VERMONT MEDICAL SOCIETY COUNCIL POLICY

Acute Inpatient Mental Health Care

Adopted by VMS Council, February, 8, 2014

Whereas, the *Journal of the American Academy of Psychiatry and the Law* reports that in a 2008 article published by the Treatment Advocacy Center (TAC), an expert panel determined that "50 public psychiatric hospital beds per 100,000 population are needed to sustain a minimum level of care;[1]" and

Whereas, applying this standard, Vermont would need approximately 300 public psychiatric beds to serve its population; and

Whereas, Vermont currently has a total of about 169 psychiatric treatment beds (voluntary and involuntary) in six designated hospitals – Brattleboro Retreat (BR), Central Vermont Medical Center (CVMC), Fletcher Allen Health Care (FAHC), Green Mountain Psychiatric Care Center (GMPCC) in Morrisville, Rutland Regional Medical Center (RRMC), Windham Center (WC);[2] and

Whereas, the 169 beds currently include approximately 35 Level 1 Acute Involuntary Psychiatric beds, 8 at the GMPCC, a public psychiatric care center, and the remaining 27 in three private hospitals, BR (14), FAHC (7), RRMC (6), that have entered "non-refusal" agreements with the Vermont Department of Mental Health (DMH); and

Whereas, when the Vermont Psychiatric Care Hospital (VPCH) in Berlin opens and is running at full capacity sometime in the second half of 2014, Vermont will have a total of 45 Level 1 Acute Involuntary Psychiatric beds - 25 public beds in Berlin, 14 beds at the Brattleboro Retreat, and 6 beds at the Rutland Regional Medical Center[3]; and

Whereas, in addition to the psychiatric hospital beds, Vermont currently has 7 secure residential recovery beds in Middlesex designed to treat patients stepping down from Level 1 hospital beds, 42 intensive residential occupancy beds; and 39 crisis beds dispersed throughout the state; and

Whereas, system-wide the four hospitals that serve Level 1 Acute Involuntary psychiatric patients have been over-capacity every month from April 2013 through October 2013 admitting patients to between 39 and 48 Level 1 acute beds, exceeding the 35 contracted beds, creating an overflow ranging from 4 to 13 beds during each of these months;[4] and

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[1] Wall, State Hospitals as "the Most Integrated Setting According to Their Needs," *Journal of the American Academy of Psychiatry and the Law,* 2013. http://www.jaapl.org/content/41/4/484.full.pdf+html

[2] Report on the Joint Meeting of the Mental Health and Health Care Oversight Committees November, 2013 (Table 2, Page 5)
http://www2.leg.state.vt.us/CommitteeDocs/Mental%20Health%20Oversight/Joint%20Committee%20Report/11-21-2013~Katie%20McLinn~Report%20on%20the%20Joint%20Meeting%20of%20the%20Mental%20Health%20and%20Health%20Care%20Oversight%20Committees%20November%202013.pdf

[3] When the Vermont Psychiatric Care Hospital (VPCH) opens the total number of voluntary and involuntary psychiatric beds will increase to 179.

[4] Report on the Joint Meeting of the Mental Health and Health Care Oversight Committees, November 2013 (Table 1 , Page 4) See, link at footnote 2)

Whereas, patients in Vermont are experiencing significant wait times for Level 1 Acute Involuntary Psychiatric beds and these waits occur in both emergency departments and at correctional facilities, with a daily average of 8 patients in Vermont emergency departments or corrections awaiting inpatient placement and the average wait for an individual who needs an involuntary Level 1 inpatient bed being three days[5][6]; and

Whereas, when a patient stays in an emergency department for twenty four hours, approximately six other emergency department patients are displaced, creating a hidden cost to the health care system, potentially resulting in increases in hospital budgets for emergency departments; and

Whereas, the Veterans Administration in White River Junction has created a separate psychiatric emergency unit to serve patients who have been unable to find inpatient psychiatric beds in Vermont, incurring new costs to support care that is less optimal than psychiatric inpatient care;

Whereas, the cost of improvising psychiatric care in an emergency department, including the cost of sheriff coverage, new facilities and displaced patients, is considerable and may exceed the cost of creating additional psychiatric beds where patients could receive appropriate treatment; and

Whereas, the Department of Mental Health does not provide psychiatric treatment[7] for individuals who are waiting for a bed, and many patients may not receive psychiatric treatment for their illness during this waiting time[8]; and

Whereas, in one community hospital emergency department, one patient waited for admission to an Acute Level 1 Involuntary Psychiatric bed for 13 days and another patient waited for 7 days; and

Whereas, emergency department physicians and psychiatrists who work with patients in emergency departments believe that admissions are even more delayed for the most severely ill and behaviorally disturbed patients, with very acute illness who pose a serious risk of significant harm to themselves and others; and

Whereas, some patients admitted to designated hospitals refuse non-emergency medication; and when efforts to encourage them to accept involuntary medication voluntarily fail, petitions for involuntary medication orders are filed with the court; and,

Whereas, the number of involuntary medication petitions filed with the courts has more than doubled between 2010 and 2013 from 31 to 65 petitions[9]; and

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[5] Report on the Joint Meeting of the Mental Health and Health Care Oversight Committees November, 2013 (Pages 10- 12; Tables 7 and 8) (Link at footnote 2)

[6] MH Oversight Committee Report December 2013 at page 6, Section VI. A System Overflow: Emergency Departments and Department of Corrections
http://www.leg.state.vt.us/reports/2014ExternalReports/296037.pdf

[7] The DMH provides funding for sheriffs to monitor patients in emergency departments on request.

[8] MH Oversight Committee Report December 2013 at page 6
http://www.leg.state.vt.us/reports/2014ExternalReports/296037.pdf

[9] Act 114 Report January 15, 2014 at page 5
http://www.leg.state.vt.us/reports/2014ExternalReports/296037.pdf

Whereas, continuing psychosis negatively impacts people's lives, including their housing and connections to others and although psychiatric medication can have very significant and serious side effects, it can be helpful to patients and is sometimes necessary to help patients become calmer; and

Whereas, according to testimony presented to the Vermont Senate Health & Welfare and Judiciary Committees by Dr. Robert Macauley, medication refusal often leads to higher rates of restraint and seclusion;[10],[11] and

Whereas, after patients are admitted to a designated hospital, the time from admission to medication order is on average 72 days and the time from commitment order to medication order is 21 days[12]; and

Whereas, these time limits are reportedly much longer than those in other states; now therefore, be it

RESOLVED, that VMS will work with the Vermont Association of Hospitals and Health Systems (VAHHS), the Department of Mental Health (DMH), and other stakeholders to enact legislation that streamlines the timing of the legal process for non-emergency involuntary medication orders; and be it further

Resolved, that VMS will work with VAHHS and DMH to support legislation or policy changes that will prioritize admission and treatment for the most severely ill and behaviorally symptomatic patients, consistent with a recommendation in the Act 114 Report to create a "fast track" for those patients whose symptoms manifest in extreme violence to themselves or others, so that judicial review could take place in days, not weeks; and be it further[13]

RESOLVED, that VMS work to ensure the mental health care system and designated hospitals in Vermont include sufficient capacity and overflow capacity to ensure that no acutely psychiatrically ill patient waits for a Level 1 Acute Involuntary Psychiatric bed at an emergency department or correctional facility for more than 24 hours; and be it further

RESOLVED, that VMS work with appropriate stakeholders to assess the mental health work force needs and develop an approach to address unmet needs.

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[10] Written testimony of Robert Macauley to Senate Judiciary and Health & Welfare Committees, January 15, 2014: http://www2.leg.state.vt.us/CommitteeDocs/Senate%20Health%20and%20Welfare/Bills/S.287/1-15-2014~Robert%20Macauley~S.287~Written%20Testimony.pdf

[11] Owiti J, Bowers L. A Literature Review: Refusal of Psychotropic Medication in Acute Inpatient Psychiatric Care, *Institute of Psychiatry at the Maudsley,* November 2010 http://www.kcl.ac.uk/iop/depts/hspr/research/ciemh/mhn/projects/litreview/LitRevMedsref.pdf

[12] Act 79 Implementation report – January 15, 2014 at page 24 http://www.leg.state.vt.us/reports/2014ExternalReports/296059.pdf

[13] Act 114 Report January 15, 2014 at page 19 http://www.leg.state.vt.us/reports/2014ExternalReports/296037.pdf