

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

**Monday, August 8, 2016**

**MINUTES**

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

MEMBERS Joe Gallagher (by telephone), Clare Munat, Malaika Puffer, Thelma Stoudt,  
PRESENT: Marla Simpson, and Dan Towle

DMH Melissa Bailey, Karen Barber, Mourning Fox, Emma Harrigan, Melinda  
STAFF: Murtaugh, and Trish Singer

**Facilitator: Marla Simpson**

Marla reviewed the agenda. Malaika volunteered to be timekeeper. After introductions, the Standing Committee members reviewed the minutes of July 11, 2016. Melinda Murtaugh asked to add the designation of Pathways—Vermont as an agenda item for brief discussion today and for more extended discussion with representatives from Pathways and action on a recommendation to the Commissioner for the Standing Committee agenda for the September 12 meeting. After reviewing the minutes of the meeting on July 11, Malaika Puffer said that she thought the section on the departmental update was too Commissioner-centric, but she did not suggest any changes. Clare made a motion to approve the minutes as submitted, and Thelma seconded it. The minutes were accepted as written.

**Departmental Update: Mourning Fox**

**Joint Commission Survey of the Vermont Psychiatric Care Hospital (VPCH).** Fox said that DMH is expecting another visit from the Joint Commission any day now as follow-up to the deficiencies noted on its visit earlier this summer. He added that the deficiencies found in VPCH's infection-control policy and in the documentation of treatment plans did not constitute threats to continuing certification. Dr. Batra has been working with hospital staff on both items to bring them into compliance with Joint Commission standards.

**VPCH Bed Capacity and Staffing in the Context of Emergency/Crisis Capacity State-wide.** VPCH has twenty-five beds, Fox told the Standing Committee, and twenty-five beds are filled currently. Nursing staff is remaining fairly steady, he continued. There is some movement of patients from one psychiatric hospital to another as their needs for higher-acuity or lower-acuity care change. Today four beds are available in the state and nine individuals are awaiting admission. Marla asked why the occupancy rate for inpatient beds

is so high now. Emma explained that inpatient hospitalization is cyclical and tends to be higher in summer. Wait times seem to be remaining steady, she added.

Malaika asked about the occupancy rate for the crisis beds scattered throughout the state. Emma replied that it is pretty low right now; it does not make much sense, actually, she admitted. Trish mentioned “subacute status” as a possible factor: individuals may not meet criteria for inpatient care, but they may also not meet criteria for admission to a crisis bed either. Someone suggested that homelessness might be a factor too, but Trish explained that DMH’s utilization review team records housing status whenever individuals are admitted to inpatient status and Fox said that inpatients are “almost never” discharged to homelessness or shelters.

Malaika asked about Soteria House, in Burlington, and Alyssum, in Rochester. Both are full, Fox said. Marla asked about housing vouchers for individuals leaving hospitalization. Melinda reminded the Standing Committee that housing is already on the list of items for future agendas and Brian Smith will be able to give an update sometime in the fall.

**A New “Duty to Warn” in Vermont.** Malaika asked about a complicated recent court case involving a patient who was discharged from inpatient psychiatric hospitalization to his parents and who then severely injured a maintenance man at an apartment house somewhere else. The injured man brought suit, resulting in a ruling from the Vermont Supreme Court that there is a duty to warn those in “the zone of danger” and also a duty to teach individuals who might find themselves in the zone of danger how to prevent violence. There are no findings so far, Karen Barber continued, so no one can say what the court really means yet. DMH has filed an amicus brief in support of appealing the case. Disability Rights—Vermont (DRVVT) has already filed an amicus brief too. In reality, Karen observed, it takes years to develop case law around facts in cases of this kind, and so it will likely be a long time before the meaning of the “duty to warn” becomes clearer.

**Collaboration Between Law Enforcement and Mental Health Providers.** Fox asked the Standing Committee members if they would like to hear from Kristin Chandler about the department’s Team 2 training for law enforcement and mental-health providers. Clare mentioned Cindy Taylor Patch and Police Academy training too. Fox said that he would get in touch with both Kristin and Cindy about coming to a Standing Committee meeting later this year.

### **Designation of Pathways—Vermont: Emma Harrigan**

Emma explained that Pathways is a new specialized service agency (SSA) for adult mental health in Vermont. It emphasizes the Housing First model of services for adults and families with mental-health needs. Pathways has been provisionally designated for about a year, Emma said, and has completed a number of plans of corrective action to come into compliance with the requirements of the state’s *Administrative Rules for Agency Designation*. Melinda distributed copies of the *Pathways Designation Report*, dated August 3, 2016. She will invite the Executive Director and others to the September 12

meeting to describe their program and the people they serve and to talk about recent developments in the context of gaining full status as a designated SSA in Vermont's public mental-health system. Areas that remain outstanding for further work toward designation include accessibility issues at Pathways offices and reporting on grievances and appeals to the Department of Vermont Health Access (DVHA) once Pathways obtains designation.

### **Membership Issues**

Standing Committee members discussed the importance of attending meetings in person versus attending by telephone or some other long-distance medium when circumstances make it impossible for someone to be physically present. Different members have different opinions on the subject and asked for more time to explore the issues involved. For the September meeting, they will consult the *Operating Guidelines* on meeting attendance. They also asked for guidance from Karen on statutory requirements for reasonable accommodations for members or other people with disabilities.

### **Zero Suicide Project (2): J Batra**

J opened by saying that he would like input from the Standing Committee members on their thoughts about the Zero Suicide model. What is good? What is missing? Clare countered with a question of her own about other successful programs that are in place around the country. J mentioned three programs that have been implemented with great success:

- The Henry Ford Health System (HFHS) in Detroit, Michigan: It started in 2001 as a program to treat depression, then evolved to include suicide prevention too. At the beginning of implementation, suicides were numbering approximately one hundred per 100,000 population. By 2009, there were no suicide deaths in the HFHS system. The system has maintained an average in the low teens over the last several years. The system has 3.1 million patient contacts yearly, J said.
- The Air Force Suicide Prevention Program: It trains clinicians to work directly with patients who are having suicidal thoughts. This program too has seen significant reductions in death by suicide.
- A partnership between Maricopa County (Arizona) and Magellan Healthcare: The goal is for all addictions and mental-health clinics to have capacities for suicide prevention. The suicide rate among clients of these clinics when the partnership began was seventy-seven per 100,000; the rate was reduced to thirty-five per 100,000 within a few years.

In response to a question from Malaika, J said that predictability for suicide is notoriously poor. A major well-known instrument in wide use is the Columbia Suicide Severity Rating Scale (CSSRS). In Vermont, suicide prevention efforts are focusing on the approach known as Collaborative Assessment and Management of Suicidality (CAMS). Pilot

projects are currently in place in Chittenden County and Franklin and Grand Isle counties in Northwestern Vermont.

Other points and resources that entered into the ensuing discussion included:

- ◆ Thomas Joiner’s interpersonal theory of suicide
- ◆ Various forums and trainings from the Suicide Prevention Coalition
- ◆ The American Foundation for Suicide Prevention
- ◆ Training called “In Our Own Voice,” from the National Alliance on Mental Illness (NAMI) for people who want to share their experience with various civic and public organizations
- ◆ Bullying and shaming as other factors that figure large in suicidality
- ◆ David Webb on Madness Radio—a different approach to suicidality
- ◆ Suicide-prevention programs in schools throughout the state
- ◆ The WISQARS database: the Web-based Injury Statistics Query and Reporting System from the Centers for Disease Control and Prevention

The end of the discussion touched on Vermont’s assisted-suicide law, which, J said, has been little used. Prevention efforts should focus on the entire life span, he urged in closing.

### **Public Comment**

None.

### **Medicaid Pathway: Melissa Bailey**

Melissa is DMH’s lead on the efforts toward a more integrated health care system. The Medicaid Pathway is a new payment method for mental health, developmental disabilities, and substance abuse services and supports to help the system move away from fee-for-service payments in order to focus more on outcomes for clients and quality of services provided. The overarching idea is to create flexible funding using the same dollars that we have now to improve the system and achieve other desired outcomes.

Vermont’s integrated model of care has the following core elements:

- ❖ Person-centered and -directed process for planning and service delivery
- ❖ Access to independent options counseling and peer support
- ❖ Actively involved primary care physician
- ❖ Provider network with specialized program expertise
- ❖ Integration between medical and specialized program care
- ❖ Single point of contact for person with specialized needs across all services
- ❖ Standardized assessment tool

- ❖ Comprehensive individualized care plan inclusive of all needs, supports, and services
- ❖ Care coordination and care management
- ❖ Interdisciplinary care team
- ❖ Coordinated support during care transitions
- ❖ Use of technology for sharing information

Vermont’s model aligns well with what is going on elsewhere, Melissa said. Both individual and systems-level outcomes are desired goals of the Medicaid Pathway. Melissa hopes that mental-health services in Vermont will be in the first phase of the move in this direction over the next one to three years. See attachment: “Vermont’s Integrated Model of Care: Summary Overview,” May 2016.

### **Items for September Agenda**

- ✓ Review of agenda and time slots assigned, introductions, approval of notes for meeting of August 8, appointment of a timekeeper
- ✓ Departmental update
- ✓ Pathways—Vermont: Designation discussion and recommendation to the Commissioner
- ✓ Public comment
- ✓ Membership issues: Meeting attendance and reasonable accommodations for persons with disabilities
- ✓ October agenda Items

### **Items for Future Agendas**

- ✓ J Batra: changes to orders of nonhospitalization
- ✓ Brian Smith: updates on housing (issues, developments, etc.)
- ✓ Kristin Chandler and Cindy Taylor Patch: Law enforcement/mental-health providers collaboration

Malaika made a motion to adjourn this meeting early. Marla seconded it. Members voted unanimously in favor. The meeting adjourned at 2:45 p.m.