White Paper

CREATING A NETWORK OF PEER-RUN COMMUNITY CENTERS AND TWO-BED PEER RESPITES

Narrowing the Gap in Recovery-Oriented Community Services

This White Paper offers an analysis of the risks and challenges posed by Vermont's planned investment in additional inpatient psychiatric beds, and makes recommendations to mitigate the risks, address the challenges, and realize Vermont's goal of a "recovery-oriented" system of mental health care.

Alyssum, Another Way Community Center, Pathways Vermont, and Vermont Psychiatric Survivors

April 2019

CREATING A NETWORK OF PEER-RUN COMMUNITY CENTERS AND TWO-BED PEER RESPITES

Narrowing the Gap in Recovery-Oriented Community Services

Introduction

In 2018, the Vermont legislature allocated $5.5 million to the Brattleboro Retreat to create 12 additional inpatient, psychiatric beds.[1] Those beds are slated to open in 2020. The UVM Health Network also plans to add 25 inpatient, psychiatric beds at Central Vermont Medical Center (CVMC) at a cost in excess of $20 million.[2] These additional, 37 inpatient, psychiatric beds will bring the total inpatient, psychiatric beds in Vermont to 239, a nearly 60 percent increase since 2012, the year the Vermont legislature adopted Act 79.[3]

In enacting Act 79, the Vermont legislature declared an intent to strengthen Vermont's existing mental health care system by offering a continuum of community and peer services. The goal was a "flexible and recovery-oriented" mental health system of care.[4] A "recovery-oriented" mental health system requires a broad range of services in the community rather than crisis-oriented, institutional care, such as inpatient hospitalization. One of the hallmarks of a recovery-oriented system is the provision of peer-run programs and services.[5]

Peer-run programs are programs or services that are controlled and operated by people with lived experience of the mental health system or mental health challenges and emphasize a non-judgmental, values-driven approach that promotes multiple perspectives, advocates for human rights and dignity, and focuses on genuine, mutual relationships that enrich the lives of those involved. Research has shown that peer-run programs result in significantly fewer hospitalizations.[6]

Vermont's investment in a "continuum of community and peer services," has not kept pace with its investment in inpatient hospitalization. Since enacting Act 79, Vermont's investment in peer services has constituted just one percent of the Department of Mental Health's (DMH) annual budget.[7]

Most stakeholders agree that Vermont needs more community-based alternatives. For example, the proponents of the additional inpatient psychiatric capacity warn that "once new inpatient capacity is built, it will remain imperative that Vermont explore alternative care settings, including enhanced community-based care settings."[8]

Purpose of White Paper

This White Paper offers an analysis of the risks and challenges posed by Vermont's planned investment in additional inpatient psychiatric beds, and makes recommendations to mitigate the risks, address the challenges, and realize Vermont's goal of a "recovery-oriented" system of mental health care.

Background

In August 2011, Vermont lost 54 inpatient psychiatric beds after Tropical Storm Irene destroyed Vermont State Hospital. The next year, Vermont passed Act 79. The Act's goal was to create a system of care grounded in and shaped by principles of recovery, integrated community living, adequate supports, and the least restrictive care as close to an individual's home as possible.[9]

After the State hospital's closure, inpatient psychiatric care came to be delivered through a decentralized system of designated hospitals across the state. In its 2013 report on the implementation of Act 79, the Department of Mental Health wrote:

> "The total number of inpatient beds in a state-operated psychiatric hospital will not return to the previous level, as expanded residential and outpatient services will allow a shift in care to more services in less restrictive settings."[10]

Two years later, in 2015, Vermont had more inpatient beds (188) than it had before loss of the Vermont State Hospital (184). Vermont added additional capacity in 2017 and 2018. The additional capacity was ostensibly intended to address prolonged emergency department waits for psychiatric patients that many have attributed to the loss of Vermont State Hospital.

However, prolonged emergency department waits for psychiatric patients are not unique to Vermont. They are a national phenomenon. Nationally, psychiatric patients wait more than twice as long as non-psychiatric patients.[11]

In 2018, Vermont Psychiatric Survivors (VPS) interviewed 25 individuals and reviewed their 2016 to 2018 hospital records to understand the drivers of emergency department visits. The interviews and chart review suggested that homelessness, the pain of isolation, interpersonal conflict in the home, and mania were leading causes of voluntary emergency department visits. (In federal fiscal year (FFY) 2018, 95 percent of visits to Vermont emergency departments for mental health care were voluntary.[12])

In the VPS study, nearly all individuals experiencing homelessness presented to the emergency department because they were homeless. While they reported suicidal ideation, they also reported feeling suicidal because they were experiencing homelessness. One man's records revealed that he had overdosed on the Prozac prescribed after a previous emergency department visit because "he had nowhere to go."[13]

Individuals experiencing homelessness averaged five emergency department visits per year; individuals adequately housed averaged less than one visit per year. When asked what would have obviated the need for a visit to the emergency department, the most frequent responses were housing (75%), friends, supportive family, physical affection, and someone with whom to talk. These individuals also stated they did not know anything to do for their distress other than visit the emergency department.[14]

While it is not clear how generalizable are these results as this was not a random sample and the sample size was small, the VPS study does suggest that the lack of community resources

and community supports contributes to increased emergency department visits and inpatient admissions. Other research studies support the validity of these results. For example, homelessness has been identified as a factor in prolonging a psychiatric patient's wait in the emergency department[15] and in extending a psychiatric patient's length of stay once admitted.[16]

Clients of Vermont's community mental health agencies also report lower "improved social connectedness from services" and lower "improved functioning from services" than their U.S. counterparts.[17] This finding is consistent with the feelings of social isolation and lack of service alternatives expressed by the VPS study cohort.[18]

Finally, Vermont's investment in additional inpatient beds is based on an assumption that prolonged waits in emergency departments are caused by a bottleneck in inpatient beds. A bottleneck is the one step in a chain of steps, whose limited capacity reduces the capacity of the whole chain. You can usually identify a bottleneck by the step in a chain of steps that accumulates the longest waits or lines. However, this is not always the case.

Take what happens in grocery stores, for example. When lines occur at the check-out stand, managers will often call for more cashiers, assuming that the cashier is the bottleneck because that is the site of the long line. However, studies have shown the bottleneck is actually the lack of a bagger. It is more efficient to add a bagger than an additional cashier, assuming a dedicated bagger is not already a part of the process.

The proponents of additional inpatient beds have assumed that the bottleneck in the mental health system is caused by too few inpatient beds because the waits are in emergency departments for inpatient beds. However, like the bagger in the grocery store example, the bottleneck may actually be insufficient community resources or inadequate alternatives to emergency departments, rather than simply a shortage of inpatient psychiatric beds.

Simply increasing inpatient capacity without offering a continuum of community and peer services, such as peer/crisis respites, housing, and opportunities for social connection, may result in a revolving door of multiple acute treatment episodes which in itself generates the need for additional inpatient capacity.

Risks and Challenges

Vermont's planned increase in inpatient beds poses risks and challenges that if not addressed will further strain Vermont's mental health system. These risks and challenges include: (1) increased barrier days; (2) shortages of nurses and psychiatrists; (3) loss of Medicaid funding through the IMD exclusion; and (4) increased risk of suicide.

Increased barriers days

The number of days Vermont psychiatric patients spend in the hospital (length of stay) has increased over the last several years. While some of the increase is attributable to more refractory illnesses, a 2017 University of Vermont Medical Center study revealed that 62 percent of patients who had lengths of stay greater than 30 days at UVM Medical Center between October 2014 and March 2017 were hospitalized longer than medically necessary because of a lack of community resources.[19] This phenomenon creates barrier days, defined

as the number of days from when a patient is ready to be discharged to the actual day of discharge. The unavailable community resources that precluded discharge included (1) housing; (2) step-down programs; (3) transportation to outpatient treatment; and (4) a support system.[20] The Brattleboro Retreat has also identified "bottlenecks in the system," and a lack of step-down services as a barrier to discharge for its patients.[21]

In the UVM study, total barrier days utilized two inpatient beds for non-medically necessary reasons and caused the lost opportunity to treat 57 patients annually.

Without an additional investment in community resources, the planned increase in inpatient beds will lead to yet more barrier days, effectively reducing inpatient capacity despite the addition of new beds.

Staffing shortages

Vermont is banking on increased inpatient capacity to address prolonged emergency department waits. However, beds alone do not increase capacity. Those beds must also be staffed with nurses and psychiatrists. In January 2019, the representative of the trade association for Vermont hospitals testified in the legislature that "despite paying competitive wages, hospitals continue to struggle with hiring, and [their] provider partners at all levels are faced with the same challenge."[22] Vermont Psychiatric Care Hospital (VPCH) opened in 2014 and five years later it is still challenged by nursing shortages that have at times required the hospital to close beds.[23]

Loss of Medicaid Funding through IMD Exclusion

Federal funding under Medicaid is generally not available for any services provided to a Medicaid-eligible adult between the ages of 21 and 65 while that adult is an inpatient at an "Institution for Mental Diseases" (IMD). An IMD is defined as a facility with more than 16 beds that is "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases." If the Centers for Medicare and Medicaid Services (CMS) determines that a facility is an IMD, the facility loses federal Medicaid funding for all of the care it delivers, not only mental health care.[24]

UVM Health Network's decision to expand its inpatient psychiatric capacity at CVMC from 15 to 25 puts the hospital at risk of the IMD exclusion. CMS will not determine whether a facility is an IMD until after the capacity has been added.

In addition, while Vermont is currently operating with a waiver of the IMD exclusion, CMS has required Vermont to submit a phase-down schedule for the de-funding of its IMDs. Vermont's current IMDs include VPCH and the Brattleboro Retreat. The loss of federal funding for Vermont IMDs will drastically shrink Vermont's inpatient psychiatric capacity.[25]

It is critical that Vermont close the gap in community resources well before the loss or threatened loss of Vermont's IMD exclusion waiver.

Increased risk of suicide

Vermont's planned increase in inpatient psychiatric beds increases the risk of suicide because individuals are at a dramatically high risk for suicide for at least a month following

discharge from a psychiatric hospital.[26] This is not a benign consideration. Vermont's rate of suicide already exceeds national averages.[27] Between 2015 and 2016, 32 percent of the Vermonters who took their own lives were receiving mental health treatment.[28]

Vermont must insure that there is a continuum of recovery-oriented resources in the community sufficient to engage and support individuals as soon as they leave psychiatric hospitals and beyond.

Recommendation

Fund the Creation of a Network of Six, New, Peer-Run Community Centers with Attached Two-Bed Respites

There seems to be little disagreement that Vermont must invest in additional, community resources. For example, the Agency of Human Services stated in its 2019 Report to the Legislature:

> "… there is a continuing need and opportunity to provide increased community capacity to offset unnecessary ER wait times or inpatient admissions."[29]

However, there has been little to no public discussion about what those investments should be.

Ideally, future investments should (1) align with the goal of a recovery-oriented mental health system; (2) significantly increase community capacity to keep pace with planned inpatient psychiatric beds; and (3) mitigate the risks and address the challenges created by the planned increase in inpatient psychiatric beds.

Applying this rubric, we recommend Vermont fund the creation of a network of at least six, new, peer-run community centers with attached two-bed respites to be located across Vermont in a manner to increase the likelihood of care as close to an individual's home as possible.

While the Network will not close the entire gap in Vermont's community capacity, the Network is an effective and efficient way to (1) divert individuals away from inpatient hospitalization; (2) provide a step-down from inpatient hospitalization; and (3) provide community services the lack of which currently create barrier days, all without increasing the risk of suicide. The Network would also disrupt the revolving door of inpatient hospitalization for acute episodes by offering peer programs in the community that promote resilience, connection, and belonging.

The Network would not face the same staffing challenges as hospitals and designated agencies. It is much faster to train peer workers than psychiatrists and nurses. The Network would also be unaffected by the IMD exclusion and could be up and running before the phase out of Vermont's IMD Medicaid funding.

The Network

The Network would be a statewide association of six, peer-run community centers, each with an affiliated two-bed, peer respite, located in communities across the state. The Network would serve individuals who lack meaningful social and community connection and who do not or cannot get their needs met in a traditional, mental health clinical setting. Formally trained peer staff would provide community-based, trauma-informed, person-centered support to prevent and help individuals overcome mental health challenges and crises. Programs such as these are associated with significantly decreased hospitalizations.[30]

The Network provides an opportunity for care and concern that is not segmented by funding source or diagnosis, such as the traditional split between mental health, addiction or homelessness. The Network would embrace the whole person, whatever their challenges.

Peer-Run Community Centers

Community centers address the social isolation and lack of social connectedness that some emergency department visitors say they feel. Similar to the Vermont Recovery Network's (VRN) recovery centers, the peer-run community centers would offer a range of services, including peer support, support groups, assistance in obtaining housing and employment, transportation to outpatient appointments, art, music and educational activities, meals, Internet access, body work, recreation, exercise, and showers. The centers would also offer participants opportunities to develop new social and interpersonal networks and to become full members of an inclusive and accepting community.

Community centers would also teach attendees how to live in a more community-supported and resilience-based way, grounded in close personal connections and community connectedness. The community centers would also focus on providing peer support to people experiencing homelessness. Meta-analysis of peer-reviewed, research has shown that Intentional Peer Support, the modality to be used by the proposed network, resulted in a significant reduction in drug/alcohol use, improved mental and physical health, and increased social support for people experiencing homelessness.[31]

There are currently two peer-run community centers in Vermont: Another Way in Montpelier (founded in 1984) and Pathways Community Center in Burlington, which opened its doors in May 2012. Together they serve more than 1,000 unique, individuals annually.[32] Both centers are particularly adept at using peer support to aid those experiencing homelessness in a way no other support services can or do.[33]

Peer-run Respites

Peer respites are voluntary, short-term, overnight programs that provide community-based, trauma-informed, and person-centered crisis support and prevention 24 hours a day in a homelike environment.

In control-group, research studies, guests of peer respites were 70 percent less likely to use inpatient or emergency services. Respite days were associated with significantly fewer inpatient and emergency service hours.[34] Respite guests showed statistically significant improvements in healing, empowerment, and satisfaction. Average psychiatric hospital costs were $1,057 for respite users compared to $3,187 for non-users.[35] Respite guests also

experience greater improvements in self-esteem, self-rated mental health symptoms, and social activity functioning compared to individuals in inpatient facilities.[36]

Vermont currently has one, two-bed, peer-run, respite named Alyssum[37]. Located in Rochester, Alyssum operated at 92 percent capacity in FY2018, had a five-day wait time for a bed, and drew guests from every Vermont county save Essex, Lamoille, and Grand Isle. In contrast, crisis respites run by designated agencies operated at 75 percent capacity in FY2018, below DMH's targeted 80 percent occupancy rate.[38]

The under-utilization of crisis beds run by designated agencies, Alyssum's high occupancy rate and the five-day wait for an Alyssum bed are all indicative of a preference and need for additional, peer-run respites in Vermont.

Funding Recommendations

Startup Costs

The proposed roll-out calls for opening one center in year one, two centers in years three and four, and three centers in years five and six.

There are two possible organizational structures. In Scenario One, each community center and adjoining peer respite would operate independently. Each would be governed by its own Board of Directors and each would be managed by an Executive Director.

In Scenario Two, the six community centers/peer respites would be part of a Network. The Network would be managed by a single Executive Director. The Executive Director would be supported by a Business Manager, a Director of Development, and an Administrative Assistant. A Program Director and House Manager would oversee the day-to-day operations at each community center/peer respite.

The Network approach allows the six community centers/peer respites to achieve economies of scale and relieves each community center/peer respite of administrative responsibilities, allowing them to focus exclusively on programming.

Startup costs for each scenario, by year, are as follows:

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Centers at Year End	0	1	1	2	3	5	6
Independent	$164,075	$50	$164,025	$154,075	$323,699	$169,825	$1,550
Network	$316,896	$1,550	$58,800	$60,350	$92,350	$73,600	$4,050

Total startup costs under the independent structure and network structure are $987,299 and $590,966, respectively.

A detailed itemization of startup costs for each scenario is included in the Appendix.

Projected Annual Budget

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Centers at Year End	1	1	2	3	5	6
Independent	$832,049	$835,505	$1,678,336	$2,529,153	$4,235,837	$5,109,183
Network	$1,156,032	$1,160,971	$1,952,194	$2,750,190	$4,348,222	$5,173,440

The Network structure will achieve cost-savings over the long-term by centralizing administrative functions such as human resources, bookkeeping, executive management, staff development, fundraising, communications, and oversight by a single board of directors. The projected budgets are conservative; therefore, not all possible cost-savings are reflected in the projected budgets. In addition, the Network structure has the advantage of a full-time Director of Development which will allow the Network to raise money to fund additional programs and services and offset the Network structure's larger, annual budget. This offset is not included in the budget provided.

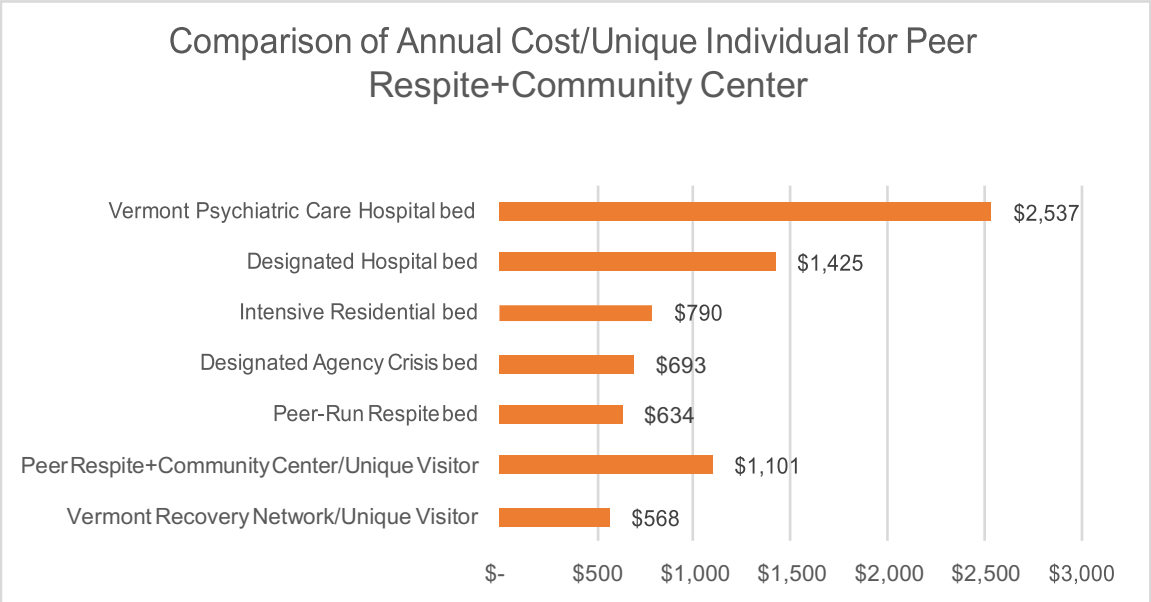
A more detailed budget for the independent structure is included in the Appendix.

Return on Investment

Based on the operational statistics of current community centers, we project that by year six, when all six peer respites/community centers are projected to be operational, the six community centers will serve a minimum of 4,100 unique guests a year. By year eight, when all six community centers will have been operational for at least three years, the community centers will serve a minimum of 4,500 unique visitors a year.

The six peer respites will serve approximately 540 guests a year, assuming an average occupancy rate of about 87 percent and an average length of stay of one week. The six additional peer respites will raise the total number of peer respite/crisis beds in Vermont from 38 to 50, a 31 percent increase.

The annual cost per unique guest/visitor when all six entities are fully operational in year 6 is approximately $1,101. The following chart compares the cost of various interventions against the center-respite's annual cost per each unique individual served.[39] As the chart reveals, the annual cost per unique individual ($1,101) is less than the combined annual cost per unique visitor/guest to a VRN recovery center and a peer-run respite bed ($1,202).



Not only does the proposed Network cost less than other options, it also includes more services and benefits. The Network of center-respites provides a support person available around the clock, high-quality, nutritious food, and wraparound services, including support for establishing and strengthening social support networks, and support for addressing issues of community integration such as housing, employment, meaning making, and other social determinants of health.

The investment will also create much needed jobs for people with lived experience of mental health challenges, a segment of the population that is impacted by high rates of unemployment due to discrimination.[40] The Network structure will create 20 jobs in year one, and 98 in year six, with a weighted average wage per new job created of $21.64 per hour.

Finally, the Return on Investment (ROI) is 45 percent ($7,164,824), based on savings from diverting individuals from inpatient hospitalization. If you include the additional savings achieved by providing a stepdown option for individuals who are currently hospitalized or who would be hospitalized for longer than medically necessary because of the unavailability of a stepdown facility, the ROI is 91% ($14,284,348).[41]

Funding Source

We recommend that Vermont allocate money from the tobacco Master Settlement Agreement (MSA) to fund the Network. Vermont receives millions of dollars annually, in perpetuity, from the tobacco MSA. Vermont's 2017 payment was $35 million, and its 2018 payment was $59 million.[42]

The tobacco industry specifically and deceptively marketed cigarettes to patients with mental health diagnoses and worked successfully to exempt psychiatric hospitals from smoking bans.[43] Psychiatric hospitals have historically rewarded patients with cigarettes or outdoor smoke breaks for good behavior or medication compliance[44] and requested and accepted free or cheap cigarettes from tobacco companies.[45]

Given the tobacco industry's deceptive practices to promote and maintain cigarette use among people with mental health diagnoses, it is only just that a share of the settlement proceeds be devoted to the health needs of psychiatric survivors.

The Volkswagen settlement, the proceeds from which will become part of Vermont's general fund, is another source of money to fund the start-up costs of the Network. Locating community resources closer to an individual's home reduces car travel, which in turn reduces air pollution and emissions which are consistent with the purpose of the settlement.

About the Authors

Alyssum

Alyssum provides a two-bed peer-run, short-term, mental health alternative to hospitalization in a trauma informed program which supports individuals to emerge from crisis with wisdom, new perspective and the personal responsibility skills for living well.

Alyssum is home-like and provides a calming and comfortable environment where people feel safe sharing and connecting with others. Guests are encouraged to focus on self-determined

goals and to decide for themselves how they would like to work on these goals. Guests create their own healing program with support and/or guidance from staff throughout this process.

Alyssum's staff have all experienced personal mental health challenges and bring their learned experience, wellness tools and other resources to support guests as equals. Staff are awake and available 24/7, often with a 1:1 staff-to-guest ratio. Staff practice being non-judgmental and curious and have been trained in Intentional Peer Support, Wellness Recovery Action Planning, Non-Violent Communication, and trauma-informed supports.

Another Way Community Center

Founded in 1984 in Montpelier, Vermont, Another Way Community Center provides a safe and friendly place to share community, to network, and to learn from one another. Another Way welcomes everyone, especially persons seeking to overcome struggles and live well. Another Way grew out of the psychiatric survivor movement to counter oppressive systems of control and it continues to advocate for freedom and self-determination of care.

Pathways Vermont

Pathways Vermont supports people to live and thrive in the community at times in their lives when they are most distressed: when they are struggling with thoughts of suicide, are experiencing homelessness, incarceration, institutionalization, mental health struggles or substance use challenges.

Pathways Vermont is the first and largest Housing First organization in Vermont, providing permanent housing without requirements or barriers. This evidence-based model has been proven to be the most successful approach to ending and preventing homelessness. Through their Housing First programs, Pathways serves people struggling with mental health and substance abuse issues, as well as veterans, families, and people coming out of correctional facilities and other institutions.

Pathways Vermont uses a peer-supported alternative approach to mental health in which individuals with lived experience of mental health challenges guide and aid those experiencing similar challenges. From their Community Center that provides peer support in a friendly setting, to the Soteria House which supports people experiencing mental health crises for the first time, to our seven days/week, non-judgmental phone Support Line, their programs have an immeasurable impact on the everyday lives of our neighbors in need.

Vermont Psychiatric Survivors

Vermont Psychiatric Survivors, Inc. (VPS) is an independent, statewide mutual support and civil rights advocacy organization run by and for psychiatric survivors. Founded in 1983, its mission is to provide advocacy and mutual support that seeks to end psychiatric coercion, oppression and discrimination.

VPS offers mutual support, publishes a quarterly newspaper that is distributed throughout Vermont, offers patient representation in Vermont psychiatric hospitals and residential facilities, sponsors peer-led support groups, offers technical assistance to allied organizations, and advocates and educates to challenge discrimination.

Endnotes

[1] Josephson, Louis. "Overview & Update: Capitol Plaza Hotel, Montpelier, Vermont," p. 18 (February 22, 2019: Brattleboro Retreat).

[2] Noonan, Anna T. "Green Mountain Care Board Psychiatric Inpatient Capacity Planning Update," p. 6 (February 20, 2019: The University of Vermont Health Network).

[3] Vermont Department of Mental Health. "Vermont2019 Reforming Vermont's Mental Health System: Report to the Legislature on the Implementation of Act 79," p. 10 (January 15, 2019: Vermont Department of Mental Health, Agency of Human Services).

We use 2012 as a base year because that was the year Vermont adopted Act 79, which set out Vermont's vision for its mental health system.

Vermont lost 54 inpatient beds in August 2011 from the destruction wrought by Tropical Storm Irene. In 2013, the Department of Mental Health wrote that "[t]he total number of inpatient beds in a state-operated psychiatric hospital will not return to the previous level, as expanded residential and outpatient services will allow a shift in care to more services in less restrictive settings." *See* "Vermont 2013 Reforming Vermont's Mental Health System: Report to the Legislature on the Implementation of Act 79," p. 9, (January 15, 2013: Department of Mental Health Agency of Human Services).

If one uses pre-Tropical Storm Irene as a base year, the planned, additional inpatient capacity constitutes a 30 percent increase over pre-Tropical Storm Irene levels.

[4] Act 79, Sec. 1.

[5] The National Consensus Statement on Mental Health Recovery (February 2006: Substance Abuse and Mental Health Services Administration)

[6] Mead, S., & Hilton, D. (2003). Crisis and Connection, *Psychiatric Rehabilitation Journal*, 27, 87-94; Dumont, J. & Jones, K. (2002, Spring). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook*, 4-6; Burns-Lynch, B., & Salzer, M.S. (2001). Adopting innovations – lessons learned from a peer-

based hospital diversion program. Community Mental Health Journal, 37, 511-21.

[7] Squirrel, Sarah; Fox, Mourning; Thompson, Shannon. "FY20 Budget Presentation," p. 13 (February 11, 2019: Vermont Department of Mental Health); Bailey, Melissa. "FY2018 Budget Presentation," p. 11 (February 9, 2017: Vermont Department of Mental Health).

In FY 2018, DMH's investment in peer services was $2,686,850 out of a total budget of $225,103,851. In its proposed FY2020 budget, DMH proposes an investment in peer services of $2,499,767, out of a total budget of $240,166,999.

[8] Brumstead, John, "UVM Health Network quarterly report on inpatient mental health capacity," p. 5 (October 15, 2018: University of Vermont Health Network).

[9] 18 V.S.A. §7251.

[10] Department of Mental Health. Vermont 2013 Reforming Vermont's Mental Health System: Report to the Legislature on the Implementation of Act 79, p. 9, (January 15, 2013: Department of Mental Health Agency of Human Services).

[11] White, Wilda L. "ED Waits Literature Review – As Presented," presented at DMH S.133/Act 82 Public Meeting on August 17, 2017, https://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Literature_Review_of_ED_Waits_Presented_Aug_17_2017.pdf

[12] Vermont Department of Mental Health. Vermont 2019 Data Collection and Report; Patients Seeking Mental Health Care in Hospital Settings: Report to the Legislature, pp. 3 and 5 (January 31, 2019: Vermont Agency of Human Services, Department of Mental Health).

[13] Vermont Psychiatric Survivors. *Report-Addendum to the Legislature on the Implementation of Act 82 Sec. 5, Involuntary Treatment & Medication Review*, January 15, 2018, at p. 4. Accessed on March 8, 2019, https://legislature.vermont.gov/Documents/2018/WorkGroups/House%20Health%20Care/Reports%20and%20Resources/W~Vermont%20Psychiatric%20Survivors~Report-%20Addendum%20to%20the%20Legislature%20on%20the%20Implementation%20of%20Act%2082%20Sec.%205,%20Involuntary%20Treatment%20and%20Medication%20Review.%201-15-2018~5-4-2018.pdf

[14] Vermont Psychiatric Survivors. *Report-Addendum to the Legislature on the Implementation of Act 82 Sec. 5, Involuntary Treatment & Medication Review*, January 15, 2018, at p. 4. Accessed March 8,

2019, https://legislature.vermont.gov/Documents/2018/WorkGroups/House%20Health%20Care/Reports%20and%20Resources/W~Vermont%20Psychiatric%20Survivors~Report-%20Addendum%20to%20the%20Legislature%20on%20the%20Implementation%20of%20Act%2082%20Sec.%205,%20Involuntary%20Treatment%20and%20Medication%20Review.%201-15-2018~5-4-2018.pdf

[15] Weiss AP, Chang G, Rauch SL, Smallwood JA, Schechter M, Kosowsky J, Hazen E, Haimovici F, Gitlin DF, Finn CT, Orav EJ. Patient- and practice-related determinants of emergency department length of stay for patients with psychiatric illness. *Ann Emerg Med.* 2012 Aug;60(2):162-71.e5. doi: 10.1016/j.annemergmed.2012.01.037. Epub 2012 May 2. PMID: 22555337

[16] Hoar, Eve MBA; Desjardins, Isabelle, MD; Whalen, Eileen MHA, RN. "Inpatient Psychiatry Barrier Days Analysis," p. 1. (May 31, 2017: University of Vermont Medical Center). https://mentalhealth.vermont.gov/sites/mhnew/files/documents/News/82/Inpatient_Psychiatry_Barrier_Days_Analysis.pdf

[17] Vermont 2017 Mental Health National Outcomes Measures: SAMHSA Uniform Reporting System, Outcomes Domain: Change in Social Connectedness and Functioning, FY 2017, p. 22 (2017 SAMHSA Uniform Reporting System (URS) Output Tables).

[18] Twenty-three members of the VPS cohort (about 90 percent) were or had been clients of a designated agency (DA) at one time or another.

[19] Hoar, Eve MBA; Desjardins, Isabelle, MD; Whalen, Eileen MHA, RN. "Inpatient Psychiatry Barrier Days Analysis," p. 1. (May 31, 2017: University of Vermont Medical Center). https://mentalhealth.vermont.gov/sites/mhnew/files/documents/News/82/Inpatient_Psychiatry_Barrier_Days_Analysis.pdf

[20] Ibid. at p. 4.

[21] Josephson, Louis, PhD. "Brattleboro Retreat: Overview & Update," Capitol Plaza Hotel, Montpelier, Vermont, p. 11 (February 22, 2019: Brattleboro Retreat).

[22] Green, Devon. "Vermont Hospital Challenges," p. 2 (January 22, 2019: Vermont Association of Hospitals and Health Systems).

[23] Hewitt, Elizabeth, "Nursing shortage closes unit of Vermont psych hospital," *vtdigger.org*, August 10, 2015, https://vtdigger.org/2015/08/10/nursing-shortage-closes-unit-of-vermont-psych-hospital/

[24] Noonan, Anna T. Rn, BSN, MS. "Green Mountain Care Board Psychiatric Inpatient Capacity Planning Update," at pp. 12-13. (February 20, 2019: The University of Vermont Health Network).

[25] Gobeille, Al, Secretary, Vermont Agency of Human Services. "Report on Vermont's Institutions of Mental Disease: Act 200 of 2018," p. 4. (January 15, 2019 (revised January 30, 2019): State of Vermont Agency of Human Services).

[26] Ping Qin, M.D., Ph.D; Merete Nordentoft, MD, Ph.D.; *Suicide Risk in Relation to Psychiatric Hospitalization Evidence Based on Longitudinal* Registers. Arch Gen Psychiatry. 2005; 62(4):427-432; Freedenthal, Stacey, Ph.D., LCSW, "The Most Dangerous Time: Suicide after Discharge from a Psychiatric Hospital," (May 30, 2013: Speaking of Suicide.com) http://www.speakingofsuicide.com/2013/05/40/suicide-after-hospitalization/#sthash.rSqzL3wL.dpuf

[27] Delaney, Tom, PhD, "Identifying Trends and Patterns in Vermonters Who Die by Suicide," p. 2 (February 14, 2019: Vermont Child Health Improvement Program, University of Vermont College of Medicine).

[28] Krompf, Alison; and Dolan, Tracy. "Suicide Prevention Update 2019, p. 9. (2019: Vermont Department of Health).

[29] Vermont Agency of Human Services. Vermont 2019 Evaluation of the Overarching Structure for the Delivery of Mental Health Services: Report to the Legislature, pp. 5, 43 (January 15, 2019: Vermont Agency of Human Services).

[30] Mead, S., & Hilton, D. (2003). Crisis and Connection, *Psychiatric Rehabilitation Journal*, 27, 87-94; Dumont, J. & Jones, K. (2002, Spring). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook*, 4-6; Burns-Lynch, B., & Salzer, M.S. (2001). Adopting innovations—lessons learned from a peer-based hospital diversion program. Community Mental Health Journal, 37, 511-21.

[31] Barker, Stephanie L.; Maguire, Nick. "Experts by Experience: Peer Support and its Use with the Homeless," *Community Ment Health J* (2017) 53: 598-612. DOI 10.1007/s/0597-017-0102-2.

[32] Another Way Community Center. "Another Way Community Center FY2018 Grant Reporting," at p. 1. (June 30, 2018). Available from Another Way Community Center and the Vermont Department of Mental Health.

[33] See European Federation of National Organizations working with the Homeless Policy Paper. "Peer Support: A Tool for Recovery in Homelessness Services," (October 3, 2015: European Federation of National Organizations working with the Homeless).

[34] Croft, B, & Isvan, N. (2015). Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services, *Psychiatric Services*, 66(6), 632-637

[35] Greenfield, T.K., Stoneking, B, Humphreys, J, Sundby, E, & Bond, J. (2008). A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis. *American Journal of Community Psychology*, 42(1), 135-144.

[36] Dumont, J, & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook* (Vol. Spring 2002, pp. 4-6). Cambridge, MA: Evaluation Center @ HSRI and National Association of State Mental Health Program Directors (NASMHPD) Research Institute.

[37] Peer-run is defined as autonomous organizations that are fully controlled by people with lived experience of mental or emotional challenges and/or the mental health system. Full control includes complete authority over policy, fiscal/budget, personnel and programming decisions.

[38] van den Berg, Gloria. "Alyssum Fiscal Year 2018 Fourth Quarter and Year End Program Report," at pp. 1-3. (June 30, 2018). Available through the Vermont Department of Mental Health and Alyssum.

[39] Vermont Care Partners. "FY2018 Outcomes and Data Report," p. 14 (2018); Vermont Department of Health, Division of Alcohol and Drug Abuse Programs. "Annual Overview 2017," p. 3 (2017). Accessed on March 8, 2019 http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Annual_Overview.pdf

[40] Stuart, Heather. (2006). Mental Illness and employment discrimination. Current opinion in psychiatry. 19. 522-6. 10.1097/01.yco.0000238482.27270.5d.

[41] Return on investment (ROI) is the gain from an investment less the cost of the investment divided by the cost of the investment. Here, ROI is calculated based on costs and gains over the first six years of the Network's operation.

The gain from the Network investment ($30,039,099) are savings achieved by diverting individuals from both emergency departments and inpatient hospitalization. The calculation assumes that 79

percent of the Network's guests would have sought treatment in the emergency department had a Network bed not been available. That assumption is based on the profile of Alyssum's current guests, 79 percent of whom are diverted from emergency departments and hospitalization.

The calculation assumes that 50% of the respites' guests who were treated in the emergency department would have been hospitalized for an average length of stay of 20 days. Twenty days is the average length of stay for Vermont psychiatric patients. Vermont's psychiatric patient admission rate in FFY2018 was 50%.

The ROI also includes savings from approximately 14 patients each year who would have been timely discharged from inpatient hospitalization as a result of the Network's added capacity, and thereby avoided the costs of barrier days.

The cost of the investment ($15,754,741) includes startup costs and the Network's annual expenses in years one through six.

The calculation uses $1,560 as the daily cost of hospitalization, which is the weighted average cost of an inpatient bed in Vermont. The calculation uses $1,759 as the cost of an emergency department visit, as reported by the 2018 Hospital Report Card Comparative Pricing Summary for Vermont accessed on March 8, 2019. http://www.healthvermont.gov/sites/default/files/documents/pdf/CPT_3D_2018.pdf.

[42] https://www.kff.org/health-costs/state-indicator/tobacco-settlement-payments/?currentTimeframe=1&selectedRows=%7B%22states%22:%7B%22vermont%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D Accessed on March 8, 2019.

[43] The tobacco industry promoted research that has been since discredited that attempted to prove that patients with a diagnosis of schizophrenia were less susceptible to lung cancer. Tobacco companies also funded research to support the idea that people with a diagnosis of schizophrenia needed to smoke as a form of self-medication – an idea that is unsupported by any evidence[43] and hired a psychiatrist to persuade the Food and Drug Administration Drug Abuse Advisory committee that nicotine is nonaddictive. *See* Prochaska, Judith J., Hall, Sharon M., and Bero, Lisa A. "Tobacco Use Among Individuals with Schizophrenia: What Role Has the Tobacco Industry Played?" Schizophrenia Bulletin 34.3 (2008): 555-567. PMC. Web. 29 Nov. 2015; Cloninger CR. *The State of Texas vs.*

the American Tobacco Company, et al. Videotaped Oral Deposition of C. Robert Cloninger.

[44] Hall SM, Prochaska JJ. Treatment of smokers with co-occurring disorders: emphasis on integration in mental health and addiction treatment settings. *Annu Rev. Clin Psychol* 2009; 5:409-31.

[45] Torry EF. Cigarette donation request for long-term psychiatric patients https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/#id=qxxw0083

APPENDIX

CREATING A NETWORK OF PEER-OPERATED COMMUNITY CENTERS AND PEER RESPITES
PROJECTED SIX-YEAR SUMMARY BUDGET

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Number of Centers Added	1	0	1	1	2	1
Number of Centers at Year End	1	1	2	3	5	6
Personnel Expenses						
Salaries and Wages	$550,994	$550,994	$1,101,988	$1,652,982	$2,754,970	$3,305,964
Fringe Benefits	$131,560	$135,016	$277,358	$427,686	$733,392	$906,249
Total Personnel Expenses	**$682,554**	**$686,010**	**$1,379,346**	**$2,080,668**	**$3,488,362**	**$4,212,213**
Building Expenses	**$52,200**	**$52,200**	**$104,400**	**$156,600**	**$261,000**	**$313,200**
General and Administrative	**$45,450**	**$45,450**	**$90,900**	**$136,350**	**$227,250**	**$272,700**
Respite Program Expenses	**$32,025**	**$32,025**	**$64,050**	**$96,075**	**$160,125**	**$192,150**
Community Center Program Expenses	**$19,820**	**$19,820**	**$39,640**	**$59,460**	**$99,100**	**$118,920**
TOTAL EXPENSES	**$832,049**	**$835,505**	**$1,678,336**	**$2,529,153**	**$4,235,837**	**$5,109,183**

CREATING A NETWORK OF PEER-OPERATED COMMUNITY CENTER AND PEER RESPITES
PROJECTED SIX-YEAR STARTUP COSTS

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	
Number of Centers Added in Year	**0**	**1**	**0**	**1**	**1**	**2**	**1**	
Professional Fees								**Total**
Incorporation	$500	$0	$500	$500	$500	$1,000	$0	$3,000
Application for Tax-Exempt Status	$2,500	$0	$2,500	$2,500	$2,500	$5,000	$0	$15,000
Graphic Design (Trade Dress, Marketing, Website)	$1,500	$0	$1,500	$1,500	$1,500	$3,000	$1,500	$10,500
Total Professional Fees	$4,500	$0	$4,500	$4,500	$4,500	$9,000	$1,500	$28,500
Filing Fees								
Articles of Incorporation	$125	$0	$125	$125	$250	$125	$0	$750
Trade Name Registration	$50	$50	$0	$50	$50	$100	$50	$350
Form 1023 User Fee	$600	$0	$600	$600	$1,299	$600	$0	$3,699
Total Filing Fees	$775	$50	$725	$775	$1,599	$825	$50	$4,799
Personnel								
Executive Director	$33,000	$0	$33,000	$33,000	$66,000	$33,000	$0	$198,000
House Manager	$26,000	$0	$26,000	$26,000	$52,000	$26,000	$0	$156,000
Program Coordinator	$17,000	$0	$17,000	$17,000	$34,000	$17,000	$0	$102,000
Bookkeeper/Human Resources	$5,000	$0	$5,000	$5,000	$10,000	$5,000	$0	$30,000
Total Personnel Startup Expense	$81,000	$0	$81,000	$81,000	$162,000	$81,000	$0	$486,000
House Startup								
Lease/Purchase Costs	$7,500	$0	$7,500	$7,500	$15,000	$7,500	$0	$45,000
Renovation	$10,000	$0	$10,000	$10,000	$20,000	$10,000	$0	$60,000
Oil	$2,500	$0	$2,500	$2,500	$5,000	$2,500	$0	$15,000
Trash/recycle/compost	$2,500	$0	$2,500	$2,500	$5,000	$2,500	$0	$15,000
Peer Respite Furnishings	$6,500	$0	$6,500	$6,500	$13,000	$6,500	$0	$39,000
Community Center Furnishings	$2,500	$0	$2,500	$2,500	$5,000	$2,500	$0	$15,000
Total House Startup Expense	$31,500	$0	$31,500	$31,500	$63,000	$31,500	$0	$189,000
Infrastructure								
Telephone/Internet/Web Host	$6,500	$0	$6,500	$6,500	$13,000	$6,500	$0	$39,000
Security System	$1,200	$0	$1,200	$1,200	$2,400	$2,400	$0	$8,400
Total Infrastructure Startup Costs	$7,700	$0	$7,700	$7,700	$15,400	$8,900	$0	$47,400
Office Equipment/Supplies Startup Costs								
Equipment (computer, copier, fax)	$5,000	$0	$5,000	$5,000	$10,000	$5,000	$0	$30,000
Supplies	$2,500	$0	$2,500	$2,500	$5,000	$2,500	$0	$15,000
Mobile Telephones	$0	$0	$0	$0	$0	$0	$0	$0
Total Office Equipment/Supplies Startup Costs	$7,500	$0	$7,500	$7,500	$15,000	$7,500	$0	$45,000
Board of Directors Recruitment and Retention								
Travel expenses	$0	$0	$0	$0	$0	$0	$0	$0
Continuing education	$0	$0	$0	$0	$0	$0	$0	$0
Total Board of Directors Startup Costs	$0	$0	$0	$0	$0	$0	$0	$0
Staff Recruitment								
Advertising/Marketing	$4,500	$0	$4,500	$4,500	$9,000	$4,500	$0	$27,000
Staff Training & Development	$10,000	$0	$10,000	$10,000	$20,000	$10,000	$0	$60,000
Staff Travel	$5,000	$0	$5,000	$5,000	$10,000	$5,000	$0	$30,000
Total Staff Recruitment Startup Costs	$19,500	$0	$19,500	$19,500	$39,000	$19,500	$0	$117,000
Insurance Startup Costs								
Prepaid Workers Compensation (deposit)	$5,100	$0	$5,100	$5,100	$10,200	$5,100	$0	$30,600
Prepaid CGL/E&O Insurance (deposit)	$6,500	$0	$6,500	$6,500	$13,000	$6,500	$0	$39,000
Total Insurance Startup Costs	$11,600	$0	$11,600	$11,600	$23,200	$11,600	$0	$69,600
Total Startup Costs	**$164,075**	**$50**	**$164,025**	**$164,075**	**$323,699**	**$169,825**	**$1,550**	**$987,299**

CREATING A VERMONT NETWORK OF PEER-OPERATED COMMUNITY CENTERS AND PEER RESPITES
PAYROLL COST ASSUMPTIONS

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	
	Number of Centers in Network (Year Beginning)	0	1	1	3	5	6	
	Number of Centers Added (End of Year)	1	0	2	2	1	0	
	Total Number of Center (Year End)	1	1	2	3	5	6	
	Total Number of Employees	15.64	15.64	31.28	46.92	78.2	93.84	
Staff Wages/Salaries		**Wages/Salaries**	**Payroll Taxes**	**Workers Comp**	**Dental**	**Health Insurance**	**HSA**	**Total**
	Executive Director	$ 54,600	$ 4,177	$ 1,054	$ 900	$ 5,760	$ 390	$ 66,881
	House Manager	$ 45,500	$ 3,481	$ 878	$ 900	$ 5,760	$ 1,560	$ 58,079
	Bookeeper PT	$ 27,950	$ 2,138	$ 84	$ -	$ -	$ -	$ 30,172
	Peer Respite FT Hourly	$ 194,616	$ 14,888	$ 3,756	$ 5,400	$ 34,560	$ 9,360	$ 262,580
	Peer Respite PT Hourly	$ 163,456	$ 12,504	$ 3,155	$ -	$ -	$ -	$ 179,115
	Community Center FT Hourly	$ 64,872	$ 4,963	$ 1,252	$ -	$ 11,520	$ 3,120	$ 85,727
	TOTAL	$ 550,994	$ 42,151	$ 10,179	$ 7,200	$ 57,600	$ 14,430	$ 682,554
	Peer Respite	$ 486,122	$ 37,188	$ 8,927	$ 7,200	$ 46,080	$ 11,310	$ 596,827
	Community Center	$ 64,872	$ 4,963	$ 1,252	$ -	$ 11,520	$ 3,120	$ 85,727

ASSUMPTIONS		
Hourly Wage		
	Executive Director Hourly	$ 30
	House Manager Hourly	$ 25
	Bookkeeping Hourly	$ 25
	Peer Respite Full-Time Hourly	$ 18
	Peer Respite Part-Time Hourly	$ 16
	Community Center Full-Time Hourly	$ 18
Annual Hours		
	Executive Director Annual Hours	1,820
	House Manager Annual Hours	1,820
	Bookkeeping Annual Hours	1,118
	Peer-Respite FT Annual Hours	1,802
	Peer-Respite PT Annual Hours	1,277
	Community Center FT Annual Hours	1,802
Fringe Benefits		
	Workers Compensation Bookkeeper	0.30%
	Workers Compensation Non-Bookkeeper	1.93%
	Payroll Taxes	7.65%
	HSA/month	$130
	BCBS/month	$480
	Dental/month	$75
Staffing Levels		
	Executive Director	1
	House Manager	1
	Bookeeper PT	1
	Peer Respite FT	6
	Peer Respite PT	8
	Community Center FT	2
Number of Centers		
	Year 1	1
	Year 2	1
	Year 3	2
	Year 4	3
	Year 5	5
	Year 6	6
Other Assumptions		
	COLA	0.00%
	BCBS Annual Increase	6%