital transfers of individuals requiring emergency psychiatric care, especially children, are carried out in accordance with trauma-informed practices and relevant state and federal law.

¹ Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15001 *et seq.*, 45 C.F.R. Part 1385 *et seq.*; Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 *et seq.*; 42 C.F.R. Part 51 *et seq.*; Protection and Advocacy of Individual Rights, 29 U.S.C. § 794(e) *et seq.*, 34 C.F.R. Part 381 *et seq.*

² 42 C.F.R. § 489.24 *et seq.*; 42 U.S.C. § 1395dd. EMTALA is also referenced as Section 1867 of the Social Security Act and Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985.

II. BACKGROUND

A. The Youth

The youth³ is a seven year old male who lives with his grandmother and sixteen year old half-brother in central Vermont. The youth has been in his grandmother's care and custody since age one. He has infrequent visits with his biological parents. He receives outpatient psychiatric treatment, including prescribed psychotropic medications. His documented disabilities include Bipolar Disorder, Attention Deficit and Hyperactivity Disorder (ADHD), Attachment Disorder, and possible Post Traumatic Stress Disorder (R/O PTSD). He has a noted history of trauma including parental neglect and physical abuse at a very early age. The youth receives special education services and has an Individual Educational Plan (IEP). He was transferred to an alternative education program within the public school system in 2005 following many behavioral difficulties including physical aggressiveness towards both peers and staff. He has a lengthy, documented history of impulsivity, threatening behavior, property destruction and physical assaultiveness towards others and most often directed towards school staff. It was noted in psychiatric treatment records from the Brattleboro Retreat that the youth "appeared to developmentally behave and appear more like a toddler than a 7 1/2 year old boy."

The youth's grandmother described the youth's behaviors at the time of the incident under investigation as often very uncooperative and very aggressive, not towards her but towards school staff. She said he would kick, bite, and destroy things in the classroom. Outside of these episodes she further described the youth as caring and compassionate, stating that he is "a very loving child" who demonstrates concern about others. He enjoys building and constructing things, fishing, and playing on the computer.

B. Involuntary Patient Transport in the State of Vermont

In May of 2003, Rep. Thomas Koch, the Chair of the Vermont House of Representatives Committee on Health and Welfare, sent a letter to then-Commissioner Susan Besio of the Vermont Department of Development and Mental Health Services (DDMHS)⁴ requesting an evaluation "of options which could reduce or eliminate the reliance upon law enforcement and the use of prisoner shackles for patient transport." Rep. Koch wrote in his letter "(t)he use of the sheriff's department and of prisoner leg and wrist shackles for transporting mentally ill patients in your care and custody may be a practice which is anti therapeutic, traumatic, and unnecessarily coercive to achieve the objectives of patient and community safety."

In January of 2004, DDMHS submitted the requested report to the House Health and Welfare Committee entitled: "Transportation of People for Emergency Examination under Mental Health Law" (hereafter referred to as the "DDMHS Transportation Report"). The DDMHS

³ In order to protect the confidentiality of the juvenile subject of the November 2006 secure transport under investigation, he will be referred to as "the youth" throughout this report.

⁴ The Department of Developmental and Mental Health Services (DDMHS) has since reorganized into two separate entities within Vermont's Agency of Human Services: Developmental Services and the Department of Mental Health. DDMHS will be referred to throughout this report relative to the Transportation Report issued in 2004.

Transportation Report identified that a contract between the Agency of Human Services (AHS) and all fourteen county sheriffs departments throughout the state governed the transportation provided for inmates in the custody of the Department of Corrections (DOC), children in the custody of Social and Rehabilitation Services (SRS)⁵ and individuals with mental illness who are involuntarily committed to the custody of DDMHS. The DDMHS Transportation Report stated that no clinical or medical criteria, assessments, or evaluations were specified in the transportation contract regarding the use of restraints and/or the necessity of same. The report did indicate that the policy of all county sheriffs departments “is that restraints should always be used for all people transported. The restraints used are typically metal cuffs, and sometimes metal wrist-to-wrist restraints, and ankle hobbles. Some sheriffs departments have available and use ‘Humane Restraints’ made of leather, nylon, or polyurethane.”

With the exception of Southwestern Vermont Medical Center in Bennington County which has regularly utilized ambulance transport, the long-standing practice in other areas of the state at the time of the DDMHS Transportation Report regarding the transfer from one hospital setting to another for individuals being involuntary admitted for psychiatric evaluations had been the use of secure transport involving law enforcement personnel and mechanical restraints. Regarding the transport of youth requiring involuntary admission to the Brattleboro Retreat for psychiatric evaluation, the DDMHS Transportation Report cited the need for “special consideration” to be made. “Parents and family members are now sometimes unable to accompany their child to the hospital if they have no transportation. Sheriffs’ policies do not permit others to ride in the cruiser, and thus a long ride in shackles to a hospital admission is sometimes the experience of youth.”

In June of 2004, §1711 of 18 VSA, Chapter 179 was added to read:

(a) The commissioner shall ensure that all reasonable and appropriate efforts consistent with public safety are made to transport or escort a person subject to this chapter to and from any inpatient setting, including escorts within a designated hospital or the Vermont state hospital, in a manner which:

- (1) prevents physical and psychological trauma;
- (2) respects the privacy of the individual; and
- (3) represents the least restrictive means necessary for the safety of the patient.

(b) The commissioner shall have the authority to designate by rule the professionals who may transport patients under the commissioner's care and custody.

⁵ The Department of Social and Rehabilitation Services was renamed the Department for Children and Families under the AHS reorganization referenced in footnote 3.

The enactment of this statute demonstrates, in theory, the movement of the state towards a mental health system that is sensitive to trauma-informed principles of care and protective of the dignity of individuals experiencing psychiatric crisis. It also demonstrates that the Vermont Legislature accepted the seriousness of the concerns and recommendations in the DDMHS Transportation Report.

It was not until May of 2005 that the Vermont Department of Health (VDH) publicly issued draft guidelines to begin addressing the recommendations of the January 2004 DDMHS Transportation Report and the June 2004 statutory language surrounding involuntary transport. VDH posted the “Involuntary Transportation Guidelines Final Version” on the Department’s website on June 17, 2005. The guidelines set forth “overall principles that can be used” by the professionals involved at the time involuntary transport is necessary. Included were general guidelines suggesting that assessment be done by the involved professionals to determine the type of transport needed based upon input from all available parties; the provision of choices to the patient about modes of transport consistent with safety; and the use of individual mental health staffing in addition to or instead of law enforcement transports if considered safe and within the limitations of available funding.

Specific guidelines regarding use of restraint suggested that evaluation should occur to determine the level of risk and the need for restraints; the use of non-metal restraints as the “preferred option” when restraint use is determined to be necessary; and efforts to ensure the unobtrusiveness of such restraints in areas where other individuals may be present. The inconspicuous use of sheriffs was also listed in the guidelines whenever possible, i.e. the use of unmarked cruisers and officers in plain clothes, as well as the provision of in-service training for all officers providing mental health transports. The guidelines suggested that ambulances be used, with sheriffs backup if necessary, in situations when skilled medical supervision or intervention is determined appropriate by the emergency department physician; that the guidelines should be followed in an ambulance when restraints, other than the gurney safety strap, are necessary; that training specific to mental health issues and mental health transport should be received by emergency medical technicians; and that Medicaid reimbursement or other funding would be pursued for the costs associated with ambulance transport.

Throughout 2005, the VDH Restraint and Involuntary Transport Guidelines were further developed to include “Protocol for Transport of Children to an Involuntary Hospital Setting” and a “Transport Information Checklist” to aid in the decision making process regarding the mode of transport to be utilized. The children’s transport protocol restated policies requiring the use of the least restrictive method and/or mode of transport consistent with safety to self and others, that restraints should be used only when determined necessary by a Qualified Mental Health Professional, and that when restraints are determined necessary, non-metallic restraints are preferred and would be provided by VDH to the sheriffs’ departments. Additionally, the children’s protocol cited encouragement for a parent to accompany a child during transport if clinically appropriate and allowed (by mode of transport). The new protocol stated three available transport options from least to most restrictive:

1. Transport in an unmarked vehicle (either private or public transport), without restraints, with patient accompanied by a mental health transport specialist and/or a parent or parent surrogate;
2. Transport by ambulance accompanied with or without a mental health transport specialist and/or parent or guardian (if allowed by EMS);
3. Transport by uniformed sheriffs' services, with unaccompanied child in restraints.

In May of 2006, 18 VSA §7511 was amended to provide broader authority to professionals designated by the Commissioner of the Department of Health to "(b)...authorize the method of transport of patients under the commissioner's care and custody." Additionally, the following was added to the statute:

(c) When a professional designated pursuant to subsection (b) of this section decides an individual is in need of secure transport with mechanical restraints, the reasons for such determination shall be documented in writing.

(d) It is the policy of the state of Vermont that mechanical restraints are not routinely used on persons subject to this chapter unless circumstances dictate that such methods are necessary.

III. VERMONT PROTECTION & ADVOCACY, INC. INVESTIGATION

In November of 2006, VP&A received a complaint from the youth's grandmother/legal guardian who stated that the youth had been inappropriately transported, in handcuffs and shackles, by sheriffs deputies from Rutland Regional Medical Center (RRMC) to the Brattleboro Retreat, Vermont's only child and adolescent inpatient psychiatric facility. The youth's grandmother was incensed that her seven year old grandson was treated "in such a traumatic way, as if he were a criminal."

Pursuant to our federal mandates VP&A initiated an investigation into the circumstances surrounding the youth's secure transport by law enforcement personnel, which included the following:

- Interviews with the youth's grandmother and the youth.
- Review of the youth's Rutland Mental Health Services Emergency Team Reports and Records dated October 10, 2005, November 2, 2006 and November 3, 2006.
- Review of the youth's Rutland Regional Medical Center Emergency Department Reports and Records dated October 10, 2005, November 2, 2006 and November 3, 2006.
- Review of Rutland Regional Medical Center Security Staff Logs dated November 3, 2006.
- Review of Rutland County Sheriff's Department Records regarding the transport of the youth from Rutland Regional Medical Center to the Brattleboro Retreat, dated November 3, 2006.

- Review of the youth's Brattleboro Retreat Inpatient Medical Records dated November 3, 2006 through November 17, 2006.
- Review of the youth's Rutland Mental Health Services Outpatient Psychiatric Treatment Records dated October 27, 2005 through January 9, 2007.
- Telephone Interview with Rutland Mental Health Services Crisis Clinician.
- Telephone Interview with Rutland Mental Health Emergency Services Director.
- Telephone Interview with Rutland City Police Officer/School Resource Officer.
- Interview with the youth's School Clinician.
- Review of the Department of Developmental and Mental Health Services report entitled "Transportation of People for Emergency Examination under Mental Health Law" dated January, 2004.
- Review of the Involuntary Transportation Guidelines and related documents issued by the Vermont Department of Health.
- Telephone Interview with Southwestern Vermont Medical Center Emergency Department Patient Coordinator.
- Review of Southwestern Vermont Medical Center's Patient Transfer Policies.

IV. CHRONOLOGY OF EVENTS

A. Rutland Mental Health Services and Rutland Regional Medical Center Emergency Department Reports and Records

On November 2, 2006 at 1:00 p.m., the youth was brought to the Emergency Department at RRMC by his grandmother "after extreme escalation at school" according to RMHS Emergency Team Reports. He was evaluated by a RMHS crisis screener who wrote that when the youth was interviewed, he stated "I hit people" and "I don't know why." The youth identified that prior to his arrival at RRMC, he had hit a counselor at his school. Apparently, the counselor had been attempting to process behavioral issues with the youth who then became escalated and agitated as a result. The youth indicated he was angry at the counselor for holding him accountable for his behaviors at the school. The RMHS crisis screener interviewed the youth's school clinician who reported that the youth "has frequent mood swings in school but had escalated above usual level today." The school clinician stated that the youth had run out the school building and threw mud and rocks at the building and the counselor. He had also thrown food at the counselor. Additional information obtained by the RMHS crisis screener from the school clinician indicated that the youth "has hit people in the past in anger and has even been physical with his grandmother when very agitated."

During this crisis evaluation, the youth discussed experiencing difficulty sleeping, having nightmares several times a week, and seeing and hearing people who are not there. The RMHS crisis screener wrote that it is unclear whether "these occurrences represent true hallucinatory experiences." The youth's school clinician reported to the crisis screener that the youth "has numerous psychosocial stressors related to father's frequent incarcerations and mother's abandonment of him." The youth's grandmother, when interviewed by the crisis screener, also stated her belief that his father's frequent incarcerations have been "a major trigger" for him. Medications prescribed by the youth's outpatient psychiatrist were listed as Trileptal, Depakote,

Risperdal, and Concerta. The crisis screener identified his diagnostic impressions of the youth as Axis I: Bipolar and PTSD; Axis II: Deferred; Axis III: None; Axis IV: Problems with his Primary Support Group, Problems Related to the Social Environment, Educational Problems, Other Psychosocial Environmental Problems; Axis V: 40. The crisis screener wrote that the youth's judgment at the time of the evaluation was poor, his ability to control impulses was fair, and his ability to understand and comply with his treatment plan was fair. His summary of an assessment of dangerousness was identified as "Patient has been escalating physically and could hurt someone if this continues. Level of Risk: Medium."

After examination by the attending RRMC Emergency Department physician and consultation with the on-call psychiatrist, the RMHS crisis screener suggested the possibility of an inpatient psychiatric admission to the Brattleboro Retreat. According to the records written by the crisis screener, the youth's grandmother "has been very reluctant to even entertain possibility of patient going to Bratt. Ret. . . She does not want patient going to Bratt. Ret. at this time." The youth's grandmother indicated that she felt she could provide for the youth's safety at the time. Given the choice of the youth's discharge home or admission to the Brattleboro Retreat, the youth's grandmother agreed that the youth would go home with her that night, they would explore with his outpatient psychiatrist the possibility of medications that would help with his difficulty sleeping, that he would be expected to process his recent behavioral issues the next morning at school and that, if he escalated again, he would be brought back to RRMC and re-evaluated for admission to the Brattleboro Retreat. The youth was discharged home from the Emergency Department at 3:35 p.m.

The following day, November 3, 2006, at 11:30 a.m., the youth's school clinician placed a call to RMHS regarding a new crisis involving the youth at school. The crisis screener on duty at the time promptly responded to the call. She wrote in her RMHS Behavioral Emergency Team Report records that she received an "Alert on pt. RE: out of control behavior at school. Pt. screened yesterday in ER by [RMHS crisis screener]. Guardian unwilling to let pt. go to the Brattleboro Retreat. Plan was made to D/C home with plan that if pt escalates again, he should be brought back to the ER for screening for BR [Brattleboro Retreat]. Pt. is escalating again. School requested crisis to go to school, but contained environment with supports for crisis needed to facilitate a BR admission if needed."

RRMC medical records indicated that the youth arrived in the Emergency Department on November 3, 2005 at 12:05 p.m. He was accompanied by the school resource officer and his school counselor. The chief complaint listed was "out of control" at school, swinging a pipe and trying to run away. It is noted in the record that he had been seen in the Emergency Department the day before for similar events. At 12:15 p.m., prior to an assessment with the attending Emergency Department physician, a nurse wrote "@ present, pt with grandmother cooperative."

At 12:20 p.m. a RMHS crisis screener met with the youth, his grandmother, and his school clinician in the Emergency Department. This crisis screener wrote the following RMHS Behavioral Emergency Team Report: "Re-evaluation – client was at school today experienced another violent episode which involved [the youth] being impulsive and dangerous. [The youth] ran into the woods and behind the school with another student. The other student came back, but [the youth] did not. Instead he found a metal pipe and refused to put it down, swinging it at

several staff and shouting he was going to hurt them. According to [staff person], there were 5 counselors and staff plus the principal and another administrator all trying to de-escalate him.”

The RMHS crisis screener further reported in her records that “[the youth] was a little gamey during the 40 min. I was with him. Often smiling, mostly calm and not responding to directions I would give him. He did tell me he didn’t feel badly for wanting to hurt people. Discussed with [the youth] that we were looking at ways we could help him and sometimes that means going away for awhile.” She consulted with RRMC’s on-call psychiatrist who agreed to evaluate the youth as part of an Application for Emergency Examination, pursuant to 18 V.S.A. § 7504. The crisis screener recorded her Diagnostic Impressions and Assessment as “Client is in need of placement that will keep him and others around him safe i.e. hospitalization.”

At 12:35 p.m., the RMHS crisis screener who had responded earlier to the call from the youth’s school clinician also appeared at RRMC and became involved in the screening process. She completed an Application for Emergency Examination writing the following: “Reason for Application: [the youth] was screened on 11-02-06 for dangerous behavior, but was not hospitalized due to resistance from family and an agreement by [the youth] to calm down and follow up with his school and process the issues on 11-03-06. It was recommended that if [the youth] continued to behave in a dangerous manner, he would need to return to the ER for an evaluation to Brattleboro Retreat. Today he ran from [school], got a hold of a pipe and was threatening to hit school staff with it. He continued to escalate and would not calm down as agreed yesterday. Once [the youth] arrived to the ER he was uncooperative with this screener and basically refused to engage in any discussion. He was sitting on his grandmother’s lap and was using the string on his hospital johnny to try and hurt his grandmother by trying to wrap it around her arm very tightly. At one point he told his grandmother that he was going to cut off her fingers. [The youth] appears to have little or no insight into his behavior and his impulsivity is of great concern compromising his safety and others around him. Given that [the youth] has had two days of dangerous behavior, putting himself and others at risk and is not able to be calmed down by several professionals, it is recommended that he be placed at the Brattleboro Retreat for safety and stabilization. He is unable to consent for hospital level of care at this time.”

At 1:16 p.m., a RRMC security officer wrote in his log, “Patient is calm at this time.” At 2:00 p.m. the RRMC Emergency Department nurses’ notes indicated that the RMHS crisis screener was “working with case – pt watching video – grandmother with pt.”

Also at 2:00 p.m. on November 3, 2006, the records indicate that a RRMC psychiatrist examined the youth and signed a Physician’s Certificate for Emergency Examination stating: “In my opinion this patient [the youth] is (A) not only mentally ill, but (B) poses a danger of harm to him/herself or others and (C) should immediately be admitted to a designated hospital for an emergency examination.” He outlined the events, as noted above, leading to the youth’s two crisis emergency department visits in two days and wrote that “he is a danger to others given his assaultive, impulsive behavior, with limited insight into how his behavior may be dangerous to others or potentially himself.” The psychiatrist recorded the youth’s tentative diagnoses as Bipolar Disorder and PTSD. Regarding his obligation to consider alternative forms of care and treatment without requiring hospitalization, the psychiatrist wrote: “...[the youth] is not able to consent reliably for treatment. It was recommended by this clinician yesterday that if his

threatening behavior continued, that he be evaluated on an inpatient [sic] basis. Given his impulsivity, his threatening behavior, and his lack of insight into the consequences of his behavior, he is a person in need of treatment on an involuntary basis.”

The RRMC attending Emergency Department physician signed a “Physicians Certificate to Transfer” form (RRMC Form # 1715) recording that the receiving hospital, the Brattleboro Retreat, had provided acceptance for the youth’s transfer at 2:00 p.m. The physician indicated on the form that the youth’s medical condition was: “(B) STABLE: I certify that the patient suffered from a medical condition but was stabilized at the time of transfer. Furthermore, the hospital’s obligation under the law and the reasons for transfer have been explained to the patient or responsible individual and the patient or responsible individual understands and agrees.” The method of transfer was listed as “Sheriff” and the Provider was specified as “Rut. Cty Sheriff.”

A “Patient Consent to Transfer” form (RRMC Form # 1716) was signed by the youth’s grandmother and legal guardian, stating “Transfer Consent: This is to certify that I [the youth] have been examined at the Rutland Regional Medical Center, and that I have (check one):

(x)1. Given my consent to transfer from this hospital to another facility. I acknowledge that I have been fully informed of the hospital’s obligations under the law and the risks involved in transfer. I hereby release the attending physician, and the hospital from all responsibility for any ill effects which may result from the transfer.”

At 2:21 p.m. a RRMC security officer wrote that “[RRMC psychiatrist] in and out of Rm #16 Pt. [the youth] no problems.” At 2:48, the security officer returned to duty outside of the youth’s room and again indicated that there were “no problems.” At 3:02 p.m., a second RRMC security officer relieved the first of duty and wrote “Pt [the youth], (7 yr old) has been evaluated by Crisis and will be going to Brattleboro Retreat by Sheriff Dept. Pt [the youth] has been very calm and cooperative.” At 3:30 p.m. a RRMC nurse recorded that the crisis screener was with the youth and his family, and again wrote “child cooperative watching movie, 0 outbursts.”

At 4:25 p.m. a Department of Mental Health Child & Adolescent Inpatient Admission Notification Form was faxed to Vermont State Hospital by the RMHS crisis screener. Under the category of “Alternatives Considered” the Baird Center was checked but admission was refused due to the following reasons: “No beds. Plus case continued to be more difficult indicating higher level of care needed.”

At 4:30 p.m. a Vermont Department of Health, Division of Mental Health “Transport Information Checklist for Persons on Involuntary Status” form was completed by the same RMHS crisis screener.

On the Transport Information Checklist, the “Recently Reported and/or Currently Observed Behaviors” under the heading of “Criteria for Determination of Method of Transport” were listed as: “(v)erbal abuse or threats to harm self or others; (v)iolent episode, unpredictable, impulsive; (u)se, possession or attempted possession of a weapon; and (a)gitated and out of control.”

Under the heading of “Determinant Factors for Mode of Transportation” the following categories were marked with a check: “(i)individual exhibited inconsistency in ability to control behavior; and (i)individual lacks insight into dangerous behavior.” Unchecked were the following: “(i)individual maintained escalation in behavior; (i)individual was able to be approached with options regarding transport and was amenable to less restrictive means of transport; (i)individual is known to DA [Designated Agency].”

The “Mode of Transport Used” section showed a check mark next to “(u)niformed sheriff’s services” while other choices available on the form but not checked are described as “(a)mbulance with or without mental health transport specialist; or (o)ther transport without restraints, with mental health transport specialist and/or parent/surrogate if child.” The “Justification for Mode of Transport Used” was specified as “(c)hild can become violent in unpredictable ways.”

At 5:30 p.m. that evening, an Emergency Department nurse wrote that the youth would be transported to the Brattleboro Retreat and at 6:15 p.m. the records indicated that he was discharged from the Emergency Department to the Brattleboro Retreat, accompanied by the Rutland Sheriffs’ Department.

At 6:00 p.m. on November 3, 2006, a RRMC security officer recorded in his log that two Rutland County Sheriff Department Deputies arrived to transport the youth to the Brattleboro Retreat. He wrote that there was some question as to whether the youth’s grandmother could accompany her grandson during the transport. The question was resolved with the deputies seeking and receiving permission from the “High Sheriff ... for her to travel in the Police Unit, the family was also visably [sic] upset when [the youth] was handcuffed for transport.”

The attending physician’s Emergency Department/Fast Track Report restated the events leading to the crisis evaluations that had occurred and indicated that “yesterday, grandmother asked that the patient be sent home under her supervision, although we were concerned about the patient’s behavior.” During his assessment of the youth, the Emergency Department physician wrote “this is a male who is rather agitated, calms with me.” The ED Course/Procedures were reported as “patient had screening by Crisis, and it was decided that it would be better for patient to be admitted to Brattleboro Retreat. The patient is unable to control his impulses and somewhat dangerous to transfer in an unrestrained environment for concern he may harm himself by opening the door in a moving car. Grandmother is very uncomfortable, but under these circumstances, it is safest for patient to be transported by law enforcement under restraint, which is our solution of last resort, but in this case, it seems to be the safest. The patient was transported by law enforcement in restraint, and grandmother voiced her disapproval.”

B. Rutland Mental Health Crisis Screener’s Recollections

The RMHS crisis screener who completed the Application for Emergency Evaluation and Transport Information Checklist regarding the youth’s need for secure transport to an inpatient psychiatric hospital recalled, in a telephone interview with VP&A, that what stood out for her at the time of the screening was her concern and curiosity about the youth reportedly having been

out of control for a two day period, particularly because he'd had a similar experience the day before at his school. In response to questions about any threatening or aggressive behavior she may have witnessed while in the Emergency Department with the youth, the crisis screener stated "he was threatening to hurt his grandmother and threatening to chop her head off or something like that." Regarding any specific harm he attempted upon his grandmother, the crisis screener said that she witnessed the youth "trying to hurt his grandmother – he was wrapping a string around her wrist very tightly."

When asked about the youth's and his grandmother's willingness to have the youth admitted to the Brattleboro Retreat for inpatient treatment, the crisis screener stated that she did not remember the youth's response to her questioning him about whether he'd be admitted voluntarily, however "he was considered an unreliable reporter based on the events of the last two days." His grandmother's response to the idea of inpatient admission for the youth was described as "she still didn't want him to go and made it very difficult. She was very resistant to the possibility of this child being placed in a secure and safe environment to be assessed and clinically evaluated." The crisis screener further elaborated that the youth "was clearly a child in need of services. He was very immature for his age, didn't really understand why he was here, had no insight, no remorse, was completely unpredictable and had no ability to modulate his behaviors."

The crisis screener described generally the options available for the transport of individuals from RRMC to the Brattleboro Retreat for evaluation and treatment purposes as either sheriffs transport, transport by the local public transport system ("The Bus") with non-clinically trained escorts if an individual is not a danger to oneself or others, or family transport, also if not a danger to self or others. The crisis screener confirmed that the youth's grandmother did request that she be allowed to transport her grandson to the Retreat, however, "given the grandmother's resistance [to inpatient admission] we weren't guaranteed that she would take him." Since the statutory amendments regarding involuntary patient transport were enacted into law, the crisis screener stated that RMHS has been using "a lot more family transports and use of The Bus" but explained that this youth "was the exception... One of the things we like to do is to have the family transport, but given this situation, would she turn around and not take him there? Would he jump out of the car? Would he put others at risk?" She further explained her concerns for the youth's and others safety and for liability if secure transport had not been utilized in this situation. When questioned about who else was involved in the decision to use secure transport for this child, the crisis screener said "it's the State; it's what's mandated to us – to use the checklist, but this kid was so unpredictable. You always want to use the least restrictive but in this case I don't think there was any other choice."

Regarding the classification by an Emergency Department physician that the youth was "stabilized for transfer," the crisis screener recalled "yes, he was medically stable, but behaviorally he was not stable." When asked about any available options for ambulance transport of patients for purposes of hospital to hospital transfer, she stated "not from here. I don't believe the local ambulance has that kind of set-up... Even for the ones that do [in other parts of the state], I don't believe they have the training to transport someone who needs to be in restraints or who is a flight risk."

The crisis screener reported that although she wasn't present at the time, the other RMHS crisis screener with whom the youth initially met upon arrival at RRMC that day was present when the sheriffs arrived to transport the youth to the Brattleboro Retreat. VP&A attempted to interview the other involved crisis screener, but found she was no longer employed with RMHS at the time of the present investigation. According to the crisis screener interviewed by VP&A, when they called to request secure transport by the Sheriffs Department, they indicated the transport was for a child, but she said she recalled learning later that the Sheriffs "didn't bring the proper restraints" resulting in the use of metal handcuffs and shackles on the youth.

C. The Youth's School Clinician's Recollections

During an interview with VP&A, the youth's school clinician reported that on November 3, 2006, the youth and another student had run out of the school building. They ran to the back of the property, a wooded area, where the youth found a lead pipe. The youth picked up the pipe and started swinging it, threatening to kill everyone and chasing after staff with it. Another staff person was able to get behind the youth and took the pipe away from him. The youth was transported to RRMC because "he was so out of control at the time."

The youth's school clinician accompanied the youth to RRMC, driven by the school resource officer. She stated that the youth was calmer at the hospital but she partly attributed this to his grandmother telling him he wouldn't have to go to the Brattleboro Retreat. The school clinician said that just because the youth was calm at that moment, it didn't mean he wouldn't escalate. She said that she would consider transport from RRMC to the Brattleboro Retreat "a very high risk situation" in that any time limits are set with him, that's when he escalates. She also said the youth's grandmother has difficulty setting even very simple limits with him.

The school clinician had worked with the youth for approximately a year and a half at the time of the November 3, 2006 incident. She described the youth as a child with explosive behavior and many temper tantrums. He quickly escalates and makes homicidal statements towards staff and peers. She said he is very hypervigilant and he often throws objects at staff i.e. chairs, computers, and tables. He has been violent towards his grandmother also – the school clinician said she has observed the youth trying to strangle his grandmother and pulling her hair. She also has seen him kick and punch his grandmother's car and car windows. Additionally, the school clinician said the youth is "very difficult to de-escalate."

D. The Youth's School Resource Officer's Recollections

In a telephone interview with VP&A, an officer from the Rutland City Police Department reported that his involvement with the youth on November 3, 2006 was a part of his regular duties as the School Resource Officer at the youth's school. The officer reported that the youth and another student had run out of the school towards a street bordering the school property. Because he was concerned that they'd run into the street, he drove over to head them off. He saw that the other student had a stick in his hand and that the youth had a pipe with which he had been threatening to hit the teachers and counselors. By the time the officer made it around to the

road in his car, the other student had dropped the stick and the school staff were physically restraining the youth. The staff brought the youth “to a special room that was set up for him” because he had been having problems before this incident. The counselor asked that the youth be screened at the hospital. The officer drove the youth a very short distance to the hospital accompanied by school staff. The youth’s grandmother was called and met them at the hospital. The youth was able to walk in to the hospital with his grandmother. The officer said that while at the hospital, the youth was “not as threatening as he had been at school, but still very agitated.”

The officer stayed for a short time at the hospital while the youth was admitted into the Emergency Department. He advised security staff of the youth’s presence in the Emergency Department and then left.

Regarding similar situations involving the youth, the officer stated “there have been other incidents in which he has become very, very violent...he punches, he bites, he kicks, he threatens to stab and to kill people.” The officer further described the youth as a boy who is in need of a great amount of supports and treatment.

E. The Youth’s Grandmother/Guardian’s Recollections

Although the youth was present for the initial interview conducted by VP&A for purposes of this investigation, his grandmother/legal guardian provided most of the detailed information pertaining to their recollections of the chronology of events that led up to the youth’s secure transport from Rutland Regional Medical Center to the Brattleboro Retreat.

According to the youth’s grandmother, school staff called her on November 2, 2006 stating that the youth was having difficulties at school that day. The staff person told her that the youth had been hitting a school counselor and suggested that he be seen for a crisis evaluation at RRMC. The youth’s grandmother picked the youth up from school and brought him to RRMC. They were presented with admission to the Brattleboro Retreat as an option for the youth if needed, but they chose to return home.

The next day, on November 3, 2006, the youth’s school clinician called the youth’s grandmother and asked her to meet the youth and school staff at RRMC. The youth’s grandmother drove directly to the school which is across the street perpendicularly to RRMC.

The youth’s grandmother disputed the youth’s school clinician report that she was unable to set limits with her grandson. In fact, she stated, she has been called numerous times in the past to respond to the youth’s behavior during the school day. She reported to VP&A that often her appearance at the school in response to a call from the staff would be effective in de-escalating the youth.

When she arrived at the school, she saw that the youth’s school clinician and the school principal were physically restraining the youth in the back of the school resource officer’s police car. She was informed that the youth had found a metal pipe and was swinging it around towards staff. The youth’s grandmother was told that the youth had run out of the door at school and found the

pipe outside. The youth's grandmother said that the youth became agitated when staff chased him after he had run out the door – had they let him have some time to cool off outside she believes there would have been a different outcome. Although the youth had run out of school several times during the prior school year, this was the first time this year according to her. She said that the youth had never left school grounds during any of these incidents. The school resource officer, at the request of school staff, was planning to drive the youth to the RRMC Emergency Department for a crisis screening. The youth's grandmother said that the youth was crying, pleading to be allowed to go to RRMC with his grandmother. The youth's grandmother asked to take him but that request was denied. The youth was transported a short distance to RRMC by the officer with the school clinician and principal in the back seat with him. When they arrived in the parking lot at RRMC school staff took the youth out of the car, he hugged his grandmother, and according to her, he was “clearly upset but his behavior was fine from that point on.” The youth's grandmother disagreed with the school resource officer's assessment that the youth remained agitated upon arrival to the hospital.

While waiting to be seen by the crisis screener in the Emergency Department at RRMC, a hospital security guard was present at the door to the youth's room. When the youth's grandmother asked the reason for the security guard's presence, she said she was told “it's policy.” The RMHS crisis screener discussed admission to the Brattleboro Retreat for the youth with the youth's grandmother. The youth's grandmother said that she told the crisis screener that the youth was willing to go and that she was willing to let him go there. According to the youth's grandmother, she was then told by the crisis screener that they needed to do an involuntary placement “as a formality” in case he changed his mind and didn't agree to sign in voluntarily when he arrived at the Retreat. The youth's grandmother said they then waited in the Emergency Department for hours in order for paperwork to be completed. During that time, she overheard the RMHS crisis workers talking about sheriffs' transport and she “went berserk.” She said had she known that involuntary admission was going to involve transport by sheriffs, she would not have been so complacent about it. When she questioned the reason for sheriffs' transport, the youth's grandmother said she was told by the RMHS crisis screener that “it's policy.” She wasn't told about the potential use of shackles at that point and learned of that when the sheriffs arrived for the transport. She said the youth was already asleep by the time the sheriffs arrived. The youth's grandmother asked why she and the youth's grandfather and brother, who were also present in the Emergency Department, couldn't take the youth to the Brattleboro Retreat themselves. She said the crisis screeners' response to her question was that “it's policy and because he's now in state's custody it's out of our hands.”

In response to a review of the records documented by RRMC, the youth's grandmother denied that the youth attempted to hurt her with the strings of a hospital johnny (similarly, she denied the school clinician's statement that her grandson had ever attempted to strangle her); she stated that the initial crisis screener's “40 minute evaluation” was not nearly that long – she reported it having been closer to 10 minutes in duration; and she also said that she does not believe that a psychiatrist actually met with the youth face to face. The youth's grandmother stated that with the exception of her brief departure from the Emergency Department in order to retrieve the youth's belongings at their home, which was much later in the day than the 2:00 p.m. meeting time documented in the records, she was present with the youth in the Emergency Department and does not recall the youth being seen by a psychiatrist at any time on November 3, 2003. Not only

was she not made aware of any such meeting between the youth and a RRMC psychiatrist if it did actually occur as documented in the records, but the youth's grandmother said she was not interviewed or offered an opportunity to meet with the psychiatrist to provide information about her grandson or input regarding the plans being made for further evaluation and treatment as she would have expected as part of a thorough psychiatric assessment.

The youth's grandmother reiterated her dissatisfaction that a discussion about the transportation option being planned, namely secure transport by law enforcement officers, never occurred with her, nor was any conversation about what she could provide for transportation safety measures initiated at any time. She said no one took the time or opportunity to find out that she had supportive family members ready to accompany her and the youth on the trip to the Brattleboro Retreat and that her vehicle's child safety locks could have been enabled as an extra safeguard. She again stated that the use of secure transport was completely inappropriate, especially given that the RRMC nurses' and security officers' records confirmed the youth's calm and cooperative demeanor during the hours he spent in the Emergency Department that day.

The youth's grandmother described to VP&A a feeling of betrayal at the hands of the involved professionals. She said she felt as if there was not enough effort put forth to determine that her intent to take him to the Brattleboro Retreat was genuine. She reported that not only did she provide her verbal consent for the youth to be admitted to the Retreat, she also went home and packed clothes and other belongings which she brought back to the hospital for the youth to have with him for his anticipated stay at the Retreat. Additionally, she said the way she found out about the plans for the youth to be transported by sheriffs was completely inappropriate and insensitive. There were many opportunities for the involved staff to have informed her in an upfront manner about their plans for sheriffs' transport, including when one of the crisis screeners asked her how the youth was planning to get to the Retreat yet did not respond to the grandmother's statement that she would be taking him. The youth's grandmother said that, in hindsight, it was clear that the involved staff had made the decision early on to utilize what she believed was a totally unnecessary mode of transport and therefore purposely did not discuss that decision with her.

When the sheriffs arrived to transport the youth to the Brattleboro Retreat, in uniform and with a marked cruiser, the youth's grandmother recalled that she said to them "I'm going with him." She was told by the sheriffs that they don't normally take anyone else with them aside from the patient. They did finally agree to allow her to accompany them for the transport and told her what had to happen – that she would have to wear a seatbelt and that they would have to handcuff and shackle the youth. The youth's grandmother said she was sobbing and she pleaded with them not to use the handcuffs and shackles but she was again told "it's policy." The sheriffs then agreed to not handcuff the youth if one rode in the back seat with him, but that they would require her to ride in the front seat because there wasn't enough room for all three of them in the back of the cruiser. The youth's grandmother said that the youth was hugging and grabbing onto her and because he didn't want to let go, she decided to ride in the back with him while the sheriffs decided to use the handcuffs and shackles on the youth for the transport.

The youth's grandmother said that the RMHS crisis screener told the sheriffs that the youth had not been a problem during the time they spent with him at the hospital that day. According to the

youth's grandmother, one of the sheriffs replied "well, I have to admit, this is the youngest I've ever had (to transport)." The sheriffs shackled the youth and a RRM security guard, who the youth's grandmother described as very nice, put a blanket on him to cover the restraints before wheeling him to the cruiser. They drove to the Brattleboro Retreat, approximately seventy-five miles away, without incident. The sheriffs removed the handcuffs and shackles after the youth was brought into the admissions building at the Brattleboro Retreat. Because it was so late at night when they arrived, the admissions staff said they'd review the voluntary admissions paperwork with the youth the next day. The youth was converted to voluntary status at the Brattleboro Retreat the next day with no difficulties.

Since this incident, according to the youth's grandmother, the youth has experienced nightmares often involving some form of restraint while in a vehicle and he has fear with regard to police officers now whereas he hadn't previously. In addition, the trauma evoked for the youth's grandmother was quite evident each time she discussed the situation with VP&A. Not only does she feel she let her grandson down by not protecting him from such a dehumanizing experience, she doesn't believe she could have adequately prepared him for what was to happen because she was not fully informed. Each time she questioned RRM and RMHS staff in the Emergency Department about their restrictive decisions, she was told "it's a formality" or "it's policy." She had no idea that transport by law enforcement for the youth was ever a possibility until she overheard RMHS staff discussing it. She had no idea that the law enforcement personnel would likely utilize handcuffs and shackles until they arrived with the metal restraints ready for use in order to transport the youth for his first-ever psychiatric hospital admission.

V. VERMONT PROTECTION & ADVOCACY, INC. FINDINGS AND CONCLUSIONS

A. Violations of Federal and State Law

VP&A acknowledges the cooperation and candor of all parties involved throughout this investigation. VP&A appreciates that the decision to utilize secure transport was based on an apparent concern for potential danger on the part of the youth coupled with possible resistance to a voluntary admission to the Brattleboro Retreat. VP&A concludes, however, that the use of secure transport, specifically the use of uniformed law enforcement in a marked cruiser using handcuffs and shackles on any emergency department patient requiring transfer to inpatient psychiatric care is inappropriate and a violation of federal law.

Federal regulations governing appropriate emergency department transfers and discharges, the Emergency Medical Treatment and Active Labor Act (EMTALA),⁶ define an Emergency Medical Condition (EMC) as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to

⁶ 42 C.F.R. § 489.24 *et seq*; 42 U.S.C. § 1395dd. EMTALA is also referenced as Section 1867 of the Social Security Act and Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985

result in – (i) placing the health of the individual... in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part...”⁷

Although it was reliably reported that the youth may be prone to explosive outbursts at times as demonstrated earlier in the day in question, the only uncooperativeness, agitation or possible expressions of aggression demonstrated during the six hours he was at RRMC occurred at the onset of his admission to the Emergency Department. All RRMC nursing reports and security staff reports indicate that the youth was calm and cooperative, beginning at 1:16 p.m. until his departure for transfer to the Brattleboro Retreat at 6:15 p.m. on November 3, 2006. This leads VP&A to conclude that at the time secure transport was utilized, the emergency medical condition the youth experienced earlier in the day may have possibly subsided over the hours spent in the Emergency Department and therefore alternative transport modes should have been reconsidered as a more appropriate method of transfer to the Brattleboro Retreat for further evaluation and treatment of his psychiatric conditions.

According to the EMTALA regulations, an emergency medical condition is considered stabilized when “no material deterioration of the condition is likely, within reasonable probability, to result from or occur during the transfer of an individual from a facility...”⁸ The corresponding Center for Medicare and Medicaid Services (CMS) Interpretative Guidelines state: “(i)n the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC [Emergency Medical Condition]. Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others. The administration of physical or chemical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and, if not treated for longevity, the patient may experience exacerbation of the EMC. Therefore practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.”⁹

Furthermore, Vermont state law requires that “(m)echanical restraints not be applied to a patient unless it is determined by the head of the hospital or his designee to be required by the medical needs of the patient or the hospital. Every use of a mechanical restraint and the reasons therefor shall be made a part of the clinical record of the patient under the signature of the head of the hospital or his designee.”¹⁰

VP&A is concerned that RRMC abdicated their responsibilities under federal and state law when legal custody of the youth was transferred from his grandmother to the commissioner of mental health as an involuntary patient and when physical custody of the youth was granted to law enforcement personnel for purposes of a hospital to hospital transfer.

⁷ *Id.* For purposes of this investigative report, citations relating to pregnant women have been omitted from the quoted EMTALA regulations.

⁸ *Id.*

⁹ Center for Medicare and Medicaid Services, *State Operations Manual, Appendix V – Interpretative Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases* (Rev. 1, 05-21-04) Tag A407.

¹⁰ 18 V.S.A. § 7704

Regarding the possible medical necessity for the use of restraints on the youth, the attending Emergency Department physician wrote “(t)he patient is unable to control his impulses and somewhat dangerous to transfer in an unrestrained environment for concern he may harm himself by opening the door in a moving car...under these circumstances, it is safest for patient to be transported by law enforcement under restraint, which is our solution of last resort, but in this case, it seems to be the safest.” The physician’s medical opinion, coupled with the RRMC psychiatrist’s certification that the youth is “(A) not only mentally ill, but (B) poses a danger of harm to him/herself or others and (C) should immediately be admitted to a designated hospital for an emergency examination” and information submitted by the RMHS crisis screener on the Transport Information Checklist as outlined earlier in this report suggest that the youth was determined to be in need of a level of care that required constant observation and specific safety precautions in order to ameliorate any potential risk of harm during his transfer to the Brattleboro Retreat.

Federal regulations concerning the use of restraints in Medicare participating hospitals outline very specific requirements for their use, i.e. by physician’s order based on medical necessity to prevent imminent harm, time limitations for use, and continual observation and assessment. There is an exception granted by CMS with regard to the use of restraints on patients in a hospital setting by law enforcement personnel “for custody, detention, and public safety reasons,” not related to the provision of health care. “Therefore, the use of restrictive devices applied by and monitored by law enforcement officers who are not employed or contracted by the hospital, and who maintain custody and direct supervision of their prisoner, are not governed by §482.13(f)(1-3). The individual may be the law enforcement officer’s prisoner but he/she is also the hospital’s patient. The hospital is still responsible for providing safe and appropriate care to their patient. The condition of the patient must be continually assessed, monitored, and re-evaluated.”¹¹

VP&A’s interpretation of the EMTALA regulations is that administration of chemical or physical restraints necessary for safe transfer of an involuntary patient from RRMC to any other hospital for purposes of an emergency examination must be performed by appropriate and qualified medical personnel and not by law enforcement officers using mechanical restraints. VP&A concludes that the potential public safety concerns cited by the involved professionals leading to the use of secure transport by law enforcement personnel were in fact related to the provision of health care and, specifically, the youth’s transfer to a hospital that could provide appropriate evaluation and treatment. When the decision was made that adequate treatment could not be provided at RRMC to minimize or eliminate the perceived potential danger posed by the youth, the hospital had the responsibility to provide a more medically and clinically appropriate method of transport to an alternative hospital, in this case the Brattleboro Retreat. An “appropriate transfer” as defined in the EMTALA regulations is one that would have been “effected through qualified personnel and transportation equipment.”¹²

¹¹ Center for Medicare and Medicaid Services, *State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals* (Rev. 1, 05-21-04)

¹² 42 C.F.R. 489.24 (e)(2)(iv)

Under these regulations, VP&A suggests that an appropriate transfer is one performed by medically trained professionals and/or mental health staff, not law enforcement personnel. It is of great concern that the medical professionals at RRMC, and ultimately the appointed officials within the state's mental health administration, allow patients such as this 7 year old child to be treated as "prisoners" and shackled for purposes of transfer to psychiatric care facilities throughout the state.

As mentioned previously there is at least one hospital in Vermont, Southwestern Vermont Medical Center (SVMC), that views their obligations under EMTALA to require the use of "an appropriate method of transport with appropriate medical personnel," specifically ambulance transport, when transferring an involuntary patient from their hospital to another treatment facility for psychiatric admission. Although SVMC does request that a sheriff accompany an involuntary patient in the ambulance for safety and security reasons, law enforcement personnel are not used to actually effect the transfer as was the case in the present investigation.

B. The State of Vermont's Continued Reliance on Secure Transport

VP&A is concerned that although statutory changes, policy changes and some alternative transport modes have been implemented across the state, there remains no appreciable difference over time in the number of children being securely transported by law enforcement personnel to the Brattleboro Retreat for inpatient psychiatric hospitalization.

In July of 2005, as reported in Division of Mental Health (DMH) documents regarding planning and implementation of the Involuntary Transportation Guidelines, the Agency of Human Services, the Vermont Department of Health (VDH) and designated mental health agencies began developing alternative transport systems in select counties for children being sent to the Brattleboro Retreat for emergency examinations. Statewide implementation of alternatives and accompanying protocols was anticipated to occur by January 1, 2006. In November of 2005, the Director of Children's Mental Health stated that arrangements had been made with public transportation companies in Rutland and Chittenden Counties as an alternative to secure transport by sheriffs when security risks do not necessitate their use. Statistics previously provided by DMH indicated that between September 2005 and the beginning of December 2005, 9 children aged 12 through 17 were transported to the Brattleboro Retreat for emergency examination. Of those 9 children, only 2 were transported by means other than sheriffs - one by parents and one by ambulance. In December of 2005, the Director of Children's Mental Health reported that the DMH had performed a review of all secure transports that had occurred in the Department's 2005 fiscal year. Of the 44 secure transports of children experiencing psychiatric crisis, only 15 were reportedly determined to not be in need of secure transport resulting in the finding by DMH that 29 secure transports were appropriate at the time.

The data provided by VDH to the Vermont State Legislature in February of 2007 indicated that during the period of September 14, 2005 through January 31, 2007, 60 children were transported involuntarily for admission to the Brattleboro Retreat. Of those 60 youths, 31 experienced secure transport while 29 were transported by alternative means.

Although a precise comparison is made difficult by the difference in the above reporting timeframes, the fact that 31 children in this most recent reporting period were transported by sheriffs is of great concern. The latest statistics were presented to the Legislature three years after the then DDMHS' (now DMH's) own report highlighting "the overall issues of privacy, stigma, traumatization, and least restrictive and obtrusive practices," demonstrating the apparent failure of the State of Vermont's psychiatric treatment system to fully embrace the philosophy of trauma-informed principles of care in the transportation of patients in need of psychiatric care. The statistics also leave VP&A concerned with the continued reliance on the use of sheriffs' transport and, therefore, the continued use of restraints for many of the most vulnerable children in our state.

VP&A commends the current initiative underway, led by the Howard Center for Human Services and Washington County Mental Health, in which qualified, non-law enforcement staff plan to utilize specially equipped vans as an alternative to secure transport for adults experiencing a psychiatric crisis. The initiative involves transport of adults in Washington, Chittenden, Franklin/Grand Isle and Addison Counties. We remain hopeful that the anticipated success of this program can be replicated throughout the state for all persons experiencing a psychiatric crisis in need of hospital to hospital transfer, particularly for children requiring transfer to the Brattleboro Retreat.

Notwithstanding VP&A's conclusions that secure transport is entirely inappropriate, dehumanizing, and potentially traumatizing when used for the purposes of hospital to hospital transfer of patients in need of psychiatric care, VP&A acknowledges the sensitivity of the Rutland County Sheriffs, who responded to the transport call regarding the youth on November 3, 2006 and made it possible for the youth's grandmother to accompany him in the cruiser during the transport.

VP&A remains concerned, however, that mechanical restraints were utilized on the youth, particularly after he demonstrated hours of cooperative behavior in the Emergency Department. Reportedly, when the Rutland County Sheriffs arrived to transport the youth on November 3, 2006 they did not have with them the so-called "humane restraints" provided to each Sheriffs department by the Vermont Department of Health. Even if they had, they may have been of no use during the youth's transport considering that the polyurethane restraints provided by the state have been found in other cases to be too large for actual use on children.

VI. RECOMMENDATIONS

As a result of this investigation and the findings detailed above, VP&A strongly advocates for the following changes to occur:

1. The Commissioner of the State of Vermont's Department of Mental Health should immediately cease the dehumanizing and potentially traumatizing use of secure transport by law enforcement personnel on involuntary patients in the care and custody of the state who require hospital to hospital transfer for psychiatric evaluation and treatment.

2. Rutland Regional Medical Center, pursuant to EMTALA regulations and CMS guidelines, should immediately require the use of an appropriate method of transport with appropriately qualified personnel for all involuntary patients requiring transfer from the Emergency Department to another hospital for purposes of psychiatric evaluation and treatment.
3. As long as secure transport by law enforcement is utilized in the state, the State of Vermont's mental health service delivery system should require that all sheriffs' departments providing secure transport prioritize their participation in the Law Enforcement Mental Health Training pursuant to Act 80 and provided through the Vermont Criminal Justice Training Council.
4. As long as secure transport by law enforcement is utilized in the state, only "humane restraints" i.e. leather, nylon or polyurethane should be used on individuals for whom restraints are deemed necessary during hospital to hospital transfers for purposes of psychiatric evaluation and treatment.
5. As long as secure transport by law enforcement is utilized in the state, it should be provided in the most inconspicuous, least stigmatizing manner possible, i.e. in unmarked cars with personnel dressed in plain clothes.
6. The State of Vermont's Department of Mental Health and Vermont Association of Hospitals and Health Systems should examine whether or not the use of secure transport for individuals in need of mental health treatment violates the U.S. and Vermont constitutional protections against excessive force and undue restraint. This recommended examination should also address whether it is a violation of the equal protection clause of the Americans with Disabilities Act (ADA) to transport individuals with mental illness in handcuffs and shackles for psychiatric treatment since that is not typical of transport for treatment of other medical conditions.
7. The State of Vermont's mental health service delivery system should take additional action to fully embrace and implement the AHS Policy Statement on Trauma (December 2003): "The Agency will seek to reduce and eliminate those practices identified as having a negative effect on trauma survivors. The Agency and its providers will work to assure the provision of trauma-informed services by identifying and eliminating insensitive practices, combating systemic challenges, conducting on-going evaluation of their practices, and providing training to staff in contact with trauma victims."

VP&A welcomes comments regarding this report. Please send comments to Ed Paquin, Executive Director, Vermont Protection & Advocacy, Inc., 141 Main Street, Suite 7, Montpelier, Vermont 05602, or to info@vtpa.org.