Progress Report of the Mental Health Oversight Committee
January 2011

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I. Responsibilities of the Mental Health Oversight Committee

The Mental Health Oversight Committee (MHOC) was created by the General Assembly in 2004 primarily to oversee the development and implementation of the Vermont Mental Health Futures Plan (Futures Plan) and to ensure that Vermonter have access to a comprehensive and integrated continuum of mental health services. The charge of the MHOC was amended during the 2007 legislative session to focus on Vermont’s mental health system in general and to remove the committee’s sunset date (see Appendix 1).

The MHOC is a bipartisan committee composed of senators and representatives who serve on the health and welfare, human services, appropriations, and corrections and institutions committees, with one member from each body “at large.” As of 2006, the MHOC has been required to provide an annual progress report to the standing committees. This is the fifth progress report of the MHOC.

II. Summary of Committee Activities

The MHOC met four times during the 2010 interim. Public meetings were held at the Brattleboro Retreat, Rutland Regional Medical Center, Fletcher Allen Health Care in Burlington, and Northeastern Regional Hospital in Saint Johnsbury to discuss how the current community mental health system and hospitals are meeting local mental health needs. In every community, the MHOC received testimony where needs were identified and providers and community members worked together to come up with innovative ways to serve those needs. The MHOC also learned that the need for mental health services is outpacing available mental health resources and that this creates a strain on local governments, police, and hospital emergency departments. The committee heard from a broad array of organizations and individuals (see Appendix 2 for the 2010 Witness List). Special emphasis was placed on receiving testimony from consumers and family members.

Brattleboro

In Brattleboro, the MHOC visited the Brattleboro Retreat (“Retreat”) and Meadowbrook, a collaboration between the Retreat and Health Care and Rehabilitation Services (HCRS). The MHOC toured the psychiatric facilities and during the tour heard testimony about moving to Brattleboro patients who require the level of care provided by Vermont State Hospital. The Retreat proposes to add a 16-bed unit to replace 16 beds from the state hospital. Meadowbrook is a step-down facility with a homelike atmosphere which opened this year for former patients of the Vermont State Hospital. The Retreat is a mental health facility with approximately 150 licensed beds and 525 employees. In 2009, the Retreat admitted 2,400 adult patients and 570 children and adolescents.
HCRS provides comprehensive mental health and substance abuse services to community members across Windsor and Windham counties. HCRS serves almost 5,000 individuals each year through its five major service programs: Adult Outpatient, Children’s Division, Community Rehabilitation and Treatment (CRT), Developmental Services (DS), and Windham/Windsor Recovery Assistance Program (WRAP).

The Brattleboro testimony focused on the strain that a mental health or substance abuse crisis places on the local police force and hospital emergency department. Witnesses testified that placing persons with a mental health or substance abuse crisis in police custody takes patrol officers off the streets, crowds jail cells, is not therapeutically appropriate, and puts everyone involved in danger because police officers, unlike the security officers at the Brattleboro Retreat, are armed. Detox centers and programs to prevent the incarceration of individuals with substance abuse or alcohol issues were presented as effective solutions that better serve individuals’ health care needs and therefore reduce the strain on law enforcement. The MHOC also heard testimony that the local hospital, Brattleboro Memorial Hospital (BMH), does not have a mental health unit or adequate medical and security staff to handle the rise in mental health and substance abuse patients that seek treatment in the emergency department. Patients who with a mental health crisis who enter the emergency department are subject to long waits and may not receive appropriate treatment. A planned crisis-care center developed by HCRS and modeled after its pilot project in Springfield may divert patients away from the hospital emergency department in the future.

The following topics were also discussed:

- raising the age of consent for mental health services
- increasing funding for community social workers and individual case managers

Rutland

In Rutland, the MHOC met at the Rutland Regional Medical Center (RRMC). RRMC is an acute care hospital with a 19-bed psychiatric inpatient unit. The average daily census in the psychiatric inpatient unit is 12 patients. According to the hospital, RRMC treats about 700 psychiatric patients a year, about one-half of whom live in Rutland County. RRMC proposes building a new 26-bed facility connected to the main hospital building to replace its own and VSH beds if the project receives adequate funding from the state. The MHOC toured the existing psychiatric facilities.

Rutland Mental Health Services, Inc. (RMHS), as the designated agency for the Rutland region, is the region’s primary community health and disabilities system. RMHS provides clinical and supportive services to promote the health of Rutland County residents. The programs of RMHS include: substance abuse programs, including the Evergreen Substance Abuse Program Quitting Time, an intensive outpatient program; onsite psychiatric services; aftercare program; cooccurring services; Rocking Horse program; Project CRASH; drug court services; Incarcerated Women’s Initiative;
specialty groups; and individual counseling. RMHS served 3,069 clients in FY 2009.

As in Brattleboro, witnesses at the Rutland meeting testified about the problems caused when people in mental health crisis enter the hospital emergency department or police custody. They advocated for more funding and beds for an existing crisis bed stabilization program and more funding and training for RMHS to do crisis evaluations in the community (rather than in the hospital emergency department) as ways to save money and better serve individuals’ needs. Witnesses testified that case management services are lacking for people who need help with basic living skills such as maintaining a job or housing. Witnesses also testified that particular provisions of the legislation establishing a statewide pharmacy monitoring system create problems with accuracy and access (e.g., vital sheets do not capture cash transactions at pharmacies).

The committee learned that there is a lot of collaboration between RRMC, RMHS, and various other human services agencies in the area.

Burlington

In Burlington, the MHOC visited HowardCenter and Fletcher Allen Health Care and toured Fletcher Allen’s psychiatric facilities. HowardCenter provides developmental, mental health, substance abuse, and child, youth, and family services to 15,000 people each year. Fletcher Allen, Vermont’s academic medical center, has two acute care inpatient psychiatric units; one is a 16-bed locked unit, and the other is a 12-bed unlocked unit for lower risk patients.

Consumers at the Burlington meeting testified about the importance to their treatment of case managers and life skills counselors. The Burlington and Shelburne police chiefs testified about the challenges officers face as first responders to mental health crises, including the safety problems caused by service-resistant individuals. The chiefs advocated for structured living facilities, better wrap-around services, and a “one-stop shopping” approach to drug and alcohol detoxification. Several witnesses advocated for better and more immediate access to mental health and substance abuse services for people seeking treatment. The MHOC learned about Burlington’s Community Street Outreach Project, a multi-sector partnership whose purpose is to intervene with youth and people with mental illness in the downtown business district when behavior is inappropriate or unsafe and to refer those people to appropriate services.

The following topics were also discussed:

- consent requirements regarding use of medication for people in mental health crisis
- lack of treatment options at Fletcher Allen for children under 18 in mental health crisis

Saint Johnsbury

In Saint Johnsbury, the MHOC met at Northeast Kingdom Human Services (NKHS).
NKHS is a community-based health and human service agency serving more than 2,000 individuals and family members at any given time. NKHS provides services to children and adults with chronic mental illness, developmental disabilities, substance abuse problems, and other mental health and medical psychiatric needs. NKHS provides emergency services 24 hours a day, seven days a week.

The committee heard testimony about the positive effects of widespread collaboration between mental health agencies and providers in the Northeast Kingdom. Examples of this collaboration include the sharing of board members between different entities, the Northeast Kingdom Community Crisis Response Committee, and Family Treatment Court. The committee also heard testimony about how the uniqueness of the Northeast Kingdom, as compared to other parts of Vermont, affects mental health services. For example, witnesses testified about the logistical challenges providers face in covering such a large rural area.

The following topics were also discussed:

- Vermont Prescription Drug Monitoring Program
- Shortage of psychiatrists in Vermont
- Teledicine
- Blueprint for Health
- Case management funding
- Challenges for Change
- Vermont State Hospital

The committee’s recommendations are outlined below.

### III. Committee Recommendations

The MHOC is very concerned that the community mental health system is under-resourced, given the mental health and substance abuse needs in its service areas. When the needs of individuals with mental illness are unable to be met with community services, there is an increased risk that an individual will have a more severe crisis. Addressing the crisis with a police response or in the emergency room increases costs and is less effective than addressing the situation before it becomes a crisis through education, prevention, treatment, and intervention. In addition, allowing unmet needs to escalate to a crisis creates pressures on other agencies and services that are not part of the mental health system and that have staff who are not trained for that purpose and may lack the resources to deal with the situation. The MHOC recognizes that community activists, consumers, providers, and local governments work every day to identify social needs, develop strategies to meet those needs, and find innovative ways to work together. These efforts are an excellent resource to the general assembly for best practice and money saving strategies.
Law Enforcement, Local Government, and Hospital Emergency Departments

Recommendation: The committee recommends that the House Committees on Appropriations and on Human Services and the Senate Committees on Appropriations and on Health and Welfare examine the pressures placed on law enforcement, local government, and hospital emergency rooms by mental health crises and identify ways to alleviate the current pressures on their services and how best to use community services to avoid having situations rise to these crisis levels. Service delivery initiatives under the Department of Health Division of Alcohol and Drug Abuse Programs (ADAP) and the Department of Mental Health (DMH) in the Challenges for Change should prioritize responses in these areas, taking particular note of:

- public inebriate needs
- the proposed restructuring of community services, how it will affect diverting and responding to crises, and how it will recognize that uniform approaches are not necessarily appropriate to every community
- expanded use of telemedicine to reduce Medicaid costs and alleviate the shortage of psychiatrists

Further Recommendations

In addition, the MHOC recommends that the committees of jurisdiction consider whether legislative action is needed regarding:

- revisions to the prescription drug monitoring system, including requiring chain pharmacies to comply with the program as a condition of doing business in Vermont
- a minor’s right to refuse hospitalization and an incompetent adult’s right to refuse medication on an expedited basis
- the need for the speaker and the committee on committees to have more discretion in appointing MHOC members
- fixing impaired access to necessary and appropriate mental health and substance abuse services caused by a lack of parity in management and reimbursement for these services
## 2010 Report of the Mental Health Oversight Committee

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Appendix 1.
Amended Charge of the Mental Health Oversight Committee

Sec. 124b of No. 65 of the Acts of 2007 amended the original charge of the MHOC as follows:

Sec. 124b. Sec. 141c of No. 122 of the Acts of 2004 (creating the mental health oversight committee), as amended by Sec. 293a of No. 215 of the Acts of 2006 (extending sunset to July 1, 2009; requiring progress report), is amended as follows:

Sec. 141c. THE MENTAL HEALTH OVERSIGHT COMMITTEE

(a) The mental health oversight committee is created to oversee the development and implementation of the secretary of human services’ strategic plan to develop alternatives for services currently provided by the Vermont state hospital and to ensure that consumers have access to a comprehensive and adequate continuum of care and that Vermont has a financially sustainable department of developmental and mental health services designated agency provider system mental health services. The committee shall be composed of one member from each of the house committees on human services, institutions, and appropriations and a member-at-large to be appointed by the speaker of the house, not all from the same party, and one member from each of the senate committees on health and welfare, institutions, and appropriations and one member-at-large to be appointed by the committee on committees, not all from the same party. Initial appointments shall be made upon passage.

(b) The committee shall review whether the secretary’s study on the department of developmental and mental health services designated agency provider system required in Sec. 141 of this act, the strategic plan for developing alternatives to the Vermont state hospital required in Sec. 141a of this act, and the department of corrections mental health services plan achieve the goals and principles stated herein effectively, efficiently, and satisfactorily, including that the findings and recommendations of the reports are coordinated and complementary. The committee shall specifically:

1. solicit input from individuals and their families served by the mental health system;
2. monitor the study and planning processes and time lines;
3. measure the efforts of the agency of human services against the goals and principles described in this act; and
4. review and approve, modify, or disapprove the recommendations contained in the reports required by Secs. 141 and 141a of this act and authorize preliminary
implementation steps for developing alternatives to the services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services.

(c) Based on the reports required by Secs. 141, 141a, and 141b of this act, the committee shall recommend areas of further study needed to develop a comprehensive continuum of care for mental health services.

(d) The committee is authorized to meet up to six times per year while the general assembly is not in session to perform its functions under this section.

(e) The secretary of the agency of human services commissioner of mental health shall report to the committee as required by the committee and Secs. 141 and 141a of this act and this section.

(f) Members of the committee shall be entitled to compensation and reimbursement for expenses under section 406 of Title 2.

(g) The secretary of administration, the legislative council, and the joint fiscal office shall provide staff support requested by the committee.

(h) The mental health oversight committee shall provide a progress report to each of the committees represented thereon no later than January 15 of each year.

(i) The committee shall cease to exist on July 1, 2009.
Appendix 2.
2010 Witness List

Mark Ames, Vermont Recovery Network
Mark Baglini, Board Member/Community Member, HowardCenter
Stan Baker, Clinical Director, Developmental Services, HowardCenter
Barry Beeman, CEO, Brattleboro Memorial Hospital
Paul Bengston, Director, Northeastern Vermont Regional Hospital
Carol Boucher, Chief of Behavioral Health Operations, Northeast Kingdom Human Services
Estelle Burton, Consumer
Sid Burton, Consumer
Todd Centybear, Executive Director, HowardCenter
Timothy Clouatre, Vermont State Police
Kathy Connolly, Board Member/Family Member, HowardCenter
Ben Coplan, Vermont Mental Health Performance Indicator Project
Linda Corey, Executive Director, Vermont Psychiatric Survivors
Rick Edelstein, Medical Director, Northeast Kingdom Human Services
Kathryn Gallager, Consumer
Mike Gavin, Consumer
Kevin Geno, Rutland Police
Clay Gilbert, Evergreen Substance Abuse
Eric Grims, Executive Director, Northeast Kingdom Human Services
Chris Hart, Brattleboro Housing Authority
Michael Hartman, Commissioner, Department of Mental Health
Judith Hayward, CEO, Health Care and Rehabilitation Services
James Helmstetter, Director, Agency of Human Services Field Services
Tom Huebner, President, Rutland Regional Medical Center
Larry Jensen, Chair, Rutland Police Commission
Andrea Livermore, Build a Better Brattleboro
Dr. David Logan, Serenity House
David Long, Vice President, Rutland Mental Health
Chris Louras, Mayor, Rutland City
Lisa Lynch, Executive Director, ARC-Rutland Area
Greg MacDonald, District Leadership, Agency of Human Services
Jeffrey D. McKee, Psy.D, Rutland Regional Medical Center
Gretchen Morse, Executive Director, United Way of Chittenden County
Julie Mulroy-Evans, Board of Directors, Northeast Kingdom Human Services
Neil Muse, Consumer
Doug Norford, Children Services, Rutland Mental Health
Bernard Norman, PhD, Northeast Kingdom Human Services
Dr. Robyn Ostrander, Child Psychiatrist and Medical Director of Child and Adolescent Services, Brattleboro Retreat
Robin Pesci, Director, First Call Children’s Mental Health Crisis Services
Robert Pierattini, MD, Chief of Psychiatry, Fletcher Allen Health Care
Darryl Pillsbury, Brattleboro Select Board
Gail Rafferty, Director, Childhood Mental Health
Ron Redmond, Burlington Business Owner
Valerie Rooney, M.D., Brattleboro Pediatrician
Laura Ruggles, Blueprint for Health
Traci Sawyers, Blueprint for Health
Michael Schirling, Chief, Burlington Police Department
Rob Simpson, CEO, Brattleboro Retreat
Pam Smart, Blueprint for Health
Barbara Sontag, Brattleboro Town Manager
Steve Stein, MD, Emergency Room Physician
Marne Stothart, Director, Chittenden Clinic Methadone Program
Beth Tanzman, Deputy Commissioner, Department of Mental Health
Ernie Tatro, Consumer
Trina Tatro, Consumer
Julie Tessler, Director, Vermont Council of Developmental and Mental Health Services
Carmen Thibodeau, Board Member/Family Member, HowardCenter
Scott Tucker, Rutland Police
James Warden, Chief, Shelburne Police Department
Nancy Warner, Board of Directors, Northeast Kingdom Human Services
Tina Wood, Disability Vermont
Bill Young, Executive Director, Maple Leaf Farm
Meika Zilberberg, Prescription Monitoring System Program Coordinator, Vermont Department of Health