S.133 Testimony - House Committee on Health Care **April 7, 2017**

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Thank you for the opportunity to provide commentary on the issues of examining and improving the current mental health system in Vermont. This discussion could not be timelier, as the issues that are facing the mental health system, and in turn facing some of the most vulnerable individuals across our state, are continuing to compound, they are reaching a critical mass. In reading the bill as introduced, it notes that "care provided by the designated agencies is the cornerstone upon which the entire mental health system balances". Without a true understanding and appreciation of how the designated agency system and infrastructure works and benefits not only the people that we serve, but all Vermonters, the impacts will not be felt until that cornerstone starts to crumble.

The significant work that the designated agencies provide is much broader than simply critical mental health care, substance abuse treatment, and developmental disabilities services. Our work directly impacts the very fabric of all of our communities, the social determinants of health, and it supports a safe and healthy work force. This critical part of the health care system must be viewed in the context of ongoing generational care. When we are providing services to an individual, we are impacting everyone else that is part of that individual's life (family, friends, neighbors, employers, businesses, etc.). In most situations we are also providing parallel support services to other members of their families through the original client's care. Our important interventions positively improve family systems which has far-reaching effects. The impacts of this work can last for generations. As referenced in Section 1 (9), improving an individual's trajectory requires addressing the needs of children and adolescents in the context of their family. This means Vermont must work within a two-generational framework. It is not uncommon for multiple family members to be treated and for care to be coordinated across the spectrum of providers, with joint treatment as needed, and coordinated case consultations. The earlier, the sooner that we can become involved in helping families, the better the outcomes. Earlier intervention interrupts paths that were headed to repeated psychiatric hospitalizations, further abuse which is perpetuated generation after generation (and impacts health, safety, education), further costly substance use, further costs to the criminal justice system.

I had the opportunity to speak with the Senate Committee on Health and Welfare in regard to this bill in January of this year. **What was discussed then remains true today, if we as a state want to decrease reliance on emergency care, we need to adequately fund those tasked with providing the upstream preventative and community based care that will help keep people stable and out of more costly inpatient care and services**. To do that work with skill and compassion, it demands a skilled workforce that is valued and invested in by the legislature, the state, and the communities. We cannot continue to erode the ability to provide quality care for those with mental health challenges at their most vulnerable points in life and instead support them to remain productive and contributing members of our communities. Without the support of a skilled, strong community based system the likelihood of escalating crises hitting communities, involuntary psychiatric care and long emergency waits will only just continue. In light of these remarks, there are two specific sections of the proposed bill that I want to focus written commentary on.

<u>Section 10: Workforce Development</u>

The designated agency system has broad capacity and proven ability to serve the ongoing training needs of both experienced and newly hired staff. The system is able to provide for and connect with

opportunities for continuing education on evidence-based best practice topics across the continuum of need. We are often a training ground for interns and new graduates who must complete required hours of direct clinical work (while under clinical supervision) in order to pursue clinical licensure. Many graduate students choose to get their internship training through community mental health agencies because the exposure to a variety of client populations and the structure of an agency with professional supervision strengths. This training towards licensure requires oversight by a licensed staff member in select disciplines, in the case of social workers 3 years post-masters degree. The Clara Martin Center currently supports 7 different interns across all our programs, each with varying school requirements.

The workforce retention issue in the community mental health system impacts the future of those people who want to go into this professional field. The well-documented pay disparities of state employees and those of the designated agency system has created an alarming exodus of licensed staff to be able to provide the clinical supervision needed towards licensure, making it more challenging for new graduates to receive the quality oversight and qualified training to provide the best practice. A pattern has developed over the past few years that as we accommodate new graduates and provide rigorous training opportunities in evidence-based care, after three years of supervision required for licensure, a clinician passes their licensing exam and then shortly after leaves the DA system or is recruited away for higher paying positions at the state level. This is a stripping away of the community based system of a trained workforce that was just invested in, intense training that the DA is not compensated for providing. As this happens, the training cycle is continually repeating. Within the span of a year's time, the Clara Martin Center invested in certain staff members being trained in specific topics like Mental Health First Aid so those staff members could then return to the agency and train staff themselves on these best practices. Within a year, all staff members that had been trained ended up leaving the agency for higher paying jobs, taking that knowledge with them, resulting in the internal discussion on whether we could afford to restart the process of training new staff on this assessment model prior to being able to train internally. Examples such as this occur frequently and affect the ability to provide Dialectical Behavior Therapy, Reactive Attachment Therapy, Sex Offender Treatment, Batterer's Intervention Treatment and other specialty services that are not provided anywhere else across the community system.

The ongoing challenge of workforce development at the designated agency continues as staff turnover remains at all-time highs. Agencies are losing qualified, credentialed and experienced staff at alarming rates, leading to an inability to provide quality services to those seeking our care. In rural areas, this loss is felt even more profoundly. In the Bradford area of Orange County over the past two years, the workforce development and retention efforts became so challenging, that our agency needed to drastically scale back the ability to serve clients in our child and family program, to the point we could no longer provide routine services out in the community, at client's homes, schools, etc. The only option to see someone ongoing was for them to come into the office and even then there wasn't a guarantee that they would be able to meet with a trained clinician. Instead they were offered as best a wrap around plan with supportive case management services that could be cobbled together in an attempt to at least maintain some connection while continued recruitment efforts occurred. And that was only if they had transportation to get to the office. We have had to stretch other programs across our rural catchment area by taking some time from one program area and sending the staff to another site to help cover the needs. This puts a heavier burden on all the teams who are doing more work to help out and hoping that no one else resigns. As a client, having to constantly restart treatment with new providers, erodes trust in the institution itself, and can make people less willing to speak out and ask for help when they need it. This in turn can lead to an increase in critical situations of life and death that could have had the potential to be averted if there had been consistency in care.

As discussed in this section of the bill, there is intent to form a Workforce Study Committee with certain required members to participate. As written, a representative of the designated and specialized service agencies may be included. As the people providing the care, it is vastly important that we do have a representative on this committee to speak to what is working, what is needed, and evidence based care, so I would suggest that the DA representative not be an optional member, but one that is required to participate.

Section 12: Rates of Pay

The rate of pay is a significant issue of which the ultimate impact in the end is safety for our communities. When the erosion of a far-reaching community based designated system is slowly undermined, then the preventative interventions are reduced and opens up the communities to future risky events. The community mental health agencies are the eyes and ears for a community needs as well as giving individualized support to vulnerable people.

The rate of pay has not kept pace with cost of living, has not kept pace with other health care professions, has not kept pace with other health care institutions such as hospitals and doctor's offices, and not kept pace with comparable jobs at the state. The designated agencies spend two to three years training an individual and soon after that the individual leaves to obtain a higher rate of pay. The continual erosion of community mental health centers by low pay will have long term impacts on a community's health and safety and far-reaching negative financial impacts for other health care systems in the future.

As stated, when establishing rates of payment for designated and specialized service agencies, the Secretary shall adjust rates to take into account factors that include:

(1) The reasonable cost of any governmental mandate that has been enacted, adopted, or imposed by any State or federal authority

The financial burdens of unfunded mandates continue to impact availability of clinical services provided. The changes in supervised billing alone have drastically altered ways of practice and created barriers to care, as now licensed providers need to reduce their available clinical time to review and sign off on documentation for staff that have not achieved their licenses yet, and as previously stated, new graduates typically require 3 years of post-graduate clinical work in order to even be eligible to sit for licensure. In addition, licenses are not transferrable across disciplines, so a licensed social worker cannot supervise substance treatment provided, and vice versa, a licensed alcohol and drug counselor cannot supervise mental health treatment provided, even though best practice encourages co-occurring treatment and integration. For our agency, that results in many times where a clinician will have two distinct billing supervisors overseeing one client's care.

Additional examples of unfunded mandates that impact the system include disaster response in relation to both natural disasters as well as human made disasters/tragedies. When a tragic situation occurs in the community, usually one of the first calls after emergency medical services is a call out to the local designated agency to coordinate on-scene responses and provide psychological first aid. As one Emergency Services Director shared the impact of this issue for their agency:

> "We have had a number of tragic civil events in our county in the last 2 years. Our Disaster Response Team, along with our screeners, has had to respond to multiple events. As you know, those hours and hours of response (and capacity availability) are not billable and create

immense stress for our system. Of course this is a service we want to provide our community but it is overwhelming when it is not funded and yet is an expectation. (Four recent tragic events in our county all happened on the weekend so that makes it even more complicated to find 'volunteers' at the agency who are willing/able/available to respond.)

Thank you for the opportunity to speak with the committee today, and consideration of these remarks as you continue the work you do to address issues at the state level this legislative session.

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