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## LEGISLATIVE UPDATE FOR FEBRUARY 15, 2023

Over the last week legislative committees worked on the Fiscal Year (FY) 24 budget request, suicide prevention, school mental health, adult protective services, developmental services (DS) payment reform and violence in health care settings.

### *TESTIMONY*

#### **Human Services FY24 Budget Request Presented to House Appropriations Committee**

In presenting to the House Appropriations Committee, Agency of Human Services (AHS) Secretary Samuelson emphasized that this agency-wide budget has priorities that include stabilizing the health and human services, and targeted investments in mental health and substance use services. Additionally, there are one-time investments. The total proposed Agency budget is \$3.2 billion in total funds, which is a 10.82% increase in general fund (GF) and approximately 7% increase in total funds from the FY23 budget.

Base Investments include additional funding of \$6.5M general fund (GF) to DCF including funding for emergency shelter services, stabilizing and inflationary rates for Private Non-medical Institutions (PNMI), and stabilization funding and increases in contracted staff support to address the Family Services Division historically high caseloads. The Secretary highlighted \$2.9M GF at DAIL for 3 OPG positions, Home Health Long Term Care (LTC) rate increase, and Developmental Disabilities Services Division (DS) system stabilization. She also highlighted investments of \$2.3M GF at DMH for Mobile Response expansion, therapeutic alternatives to Emergency Department (ED) care, and PNMI rate increase. One-time initiatives include: \$9.2M GF (\$20.9M total funds) for Blueprint/Hub & Spoke two-year pilot for mental health and substance use.

Secretary Samuelson explained that while DMH is studying cores services and statewide distribution of services, they are making key investments in services including a \$2.3 million (\$1.15M GF) expansion of mobile crisis statewide. She said that where we don't have staff who are being utilized effectively, this approach will be more cost effective. Additionally, she noted that this service has an 85% federal match on an ongoing basis and will be a regional approach to make it sustainable. She said the goal is for people to have "someone to ask, someone to call, someplace to go and someone to come to you." In relation to the DMH budget, the Secretary explained that to stay competitive in the market it was important to upgrade pay classifications at VCPH.

The Secretary said the current APM ACO model is being evaluated and they are determining how to cover the costs going into the future that are currently funded through Medicare. Options under consideration include looking at global payments and what waivers would continue from the current ACO model if it doesn't continue beyond the current two-year extension.

### **House Appropriations Committee Hears DAIL Overview and FY24 Budget Request**

Commissioner White presented an overview and the FY24 budget request for the Department of Disabilities, Aging and Independent Living (DAIL). She spoke about the upcoming reforms of the home and community-based services. She noted that CMS will be providing guidance on strengthening quality improvement. Rep Lanpher asked about the potential for an ombudsman for DS. The Commissioner said they are looking at leveraging ARPA funds to pilot an ombuds program. The total requested funding for the developmental services is \$282 million.

#### Specific DS Budget Increases

DS caseload increase for 353 individuals \$8.3 million in global commitment (GC)

- Public safety caseload for 15 people \$1.2 million GC
- Annualization of DS Public Safety/Act 248 Caseload outliers, 5 individuals \$1.9 million GC
- AFSCME Collective Bargaining Agreement \$1.8 million GC
- Upper Valley Services (UVS) Crisis Capacity Expansion \$.95 million GC

### **House Appropriations Committee Hears DMH Overview and FY24 Budget Request**

DMH Commissioner Hawes presented a proposed \$310 million total funds FY24 budget request to the House Appropriations Committee.

#### DMH Budget Ups—\$11 million Total Funds

- Salary and Fringe (including Shift Differential Increases and Overtime)
- Benefit rate changes, including retirement
- Impact of position classification action requests
- Internal Service Fund Changes
- Contract and operating expenses for new secure residential
- Travel Nurse contract increases
- Psychiatry contract increases
- 4 Positions for Mobile Crisis Response
- Increases to 988 activities
- Private Non-Medical Institution (PNMI) rate adjustment
- Washington County Mental Health (WCMH) Micro-residential increases
- CMC ServicePoint license for housing

#### Budget Initiatives—\$4.9 million Total Funds

- Mobile Crisis Response Expansion
- Peer Support Credentialing

- Therapeutic Alternatives to Emergency Department in the Northeast Kingdom Region

There were questions about Success Beyond Six (SBS) and how it is working. Deputy Commissioner Krompf said SBS was designed for children with high needs and that schools may be hiring staff for other levels of mental health needs. Chair Lanpher noted that some of the students are not Medicaid eligible and expressed concern about schools hiring away DA staff. Mobile Crisis Response will require upping the bar to include full 24/7 response with 2-person teams for both mental health and substance use to receive enhanced federal match. It is the person and family who define that they are in crisis and the threshold for intervention will be lower than the current emergency service responses. DMH will be hiring four positions to manage these services. The Committee saw the information on the mental health needs of students and their improvements after receiving services as measured by the CANS. The committee is worried about the mental health challenges of children, especially younger students.

Deputy Commissioner Krompf shared that Vermont has a 30% higher rate of suicide than the national average and noted that risk is higher people who are white, male, live in rural areas and have firearms. When reviewing data on access to care and treatment, it was pointed out that staff vacancies are reducing access to services.

When Committee Chair Lanpher asked if DAs are part of the budget conversations up front, the Commissioner replied that they meet with the DA partners monthly at executive and program directors' meetings.

### **House Human Services Hears Testimony on Adult Protective Services (APS) in H.171**

Michael Benvenuto of Vermont Legal Aid testified that they had actively participated on the APS Advisory Committee and sees the bill as making significant Improvements including coverage of financial exploitation. However, he is recommending improvements such as adding victim's rights, clarifying when just an assessment is done rather than a full investigation, and speeding up the timing of APS responses to 48 hours rather than 2 business days.

Jessica Barquist, Policy Director for the Vermont Network, which focuses on domestic violence, testified against the expansion of mandated reporters to "all concerned persons" because it could "unintentionally limit and restrict a vulnerable adult's social support networks." There could be a significant risk for a vulnerable adult to rely on others for support or to talk confidentially about issues in their life. This may limit their ability to seek help from anyone outside of crisis workers without fear of reporting and/or having to deal with the stressors of responding to unnecessary or unwanted reports. She said "we all need to be able to talk confidentially with the individuals who we trust to provide us with support and counsel—and vulnerable adults are no exception to this."

Kirsten Murphy of the Developmental Disabilities Counsel agreed with the Elder Law Project recommending the development of a bill of rights for elders. She recommended the 48 hours stay and that it expands the way the APS can work with people to flexibly respond to

complaints. DD Council has serious concerns about quality oversight for people with developmental disabilities. They would like an ombuds office and more staff for quality review. In discussing quality issues, Kirsten Murphy recommended a return to the Core Indicators review.

Testifying for the Disability Rights Vermont, Lindsey Owen had a very specific list of adjustments she would like to see made to the bill. For this detailed information see this [link](#).

Mary Hayden, testifying on behalf of the Area Agencies on Aging, was generally supportive of the bill and process to develop it but asked for specific improvements including clarifying mandated reporters; the definition of vulnerable adult; definition of caregiver; definition of self-neglect; limiting access to records to the incident under investigation; and ensuring the right of the victim to review unsubstantiated determinations.

Max Barrows, Outreach Director of Green Mountain Self Advocates (GMSA), testified that GMSA agrees and supports the recommendation from Vermont Legal Aid for a separate section governing victims' rights and communicated in plain language. Mr. Barrows urged the committee to add language for APS to work with self-advocates on short videos and other methods to provide clear explanations on report filing and what to expect during an investigation.

He said at times the presence of mandated reporters can have unintended consequences. When self-advocates are working toward autonomy and independence, reporting can affect those efforts by imposing restrictions to "protect our safety" or on financial freedom. He said a court might give us a guardian that we don't want or need as a result.

Max explained that people can feel betrayed if a staff reports to APS, because the staff person is worried about getting into trouble. Suddenly many people know about a person's personal and upsetting incidents. It is for this reason that some self-advocates say they would not tell staff at their agency because they will lose their privacy and they might get in trouble or be blamed for what happened. "They don't feel they can trust their staff after a report has been made." He specified, "Some people with disabilities have said that the last person they would tell if something sexual happened to them would be people at their agency." They fear getting into trouble for hanging out with the wrong people and want to have control over whether to disclose abuse. They don't want reports filed behind their backs. "In situations involving sexual violence, our choice about being intimate with someone has been violated. It has been stolen from us. One important way a person can heal from being sexually assaulted is to make sure we are in charge of the decisions being made about reporting. We need to be able to make the decision about who knows, what they know and when they know it. This gives us back some control over our situation." Given the APS substantiation rate of just 20%, Max Barrows said they don't want to make reports if nothing is going to happen.

As to the expansion of the definition of a vulnerable adult to include all people who receive Home and Community-Based Services (HCBS), Mr. Barrows advised the committee that all

those people need to understand the role of APS, including mandated reporters. Additionally, some advocates want the choice to decide if they want to disclose abuse. With 1 out of 4 positions vacant at agencies, people receiving services need assurance that staff are educated about their right to decide if they want a report filed. In the case of sexual violence, or when the choice about being intimate has been violated, one way to heal is to keep the person involved in charge of decision making.

Elizabeth Anderson, Director, Attorney General's Medicaid Fraud and Residential Abuse Unit (MFRAU), testified in support of H.171 with one exception. Ms. Anderson works routinely with APS and Licensing and Protection divisions under DAIL. H.171 falls under the Title 33 Human Services statute, and MFRAU also works under the Title 13 Crimes and Criminal Procedure statute, changing the definitions under Title 33 will put the two out of alignment. Specifically, if the definition of vulnerable adult is changed to require residency in a licensed facility within 30 days after an alleged incident, it is unclear if that can be transferred to a criminal context.

Julie Cunningham, Executive Director, Families First, and Joanne Larsen, Community Services Manager, United Counseling Services, testified for Vermont Care Partners about considerations for designated and specialized services agencies. Ms. Larsen noted that there doesn't seem to be a mechanism to alert APS that the situation is of particular or urgent concern. Education on criteria for investigation would be helpful as the process is not clear in current practice. Chair Wood shared that the request for APS to provide more information and education has been a common theme across testimony so far.

Ms. Cunningham testified that it is the responsibility of agencies to protect people from bad actors with training and best practices from seasoned and experienced staff. With 24% staff vacancy rates across DS programs and many people waiting for homes, consistency can be difficult to maintain, leading to increased vulnerability. She said it would be helpful to understand how and why substantiations are determined. Also, the case manager signs on the Individual Service Agreement that they are responsible for the health & safety of that person. This is a serious responsibility which exceeds the current pay rates. She concluded that maintaining quality staff is the best insurance policy to keep people safe in their homes and communities.

As to H.171, both witnesses prefer the change from 48-hour response time to 2 business days, which would stretch to 3-4 days if reported on a Friday or weekend. More serious situations that would require a quicker response include a person with a disability being thrown out of their home, or physical assault. Typically APS written responses are received within 1-2 weeks, sometimes accompanied by a call. The APS division is working on communication and acknowledges improvement is needed in this area. Self-neglect, also included in the bill, is a serious issue, and if reported to APS, DAs would be amenable to working with APS to address it.

Joanne Larsen, Community Services Manager for UCS, explained that they do a great deal of direct service with people with severe and persistent mental illness. They often report that there are people experiencing abuse and neglect. There is no mechanism to let APS know when

situations are serious because all reports look the same. It seems like few reports are followed up by APS. She is wondering if the case manager reports are taken seriously compared to reports by physicians. She would like a better response from APS to understand the disposition of the reports. She expressed concerns about the speed of follow-up and suggested that APS might need more resources. She spoke about self-neglect and the need to support people who are at risk but maintain autonomy, mentioning people that don't eat and who can become emaciated.

Jill Mazza Olson provided detailed testimony on behalf of health providers: The Vermont Association of Hospitals and Health Systems, Vermont Health Care Association, Vermont Medical Society, VNAs of Vermont, and Vermont Association of Adult Day Services. One concern of the health associations is that the bill expands the definition of Abuse to include . . . “any treatment administered purposefully, knowingly, recklessly, or **negligently** that places the life, health, or welfare of a vulnerable adult in jeopardy and is likely to result in impairment of health to the vulnerable adult.” She pointed out the several changes adding neglect to the definition of abuse may lead to “dramatically expands the scope of mandatory reports to include unintentional mistakes by a caregiver such as a missed dose of medication, or a fall.” The broadening of the reporting standard is a concern of the providers, too, because all information must be acted on regardless of its credibility, or if others have already reported. Confidentiality of the reporter was also raised as a concern. Please see this [link](#) for the detailed written testimony.

### **Developmental Services Payment Reform Testimony in House Human Services Committee**

Jessica Bernard, Deputy Director of Payment Reform, Department of Disabilities, Aging and Independent Living testified to the House Human Services Committee to provide a background and timeline for developmental services payment reform. DAIL heard the feedback and has committed to a strong stakeholder engagement effort, as evidenced by the Payment Reform Advisory Group and Standardized Assessment Advisory Group. Payment Reform work is also presented regularly to the Developmental Services State Standing Committee and DAIL Advisory Board and quarterly public engagement sessions are co-led by Public Consulting Group (PCG) and DAIL.

Chair Wood noted that Payment Reform represents one piece of a major amount of change to the System of Care and is causing a great deal of anxiety across many groups in the State. The benefits to people receiving services aren't apparent and seems bureaucratic and top-heavy, and possibly taking funding away from services. Ms. Bernard acknowledged the feedback and shared that it is a priority for stakeholders to have significant say, and payment modeling will be built on what Vermonters need. The goal is to not cut anyone's budget, safeguards have been built into the system for that purpose.

While Payment Reform work is underway, Conflict Free Case Management (COI) work is occurring concurrently. The COI corrective action 3-year plan is in effect and work has begun on

selecting a project manager and preparing for stakeholder engagement sessions. Areas where Payment Reform and COI intersect are:

- Assessments: CMS COI rules require that assessments are handled by a third-party separate from providers. This is already underway with the SIS-A assessment.
- Person Centered Plan Development: Payment Reform activities include context work on the SIS-A to be in line with COI changes.
- Rates: If COI results in a separate case management entity, the rates will have to reflect the system changes.
- Transition dates: Payment Reform and COI are aligning major system or payment model changes to avoid prolonged or repetitive periods of change.

Since last year, assessment time has leveled out to 1.5-2 hours with some exceptions. People using augmentative communication can book additional sessions if needed and ASL or language interpreting is provided on request. While it is used internationally, the cultural flexibility of the tool could be improved. Response to feedback is typically via advisory groups, SIS-A engagement sessions, and provider updates.

The future payment model has not been drafted yet and will include an updated rate study, consideration of context in the assessment score, exceptions and appeals process, and more. The person-centered planning process will remain as the primary driver to determine services.

Chair Wood noted the general concern that it is as yet unclear how case management funding dollars will be distributed with COI, and how that will affect services from agencies. The committee is anticipating a significant budget ask in the near future, and would appreciate advance notice on the magnitude of anticipated costs.

### **Testimony on S.36 Workplace Violence Prevention Bill in Senate Judiciary Committee**

Senate Judiciary heard testimony from members of the law enforcement community on their perspectives on this bill, which would allow for arrests without a warrant for assaulting a health care worker, criminal threatening, and disorderly conduct. Most witnesses emphasized that law enforcement already has the tools for people who are not patients. Department of Public Safety Deputy Commissioner Daniel Batsie testified that scenarios where this proposed law would apply are often very gray, rather than black and white. Committee members asked about barriers to law enforcement staying at the hospital when dropping off a patient. Law enforcement responded that this was often a resource issue since they are needed elsewhere. Sen Hashim also wondered about law enforcement liability if they remove a patient who was not medically cleared to be removed. There was also discussion about how HIPAA could prevent healthcare providers from disclosing patient information when calling the police; this applies to body-worn cameras, noted DPS Consultant Wilda White.

Jim Finger and Drew Hazelton, representing ambulance and Emergency Medical Services respectively, testified that they are also seeing an increase in disruptive behavior. Hazelton testified that laws already exist to protect EMS professionals. He noted they have seen

increased law enforcement reluctance to go to scenes as a result of the new Use of Force Policy. Meg Polyte, representing the Vermont Chapter of the Alzheimer's Association, asked for a carveout for people with dementia. Data from South Carolina shows that 8% of people being charged with assault on healthcare workers have dementia. She is concerned about people with dementia who are brought to EDs, a stressful and disorienting place, being charged. In discussion after the testimony, Sen Hashim was sympathetic but expressed reluctance to carve out dementia, as it could lead to carving out exceptions for others, naming schizophrenia and bipolar disorders. Sen Sears underscored that this is happening in an under-resourced system. People are out of control, often brought on by waiting for a bed for a long time in what is intended to be a short-term location.

The Committee also heard testimony from Health Care Advocate Mike Fisher, who deeply acknowledged the experiences of health care workers, and yet based on his experiences working with vulnerable populations who may be hard to work with, he is concerned about disparate treatment of the most vulnerable Vermonters. He is concerned about implicit bias and the unintended consequences for BIPOC Vermonters. Sen Sears countered with his own concern about BIPOC health care providers who have to endure racist taunts and threats. Fisher is most concerned about the inclusion of "disorderly conduct."

After discussion and clarification, the committee revised the bill to add language that allows a healthcare facility to let law enforcement receive information that a patient has been medically cleared. The committee voted out a revised version of the bill out and it will be sent to Senate Health Care, with a request to look into the disorderly conduct piece as well as de-escalation strategies at hospitals. Sen Vyhovsky voted against it. She supports most of this bill but has concerns about the inclusion of disorderly conduct.

### **House Health Care Committee Supports the Interstate Counseling Compact H.62**

House Health Care voted H.62, which would adopt an Interstate Counseling Compact, out of committee (see last week's legislative agenda), with an amendment ensuring background checks. Committee members strongly endorse increasing access to care through the use of compacts for mental health related licenses.

### **Suicide Prevention Testimony Heard in House Health Care Committee**

House Health Care heard testimony focused on Suicide Prevention throughout the week. The Vermont Department of Health [VDH] [shared data](#) on increases in suicides and at-risk populations, including males, LGBTQ+ Vermonters, rural Vermonters, veterans, and Vermonters with disabilities. VDH updated the committee on various grant funded work, including FacingSuicideVt.org. Rep Cina noted that the data only included suicide attempts that were quantified in hospital EDs and not attempts that were responded to in other settings.

The Department of Mental Health [DMH] [provided testimony](#) on its suicide prevention efforts. Chris Allen, the new Suicide Prevention Coordinator at DMH, shared data on Zero Suicide implementation across the designated agencies, including training, screening, and safety

planning. DMH noted that there is postvention happening across the state, but it is variable depending on region, and the State has a lot of work to do in this area. Rep Black asked about support groups and where the State saw gaps. Nick Nichols from VDH identified that many support group resources are now online. Rep Whitman asked about why DMH data showed that designated agency intellectual and developmental disability programs were slower to implement Zero Suicide. DMH Deputy Commissioner Alison Krompf noted that implementation primarily started in DA mental health crisis programs, and have spread from there. Rep Goldman asked about whether there are delays in referrals from primary care providers to designated agencies.

The Committee also heard from Dr. Rebecca Bell and Dr. Tom Delaney from UVM on [Increasing Lethal Means Safety and Suicide Prevention](#). Dr. Bell is seeing increased severity of intentional self-harm by poisoning and sees opportunities for intervention by health care. Impulsivity is a big factor when youth are involved, and the presence of firearms significantly increases lethality. There are 13,000 households in Vermont with kids with non-optimally stored firearms. Dr. Bell shared efforts to train providers on lethal means safety. The State will be launching GunSafeVt.org soon to support Vermonters in safe storage.

The Committee heard testimony about suicide loss from several families. Desirae Hawkins is advocating for increased accountability for schools to address bullying after the loss of her 12-year-old son. Paul Henning shared about the weeks leading up to his wife Cheryl Hanna's suicide. He spoke of the public stigma that his wife feared, and the impact of her suicide on not only their children but the whole state, given her role as a voice of legal scholarship. Paul Black, the husband of Rep Alyssa Black, shared the devastating loss of their son at age 23. He had previously testified four years ago advocating for gun safety measures. Black said this bill isn't really about firearm safety, it's about asking legislators to support more time—time to ensure that impulsive choices don't lead to devastating outcomes. Chair Lori Houghton pledged to do everything in her power so that Black doesn't have to return to the legislature again.

### **Testimony on Mental Health Needs in Schools Considered by House Education Committee**

School superintendents presented to House Education on mental health needs in schools. In her [testimony](#), Franklin Northeast Superintendent Lynn Cota identified four categories of behaviors that are growing: violent outbursts and vandalism, sexualized behaviors, disruption/defiance/elopement, and threats of harm to self or others. Schools are seeing increases in numbers of students with these behaviors, and the severity of the behavior, as well as adult mental health needs, substance use, and domestic violence in the community. There is an increase in the number of families seeking mental health care for youth, and out of desperation they are going to EDs. ED visits for Vermont middle school students quadrupled between June 2020 and March 2021, high school have tripled. Cota also reflected that students in need of residential care are seeing that care shifting from in-state to out-of-state. Cota provided a graphic of a tiered system of supports, and while “not trying to blame our designated agencies,” demonstrated the lack of resources at each level of care.

Cota stated that “out of sheer desperation, we have to build our own resources to fill those gaps.” Cota described a continuum of resources that their school district has built to respond to mental health needs of students, including creating staff positions for social workers and mental health, Behavioral Interventionists, and Behavior Analysts, they are pulling from DCF and designated agency staff. She wanted legislators to be aware that the money spent on mental health from the Ed Fund has “unintended consequences for our designated agency and social services partners, creating longer waitlists...By trying to solve our problem, we are adding to the problem for those agencies.” The more revenue that is taken away from DAs, the more capacity the state loses because schools are not allowed to draw down that same level of Medicaid revenue and the more federal funding the state loses. “Our mental health partners are a part of the fabric/foundation that we need—our partners need help.” Cota said, “you could best support us in education by focusing on the mental health crisis and ensuring that our designated agencies have the resources and the capacity in schools, homes, and communities.” She sees mental health partners as the experts in mental health and investing there will prevent burnout from educators.

Montpelier/Roxbury Superintendent Libby Bonesteel was testifying the day after a school shooting hoax shook her district. She said there is a need for high quality mental health care. Teachers are scared and students need immediate supports. Every school system within her county is currently building their own mental health systems; and they are discussing building a regional crisis center because WCMHS and regional therapeutic schools do not have sufficient capacity to help. “Because of a lack of screeners, we are told to have parents drive the kids to the ER.” In the past, screeners used to be able to come to schools.

Bonesteel’s district is currently investing \$60,000 per year on TalkSpace, with 80 people enrolled. Five years ago, the district spent \$700,000 on mental health supports; they are now spending \$1.7 million per year. “Our mental health agencies need help. This cannot be answered district by district, and the answer is not to throw grant money at the schools...DAs need support that only our state can provide.”

Sherry Sousa from Windsor Central Supervisory Union testified that because their district has multiple DAs [HCRS Springfield, HCRS Hartford, and RMHS] serving it, they are pulled to urban areas of the state and their district has to create their own services. “In the past, we were able to partner with our DAs to provide access to short- and longer-term therapeutic services...That is no longer the case. Even before the pandemic, collaborative meetings became oppositional as DAs maneuvered to ensure that they had no responsibility for student programming. Whether it was a procedural misstep, a noncompliant family, or a technical omission, it became apparent that DA staff were coached to not agree to any placement outside of the school district. Time after time, meeting after meeting, we heard that ‘wrap around services’ in the home and community must be tried prior to placement. What needs to be heard today is that there was never the personnel or the program for the children and their families to access.” She testified that the Act 264 system is failing. A school district or other LIT team member should be able to appeal a denial from a designated agency to the Case Review Committee, or the statute should be amended to force cost sharing for residential by the designated agency.

Tiffany Moore, Director of School-Based Services at WCMHS, shared that staffing/professional resources are an enormous challenge. They have completely exhausted the concept of “doing more with less,” and still have significant waitlists. Special Education Directors meet monthly to talk about needed services. They do their best to triage the needs and help families navigate to other services. She described a robust set of services with waitlists at all levels, including enough referrals for five additional positions. WCMHS secured ESSR funds to provide training and support to the district on trauma and youth Mental Health First Aid. Moore testified that salary levels are a huge barrier and that recent retention bonuses staved off the loss of staff. In response to a question about family substance use, Moore noted that some student clients had seen or administered Narcan to family members, and some were unknowingly involved in making deliveries. There is a strong family component to their services. Rep Conlon noted the proceeding testimony where school systems often are creating and attempting to provide the services within their own system. Moore said that it goes both ways—sometimes WCMHS hires positions away from the school.

Rep Buss asked the superintendents would they rather shore up DAs or create a better mechanism for collaborating. Superintendent Karen Conroy from St Johnsbury said the DA tells her they don’t have the budget because they’ve maxed it out. Cota would love to see the effort focused on shoring up the DAs and building a thriving healthy mental health system: “We are not asking anything for us specifically, we want our partners to be well-resourced.” Sousa said the DAs can accomplish things at the family system level that schools can’t. When asked if the interventions are successful, Moore offered to share data and described a student working down the continuum from alternative placement to not needing support. Cota noted the impact of challenging behavior on teachers and on staff. Sousa reported that 200 parents showed up at a meeting the previous week about the behavior their kids are seeing at the elementary school level.

On February 10, Laurel Omland, Chief of the Child, Adolescent, and Family Unit at DMH and Marianna Donnelly, School Mental Health and Practice Development coordinator, provided an [overview](#) on Success Beyond Six to the committee (video [here](#)). She described the different levels of service and noted that collaboration looks different in each region. She explained how, with Success Beyond Six funding, schools can draw down Medicaid dollars. She noted that school-based clinical services are seeing more kids with greater acuity, which can get in the way of reaching their caseload threshold and drawing down the associated Medicaid. Their role is to help the whole school team, which includes providing training and consultation to staff. Omland shared a list of evidence-based practices, emphasizing the value of reflective supervision. She shared information about DA staff vacancies and CANS outcome data. Rep Conlon recalled the testimony from superintendents on how less resources at the DA falls to schools. Omland agreed that that was true for the school day, also noting the impact on other sectors/levels of care as well, such as Emergency Departments.

Rep Bluemle, attending as a liaison from House Appropriations, was struck by DA vacancies. “As a legislature we have appropriated money to increase salaries; we’ve invested in workforce.

This just feels like such a crisis.” Omland clarified that the vacancy data is across the whole system and there is programmatic fluctuation. She hears that agencies either don’t have applicants; do have applicants but they don’t show up; or applicants accept the position and can’t find housing. At the same time, it’s difficult to hear the stories of families who are waiting and desperate. Omland was asked if mobile crisis teams will respond to schools. Currently there is some school response from crisis teams, and the mobile response pilot in Rutland has been responding to schools as well. Dialogue with schools is important.

Rep Conlon asked: what is the roadmap out of this situation where schools have to create mental health services because they can’t partner due to lack of staff at DAs? Omland reflected that it takes a village. The solution is partly with the mental health system, but it’s all systems. Donnelly noted that it’s important to focus upstream in schools, which means you can’t always focus on the crisis. Omland said group work and skill development can ward off the need for more intensive services down the road. Adults in schools are in crisis too—and they need help with self-regulation as well.

### ***UPCOMING EVENTS***

#### **Public Hearing on Housing: Thursday, February 16, 2023 at 4:00 P.M.**

This public hearing will be held in room 267, 109 State Street (the Pavilion Building)—by the House Committee on General and Housing and the Senate Committee on Economic Development, Housing, and General Affairs. Committee Assistants: House Committee on General and Housing, Ron Wild; Senate Committee on Economic Development, Housing, and General Affairs, Scott Moore.

### ***LEGISLATIVE RESOURCES***

#### **Vermont Care Partners Advocacy Fact Sheet**

Here is a link to our Advocacy Fact Sheet: [Vermont Care Partners Advocacy Fact Sheet](#). The critical points are the rising demand, the impact of the ongoing workforce crisis and need for improved funding.

You Tube link for Mental Health Advocacy Day:  
<https://www.youtube.com/watch?v=S3ml6skUE4A>

#### **NAMI-VT Fact Sheet on Mental Health**

Here is the [NAMI-VT fact sheet on mental health](#).

#### **Vermont Care Partners Legislative Advocacy Webinar**

In case you missed it, here’s a link to the [recording](#) of our Legislative Advocacy Webinar to help guide you through the process of working with legislators. In just 40 minutes you can learn the basics for effective advocacy.

### **Key Committees in relation to Network Agencies**

Here are the key Committees in relation to our network services with the Agencies in each legislator's region noted. We encourage everyone to reach out to your local legislators to introduce yourself and share the issues most important to you: [Legislative Committees by DA and SSA Region](#).

The purpose of the legislative update is to inform individuals who are interested in developmental, mental health and substance abuse services about legislative advocacy, policy development and activities that occur in the State Legislature. The Vermont Council is a non-profit trade association which works in partnership with Vermont Care Network to form Vermont Care Partners. Together our mission is to provide statewide leadership for an integrated, high-quality system of comprehensive services and supports. Our membership consists of 16 designated developmental and mental health agencies.