

**State Program Standing Committee
for Adult Mental Health**

Monday, July 11, 2016

MINUTES

Location of Meeting: Beech Conference Room, NOB 2 North, Waterbury

MEMBERS Clare Munat, Malaika Puffer, Thelma Stoudt, Marla Simpson, Uli Schygulla,
PRESENT: and Dan Towle

DMH Karen Barber, Emma Harrigan, Melinda Murtaugh, Reba Porter, Frank Reed,
STAFF: and Trish Singer

FROM
CSAC: Greg Mairs, Alexander (Sandy) Smith, and Bob Thorne

OTHERS: Anne Donahue, *Counterpoint*

Facilitator: Marla Simpson

Marla reviewed the agenda. Dan was appointed timekeeper. After introductions, the Standing Committee members reviewed the minutes of June 13, 2016. Marla moved that they be approved as written, and Thelma seconded the motion. The Standing Committee gave its unanimous approval.

Departmental Update: Frank Reed

Joint Commission Survey of the Vermont Psychiatric Care Hospital. This year's survey follows a somewhat abbreviated survey made after Green Mountain Psychiatric Care Center moved from Morrisville into the new facility in Berlin and opened as the Vermont Psychiatric Care Hospital in July 2014, Frank said. This time, there are new rules and standards that went into effect approximately four weeks ago for hospitals for psychiatric care and were used for VPCH, he added. The surveying team included a facilities specialist, a physician, and a nurse. The formal report should be forthcoming today. Overall, Frank said, the review was favorable, although he is expecting that further work will need to be done in certain areas (for example, treatment planning, physician credentialing and competencies, and infection control). Frank said that the final report will be made available to the public when it is received. It will be sent out prior to the next Standing Committee meeting.

Federal Monitoring Visit to Vermont for the Substance Abuse and Community Mental Health Services Block Grants. The federal block grant statute mandates federal monitoring visits every five years. This year, one combined team monitored both programs

in a single visit (in past years, visits of this type have occurred separately, with one team of monitors for Substance Abuse and another for Mental Health programs). An additional difference from past years is that the 2016 visit was shortened from five days to three. Frank's impression is that this visit went well too, although he is aware of some areas that will need further work (for example, written business processes and the recommendation from the Center for Mental Health Services for technical assistance to the state's Community Mental Health Services Block Grant Planning Council). Emma mentioned an additional area for further attention: data collection. The federal monitors recommend that Vermont start collecting information on sex/gender and gender identity of clients. In the months to come, she will be reaching out for input about how useful this type of data will be from various stakeholder groups, other state entities, and designated agencies. She also foresees departmental efforts to improve communications between the Standing Committees and the Block Grant Planning Council, which, in fact, is formed around the core of DMH's two standing committees, one for Adult Mental Health and one for Children's Mental Health. In response to a question from Dan Towle about the Planning Council's lack of access to the full block grant application for FY 2016-2017, Frank acknowledged the difficulties experienced last year because of late distribution of the Application Guidance to states; time was very short until the deadline of September 1 for submission to CMHS. DMH will be looking at other ways to make the document in its entirety more accessible to the Planning Council along with other members of the general public who may be interested in seeing it.

DMH and Assisted Outpatient Treatment. Frank said that DMH is working with the Substance Abuse and Mental Health Services Administration (SAMHSA) on the possibility of getting technical assistance to maximize Vermont's existing laws for assisted outpatient treatment. The Treatment Advocacy Center (TAC), which provides technical assistance to states, is being considered. DMH has been in contact with TAC, which has offered to come to Vermont to observe and give us feedback about possible improvements to our system. Frank said that DMH is interested in exploring opportunities for better outreach in the community for earlier mental-health intervention for individuals who might be in need of it, with a view to averting criminal justice involvement or decompensation later on. Malaika expressed her opinion that the TAC is very pro-psychiatric medication, which she regards as often involuntary. She added that she would like to see some counterbalance to the department's efforts. Frank pointed out that TAC's support was recommended by SAMHSA and comes free of charge as it is funded by SAMHSA, but he asked if Malaika had any alternative ideas. She offered perhaps the Bazelon Center for Mental Health Law but doubted that it would be free. Frank indicated that DMH could consider what Bazelon might be able to offer while the department is also looking at TAC resources.

Medicaid Pathway. Frank talked briefly about Vermont's work on the Medicaid Pathway to foster reform and service-design efforts with providers and other entities in the Agency of Human Services. The purpose of the overall effort is to continue to provide services and simplify payment mechanisms. DMH would like to expand the conversation to include the adult system as well. Melissa Bailey, Deputy Commissioner, is leading DMH's efforts here. She is already on the agenda for the Standing Committee's meeting on August 8.

HR 2646. A new federal bill to reform mental-health care in the United States passed the House by a vote of 422-2, Frank said. There is lots of support for helping families who are trying to deal with mental-health crises, for placing more emphasis on the prevention end of the spectrum of treatment, and for increasing access to care. The Senate has yet to take up the bill, he added. Marla said that she received a letter from Vermont Congressman Peter Welch about the bill. Malaika observed that many mental-health activists are still opposed to the legislation.

Discussion of Relationship with the Standing Committee. Frank said that he was concerned that there were issues that Standing Committee members were upset about from their meeting on February 8, but no one spoke to him about them. Instead, he found out about them when he read an article in the summer issue of *Counterpoint*. He reiterated that his door is always open, and he wants people to feel comfortable coming to talk to him if there is an issue. He may disagree, he said, but he is always willing to discuss topics and he hopes that Standing Committee members feel the same. He said that he appreciated that some people have very strong opinions about topics that are important to them, and he respects them, but his job is to represent everyone in the mental-health system—not just those with the loudest voices.

Frank also apologized for the issue with the minutes from the meeting of February 8, 2016. DMH meant to attach a document for further information about an issue raised by Malaika, given that most committee members and DMH staff were not familiar with the document she referenced during the February 8 meeting. The intent was not to influence or to add to the minutes. A second clarifying document was also not attached, which, unfortunately, probably added to the confusion. Frank again reiterated that he felt the issue could have been resolved earlier if committee members had made him aware of it so that he could have explained what happened. Frank then distributed copies of that second document that he had meant the Standing Committee to receive initially with the February 8 minutes: a letter, dated January 22, 2014, from Juan E. Méndez, UN Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment, to Drs. Jeffrey Lieberman, President of the American Psychiatric Association, Dr. Pedro Ruiz, President of the World Psychiatric Association, and Saul Levin, CEO, Medical Director of the American Psychiatric Association. In the letter, Mr. Méndez clarifies that “reports from mandate-holders like me are not submitted for adoption by the [Human Rights] Council but only for a free and open discussion.” (See attachment to these minutes for the full text of the letter.)

Frank ended the discussion by acknowledging that disagreements are inevitable, especially around charged topics such as psychiatric medication, which covers the full spectrum of opinions. He said once again that he has a duty to represent everyone in the mental-health system and not just one group or one opinion on a specific issue. He said that he will continue to do what he believes is the responsibility of a leadership position for the state’s public mental-health system and in the best interests of all the people who may need its services.

Redesignation for Counseling Service of Addison County (CSAC)

Standing Committee members introduced themselves again for their discussion of redesignation for CSAC's Adult Mental Health programs. They welcomed Alexander (Sandy) Smith, CRT Director, and Greg Mairs, Director of Adult Outpatient services, to the meeting. Bob Thorne, Executive Director, joined the meeting a few minutes later. Standing Committee members went down the list of questions they had raised at their June 13 meeting:

Community Rehabilitation and Treatment

- Affordable housing: What is the situation currently with vouchers and the Section 8 waiting list? (page 17)

Sandy Smith said that the limited availability of apartments in the area and the generally high rents are bigger issues for CSAC. The level of Section 8 subsidies are lower than fair market rentals.

- Why are there no challenges in Dialectical Behavioral Therapy (DBT) at CSAC? (pages 18-19)

That is no longer true, Greg Mairs said. The reimbursement rate for group therapy was recently reduced significantly, and the reduction has had a large impact on the agency's ability to bill for DBT. CSAC is looking for consultation for the DBT team in order to put it on a stronger footing. The 2% increase that the General Assembly appropriated for designated agencies this year goes to staffing expenses, especially costs for health care coverage.

- Why are there no data on clients in Integrated Dual Disorders Treatment (IDDT)? (page 19)

Sandy said that the agency is "really integrated" in its implementation of the Dual Diagnosis model. CSAC focuses on identifying these clients and, even more, on their individual needs.

- Explain the differences between Evergreen and the program offered at 17 Court Street. Evergreen is a long-running recovery program for CRT clients. It is just an "accepting, welcoming place" for various activities. The Center at 17 Court Street is more broadly intended for a wellness focus on activities—such as yoga, exercise, and eating well—for both CRT and AOP clients. The two programs are meant to complement each other.

- What does "competitive consumer-driven employment" mean? (page 19)

Competitive employment matches people's preferences and choices in the larger local marketplace for jobs.

- Give examples of “pivot table aggregate data” and “ability to drill down where/when needed.” (page 20)

These kinds of tools help the agency look at high or low utilization of services, Sandy said. The agency runs reports periodically throughout the year to see how it is doing.

- Explain the meaning of this statement on page 21: “CRT staff make immediate service and program development needs priorities; time for more systematic reviews is sometimes challenged by these immediate needs.”

Sandy responded that CSAC realized that the utilization review process previously used by the agency was not such a good idea after all; it was too time-intensive to be realistic.

- How does CSAC maintain IDDT fidelity without bringing in an independent reviewer? (page 23)

Sandy said that fidelity, strictly speaking, is not always the best way to offer a practice. It is better to look at individuals’ needs. He mentioned that Lindy Fox, a nationally known IDDT specialist and consultant, visited Middlebury three years ago to provide a three-day intensive training for early-engagement work.

- Why does the Client Advisory Team not have any family members?

The CAT (CSAC’s local program standing Committee) does in fact have two family members, one of whom is on the agency’s board.

- There are other organizations that could be included in feedback from the community—for example, Vermont Psychiatric Survivors (VPS) (page 29)

Sandy said that he would welcome stronger ties to VPS.

- How many clients of CSAC are students at Middlebury College?

CSAC provided services, usually Emergency Services or Adult Outpatient therapy, for fifty-five Middlebury students last year. The college has a contract with CSAC; it is the oldest contract of its kind in the country, Greg said.

- Which state funding structures work against a fluid, integrated, outreach-oriented approach to IDDT? And how do they work against it? (page 30)

Sandy did not recall the statement but said that he probably had the Division of Alcohol and Drug Abuse Programs (ADAP) in mind in this context. It is not so easy to use ADAP funding for engagement, he added.

- Give updates on all five priority areas listed on pages 31-32.
 - Housing: The agency is still hoping to develop a supported apartment, but no new funding was included in its Fiscal Year 2016 grant from the Agency of Human Services.
 - Crisis support: Act 79 dollars have gone into the program at 17 Court Street, the Emergency Team, the Cottage crisis bed program (now two beds rather than one), and more proactive efforts to get out the word about CSAC resources.
 - Supported Employment: It remains a really strong program despite the withdrawal of Vocational Rehabilitation funding.
 - Health and wellness: A nurse joined the agency's staff a couple of years ago. Now yoga, medication, and acupuncture have been added to offerings that are available locally.
 - Addiction, recovery, and engagement: The agency is providing a welcoming environment for individuals in earlier stages of change.
- Requirements on page 34: What is the agency doing to assure regular performance evaluations for CRT staff? What is the agency doing to assure local program standing committee compliance with membership requirements of Vermont's *Administrative Rules on Agency Designation*?

CSAC has a new process for staff evaluations: "meaningful conversations" once a year for all programs. Of 270 staff currently at the agency, ten are still awaiting evaluations. In addition, the evaluation format has been revised. The Vermont Chamber of Commerce recently recognized CSAC as one of the best places to work in Vermont.

- Staff turnover rates

Turnover at CSAC tends to be lower than at other agencies. Salaries in the field are so much below the market that the agency does not do a lot of hiring these days. It has actually given upon trying to attract a psychiatrist. Bob Thorne asked, "How can you prevent things from getting worse?" Greg observed that AOP revenue is lower this year than in previous years; two staff vacancies are unfilled. New requirements from the Department of Vermont health Access (DVHA) for pre-authorizations for services after a certain number of visits are burdensome too.

- Why is the percentage of CRT clients with Medicaid so low? (page 35)

Sandy said that the numbers must be data errors. Medicaid coverage for CRT clients at CSAC now is 75%.

- What models of psychotherapy are used at CSAC?

Psychotherapy at CSAC focuses on Cognitive Behavioral Therapy (CBT) and coping skills, also other ways to get at trauma history, motivational work, and Open Dialogue.

- Give an update on Open Dialogue.

Open Dialogue has been a huge project for CSAC, Sandy said. The culture is much more collaborative now. About eighty clients from all across the agency's programs have been involved in the new model so far. The agency can do higher levels of recovery work now.

Emergency Services

- ◆ Give an update on peer positions. How many are there? In what programs are they employed? What are peer support job duties? What training do they receive? Supervision?

Support positions are a mixture of identifications and roles. At Evergreen House, the emphasis is on outreach support work. The Emergency Team no longer has peer-supported positions; the simply "didn't work out." Greg added that CSAC has many staff who are also peers. The agency employs four peer-support workers. Group supervision is provided by peers; individual supervision is provided by regular management.

Psychiatry

- ⊗ What supports are available to clients for reducing, avoiding, or fully withdrawing from psychiatric medications?

Greg said that CSAC does not start treatment with psychiatric medications. Rather, treatment is extremely individualized. CSAC supports individuals who want to try to reduce their medications. Open Dialogue is a very important component of the agency's approach to psychiatry.

Overall Strengths and Challenges

1. Waiting list: It is at about fifty now for Adult Outpatient Services and Substance Abuse. A call-in clinic is available if people want to use it. The agency would like to try to have something available for everyone, but staff shortages will not allow it to do so.
2. Adult Mental Health: Bob Thorne said that he is very proud of what CSAC does in Adult Mental Health, even though the agency is currently losing several hundred thousand dollars a year. He thinks that the State Program Standing Committee should be aware of this situation. Loss of further funding would be "catastrophic" for the adult system, he said. Few dollars mean cutting programs, he said in conclusion.
3. Kudos for the *Vermont Business Magazine* and CSAC's award.
4. Need to work on standards noted in *Designation Report*.

Recommendation to the Commissioner

Marla moved that the Standing Committee recommend redesignation with minor deficiencies, with the expectation that CSAC will address the deficiencies noted within the six-month time frame provided in the *Administrative Rules on Agency Designation*. All members except Thelma Stoudt voted in favor of the motion (Thelma abstained because she is an employee of CSAC).

For Emphasis in the Standing Committee's Letter to the Commissioner

- ∞ Open Dialogue
- ∞ Award from the Chamber of Commerce
- ∞ Holistic work with medication and alternative services such as acupuncture, encouragement to broaden these approaches
- ∞ Evergreen House, and especially Wellness Wednesdays
- ∞ Contract with Middlebury College
- ∞ Thanks to CSAC representatives who came to SPSC meeting, their willingness to address improvements and to engage in constructive dialogue

Membership Issues

- See handout: DMH's Guidelines for Stipends and/or Transportation Expenses.
- The Standing Committee's *Operating Guidelines* state that "three absences without prior notification constitute resignation from the committee." (See page 11.) Email to a member who has not attended in several months went unanswered. Clare volunteered to call this individual in another attempt at outreach.
- Thelma Stoudt says that she represents consumers and not families. Melinda will check with the Governor's Office to clarify Thelma's status.
- Marla volunteered to write letters to newspapers in the Northeast Kingdom and in Northwestern Vermont about Standing Committee vacancies for providers from those areas.

Public Comment

Anne Donahue offered two informational updates for Standing Committee members on:

- ✓ DVHA's new policy on pre-authorizations for therapy after twenty-four visits
- ✓ Advance directives: the Ulysses clause and the necessity for an individual to have an agent willing to accept the authority to get around the clause

Items for August Agenda

- ✓ Review of agenda and time slots assigned, introductions, approval of notes for meeting of July 11, appointment of a timekeeper

- ✓ Departmental update
- ✓ Medicaid Pathway: Melissa Bailey
- ✓ Zero Suicide project and changes to orders of nonhospitalization: J Batra
- ✓ Public comment
- ✓ September agenda

Items for Future Agendas

- ✓ *Pathways Designation Report*
- ✓ J Batra: (1) finishing discussion of suicide prevention and (2) recent changes to orders of nonhospitalization
- ✓ Brian Smith: updates on housing (issues, developments, etc.)

Thelma moved that the meeting adjourn, and Uli seconded the motion. The meeting adjourned at 2:55 p.m.



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Mandate of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

January 22, 2014

Dr. Jeffrey Lieberman, President
American Psychiatric Association
Dr. Pedro Ruiz, President
World Psychiatric Association
Dr. Saul Levin, CEO/Medical Director
American Psychiatric Association

Dear Drs. Lieberman, Ruiz and Levin:

I have received the letter dated December 9, 2013 that you have sent to me (in my capacity as UN Special Rapporteur on Torture) and to the President of the Human Rights Council. Speaking only for myself, I wish to acknowledge the effort you have made to engage my rapporteurship in a detailed conversation about the report I presented to the Council in March 2013, on torture and cruel, inhuman and degrading treatment in some health care settings.

I will of course let President Henczel respond as to what the Human Rights Council proposes to do about my report of last year. That report was in the agenda of the Council in its session of March 2013. Several States and accredited non-governmental organizations chose to speak on the subject, some voicing criticism at some of my findings. As far as I know, there are no plans to continue the conversation or to "adopt" the report. In fact, reports from mandate-holders like me are not submitted for adoption by the Council but only for a free and open discussion. It would be up to a member State to propose a resolution to the Council on the basis of my report but I have no knowledge that any member State has such intention.

The nature of these thematic reports is of a vehicle to generate a discussion among States and interested civil society on standards that the mandate believes are necessary to cover issues and practices for which the existing normative framework is ambiguous or unclear. My thematic reports are not meant to be read as the ultimate word on the international law governing the issues I choose to deal with, but rather to initiate a discussion about what international law should provide for regarding those matters. They are also a recognition that the normative framework changes, as it must, to reflect evolving social standards and scientific advances. Precisely because that is the purpose of my report, I am encouraged by the detailed attention you have given to it and by your very substantial and authoritative contribution to the discussion I wished to generate.

With respect to the content of the report, I regret that some inartful wording has given rise to misunderstanding of some statements included in it; some passages can be legitimately read as contradictory with other passages. One example is my paragraph 32. For the record, I did not mean to propose an absolute ban on non-consensual interventions (including institutionalization and restraints) under any and all circumstances. I meant to restrict my condemnation to non-consensual treatment based exclusively on discrimination against persons with disabilities. In other words, the fact that a person is diagnosed as having a psychosocial disability should not by itself be enough to justify non-consensual treatment. Unfortunately, in many countries that is standard practice, often validated by domestic courts and even by international tribunals (in some decisions that my report criticizes). As you point out, elsewhere in my report (paragraphs 68 and 69) I do mention that involuntary detention and treatment is legitimate if its purpose is to prevent the patient harming him or herself or causing serious harm to others, and then for the limited time and scope necessary to prevent such harm. I firmly believe, however, that legislation should be revised to place the burden on the State to justify each decision to apply non-consensual treatment under such narrow grounds.

I do not doubt that my proposal coincides – in large part, at least – with the highest professional standards of your profession as reflected in the policy statements relevant to this topic that you have attached. My concern is with the many parts of the world where those professional standards are not applied. More specifically, I am concerned that domestic legislation generally allows for a very loose understanding of disability, of legal capacity, of guardianship and even of medical necessity. I believe very strongly that in many countries these provisions are the enabling legal environment where abuses take place. It is important to encourage all States to take another look at domestic legislation and to overhaul antiquated norms that effectively make free and informed consent meaningless. It seems to me that, in general at least, your associations are comfortable with the existing normative framework; if so, yes there is a disagreement between us. I hope, however, that this letter helps to narrow the scope of that disagreement.

My report was difficult to write because I believe the legal landscape on these issues is changing rapidly. In particular, the Convention on the Rights of Persons with Disabilities has altered that landscape in a significant way. Beyond what the Convention provides for in its text, the authoritative interpretation of it by the treaty body it created, the Committee on the Rights of Persons with Disabilities, may be moving that normative framework even further. Whether one agrees with the Committee's interpretations or not, there is no doubt that pronouncements of treaty bodies entrusted with a specific area of law must be taken into account. It is part of my task as Special Rapporteur to encourage States to align their domestic legislation with binding international standards. More important than the legal reasons, however, is my conviction that there is plenty of abuse of psychiatry in our world today. My report was an attempt to call attention to such abuse; not by any means to impugn the profession and the science of psychiatry, for which I hold great respect and admiration.

Let me thank you again, sincerely, for your comments and criticism. They help me understand the problem in all its dimensions. As part of my work on this issue I plan to publish a volume with contributions from many individuals and entities interested in the matter. It will include divergent views, including of course

disagreements with my report. I would very much appreciate your permission to publish your letter in full in that volume. Needless to say, I intend to include this letter as well.

Sincerely,



Juan E. Méndez

Special Rapporteur on the question of torture and other cruel,
inhuman or degrading treatment or punishment

Cc Baudelaire Ndong Ella, President, UN Human Rights Council

DMH Guidelines for Stipends and/or Transportation Expenses Effective July 1, 2016

- Purpose of Guidelines:** DMH guidelines are designed to support participation of family members, peers, and other stakeholders in Work Groups, Advisory Councils, and Committees.
- Effective Time Period:** July 1, 2016– June 30, 2017
- Individual Eligibility:** -Members of appointed groups, councils, and committees;
-Participants in groups that do not require appointment;
and otherwise meet criteria (a) through (d) in # (3) below.
- Groups Covered:** Vermont Psychiatric Care Hospital Advisory Committee
Mental Health Block Grant Planning Council
IPS Supported Employment Family and Peer Participants
State Program Standing Committee for Adults
State Program Standing Committee for Children
Act 264 Advisory Council
Vermont Cooperative for Practice Improvement and Innovation (VCPI)
- (1) Financial support applies to groups listed. DMH may add or remove groups participating in planning activities.
 - (2) Prior to participating in a work group with the expectation of a stipend and/or reimbursement of transportation expenses, stakeholders are encouraged to contact Jennifer Rowell (802-241-0137) to indicate their interest in a work group(s) and their intent to participate on a regular basis.
 - (3) A stipend of \$25 (less than 4 hours) or \$50 (4 hours or more) may be provided to peers and family members who:
 - a. receive no compensation from another source for attending
 - b. request a stipend within 45 days of meeting date on expense claim form
 - c. join the work group on or before attending their first meeting for which they request a stipend and/or transportation expenses
 - d. sign the meeting sign-in sheet to record their attendance
 - (4) Work group members are eligible for one stipend daily for the cumulative time spent at one or more work group meetings that occur on the same day.
 - (5) Travel time will be included in the cumulative meeting time based on standard "to and from" travel time from a work group member's home. "MapQuest" will be the standard application used to determine travel time and mileage.
 - (6) DMH expense claim forms should be hand delivered or mailed to:

Vermont Department of Mental Health
ATTN: Jennifer Rowell
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
 - (7) These guidelines do not envision any payment for participation by phone; however, up to \$10 may be paid at the discretion of DMH in unusual circumstances. Meal expenses are not reimbursable.