Memorandum

Date: November 9, 2007

To: Stephen Klein, Chief Legislative Fiscal Officer

From: Richard Surles, Ph.D., Lead Consultant, Vermont Futures Plan

cc: Tom Moore, Con Hogan

Re: Final Report

Pursuant to our Consulting Agreement of May 7, 2007, we are submitting our final report to the Chairs of the House and Senate Appropriations and Institutions Committees; the Senate Health and Welfare Committee; the House Human Services Committee and to the Joint Fiscal Committee; the Mental Health Oversight Committee; the Secretary of Administration and the Secretary of Human Services. You have agreed to distribute the report to the above named parties.

On behalf of me, Tom Moore and Con Hogan, the Consulting Group, we want to express our appreciation for the cooperation and support that we received in undertaking this assignment. We hope that we have met your expectations and that the report will serve as a guide to policy development and will enhance the progress toward implementing the Vermont Futures Plan for replacing VSH.

The issues were very complex and did not permit a single set of recommendations; however, our basic findings are the following:

1. Retaining VSH as an acute care hospital is not a viable alternative and financing VSH, in the short run, is a significant concern given the federal governments renewed disallowances for services provided in institutions for mental disease.

2. Federal Medicaid requirements for “medical necessity” and “active treatment” call for a review of Vermont’s current involuntary commitment law which requires that a potential patient be held without “active treatment” until a full court review can occur. This does not necessarily mean that the law needs to be changed but the cost and risks of shifting this responsibility to community hospitals need to be addressed.

3. Community hospitals, with support from the state, can eventually replace the limited acute functions currently provided by VSH but such hospitals are not appropriate settings for some of the secure care functions provided through a state controlled facility.

4. The Vermont Futures Plan should move forward in a phased process that begins with replacing the non-acute, secure care residential functions now provided only at VSH. This will allow for several decision points over the next three to four years and will made future capital and operating costs easier to plan.

5. Vermont needs to maintain its tradition of providing care as close to home as possible. Connecting multiple community hospitals with community mental health and residential support services will not only respect that tradition but can be done at far more reasonable costs than in the original Futures Plan.

6. Findings and recommendations in reference to the acute inpatient needs of the Department of Corrections are contained in Appendix F. of this report.

Our findings are the result of a careful review of the substantial record and the formal reports developed to date. We focused particularly on the extensive Futures planning documents. We are hoping and anticipating general alignment with the contents of this report by both the Legislature and the Administration so that solid and rapid progress can be made on behalf of the people we all want to serve better, namely those individuals with severe mental illness.

Vermont Legislature's Consulting Group
On the Future of VSH and
Systems of Care

Final Report

To The Committee on Committees of the
Senate and The Speaker of the House
of the Vermont General Assembly

November 9, 2007

Submitted by

Richard Surles, Ph.D.
Tom Moore
Cornelius Hogan

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Introduction

The Charge

The Vermont Legislature directed the consultants to:

1. Compile, analyze, and review the planning that has been done to date in developing the Vermont Futures Plan,

2. Investigate and make recommendations regarding federal funding,

3. Review and make recommendations regarding the feasibility of all the options available to the state for providing inpatient psychiatric services, and

4. Analyze the impact of the population involved in the criminal justice system on the needs, services, and costs of inpatient psychiatric hospitalization.

The consultants were asked not to undertake a completely new study of the issues, but to review the existing and substantial record that had been compiled to date and outline options on how to proceed.

As part of that process, the consultants met, and/or had extensive phone calls with the Secretary of Administration, the Commissioner of Budget and Management, the Department of Buildings and General Services, the Secretary of Human Services, the Commissioner and Medical Director of the Department of Corrections, the VSH leadership team, Fletcher Allen, the Brattleboro Retreat, VSEA leaders, the Vermont Association of Hospitals and Health Care Systems, N.A.M.I.- Vermont, The Vermont Association for Mental Health, The Vermont Council of Developmental Disabilities and Mental Health Services, and Vermont Protection and Advocacy. Multiple meetings were held with Department of Mental Health leadership.

In addition, the Group reviewed materials provided by the Department of Buildings and General Services and VSEA regarding capital cost for a variety of options; met with the Court Administrator; and had informal discussions with numerous non-governmental parties of interest. The consultants had frequent positive interactions with both legislative leaders and key members of the Administration. This allowed for continued clarification where there was, in fact, general policy alignment.

The Challenge

Vermont is seeking a change in its overall mental health system that, to date, no other state has managed – that is to replace the functions of its state operated system with a coordinated community system that blends community mental health centers with emergency and acute inpatient care provided by local medical centers.

The consultants are proposing a modified position, in part because of the difficulties in financing a total non-state system and the need for some level of state controlled long term, secure residential care. The consultants urge caution about total reliance on federal financial participation, believing that federal standards can limit flexibility and lead to higher than necessary cost. Federal standards are also subject to change, as recently seen in new proposed regulations for the mental health rehabilitation option that are poised to significantly limit federal financial participation for existing state approved services. In addition, the shift to community inpatient care creates complex issues regarding the need to meet federal standards of "medically necessary care" and "active treatment" as well as increasing the potential for legal liability that will be of significant concern to community hospitals.

Lastly, while the consultants did review materials regarding corrections and interviewed a number of key parties, in addition to our recommendations, there is much more to do in this arena. The Department of Mental Health very recently completed a study to determine the psychiatric inpatient capacity needed for incarcerated Vermonters. This study offers an important perspective. Our earlier recommendation to further study the use of psychotropic medications as a means of inferring the level of need for treatment in the correctional setting is supported by this study.

The consultants employed a framework, against which to judge their work, which emphasizes a system wide view of mental health. The consultants were impressed with the common vision and principles expressed by a variety of organizations throughout the process to date.

Characteristics of a Well Balanced Mental Health System

Essentially, the following characteristics of a healthy system seem to be shared by all parties. These characteristics served as a template for the development of the elements of this report.

- Contemporary public mental health systems seek to balance resources between services that promote open and rapid access to needed care as close to home as possible and services that are essential to protecting severely mentally ill people in acute crisis and during extended periods of recovery.

- The failure to promote local access to crisis care, outpatient and rehabilitation services increases adverse events thus requiring greater and increasing demand for high cost emergency, acute inpatient care and long term secure residential care.

- Mental health and physical health should be considered together even in crisis, thus the importance of comprehensive medical assessment and care.

- A well functioning mental health system is constantly vigilant in order to maintain the balance between community services and inpatient care.

Vermont has historically been the envy of other states with its focus on community and recovery while maintaining a necessary but small percentage of its public financing for state operated inpatient care. In fact, the current allocation of 25% of the state's mental health budget for state operated inpatient care is among the lowest in the U.S. The following is a more precise view of this allocation of resources with the focus on community services.

FY 07 Vermont Mental Health Appropriation		
Total Budget	137,508,075	
Less Children's	(63,229,033)	
Total Adult Budget	74,279,042	
Administration	3,774,147	5.1%
Emergency	5,239,677	7.1%
Acute Inpatient	3,463,257	4.7%
VSH	19,008,479	25.6%
Residential Treatment	10,898.113	14.7%
Rehabilitation Treatment	22,175,776	29.9%
Day & Vocational Services	2,596,444	3.5%
Outpatient Clinic Services	6,062,348	8.2%
Self-help & Advocacy	759,067	1.0%
Miscellaneous	301,734	.4%
	74,279,042	

With focus on the principle of maintaining a balanced service system, the consultants developed options beyond those of bed capacity. This approach also allowed us to combine the ideals of reasonable cost and high quality of service.

Thus, the overall approach employed by the consultants permitted the discussion to go beyond just focusing on a capital plan but to return to

Vermont’s legacy of discussing what it takes to maintain a balanced public mental health system.

Our work is based on the review of many reports, summaries of meetings involving the planning for the future of VSH, and many interviews. The report is a summary of ideas and concerns and its use is intended to stimulate continued dialogue. We offer ideas that emerged from the process we followed, and the prior Vermont Futures work.

Considerations for Legislative Action

Commitment Law for Involuntary Care

Vermont has a very low rate of involuntary hospitalization and under current policy the Department of Mental Health has designated only VSH as a site for involuntary medication and extended secure inpatient treatment. Under current law, involuntary treatment could be extended to designated acute inpatient settings at community hospitals. As Vermont develops its plans for alternatives to VSH, the issue of extending the current law to other settings will require special attention.

In 2005, VSH provided secure inpatient housing for 20 patients who required 2,180 days before a final judicial decision was made regarding treatment. (See Appendix A) If these same patients had been detained in an acute care setting, Medicaid or Medicare would not have covered the cost of such care due to the failure to determine “medical necessity” and the failure to provide “active treatment.” If Vermont elects to continue its current practices for reviewing the need for involuntary care, the state should expect to provide $2 to $3 million a year to cover this “uncompensated” care.

In using acute medical centers to replace the acute function of VSH, the Legislature needs to consider the implication of the current law. Community hospitals have a mission of rapid diagnosis and short term treatment. They are not currently equipped to absorb the financial risk or legal liability of detaining people while waiting long periods for final judicial decision in order to begin active treatment. In addition, the current design of acute psychiatric inpatient units has not anticipated the need for waiting extended periods for a judicial review.

There appear to be three options:

1. Review the administration of the current law to determine if a change could be made to expedite the hearing process. This may require the court system to visit community hospitals for hearings and also would require special state supplemental funding since billing for Medicare, Medicaid or private insurance would likely be denied due to the lack of

active treatment during the review process. (Expedited hearings would also reduce the $2 to $3 million estimate for uncompensated care.)

2. Change the current law to provide for a "competency" hearing. Massachusetts uses this process and decisions are said to take several weeks, much less time than current practice in Vermont. (See Appendix B). This process requires a court hearing to determine an individual's "competency" to make decisions about care and treatment. The standards require the state to prove that the person's current mental state does not permit him/her to make sound judgment about personal safety or care. In some cases, the court may appoint a guardian who will participate in decisions about future treatment. Once the competency hearing is complete, treatment can begin. Moreover, the competency issues can be reopened if improvement occurs.

3. Change the current law to allow for a review within 24 hours by two concurring physicians that immediate treatment is needed followed by judicial review within 5 business days. Pennsylvania has such a law that allows for a medical decision to be made in high risk situations followed by a several step judicial review. (See Appendix C) This process requires that a person be examined in a hospital setting approved by the state. A full medical review must occur within 24 hours and a decision made as to the need for further treatment. Two physicians must have examined the patient and found that he/she is "dangerous to self and/or others" and in need of treatment. This initial medical decision allows the initiation of treatment thus meeting Medicaid/Medicare requirements for payment of treatment. It also triggers a requirement for a court review of the physicians' decision and the need for any additional care.

Amend the Certificate of Need (CON) Law

Consideration should be given to requiring that all new CON requests that involve capital request for new hospital facilities or expansion of a medical function provide a review of local capacity and unmet medical needs for emergency and acute inpatient care for mental health services. Providing for behavioral health is one of the primary responsibilities of community hospitals. Such a provision would give the Health and Mental Health Departments an opportunity to participate in incorporating community hospitals into an overall system of care.

Make Provisions in the Capital Budget for Community Hospital Facility Improvement

A modest commitment of capital funds could stimulate improvements in existing emergency rooms and acute inpatient facilities that currently have structural impediments that limit the hospitals' capability to provide mental

health treatment. Such funds could be used to create a secure observation bed adjacent to the ER or to modify the current inpatient floor plan to permit the separation of patients in a more acute phase of their illness from others who are less acute. Currently, over 20% of the existing acute psychiatric inpatient beds are not being utilized in 5 community hospitals that are designated by DMH. State participation in capital funding could be a factor in improving access in those hospitals.

Create Incentives for Critical Personnel

The Vermont Futures Plan is about creating a desired system of care, not necessarily the same as the current system. It will require an extended period of transition to address the existing problems and barriers identified in this report. Clearly the future system will depend on transitioning the functions of VSH and the substantial skills and experience of the state hospital's workforce into new options such as a free standing secure residential facility, community hospitals, residential settings and extending other community supports. Transitional planning that includes new opportunities of the state workforce is essential. Such opportunities can be provided through the proposed secure residential facility and the creation of special incentives for transitioning to community support programs.

Some areas of Vermont continue to experience a critical shortage of nurses and psychiatrists. Recruiting and retaining these personnel should be part of any plan for a more decentralized and distributed system and could involve transitional placement of state employees for a period of years. Supplemental grants could also be made to hospitals and residential treatment centers to recruit psychiatrists and nurses in order to allow for expansion of existing inpatient capacity that has remained unused due to a staffing shortage. State support for these essential positions would be tied to a long term commitment of maintaining the services necessary to replace the historic functions of VSH.

Areas for Further Legislative and Administrative Study

There are several important study opportunities for the Vermont Legislature and the Administration which will inform future programmatic development. These studies include:

a. Review the physical health care needs of persons with severe mental illness and develop strategies for improving linkages between physical and mental health. Persons with severe mental illness, as they age, have a much higher frequency of co-morbid medical conditions than other Medicaid recipients. Diabetes, hypertension and COPD are highly prevalent – especially in persons over 40. Generally, medical

care is lacking and when needed usually occurs in emergency room settings or in later stages of the illness. Some preliminary work by DMH points to significant opportunities for improving care for Medicaid recipients through better coordination of mental health and medical care.

b. Remove access barriers to Medicare for Medicaid recipients who are disabled by reason of serious mental illness. Medicare is available for disabled persons who are under 65 and unable to work due to mental disease. Known as "dually eligible," such individuals can receive all Medicare benefits, including pharmacy, and only require Medicaid if the Medicare benefit is exhausted or if co-payments are required. Medicare is currently the largest payor for acute psychiatric care in Vermont, followed closely by Medicaid. (See Appendix D) There may be additional opportunities to improve the enrollment of Vermonters in the Medicare program through special local efforts to assist individuals to meet the eligibility requirements. This effort could also increase access to federal Supplemental Income Support for the disabled individual.

c. Use the results of the Milliman study and the VSH Futures and Corrections Psychiatric Inpatient Needs Study, covering the period of 9/1/06 through 8/31/07, as part of the ongoing effort to document the inpatient needs for Corrections' clients. The Futures study identified 24 persons who required acute care of which 6 were referred to VSH. Should the prevalence of acute mental illness continue at this annual rate then Futures planning should provide for approximately 3 hospital beds at any given time. (See Appendix F)

d. Undertake a review of the utilization of psychotropic medications among the Corrections population. The use of psychotropic medications can serve as a "proxy" measure of mental illness since such prescriptions should be accompanied by a medical diagnosis. Thus, understanding the type, dosage and duration of medication provides a measure of the type and intensity of mental illness that may exist. However, the results can serve only as a screening tool since the medications may be used for other medical conditions or for purposes not approved by the FDA. We have provided a matrix of the major classes of behavioral medication (See Appendix E) generally used to treat symptoms of mental illness. The Corrections' Department's mental health vendor may be able to produce this information as long as prescription documentation is organized in the same format found in most paid claims systems.

e. The consultants' charge was focused on the adult mental health system. However, because of the interrelated aspects of all parts of the mental health system and beyond, attention should be paid to the State's mental health program for children, where an important

function is performed by the Brattleboro Retreat. The Retreat remains the only source of child psychiatric inpatient care and remains a major regional resource. Issues of "aging out" and coordination with the adult service system need careful consideration.

f. Finally there is a need to examine the management and control functions needed in the proposed distributed mental health system envisioned by the Vermont Futures Plan. The distributive model results in new and different management capacities and requirements. These need to be understood early in the overall change process.

Capital Planning and Financing the VSH Futures Plan

Capital Planning

We indicated in our preliminary report that building a new state hospital for acute care services does not appear a logical option. This is because of excessive general fund and the risk of the loss of Medicaid revenue in future years as well as multiple local barriers to a project of this size and scope. Also, the emerging expectation is that short term diagnosis and stabilization of acute care patients occur in a medical hospital with full capacity for CAT scans, full medical evaluations, and rapid diagnosis and treatment. This is a more limited view than using acute care hospitals for long term treatment. We also found under used capacity for short term acute psychiatric care in several community hospitals. As a result we recommend targeted capital expenditures that would allow for full and expanded use of this capacity.

We propose a shift in the capital planning paradigm from replacing the VSH as one physical structure to a series of investments that replace the functions of VSH: acute care, secure/forensic and involuntary care, and longer term recovery and rehabilitation services. Some of these investments involve capital expenditures. Service needs, not physical space, must inform the capital decisions. Capital planning strategies for replacing the functions of the VSH must include these elements:

1. Capital plans should not overburden the Capital Construction Act in any given year.

2. Capital costs can and should be distributed and spread over multiple years.

3. There should be an incremental approach that funds higher priority services that divert people from acute crisis services before deciding on large scale capital projects. The implementation of higher priority services should lessen the need for capital expenditures and provide an empirical basis for the scope and capital need of other services.

4. Use capital expenditures to enhance and augment current acute care capacity within selected community hospitals in return for a contractual commitment to meet needs determined by the State. Community hospitals need both improvements to their physical plants and more mental health staff to carry out this function. These supports need to be in place as part of a process to move more acute care into community hospitals.

5. Explore opportunities for the State to avoid capital costs, particularly for 'step down' programs, by partnering with private sector entities which will assume capital cost in return for mid to long term lease agreements.

6. Continue to fund the residential components of the Futures Plan within Mental Health's operating budget, as this will mitigate the need for capital funding. Again, in our view, the complete replacement of VSH functions, at one time, and in one place, is too complex and costly. Further, a phased implementation will provide information that may well alter the structure and costs of different phases of the replacement plan.

7. As the impact of the above variety of actions become clear, consider adding incrementally beds for acute care strategically located in other parts of the State, in facilities such as the Brattleboro Retreat and/or at the Windham Center.

Financing the VSH Futures Plan

The consultants' operational fiscal projections are well aligned with the modeling of the Administration sponsored Pacific Health Policy Group's Report, "VSH Futures Operating Expense Model's: August 20, 2007" but with one important caveat. The consultants' modeling did not rely on obtaining Medicaid match for state operated services. The State's model takes more risk in that regard. For example, the Futures' 5 year budget shows significant Medicaid receipts in 2009 and 2010 for VSH. We think there are several important barriers to the availability of Medicaid in this period, including the certification status of the current VSH and its status as an Institute for Mental Disease (IMD).

Our position on this issue is driven by several considerations.

First, maximizing federal receipts can lead to higher overall General Fund costs because medical service frequently require capacity and staffing levels in excess of those necessary to replace many of the functions of VSH. In some cases, providing supportive levels of high quality rehabilitative services is a far more cost/effective approach. Over a ten year period, such

differences can be very significant, in the order of magnitude of two times lowest to highest costs.

Also, Vermont's existing and projected daily per bed costs at every level of the residential parts of the mental health system are significantly higher than benchmarks in other states. The implication is that General Fund financing must be more carefully constructed, particularly over the long haul where operating budget support can be reasonably forecast at somewhere about 5% increase per annum. Both the consultants' and the State's 10 year forecast bear this perspective out.

The keys to reasonable financial support over the years are inexorably connected to two variables, namely the ability of the State to control the number of high cost beds in the system and the quality of specialized treatment. Unnecessary Medicaid spending results in less control of these variables by the State and more by the federal government. A reasonable balance of federal and state financing is important.

In the current fiscal environment of difficult General Fund budgets, it is appealing to find as many offsets to the General Fund as possible in the short run. However, this can and will result in long term higher General Fund cost if not managed very carefully. Reasonable control of Medicaid spending in the Mental Health sphere is also related to the inevitable accounting to occur in 2009 of Medicaid spending under Global Commitment.

In sum, the more Vermont depends on Medicaid receipts for mental health services, the less discretion it will have in the future to meet other emerging health care and other priorities.

Optimal Strategies for Implementing the VHS Futures Plan

The consultants believe that the VSH Futures Plan should give initial priority to establishing service capacity that responds to long term needs but does not require changes in current law or require significant capital funds to be committed to the new construction of acute hospital inpatient beds. Instead, initial priorities need to address improving the use of underused resources, the creation of at least one secure residential site, preferably at a site directly controlled by the Department of Mental Health, along with the development of additional 'step down' capability.

It seems unlikely that community hospitals will be willing to make long term commitments to replace the acute functions of VSH until the state addresses the issues of reimbursement for uncompensated care, legal liability for persons who refuse treatment while waiting for legal review, and the appropriate placement for persons no longer requiring acute care.

Current Medicaid and Medicare rules require that if a patient is no longer in need of active medical treatment, that their discharge plan be to a safe and appropriate level of care. Some states do allow compensation for an extended stay in an acute care bed but at a sub-acute rate. While the overall number of patients who will require this special attention appears to be small, the issue looms large and needs careful review.

Thus recommendations for initial priorities are:

a. Develop a new Secure Residential Rehabilitation Center in the Waterbury area for extended care for persons who have a continuing need for sub-acute care in a secure setting. This new facility would be the initial priority for a capital planning commitment and would be built as a state operated or state controlled center. Many of the current "extended stay" functions that are provided by VSH would be replicated but provided in this uniquely designed facility that addresses the need for security, rehabilitation and preparation for a safe return to community care. Such a facility can be high quality and fully accredited as a rehabilitation center. Such a facility should also address some of the concerns for a state commitment for appropriate support to community hospitals for the small number of persons who have responded to acute care but for whom no other setting exists for appropriate discharge.

b. Initially establish one or two community hospitals as central receiving areas for all psychiatric assessment and acute inpatient care when such care cannot be arranged in the closest community facility and when the need for involuntary treatment is being determined or provided. The establishment of a central hospital as a receiving center will allow for the development of policies and contractual arrangements during a period when the Vermont State Hospital continues to serve as back up capacity for very unusual situations. In the long run, such receiving hospitals could be located in the major regional population centers of the state.

c. Establish an opportunity for community based hospitals to improve their current inpatient facilities to better respond to the need for psychiatric emergencies and acute inpatient care. State support would be based upon successful application to DMH, and state grants would provide one time capital funding and contractual assurance of maintenance of effort.

d. Use the results of the Milliman and recent VSH Futures and VSH Psychiatric Needs studies as one basis for determining the needed inpatient capacity for Corrections. (See Appendix F)

e. Continue to expand voluntary residential programs but give priority to smaller residential programs that are more normalized and designed

as transitional to independent living. Vermont had a very successful plan for replacing the functions provided by the Brandon Training School for developmentally disabled persons. Key to that plan was small residential programs that provided opportunities for living in non-institutionalized settings. In addition, private sector involvement permits capital support and then future conversion when the residential program was no longer needed. Development of a number of such smaller residences will give VSH some short term relief to appropriate discharge planning while longer term planning is underway.

At the same time the following additional actions could be carefully considered:

1. Implementation of procedural changes allowing expedited involuntary commitment and medication along with additional support for court related functions. Start these new expedited procedures in a community hospital.

2. Approval of capital expenditure for a community hospital to allow it to use its existing capacity to serve those with acute mental illness.

3. Full funding of the transition plan as outlined in the Future's Plan.

4. Recognition and support for the Department of Mental Health management systems to adequately supervise a more distributed system.

As the true number of secure beds becomes known as the above unfolds, then planning and capital commitment at second community hospital(s) could proceed.

Using this more distributive and staged solution results in much more manageable capital and operating scenarios. Such an approach results in a high quality, more specialized set of options at much less cost than the consolidated 50 bed solution.

This approach makes use of current unused capacity; uses hospitals in a manner more closely connected to their mission of short term diagnosis, stabilization and treatment; creates a reasonably sized rehabilitation and recovery center for forensic and long term treatment; and uses in the order of magnitude half of the General Fund resources over a ten year period than would the consolidated 50 bed option.

Solving the serious issues of treatment of the acutely mentally ill in Vermont is not only a question of resources but is a question of landing on a set of sensible state policies.

APPENDICES

Appendix A:	Time Between Significant Events Regarding Involuntary Treatment, Vermont State Hospital: Decision Dates in 2005
Appendix B:	Massachusetts Competency Law
Appendix C:	Pennsylvania Involuntary Commitment Law
Appendix D:	Medicaid / Medicare Mix
Appendix E:	Corrections Pharmacy Template
Appendix F:	A Compilation of the Consultants' Report to the Legislature that Relates to Corrections

Appendix A.

Time Between Significant Events Regarding Involuntary Treatment

	Average Time from Admission to:							
	Comm. Date		Date Filed		Hearing Date		Decision/Withdrawal Date	
	Number of Cases	Number of Days	Number of Cases	Number of Days	Number of Cases	Number of Days	Number of Cases	Number of Days
Withdrawn	4	31	4	56	3	73	4	81
Granted	14	37	14	88	14	106	14	117
Denied	2	34	2	67	2	75	2	112
Total	20	36	20	80	19	97	20	109

Based on analysis of the database maintained by the Vermont Department of Health, Division of Mental Health, Legal Division. Number of filings include multiple filings during single episodes of hospitalization for some individuals. The average time from admission to decision/withdrawal and from admission to filing are reported for the first petition for each episode of hospitalization. Subsequent petitions for the same episode of hospitalization are reported under the average time from filing to decision/withdrawal. Data represents 22 filings involving 20 patients.

Appendix B.

Massachusetts Competency Law

AUTHORIZING ANTIPSYCHCOTIC MEDICATIONS IN MASSACHUSETTS

If a patient, who is under an order of commitment in Massachusetts (*MGL c. 123*), is determined to be incompetent by his or her physician, a petition can be presented to the District Court for a substituted judgment treatment order (Commonly known as a District Court Rogers Order). (MGL c. 123 §8B) The District Court judge applies the *Rogers* standard of substituted judgment for administration of antipsychotic medication, and may also approve "other psychiatric treatment." If the *Rogers* standard is met, the court may approve the antipsychotic treatment order, thereby authorizing (and requiring) the treatment team to implement it. The Court monitors the treatment plan by scheduling review dates. The order expires when the underlying commitment order expires.

These orders are commonly called "*Rogers"* orders after a 1983 court case, in which the Massachusetts Supreme Court affirmed the right of hospitalized psychiatric patients to refuse antipsychotic medications in non-emergency situations. In the *Rogers* case, the court stated that a "… mental patient is competent and has the right to make treatment decisions until the patient is adjudicated incompetent by a judge." The court held that the trial courts must use a substituted judgment standard to decide what the respondent would want if he or she were competent to make decisions. The *Rogers* ruling states the following factors must be taken into account:

- The Respondent's expressed preferences regarding treatment;
- The Respondent's religious beliefs;
- The impact on the family;
- The side effects of the proposed treatment, and
- The prognosis with and without treatment.

Since *Rogers*, in Massachusetts, a physician must seek an order if he or she wants treat a patient, and thinks the patient is not competent to make treatment decisions, whether the patient is refusing medication or not.

Patients have the right to attend hearings, unless the court finds that there are extraordinary circumstances that prevent the patient from attending. After listening to both parties, the judge will decide whether or not the patient is competent. If he or she is competent, then the judge will deny the petition for guardianship. If the patient is found to be incompetent, the judge will make a substituted judgment decision. If the judge decides that the Patient would accept treatment if he or she were competent, the judge will issue an order authorizing a specific treatment plan.

Appendix C.

Pennsylvania Involuntary Commitment Law

Pennsylvania Commitment/ IVM Procedure

Under Pennsylvania's Mental Health Procedures Act, a person may be involuntarily hospitalized pursuant to an emergency exam statute similar to Vermont. As described in the next paragraph, involuntary non-emergency medication can begin immediately.

Pennsylvania law authorizes the person to be held for 5 days upon an emergency exam. Before then end of 5 days, an application for continued hospitalization must be filed in court. Within 24 hours from the time of filing, an informal hearing is conducted, where the court reviews the circumstances surrounding the hospitalization and explains the situation to the patient. If the court finds that the commitment standards appear to have been met, the person can be held an additional 20 days. If further hospitalization is needed, the state files for continued treatment. The court sets the hearing no later than 5 days after filing, and the court must issue its order no later than 48 hours after close of testimony. This order can last up to 90 days (or 1 year for felons/incompetent to stand trial). The next order can last up to 180 days.

If a patient refuses medication, the Pennsylvania Office of Mental Health procedures for involuntary medication govern. They essentially require a second opinion, which can be done by an in-house psychiatrist, so long as he/she does an independent assessment. If the patient continues to refuse voluntary meds, the second opinion must be conducted every 30 days. The order for involuntary meds can be issued from the day a person is admitted.

Below are key components of the statute and procedure:

Mental Health Procedures Act (50 P.S. 7301 et. seq.)

§ 7302. Involuntary emergency examination and treatment authorized by a physician--not to exceed one hundred twenty hours.

(a) Application for Examination.--Emergency examination may be undertaken at a treatment facility upon the certification of a physician stating the need for such examination; or upon a warrant ….authorizing such examination; or without a warrant upon application by a physician or other authorized person who has personally observed conduct showing the need for such examination.

(b) Examination and Determination of Need for Emergency Treatment.--A person taken to a facility shall be examined by a physician within two hours of arrival in order to determine if the person is severely mentally disabled within the meaning of section §7301

and in need of immediate treatment. If it is determined that the person is severely mentally disabled and in need of emergency treatment, treatment shall be begun immediately…..

(d) Duration of Emergency Examination and Treatment.--A person who is in treatment pursuant to this section shall be discharged whenever it is determined that he no longer is in need of treatment and in any event within 120 hours, unless within such period:

1. he is admitted to voluntary treatment pursuant to section 202 [§ 7202] of this act; or
2. a certification for extended involuntary emergency treatment is filed pursuant to section 303 [§ 7303] of this act.

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§ 7303. Extended involuntary emergency treatment certified by a judge or mental health review officer--not to exceed twenty days.

(a) Persons Subject to Extended Involuntary Emergency Treatment.--Application for extended involuntary emergency treatment may be made for any person who is being treated pursuant to section 302 [§ 7302] whenever the facility determines that the need for emergency treatment is likely to extend beyond 120 hours. The application shall be filed forthwith in the court of common pleas, and shall state the grounds on which extended emergency treatment is believed to be necessary. The application shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(b) Appointment of Counsel and Scheduling of Informal Hearing.--Upon receiving such application, the court of common pleas shall appoint an attorney who shall represent the person unless it shall appear that the person can afford, and desires to have, private representation. Within 24 hours after the application is filed, an informal hearing shall be conducted by a judge or by a mental health review officer and, if practicable, shall be held at the facility.

(c) Informal Conference on Extended Emergency Treatment Application.--

1. At the commencement of the informal conference, the judge or the mental health review officer shall inform the person of the nature of the proceedings. Information relevant to whether the person is severely mentally disabled and in need of treatment shall be reviewed, including the reasons that continued involuntary treatment is considered necessary. Such explanation shall be made by a physician who examined the person and shall be in terms understandable to a layman. The judge or mental health review officer may review any relevant information even if it would be normally excluded under rules of evidence if he believes that such information is reliable. The person or his representative shall

have the right to ask questions of the physician and of any other witnesses and to present any relevant information. At the conclusion of the review, if the judge or the review officer finds that the person is severely mentally disabled and in need of continued involuntary treatment, he shall so certify. Otherwise, he shall direct that the facility director or his designee discharge the person.

2. A record of the proceedings which need not be a stenographic record shall be made. Such record shall be kept by the court or mental health review officer for at least one year.

(d) Contents of Certification.--A certification for extended involuntary treatment shall be made in writing upon a form adopted by the department and shall include:

1. findings by the judge or mental health review officer as to the reasons that extended involuntary emergency treatment is necessary:
2. a description of the treatment to be provided together with an explanation of the adequacy and appropriateness of such treatment, based upon the information received at the hearing;
3. any documents required by the provisions of section 302; [§ 7302]
4. the application as filed pursuant to section 303(a); [§ 7303]
5. a statement that the person is represented by counsel; and
6. an explanation of the effect of the certification, the person's right to petition the court for release under subsection (g) and the continuing right to be represented by counsel.

(e) Filing and Service.--The certification shall be filed with the director of the facility and a copy served on the person, such other parties as the person requested to be notified pursuant to section 302(c) [§ 7302], and on counsel.

(f) Effect of Certification.--Upon the filing and service of a certification for extended involuntary emergency treatment, the person may be given treatment in an approved facility for a period not to exceed 20 days.

(g) Petition to Common Pleas Court.--In all cases in which the hearing was conducted by a mental health review officer, a person made subject to treatment pursuant to this section shall have the right to petition the court of common pleas for review of the certification. A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel. The hearing shall include a review of the certification and such evidence as the court may receive or require. If the court determines that further involuntary treatment is necessary and that the procedures prescribed by this act have been followed, it shall deny the petition. Otherwise, the person shall be discharged.

(h) Duration of Extended Involuntary Emergency Treatment.--Whenever a person is no longer severely mentally disabled or in need of immediate treatment and, in any event, within 20 days after the filing of the certification, he shall be discharged, unless within such period:

1. he is admitted to voluntary treatment pursuant to section 202 [§ 7302]; or
2. the court orders involuntary treatment pursuant to section 304. [§ 7304]

§ 7304. Court-Ordered Involuntary Treatment Not To Exceed Ninety Days.

(a) Persons for Whom Application May be Made.--

1. A person who is severely mentally disabled and in need of treatment, as defined in section 301(a), may be made subject to court-ordered involuntary treatment upon a determination of clear and present danger under section 301(b)(1) (serious bodily harm to others), or section 301(b)(2)(i) (inability to care for himself, creating a danger of death or serious harm to himself), or 301(b)(2)(ii) (attempted suicide), or 301(b)(2)(iii) (self-mutilation).
2. Where a petition is filed for a person already subject to involuntary treatment, it shall be sufficient to represent, and upon hearing to reestablish, that the conduct originally required by section 301 in fact occurred, and that his condition continues to evidence a clear and present danger to himself or others. In such event, it shall not be necessary to show the reoccurrence of dangerous conduct, either harmful or debilitating within the past 30 days.

(b) Procedures for Initiating Court-ordered Involuntary Treatment for Persons Already Subject to Involuntary Treatment.--

1. Petition for court-ordered involuntary treatment for persons already subject to treatment under sections 303, 304 and 305 may be made by the county administrator or the director of the facility to the court of common pleas.
2. The petition shall be in writing upon a form adopted by the department and shall include a statement of the facts constituting reasonable grounds to believe that the person is severely mentally disabled and in need of treatment. The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person. It shall also state that the person has been given the information required by subsection (b)(3).
3. Upon the filing of the petition the county administrator shall serve a copy on the person, the attorney, and those designated to be kept informed, as provided in section 302(c), including an explanation of the nature of the proceedings, the person's right to an attorney and the services of an expert in the field of mental health, as provided by subsection (d).
4. A hearing on the petition shall be held in all cases, not more than five days after the filing of the petition.
5. Treatment shall be permitted to be maintained pending the determination of the petition.

……

(d) Professional Assistance.--A person with respect to whom a hearing has been ordered under this section shall have and be informed of a right to employ a physician, clinical psychologist or other expert in mental health of his choice to assist him in connection with the hearing and to testify on his behalf. If the person cannot afford to engage such a professional, the court shall, on application, allow a reasonable fee for such purpose. The fee shall be a charge against the mental health and mental retardation program of the locality.

(e) Hearings of Petition for Court-order Involuntary Treatment.--A hearing on a petition for court-ordered involuntary treatment shall be conducted according to the following:

1. The person shall have the right to counsel and to the assistance of an expert in mental health.
2. The person shall not be called as a witness without his consent.
3. The person shall have the right to confront and cross-examine all witnesses and to present evidence in his own behalf.
4. The hearing shall be public unless it is requested to be private by the person or his counsel.
5. A stenographic or other sufficient record shall be made, which shall be impounded by the court and may be obtained or examined only upon the request of the person or his counsel or by order of the court on good cause shown.
6. The hearing shall be conducted by a judge or by a mental health review officer and may be held at a location other than a courthouse when doing so appears to be in the best interest of the person.
7. A decision shall be rendered within 48 hours after the close of evidence.

(f) Determination and Order.--Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and subject to subsection (a), an order shall be entered directing treatment of the person in an approved facility as an inpatient or an outpatient, or a combination of such treatment as the director of the facility shall from time to time determine. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. Investigation of treatment alternatives shall include consideration of the person's relationship to his community and family, his employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment shall include findings on this issue.

(g) Duration of Court-ordered Involuntary Treatment.--

1. A person may be made subject to court-ordered involuntary treatment under this section for a period not to exceed 90 days, excepting only that: Persons may be made subject to court-ordered involuntary treatment under

this section for a period not to exceed one year if the person meets the criteria established by clause (2)

2. A person may be subject to court-ordered involuntary treatment for a period not to exceed one year if:
   i. severe mental disability is based on acts giving rise to the following charges under the Pennsylvania Crimes Code: murder (§ 2502); voluntary manslaughter (§ 2503); aggravated assault (§ 2702); kidnapping (§ 2901); rape (§ 3121(1) and (2)); involuntary deviate sexual intercourse (§ 3123(1) and (2)); arson (§ 3301); and
   ii. a finding of incompetency to be tried or a verdict of acquittal because of lack of criminal responsibility has been entered.
   iii. If at any time the director of a facility concludes that the person is not severely mentally disabled or in need of treatment pursuant to subsection (a), he shall discharge the person provided that no person subjected to involuntary treatment pursuant to clause (2) may be discharged without a hearing conducted pursuant to clause (4).
   iv. In cases involving involuntary treatment pursuant to clause (2), whenever the period of court-ordered involuntary treatment is about to expire and neither the director nor the county administrator intends to apply for an additional period of court-ordered involuntary treatment pursuant to section 305 or at any time the director concludes that the person is not severely mentally disabled or in need of treatment, the director shall petition the court which ordered the involuntary treatment for the unconditional or conditional release of the person. Notice of such petition shall be given to the person, the county administrator and the district attorney. Within 15 days after the petition has been filed, the court shall hold a hearing to determine if the person is severely mentally disabled and in need of treatment. Petitions which must be filed simply because the period of involuntary treatment will expire shall be filed at least ten days prior to the expiration of the court-ordered period of involuntary treatment. If the court determines after hearing that the person is severely mentally disabled and in need of treatment, it may order additional involuntary treatment not to exceed one year; if the court does not so determine, it shall order the discharge of the person.

7305. Additional Periods Of Court-Ordered Involuntary Treatment.

(a) At the expiration of a period of court-ordered involuntary treatment under section 304(g), or this section, the court may order treatment for an additional period upon the application of the county administrator or the director of the facility to which the person is receiving treatment. Such order shall be entered upon hearing on findings as required by sections 304(a) and (b), and the further finding of a need for continuing involuntary treatment as shown by conduct during the person's most recent period of court-ordered

treatment. The additional period of involuntary treatment shall not exceed 180 days; provided that persons meeting the criteria of section 304(g)(2) may be subject to an additional period of up to one year of involuntary treatment. A person found dangerous to himself under section 301(b)(2)(i), (ii), or (iii) shall be subject to an additional period of involuntary full-time inpatient treatment only if he has first been released to a less restrictive alternative. This limitation shall not apply where, upon application made by the county administrator or facility director, it is determined by a judge or mental health review officer that such release would not be in the person's best interest.

(b) The director of the facility in which the person is receiving treatment shall notify the county administrator at least ten days prior to the expiration of a period of involuntary commitment ordered under section 304 or this section.

Procedures – Nonemergency Administration of Medication Over Objections:

Whenever a mentally ill person in involuntary treatment pursuant to Sections 302, 303, 304 or 305 of the Act protests treatment with any psychotropic medication, the following procedures are to be followed by the treatment team director or his/her designee:

(1) Determine and document whether the medication is necessary (i.e., is reasonably required to provide adequate treatment or is needed to prevent physical injury) in light of the objection and whether there are reasonable alternatives.

(2) Discuss with the patient the reasons why a specific medication is indicated and any available alternatives. Discuss with the patient his or her concerns and the reasons for the protest. Seek informed consent. Document these discussions, the reasons for the protest and whether or not consent is obtained.

(3) If the patient continues to refuse medication, obtain a second opinion from a psychiatrist concerning the degree of medical necessity/advisability for the medication. The psychiatrist providing the second opinion may be a colleague of the treating psychiatrist. However, the second opinion should be based on an independent examination of the patient and an independent review of all medical records or tests.

(4) If the consulting psychiatrist concurs that the protested medication is necessary, the medication may be administered. Appropriate respect shall be shown for the patient’s feelings and dignity. If the second opinion does not agree with the necessity of the proposed medication, a third psychiatric opinion should be obtained before proceeding. Psychiatrists consulted for a second opinion should consider the risk/benefit value of the medication if administered over protest, the reason(s) for the protest, and alternative treatment approaches available.

(5) If protests persist after medication has been tried, an additional second opinion based upon independent review should be obtained every 30 days as to the continuing need for the medication.

(6) Treatment team planning and review sessions should afford the patient and those helping the patient with opportunities to discuss concerns about or protests to any aspect of the proposed treatment. Medication over objection should be documented in the individualized treatment plan.

Appendix D.

Medicaid / Medicare Mix

Charges for Inpatient Behavioral Health Care Provided to Vermont Residents By General and Veterans' Hospitals CY2005

Principal Payer	Number of Episodes	Average Dollars / Episode	Total Dollars
Medicare	928	$10,403	$9,633,438
Medicaid	1,198	$7,414	$8,882,169
Blue Cross	350	$7,426	$2,599,043
Other Insurance	252	$7,586	$1,911,720
Self Pay	271	$6,168	$1,665,399
HMO	177	$7,320	$1,295,656
Other Payer	303	$2,674	810,321
Total	**3,479**	**$8,178**	**$26,797,746**

Information is derived from the Vermont Uniform Hospital Discharge Data Set maintained by the Vermont Health Department. The dataset includes data from Vermont, New Hampshire, Massachusetts, and neighboring counties in New York. Behavioral health care includes both mental illness and substance abuse (MDC 19 and 20).

Appendix E.

Corrections Pharmacy Template

Attached is a sample format for doing a Corrections pharmacy analysis. We recommend analyzing 11 classes on psychotropic medications. That will serve as a screening tool to assess the type of psychotropic drugs being provided to inmates. If medications are being prescribed for depression, anxiety and pain there should be less concern than if drugs are frequently prescribed for major mental illness, such as schizophrenia and bipolar disorder, and are widely used for significant duration..

Behavioral Pharmacy Use - Summary Table					
Most recent 6 months					
Total Behavioral and Opiate Pharmacy Claims					
Drug Class	Patients	Prescribers	Total # Prescriptions	AVG # per patient	# prescription > 60 days
Any Benzodiazepine					
Any Insomnia Agent					
Any Antidepressant					
Any Anticonvulsant/Mood Stabilizer					
Any Atypical Antipsychotic					
Any Typical Antipsychotic					
Any Sympathomimetic/Stimulant					
Any Antidyskinetic					
Any Substance Abuse					
Any ADHD Non-Stimulant					
Any Opiate					
Total for all Claims					

Appendix F.

An Extract of the Consultants' Report to the Legislature that Relates to Corrections

Memorandum

Date: November 5, 2007

To: Senator Richard Sears, Chair, Corrections Oversight Committee

From: Richard Surles, Tom Moore, Con Hogan

cc: Steve Klein, Joint Fiscal Office

Re: A Compilation from the Consultants' Report to the Legislature that Relates to Corrections

Background

As part of a larger, broader based charge regarding the future of the Vermont State Hospital, the Vermont Legislature also directed the consultants to "analyze the impact of the population involved in the criminal justice system on the needs, services, and costs of inpatient psychiatric hospitalization."

As part of that broader process, the consultants reviewed materials regarding Corrections and met with and had discussions with a number of key parties including the Commissioner and Medical Director of the Department of Corrections, and the Secretary of Human Services.

Before commenting on Corrections inpatient needs, following are some general observations that are reported and concurred with from source material:

- Vermont's Correction population has a higher level of mental health treatment than all but a few other states.
- Nearly 50% of the inmate population receives some type of psychiatric medication.
- The Department's specialty mental health unit (32 beds) at the Southern State Correctional Facility provides an intermediate level of care. There is disagreement about how well these units perform particularly as a way to reduce admissions to VSH.
- Correction admissions to VSH often relate to a need for involuntary medication.
- The biggest weakness in treatment and follow-up for those with mental illness appears to be after release. Coordination and placement options look to be limited.
- The issues of mental illness and substance abuse are inexorably intertwined in the Corrections population.

There is a significant incidence of mental illness in the correctional population. The challenge that Vermont faces is finding the right balance between treatment within the correctional institution and the periodic need for acute medical and psychiatric care in places other than correctional facilities.

There are two current important studies about Corrections inpatient psychiatric needs: "Actuarial Study of the Needed Bed Capacity for Adult Mental Health Services" prepared by Milliman, Inc. June 2, 2006 and the very recently completed DMH draft study (10/10/2007), "VSH Futures & Corrections Psychiatric Inpatient Needs."

Findings from the 'Milliman' Report

One of the most important sources of information for the consultants was the 'Milliman' report which was produced as part of the Vermont Futures planning process. The report contained important observations and conclusions that bear repeating. On the surface, there appears to be a significant attention to mental health services for inmates. However, given reports of the high percentage of those receiving behavioral medication, more examination is needed. The Milliman Report and the July 2007 report of medication treatment indicate that Vermont inmates received relatively higher level of service than what occurs in most states.

One of the positive aspects that Milliman points out, which was confirmed by our discussions, is that inmates with serious mental health problems are not eligible for out of state placement. This is a smart and humane policy.

Milliman indicates that somewhat less than 100 inmates have been identified, at any given time, with a mental illness that requires specialized treatment and that there is a major overlap between those in Corrections who have mental illness and substance abuse history and behavior. This is an area rife with treatment possibilities.

Findings from the DMH In-Patient Needs Study

The VSH Futures and Corrections Psychiatric Inpatient Needs Study covered the period of 9/1/06 through 8/31/07 as part of the ongoing plan to understand the in patient needs for Corrections clients. Using criteria based on long-standing community clinical criteria for hospitalization and modified to be applied to a Corrections setting, the Study identified 24 persons (20 men, 4 women) requiring acute care. Of the 24 inmates identified, 6 were actually referred to VSH. If on an annual basis, an average of 24 inmates were identified as needing acute treatment then approximately 3 hospital beds would be required at any given time.

Both of these studies should be relied upon and updated as part of a continuing process to make ongoing decisions about the inpatient needs for Correction clients.

The Need for a Pharmacy Study in the Correctional Setting

Questions have been raised about the nearly 50% of inmates on psychiatric medications as recently reported in the press. In this regard, the consultants have provided a pharmacy template for analyzing the classes of medication being used, the dosing levels and duration. (See Appendix E Attached).

As indicated in our preliminary report in August of 2007, if findings indicate most medications are prescribed for mild depression and anxiety, such medication would seem appropriate. However, if the analysis finds long term use of antipsychotic medications at high dosing range, then the inference would be that persons with severe mental illness, requiring active treatment, are highly represented in the general corrections population.

Data Source

Sound policy is directly linked with good information. Given our charge to work with the existing record, the Department of Corrections "Facts and Figures, 2006" was an important source of information. Although the publication has a great deal of useful information; it would be helpful to improve and expand available data about the mental health status and treatment of offenders for ongoing planning purposes.

In Summary

The consultants were less able to develop comprehensive findings for Corrections than for the adult mental health system that deals with acute inpatient and related care. The data and discussions did suggest that Vermont is providing services superior to other states. However, issues were raised requiring further study, especially study regarding the use of psychiatric medications, planning for the adequacy of acute care capacity and services, and coordination and access to services after release.