Report of the Mental Health Oversight Committee
December 2013

Senator Sally G. Fox, Chair

Representative Ann D. Pugh, Vice Chair

Senator Claire D. Ayer

Representative Anne B. Donahue

Senator Norman H. McAllister

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I. Executive Summary

During the summer and fall of 2013, the Mental Health Oversight Committee (Committee) met independently four times to hear testimony on numerous matters impacting the delivery of mental health services throughout Vermont. The Committee also met for a joint meeting with the Health Care Oversight Committee in November. The Committee makes the following recommendations for the 2014 legislative session:

- The committees of jurisdiction should explore methods for ensuring that temporary treatment is provided to individuals waiting for a level 1 bed in emergency departments and correctional facilities
- The Agencies of Human Services and of Education should devote greater effort to programs for children experiencing mental health issues and the committees of jurisdiction should also make children's mental health issues a priority
- The committees of jurisdiction should continue to foster equality between mental health and physical health through greater integration of systems and parity for similar services with respect to management of care and reimbursement
- The committees of jurisdiction should continue discussions as to whether a person receiving a housing benefit funded with State dollars should receive case management as a condition of receipt
- The committees of jurisdiction should investigate the nature and extent of reported staffing problems throughout the community mental health system
- The committees of jurisdiction should review reported problems regarding staff safety at psychiatric facilities
- The committees of jurisdiction should recognize the impacts of substance abuse on the mental health system when developing policy that impacts these issues
- The committees of jurisdiction focusing on judiciary and human services issues should work collaboratively to address judicial processes regarding the administration of involuntary medication
- The committees of jurisdiction should monitor the status of elders in the mental health system, particularly with regard to those elders living in the community
- The committees of jurisdiction should continue to monitor the mental health needs of Vermont's veterans
- The committees of jurisdiction should consider whether legislative oversight of State programs for persons with developmental disabilities should occur while the General Assembly is adjourned
- The House and Senate Committees on Appropriations should review how funds appropriated to the Department of Mental Health were used
- The committees of jurisdiction should consider the oversight functions and staff resources required for joint oversight committees

II. Statutory Authority and Responsibilities of the Mental Health Oversight Committee

The General Assembly created the Committee in 2004 to oversee the development and implementation of the Vermont Mental Health Futures Plan and to ensure that Vermonters have access to a comprehensive and integrated continuum of mental health services. (2004 Acts and

Resolves No. 122, Sec. 141c.) The Committee's charge was amended in 2007 to focus on the State's mental health system more generally and to remove the Committee's sunset date. (2007 Acts and Resolves No. 65, Sec. 124b.) (*See* Appendix 1: Amended Charge of the Mental Health Oversight Committee.)

The Mental Health Oversight Committee is a bipartisan committee composed of senators who serve on the Committees on Health and Welfare, on Appropriations, and on Institutions, and representatives who serve on the Committees on Human Services, on Appropriations, and on Corrections and Institutions, as well as one member from each body chosen "at large." Since 2006, the General Assembly has required the Committee to provide an annual progress report to the represented standing committees. This is the eighth progress report of the Committee to date. (2006 Acts and Resolves No. 215, Sec. 293a.)

III. Summary of Committee Activities

While the General Assembly was adjourned, the Committee convened independently four times in 2013 to hear testimony from a diverse array of stakeholders on a number of issues within its jurisdiction. (*See* Appendix 2: 2012 Witness List.) The Committee devoted much of its time to overseeing the implementation of Act 79, which authorized the construction of new mental health facilities and the operation of a clinical resource management system. (2012 Acts and Resolves No. 79). In addition, the fiscal year 2014 budget act required the Committee to meet jointly with the Health Care Oversight Committee to make certain findings and recommendations to the Joint Fiscal Committee regarding the staffing needs and number of beds needed at the Vermont Psychiatric Care Hospital, which is slated to open in the summer of 2014. (*See* Appendix 3: 2013 Acts and Resolves, No. 50, § E.314.2). The Committee also took testimony on the following subjects:

- Mental health judicial processes
- Integration of mental health within Vermont's health care reform and substance abuse efforts
- Housing opportunities for individuals with psychiatric disabilities
- Staffing at designated agencies and staff safety concerns
- Children's mental health
- Collaboration between the Departments of Mental Health and of Disabilities, Aging, and Independent Living around elder care
- Veterans' mental health services
- Budgetary impacts of the mental health system of care developed under Act 79

IV. Mental Health System Overview[1]

The Committee's charge is to provide oversight for mental health programs in the system redesigned by Act 79. Vermont's mental health system provides services to over 28,000 adults and children, ranging from acute inpatient hospitalization to noncategorical case management

[1] This section primarily refers to the adult mental health system.

and peer services. The General Assembly redefined its vision for the system during the 2012 legislative session through its passage of Act 79 (An act relating to reforming the mental health system). Prior to the start of that session, the Vermont State Hospital (VSH) was devastated by Tropical Storm Irene on August 28, 2011, leaving the State's mental health system in crisis. The General Assembly used the devastation of VSH as an opportunity to transition from a centralized system of care to a decentralized system that emphasizes community supports and services over institutionalized treatment.

Act 79 authorized the creation of several new facilities for the treatment and care of individuals with psychiatric disabilities, enhanced new and existing community services, and established a mechanism for coordinating the movement of individuals throughout the system. The Committee continued monitoring these services, and both the types of "beds" in the system as well as the operation of these new programs in the context of a statewide continuum of care. The Commissioner of Mental Health provided monthly updates to the Committee on facility usage and wait times in emergency departments and prisons, as well as summaries of the system of care. At the Committee's November meeting this year, the Department of Mental Health (DMH) reported the status of those facilities authorized by Act 79 as follows:

- *Green Mountain Psychiatric Care Center* (Morrisville): This temporary eight-bed psychiatric hospital opened in January 2013. DMH reported in November 2013 that it plans to close the facility and move all of its patients and staff to the Vermont Psychiatric Care Hospital when it opens in June 2014.

- *Vermont Psychiatric Care Hospital* (Berlin): At the Committees' November meeting, DMH reported that the Vermont Psychiatric Care Hospital was nearly 45 percent complete. Work on both the exterior and interior of the building continues, including the construction of a central courtyard and completion of plumbing, wiring, and radiant heat installation. Changes contemplated by the project managers take into account operational considerations, costs, and the construction schedule. According to DMH, its facility planning group continues to meet regularly to address construction and operational issues.

  DMH reports that all project expenses are on target with budget estimates. It is anticipated that construction will be completed in May 2014, enabling the hospital to open its doors to patients beginning in June or July 2014.

- *Secure Residential Recovery Facility* (Middlesex): After resolving legal issues raised by an owner of the neighboring property, the secure residential recovery facility was able to open in June 2013. Currently all of the beds are occupied. The route to admission to the Middlesex facility is through previous level 1 hospitalization. Most residents at the facility no longer require treatment in a level 1 hospital, but still have issues involving public safety risks.

- *Brattleboro Retreat*: Renovations for the creation of a 14-bed acute psychiatric unit were completed and the unit opened in March 2013. The Retreat was cited for deficiencies this past spring, but after working closely with DMH and the Centers for Medicare and

Medicaid Services, it worked out a plan of compliance that should avoid a loss of Medicaid funding.

- *Rutland Regional Medical Center*: Renovations for the creation of a six-bed acute psychiatric unit were completed and the unit opened in May 2013.

DMH also updated the Committee on the following community programs and supports:

- *Crisis Beds*: Crisis beds are usually used as a means of diverting individuals from hospitalization by providing a safe setting where they can be stabilized. Some crisis beds are also used post-hospitalization. Act 79 enabled each county to have at least two crisis beds. The percent occupancy rate for each unit varies significantly due to the limited capacity of each program.

- *Intensive Residential Recovery Facilities*: These facilities are often referred to as "step down beds" and are generally occupied by patients who are discharged from psychiatric hospital units. As a result of Act 79, the number of these beds increased by 16 to date. Occupancy at Hilltop House fluctuated between 80 and 100 percent over the course of the past six months. Meadowview began the calendar year at 100 percent occupancy, and beginning in June dipped to a steady 80 percent occupancy. Prior to the opening of Second Spring-Westford, the Second Spring facility in Williamstown had two crisis beds that could be used as intensive residential recovery beds on an "as needed" basis. This brought the total capacity of the Second Spring-Williamstown facility to a total capacity of 22 beds some days each month. Since opening in August 2013, Second Spring-Westford has maintained nearly 80 percent occupancy.

- *Facility for no or limited reliance on medication* (Soteria House): A project leader has been selected, who has chosen a location for a facility within Chittenden County.

- *Peer services*: Expanded capacity for peer services is under way at Another Way, Alyssum, Pathways, Vermont Center for Independent Living, Vermont Psychiatric Survivors, Rutland Turning Point Recovery Center, and Vermont Vet-to-Vet.

- *Housing subsidies*: There are long waitlists in Vermont for Section 8 certificates, and therefore vouchers will have to be sustained with monies from the General Fund and Medicaid. The fiscal year 2014 budget allocated an additional $75,000.00 to the housing voucher program. The General Fund appropriation is matched by Global Commitment funds.

- *Mobile crisis services*: All areas throughout the State have developed mobile capacity. DMH's ability to expand services has been compromised to some degree by designated agencies' inability to fill vacancies on mobile crisis teams. These teams can often prevent trips to emergency departments by averting a crisis and stabilizing the situation.

As of the Committee's final meeting in 2013, the design and implementation of the clinical resource management system was under way. The electronic bed board is not yet fully operational, as it does not function in "real time," resulting in the need to verify information with a telephone call. DMH's care managers are actively monitoring those individuals in need of beds in order to provide services where the need is greatest. DMH has undergone another change of commissioners, but it is hoped that DMH is reaching a place of greater stability. In general, DMH is moving in a positive direction with solid leadership.

V. Recommendations Pursuant to Act 50 relating to the Vermont Psychiatric Care Hospital

In November 2013, the Mental Health Oversight Committee and Health Care Oversight Committee held a joint meeting to discuss the capacity of the State's level 1 mental health system and to make recommendations on both the number of personnel needed at the new Vermont Psychiatric Care Hospital and whether the General Assembly overestimated the number of beds needed at the new hospital. The Committees made the following recommendations to the Joint Fiscal Committee in their report:

- The General Assembly should fully fund the 25-bed Vermont Psychiatric Care Hospital
- The Department of Mental Health should prepare and present a plan to the committees of jurisdiction regarding the opening of the Vermont Psychiatric Care Hospital prior to the budget adjustment process
- The Vermont Psychiatric Care Hospital should be completely operational with all 25 beds by July 1, 2014 or as soon as possible
- The General Assembly should develop contingency plans in case the need for overflow beds in the level 1 system arises (see section VI(B) below)
- The Department of Mental Health should develop specific plans and timelines for the hiring and training of Vermont Psychiatric Care Hospital employees, which should commence immediately to ensure staff are ready for patients when construction of the new facility is complete
- Any revisions to its original staffing proposal should be presented by the Department of Mental Health to the committees of jurisdiction once it has conducted a review of national standards and protocols

Based on developments since the report was submitted to the Joint Fiscal Committee in November 2013, the Mental Care Oversight Committee believes that one of the recommendations in the joint report should be amended. Namely, the Committee believes that DMH, not the General Assembly, should be responsible for developing contingency plans in anticipation that overflow beds in the level 1 system become necessary.

In addition, after the Committees finalized their joint report, the Commissioner of Mental Health presented testimony to the Joint Fiscal Committee detailing discussions between DMH and Fletcher Allen Health Care about the provision of overflow beds and medical services. This Committee supports discussions between DMH and Fletcher Allen about overflow beds to ensure that additional level 1 beds are available in the event that there are insufficient beds within the system after the Vermont Psychiatric Care Hospital opens. The Committee would

encourage similar discussions between DMH and Rutland Regional Medical Center and between DMH and the Brattleboro Retreat. The Committee also supports further discussions between DMH and Fletcher Allen regarding the possibility of Fletcher Allen providing medical services to patients at the Vermont Psychiatric Care Hospital.

VI. Findings and Recommendations

A. System Overflow: Emergency Departments and the Department of Corrections

The Committee heard testimony at several of its meetings that there were still numerous instances when an individual was in need of an involuntary inpatient bed, but no beds were available for that individual within the mental health system. As a result, the mental health system continues to see people being held at either emergency departments or at a State correctional facility until a bed becomes available. DMH estimated that the average wait time for an individual initially denied an involuntary inpatient bed was three days, and that approximately 18 percent of individuals held at emergency departments or correctional facilities were ultimately stabilized prior to hospital admission.[2]

Individuals awaiting a bed at an emergency department or correctional facility were generally not receiving any type of interim treatment or services. DMH itself does not provide any treatment for these individuals; rather, a crisis clinician reevaluates the individual's condition at 12-hour intervals. Treatment for individuals waiting for services or an open bed at another facility is at the discretion of the emergency department director or Department of Corrections, respectively.

Backups in the system also reduce the bed space available for voluntary level 1 patients. There are no statistics kept on the number of voluntary patients turned away due to the fact that the beds are occupied by involuntary patients. This is a problem that is not being addressed.

Recommendation

The Committee finds that the provision of short-term treatment for individuals waiting in an emergency department or correctional facility for a bed is essential. It renews its 2012 recommendation that the committees of jurisdiction explore methods for ensuring that temporary treatment for such individuals is provided, and sufficient numbers of level 1 beds are available.

B. Integration of Mental Health in Health Care Reform

The Committee heard testimony regarding parity and the integration of mental health with the larger health care system. There appear to be billing discrepancies related to reimbursement for services with the same service codes among physicians who are and are not psychiatrists. The Committee sent a letter of inquiry to the Department of Financial Regulation regarding the reimbursement differential.

[2] For the purpose of DMH's analysis, "ultimately stabilized prior to admission" is defined as admission notations of "Walked Off Papers," "Discharged," or "Found Not to Meet EE Criteria."

The Committee also took testimony regarding whether BlueCross BlueShield of Vermont is in violation of federal parity law through its differential treatment of preauthorization requirements for most other medical services through the services managed by its contract with Vermont Care Collaborative, LLC, which is formed jointly by BlueCross BlueShield of Vermont and the Brattleboro Retreat to provide mental health care management for BlueCross BlueShield of Vermont.

Recommendation

The Committee recommends that the committees of jurisdiction continue to foster equality between mental health and physical health through greater integration of systems and parity for similar services with respect to reimbursement, as well as the types of services provided to consumers by a continuum of providers and how management of care is addressed. The Vermont Collaborative Care approach differs from the fully integrated management model anticipated by observers and may violate federal law, and the Committee suggests that the committees of jurisdiction investigate this arrangement in greater detail.

The Committee further recommends that new accountable care organizations integrate mental health into their payment reform efforts.

C. Children's Mental Health Care

Over the past several years, much of the focus on Vermont's mental health system has pertained to the needs of adults. Consequently, the Committee believes that issues regarding children's mental health care have been neglected. The Committee took a half day of testimony from the administration, community providers, parents, and teens on the topic of children's mental health. The General Assembly needs to put the spotlight back on this system, because it is under resourced, subject to increasing caseloads, and not well integrated with schools, local programs, and the Departments for Children and Families and of Disabilities, Aging, and Independent Living (DAIL). The Committee was, however, encouraged to hear about a new grant to pilot efforts for removing silos in Addison County.

Recommendation

The Agencies of Human Services and of Education should devote greater effort to programs for children experiencing mental health issues. The committees of jurisdiction should also make children's mental health issues a priority.

D. Housing: Access and Services

At its October meeting, the Committee revisited the issue of housing opportunities available to individuals with psychiatric disabilities. Specifically, it took testimony from DMH; Angus Chaney, the Agency of Human Services' Director of Housing; and the Burlington Police Department. The Committee's primary concerns included whether there was sufficient housing

available to meet demand and when receipt of housing vouchers should be contingent upon accepting case management services.

Brian Smith of DMH reported that DMH anticipated spending $1.4 million on housing during the current fiscal year. DMH was unable to report on how much money was matched by Global Commitment funds, and what types of conditions went along with the funding. To date, 87 housing subsidies have been granted by DMH during the 2013 calendar year.

Testimony from the Burlington Police Department related largely negative experiences interacting with the agency administering DMH grants. In particular, the Police Department testified that one provider using the "housing first" model was unwilling to speak to the police about situations involving their clients. The lack of communication between the police and providers frustrates the delivery of services to those with mental illnesses and causes adverse consequences to the person and the community.

Recommendation

The Committee agrees that housing supports for individuals with psychiatric disabilities are an important element in the continuum of services for reducing treatment in more intensive settings. Since these programs are completely funded with General Fund and Global Commitment monies, the State should ensure that these dollars are managed effectively. The Committee believes that there should be continuing discussion as to whether a person receiving a housing benefit funded with State dollars should receive case management as a condition of receipt. There are few circumstances in which a person who qualifies for a voucher does not require additional supports in the community, and efforts should be made to ensure a robust case management system that works to keep the person from failing. Given that the demand for vouchers exceeds their availability, mental health housing programs must be evaluated now that the program has been in existence for two years. The Committee believes that the voucher program should have clear objectives and measurable criteria for success.

E. Staffing at Designated Agencies

The Committee heard from several witnesses who work within the mental health system at the community level that unfilled vacancies posed a problem with respect to implementing some of the initiatives envisioned by Act 79. The designated agencies specifically testified that some of these vacancies are related to salary level, the difficult nature of the work, geographic challenges, and high turnover. While the Committee did not have time to explore the extent of this problem, it does believe that further assessment is advisable.

Recommendation

The Committee renews its recommendation that the committees of jurisdiction investigate the nature and extent of reported staffing problems throughout the community mental health system. The committees should assess designated agencies' ability to provide services and supports that the General Assembly has required them to provide. In addition, it is recommended the

committees of jurisdiction identify the specific staffing impediments and how they may be overcome.

F. Staff Safety Issues

The Committee heard testimony from the Vermont State Employees' Association (VSEA) and home health providers regarding providers at the Brattleboro Retreat, Green Mountain Psychiatric Care Center, and in community settings who have suffered injuries while working with people with mental illnesses. The VSEA and providers also raised concerns regarding the role of law enforcement in mental health care, staff-to-patient ratios, and staff training.

Recommendations

The Committee did not have time to explore these issues in depth. Some concerns are the subject of collective bargaining, and others may be contractual between DMH and providers. The committees of jurisdiction should review these issues.

G. Substance Abuse

The Committee acknowledges that there are many ways in which substance abuse and mental health intersect in terms of diagnosis, care, and treatment. It further recognizes that a great deal of interplay exists between substance abuse and mental health within the State's health care, judicial, corrections, and housing systems. Therefore, the creation of a successful mental health system necessarily requires the inclusion of substance abuse prevention and treatment initiatives.

Recommendation

The Committee recommends that the committees of jurisdiction recognize the impacts of substance abuse on the mental health system when developing policy that impacts these issues.

H. Effect of the Judicial Process on Patient Care

The General Assembly believed that strengthening the community system would allow the State to reduce the number of level 1 beds in the mental health system. This year saw the opening of the Green Mountain Psychiatric Care Center, the secure residential recovery facility, and additional intensive residential recovery beds, and yet waitlists for level 1 beds persist. The anticipated reduction in emergency room waits as a result of more robust community resources has not yet come to pass.

While the Committee did not focus on this topic, it heard anecdotally from the administration, judges, attorneys for patients and the State, family members, and former patients as to why they believed waitlists for level 1 beds existed after the opening of new facilities within the system. The witnesses were divided about the causes for delay, and whether there is a problem with the relevant statutes or their implementation. Some witnesses attributed this phenomenon to delays created by waiting for orders for involuntary medication; others disagreed. Efforts are under way to improve judicial processes, which have been exacerbated by the fact that there are

currently five locations for hearings on involuntary treatment and medication, as opposed to one prior to Tropical Storm Irene. The Committee also heard testimony that the ability to provide safe and therapeutic care for all patients was impacted by other patients' violent symptoms, some of which might be addressed by medication.

Recommendation

As this issue crosses multiple committees' jurisdiction, the Committee recommends that the committees of jurisdiction focusing on judiciary and human services issues work collaboratively to address this subject. Although this is an emotional subject, the General Assembly must remain mindful of two things: first, that statutory changes affect everyone in the system, and second, that the current laws balance constitutional rights against the need for certain types of psychiatric treatment.

I. Elders' Mental Health Issues

The fact that mental health needs of older Vermonters are primarily within the purview of DAIL requires coordination and communication between the departments in the Agency of Human Services. In 2012, the overuse of psychotropic medication in nursing homes was the subject of a grant which was overseen by DAIL. Testimony in 2013 indicated that this program was succeeding.

The Committee also heard anecdotal testimony that some of the people waiting in emergency departments (and in one case a correctional facility) for a level 1 inpatient bed were elderly. These individuals were waiting for a level 1 bed because their nursing homes were not willing to take them. The question arose as to whether the State should address this population by developing a step-down facility exclusively for elders, or instead serve them within the current system. The Commissioner of DAIL agreed that there was a gap in needed services, but expressed a preference for avoiding segregated services.

Recommendation

The committees of jurisdiction should monitor the status of elders in the mental health system. Since most elders receive their health care through Medicare, the State often overlooks their needs when discussing issues of parity. Also of note is the component of the Choices for Care program which has identified a need for the provision of mental health services to elders living in the community. The committees of jurisdiction should continue to monitor this emerging need.

J. Veterans' Mental Health

The Committee heard testimony pertaining to those issues confronting veterans and military personnel who have been in combat. The incidence of post-traumatic stress disorder, suicide, and substance abuse is particularly troubling. The Committee found that the Veterans' Administration provided many mental health programs to address these issues. In addition to the VA Hospital in White River Junction, there are two local clinics for veterans.

Recommendation

At this time, the Committee recommends that the General Assembly continue to monitor the needs of this population.

K. Developmental Services

The populations of persons with mental health and developmental disabilities overlap in many ways. The Committee accedes to the Act 33 Study Committee on Persons with Serious Functional Impairments for those issues, and did not spend any time discussing developmental disabilities. In fact, this population has not been the subject of any legislative oversight committee.

Recommendation

The Committee recommends that the committees of jurisdiction consider whether there should be legislative oversight of State programs for persons with developmental disabilities while the General Assembly is adjourned.

L. Appropriations and Spending

The Committee recognizes that the General Assembly committed significant funds to the reformation of the mental health system. Since Tropical Storm Irene, capital funds appropriated, expended, or encumbered to date total $43.2 million, of which $16.7 million are from bond supported capital funds and $27 million are from insurance and FEMA payments.

The total combined State and federal operating funds appropriated for the mental health system has increased significantly since Tropical Storm Irene in early fiscal year 2012.

FY11	**FY12**	**FY13**	**FY14 Budget Adjustment**
$156.4m	$165.5m	$194.3m	$206.2m

The mental health system is funded with Medicaid funds through the Global Commitment waiver and with direct federal grants. The State portion of the fiscal year 2014 total is $86.9 million of General Fund up from $75 million in fiscal year 2011. Success Beyond Six is included in the operating totals above; this program is school-based with the State match portion provided by local school districts.

Recommendation

The Committee recommends that the House and Senate Committees on Appropriations review how funds appropriated to DMH were used. The Committee further recommends that the review include an evaluation of how the expenditures furthered the provision of services close to home

by a continuum of community service providers, as well as other principles adopted in Act 79. The probability that no increases will be included in the 2015 budget necessitates maximizing the use of funds.

M. Continuation of the Mental Health Oversight Committee

The Mental Health Oversight Committee was established several years ago to oversee the siting of and financing for VSH. In the last biennium, the Committee's role was to monitor and provide oversight to the new community system and the new level 1 treatment beds. At the end of last year, it was the opinion of the Committee that its existence continue since the new system required close scrutiny and warranted the work of one entire Committee rather than be absorbed into the jurisdiction of an oversight committee with a broader scope.

Recommendation

The Committee discussed the appropriate role of interim and standing committees in providing oversight of health care and human services issues when the General Assembly is not in session. The Committee recommends that the standing committees of jurisdiction consider the oversight functions and staff resources required for joint oversight committees. The Committee believes that the future of the Mental Health Oversight Committee be evaluated within a larger context involving other oversight committees, in particular given the policy goal of full integration of mental health within the health care system.

2013 Report of the Mental Health Oversight Committee to the Vermont General Assembly

Senator Sally G. Fox, Chair	*Representative Ann D. Pugh, Vice Chair*
Senator Claire D. Ayer	*Representative Anne B. Donahue*
Senator Norman H. McAllister	*Representative Mary S. Hooper*
Senator John S. Rodgers	*Representative Catherine Beattie Toll*

Appendix 1: Amended Charge of the Mental Health Oversight Committee

THE MENTAL HEALTH OVERSIGHT COMMITTEE

(a) The mental health oversight committee is created to ensure that consumers have access to a comprehensive and adequate continuum of 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) Members of the committee shall serve as the liaison to their respective legislative standing committees with primary jurisdiction over the various components of Vermont's mental health system. The committee shall work with, assist, and advise the other committees of the general assembly, members of the executive branch, and the public on matters related to Vermont's mental health system.

(c) 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.

(d) The commissioner of mental health shall report to the committee as required by the committee.

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

(f) The legislative council, and the joint fiscal office shall provide staff support requested by the committee.

(g) 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.

Appendix 2: 2013 Witness List

Peter Albert, Director of Government Affairs, Brattleboro Retreat

Rick Barnett, Psy.D., LADC, Vermont Psychological Association

Mitch Barron, Suicide Prevention Information Group

Wendy Beinner, Director, NAMI VT

Bob Bick, Director, Mental Health & Substance Abuse Services, HowardCenter

Steve Broer, Psy.D, Director of Behavioral Health Services, Northwest Counseling and Support Services

Paul Capcara, Clinical Nurse Manager, Adult Acute Care Unit, Brattleboro Retreat

Lesa Cathcart, Rutland Regional Medical Center

Angus Chaney, Director of Housing, Agency of Human Services

Colleen Coyle, General Counsel, American Psychiatric Association

Annie Cressey, Health Educator, University of Vermont

Kelly Deforge, Parent, Essex Junction

Ivan Deutsch, Peer, Health Care and Rehabilitation Services

Joyce Dion, President, UNAP Local 5051, United Nurses and Professionals (UNAP)

Paul Dupre, Commissioner, Department of Mental Health

Nick Emlen, Mental Health Systems Coordination, Vermont Council of Developmental and Mental Health Services

Dr. W. Gordon Frankle, Director of Psychiatric Services, Rutland Regional Medical Center

Rep. Sandy Haas, Co-Chair, Study Committee on Providing Community Support to Persons with Serious Functional Impairments

Brooke Hadwen, Burlington Police Department

Heidi Hall, Financial Director, Department of Mental Health

Steve Howard, Legislative Director, Vermont State Employees' Association

Tom Huebner, President, Rutland Regional Medical Center

George Karabakakis, Ph.D, Chief Operations Officer, Health Care and Rehabilitation Services

Dr. Betty Keller, Family practice, Fairfax

Rodger Kessler, Ph.D., ABPP, University of Vermont

John Koutras MD, Medical Director, Brattleboro Retreat

Justin Lambert, Student, South Burlington High School

Jackie Lehman, HowardCenter

Ken Libertoff, Consultant

Karen Lorentzon, Consumer, Vermont Psychiatric Survivors
Kindra Lundie, Student, South Burlington High School
Sean Lynch, HowardCenter
Brittany Manos, Student, South Burlington High School
Emily Mastaler, Director of Residential Services, Health Care and Rehabilitation Services
Charlotte McCorkel, Suicide Prevention Information Group
Jack McCullough, Director of Mental Health Law Project, Vermont Legal Aid
Jeffrey McKee, Psy.D, Director of Psychiatric Services, Rutland Regional Medical
Katie McLinn, Legislative Counsel, Office of Legislative Council
Hilary Melton, Director, Pathways Vermont
Susie Merrick, Suicide Prevention Information Group
Dena Monahan, Counsel, Department of Mental Health
Rep. John Moran, Sponsor, Wardsboro, VT
Mary Moulton, Executive Director, Washington County Mental Health Services
Floyd Nease, Director of Systems Integration, Agency of Human Services
Nick Nichols, Policy Director, Department of Mental Health
Bernard Norman, Ph.D, Chief of Clinical Operations, Northeast Kingdom Human Services
John O'Brien, Senior Advisor on Health Care Financing, Green Mountain Psychiatric
Susan Onderwyzer, Director of Quality and Care, Department of Mental Health
Graham Parker, MyPad, HowardCenter
Robert Pierattini, MD, Fletcher Allen Health Care
Amiee Powers, Parent
James Reardon, Commissioner, Department of Finance and Management
Frank Reed, Deputy Commissioner, Department of Mental Health
Richard Reed, Director, Vermont Office of Veteran Affairs
Jeff Rothenberg, Director of Mental Health Services, Department of Health
A. J. Rueben, Attorney, Disability Rights Vermont
Alice Silverman, MD, University of Vermont
Brian Smith, Department of Mental Health
Tony Stevens, Director, Crisis Services, Northwest Counseling and Support Services
Jennifer Sweet, Student, University of Vermont
Julie Tessler, Director, Vermont Council of Developmental and Mental Health Services
Greg Tomasula, Clinical Director, Start Program, HowardCenter

Lauren Tronsgard-Scott, Nurse Manager of Inpatient Mental Health Unit, Fletcher Allen Health Care

Susan Wehry, Commissioner, Department of Disabilities, Aging, and Independent Living

John Wesley, Judge, Superior Court

Robert Wheeler, Chief Medical Officer, BlueCross BlueShield

Xenia Williams, Barre Town, VT

Laura Ziegler, Concerned Citizen, Plainfield, VT

Appendix 3: 2013 Acts and Resolves, No. 50, § E.314.2

Sec. E.314.2 LEVEL 1 PSYCHIATRIC CARE EVALUATION

(a)(1) The Mental Health Oversight Committee and the Health Care Oversight Committee shall hold a joint meeting in November 2013 for the purpose of evaluating the capacity needed to treat patients in the care and custody of the Commissioner of Mental Health, specifically regarding the capacity needed within the Level 1 system of care as established in 2012 Acts and Resolves No. 79. The evaluation shall include:

(A) an assessment of the census trends for the Level 1 system of care during the last fiscal year;

(B) the status of the census capacity at Rutland Regional Medical Center and Brattleboro Retreat's Level 1 unit;

(C) the status of the construction at the state-owned and -operated psychiatric hospital in Berlin;

(D) the status of the census capacity at the intensive and secure residential recovery programs; and

(E) an assessment of whether the budget provides adequate capacity for Level 1 treatment through the end of the 2014 fiscal year and the estimated budget need for the duration of the 2015 fiscal year.

(2) The evaluation shall include a projection of the daily census need for Level 1 inpatient care in excess of the six beds projected to operate at the Rutland Regional Medical Center and the 14 beds projected to operate at the Brattleboro Retreat as of April 1, 2014. The Committees shall solicit input from those hospitals providing Level 1 care that will be discontinued once the state-owned and -operated hospital is opened. The Committees' evaluation shall be submitted to the House and Senate Committees on Appropriations on or before December 15, 2013.

(3) The evaluation shall assess the number and type of personnel necessary to staff the state-owned and -operated hospital in Berlin as of April 1, 2014. On or before December 15, 2013, the Mental Health Oversight Committee and the Health Care Oversight Committee shall make a recommendation to the Joint Fiscal Committee as to the number and type of personnel needed to operate the state-owned and -operated hospital on April 1, 2014.

(4) It is the intent of the General Assembly that the 2015 fiscal year budget provide adequate resources to fund fully the community programs as funded in fiscal year 2014 and inpatient capacity established in 2012 Acts and Resolves No. 79, including the 25 beds at the state-owned and -operated

hospital in Berlin. If the Mental Health Oversight Committee and the Health Care Oversight Committee in their evaluation and recommendation to the Joint Fiscal Committee find that less need exists than anticipated, the Joint Fiscal Committee may recommend reconsideration by the General Assembly.

(b) Each month between June and December 2013, the Department of Mental Health shall provide the following information to the Mental Health Oversight Committee and the Health Care Oversight Committee:

(1) The number of Level 1 patients receiving acute inpatient care in a hospital setting other than the renovated unit at Rutland Regional Medical Center, the renovated unit at the Brattleboro Retreat, and the Green Mountain Psychiatric Center in Morrisville, including the number of individuals treated in each setting and the single combined one-day highest number each month;

(2) The number of individuals waiting for admission to a Level 1 psychiatric inpatient unit after the determination of need for admission to emergency departments, correctional facilities, or any other identified settings is made and the number of days individuals are waiting;

(3) The total census capacity and average daily census of new intensive recovery residence beds opened in accordance with 2012 Acts and Resolves No. 79, and the annual daily census of the secure residential recovery facility in Middlesex. The census capacity shall not include a duplicate count for beds that replace those currently in operation elsewhere.