



Supporting Vermonters to lead healthy and satisfying lives community by community



LEGISLATIVE UPDATE FOR APRIL 10, 2023

Last week Vermont Care Partners provided testimony on transport of people in psychiatric crisis, FY24 budget, warrantless arrests in health care facilities and the Vermont Housing Improvement Program. We were also pleased to be present for the reading of House Resolutions on youth mental health.

PROGRESS and TESTIMONY

House of Representatives Recognizes Youth Mental Health

On Tuesday, April 3rd the House of Representatives adopted two resolutions, [H.C.R.23](#) and [H.C.R.81](#), recognizing the challenges our youth are experiencing with their mental health. The resolutions were part of the extended efforts of Mental Health Advocacy Day and were developed and coordinated by Miss Vermont Alexina Federhen, Vermont Care Partners, VAMHAR and NAMI-VT.

House Judiciary Continues Testimony on Warrantless Arrests in Health Care Facilities

The House Judiciary Committee continued to take extensive testimony on S.36—An act relating to permitting an arrest without a warrant, for assaults and threats against health care workers and disorderly conduct at health care facilities.

Suzanne Leavitt, State Survey Agency Director, DAIL, described the federal rules for conditions of participation that hospitals must adhere to. Hospitals must protect and promote patients' rights regardless of the diagnosis. The specific standards are:

1. Right to receive care in a safe setting
2. Right to be free from all forms of abuse and harassment (no coercion, intimidation)
3. Right to be free from physical and mental abuse and physical punishment. Restraint and Seclusion can only be used to ensure safety of patient, staff, or others.
4. The use of weapons for seclusion and restraint is not allowed unless there is criminal behavior. Police are responsible for use of weapons.

In a hospital setting if the hospital staff determines that a patient is at risk of harm to self or others, they may use seclusion and restraint for up to a limited amount of time and must

release when the person exhibits safe behavior. The hospital must also respond to the physical and mental distress of the patient. Staff must have training in de-escalation training and how to use restraints and seclusion and use the least restrictive option possible. Law enforcement use their own standards if taken into their custody. However, unless they take the person into custody, they may not interact with the patient.

Rep. Anne B. Donahue, spoke in her role as a mental health advocate and psychiatric survivor. She is looking for an option for law enforcement to provide support to hospital staff when the patient cannot be removed because they have not been evaluated, are not stable or are waiting for inpatient admissions. EMTALA only allows law enforcement involvement if it is a criminal matter. Donahue said there is a history of bias toward people with mental health conditions that dehumanizes and disempowers people with mental health conditions. Empathy, comfort, and support for psychiatric emergencies is not the same as for medical emergencies. She believes that this implicit bias impacts the use of law enforcement. It was pointed out that we have not achieved parity in health care with insufficient urgent care and inpatient care access. Anne Donahue expressed dismay that people are left for days in jail-like environments in emergency department (ED) when they have psychiatric conditions. "We would not tolerate this for any other conditions" she said. When there is dysregulation, the underlying medical conditions need to be considered, too. She suggested protective custody be used without arresting a person, which is a civil not criminal action. This would avoid arrest.

Chief Douglas Allen, President, Vermont Association of Chiefs of Police, is supportive of the bill as it stands, but agreed with the concept of protective custody so the person can continue to receive care from the hospital.

Lindsey Owen, Executive Director, Disability Rights Vermont, believes hospitals should be a safe space. She recognized that it is an unsafe workplace for staff, but people with disabilities have been mistreated by hospital staff, including physical assaults. She testified that the bill will not protect patients or staff because it's an after-the-fact reaction. It will disproportionately impact people with mental illness and lead them into the criminal justice system and deter them for using hospital care. In particular, she is concerned that arrest without a warrant for tumultuous conduct is too vague. She asked that the Committee eliminate disorderly conduct and require reporting by the hospital to DRVT if a request is made for warrantless arrest because she wants to ensure there are no abuses. Lindsey Owen asked if a patient is put in protective custody, where would they go? She would like hospitals to manage the need for seclusion and restraint.

Jack McCullough, Director of Mental Health Law Project, Vermont Legal Aid, testified that none of the harms identified should be happening. The incidents identified are unlawful and prosecuted. He doesn't see anything in the bill that will prevent crimes. Hospitals can already do brief hands-on or seclusion and restraints. He doesn't see this as addressing legitimate needs of hospitals. He doesn't want to see law enforcement intervening when people are in psychiatric crisis because it is more likely to escalate than deescalate the situation. He sees it as a gross violation of the patient's privacy. He pointed out that Vermont has grossly inadequate mental health services which gives rise to psychiatric crisis.

Meg Polyte, Policy Director, Alzheimer's Association, Vermont Chapter, said each year there are 3,010 ED visits by dementia patients and acting out is a normal part of confusion. They may well engage in tumultuous behavior. If the bill moves forward, she asked the Committee to carve out people with dementia and noted that some people with dementia may show up in an ED without a diagnosis. She is worried that nursing homes and residential facilities will discharge people if they are arrested and then they will not be able to find another placement with an arrest on their record.

Mary Moulton, Executive Director, Washington County Mental Health Services, spoke on behalf of VCP. She appreciates balancing the safety of health care workers and the treatment needs of people and believes the implications and unintended consequences of the bill are concerning. The language now says stabilization is required for people to leave the ED, but Mary wants to ensure the person has had medical testing for things like brain aneurysms, drug and alcohol toxicity, electrolyte imbalances, etc. She believes that people on track for inpatient psychiatric care and those with intellectual and developmental disabilities (I/DD) should be excluded from the provisions for warrantless arrest. Many have long waits for inpatient psychiatric care and the behavior of those waiting for days sometimes escalates—should the police come in and provide custody? She doesn't know. She said sometimes law enforcement calms a situation—especially if they are well trained. She said if law enforcement could stay for a short time, that might work, but that's difficult for them. If the bill passes, she recommends tracking why the person is arrested and what the conditions were prior to the arrest and reviewing in one year. The hospital staff should have a debriefing when traumatic situations occur.

In closing, Mary Moulton said we are expanding mobile crisis, but need more urgent care and public inebriate programs to prevent ED utilization. She wants us to train together and work together to achieve the best results. During questions from legislators Mary said if a person is on a treatment track, it's the hospital's responsibility to provide care, but when the person is not there for treatment, then she supports the hospital to call in law enforcement.

Mike Fisher, Chief Health Care Advocate, Vermont Legal Aid, said the bill raises knurly questions with competing values and his goal is to narrow it, not oppose it. He believes there are times when it makes sense to bring law enforcement into health care facilities, and there are substantial risks. To reduce risk, the bill should narrowly define these situations. The concept of protective/temporary custody raises concerns. Who will do what, for how long and what will the impact be on the patient and others in the ED? There may be predictable racial bias, in addition to bias against people with psychiatric conditions. Suggestions:

1. Remove disorderly conduct, or remove "tumultuous behavior" because it's too much of a judgement call or remove disorderly conduct entirely.
2. Definition of health care facility: First responder settings and ED, only.
3. Look at the health care setting to make it more therapeutic

House General and Housing Considers Access to VT Home Improvement Program

In expectation of consideration of S.100, testimony was taken by the House General and Housing Committee on the Vermont Housing Improvement Program. Julie Tessler of VCP provided an overview of VCP, DA/SSA, people served in developmental services and the residential options available to them. She spoke about the level of stress that the people served are experiencing and the challenges of meeting the residential needs of people with disabilities. She asked the Committee to consider adjustments to the language in S.100 that would enable shared living providers to access Vermont Home Improvement Program (VHIP) funds to make accessibility and home improvements, as well as to meet new requirements of the CMS settings rule.

Susan Aranoff of the VT Developmental Disability Council (VTDDC) spoke about their new Housing report which identified the need for over 600 units of housing for people with I/DD. She said improved investment into accessible housing could address the injustice people with I/DD experience because of the eugenics movement.

1. VHIP should allow all landlords to make code and access renovations;
2. Vermont should include all people receiving home and community-based services (HCBS) on the list of preferred applicants for public housing;
3. Include people who house people who received Medicaid-funded services to have access to VHIP funding. This would include shared living providers.

Chair Stevens told the Committee that he would be interested in a set aside for SLPs.

Senate Health and Welfare Takes Testimony on the 2024 Budget

Julie Tessler presented a brief overview of VCP and the designated and specialized service system. She highlighted the impact of multiple years of underfunding on staff vacancies, turnover and access to quality of care. She noted the statutory language developed by the Senate Health and Welfare Committee requiring the Secretary of Human Services to annually consider inflation and labor market dynamics when setting a rate adjustment for DA/SSAs. VCP budget asks to the Committee are:

10% Medicaid Rate Increase

- ✓ Address inflation and labor Market factors
- ✓ Reduce staff burnout and ensure Quality Care
- ✓ Reduce waits for needed services

\$1.3M GF to Improve Mental Health Rate Equity

\$453,000 GF to fully fund Eldercare mental health outreach program

\$ 6M one-time Tuition Assistance/Loan Repayment Program

- ✓ Workforce Development
- ✓ Staff Recruitment and Retention

Susan Aranoff, of the VTDDC, supported the 9 new positions for DAIL in the House FY24 budget bill for oversight and quality oversight because the HCBS is in crisis. She said there needs to be

checks and balances in the community system of care and acknowledged that “it’s been an under-resourced system for a long time.” Channeling Beth Sightler, she said if you don’t increase wages, increasing oversight will just identify the underfunding—the Agencies are competing with fast food for staff.

Ellen Riley, Member from the Developmental Disabilities Housing Initiative, spoke eloquently about how her son lives with her and her husband. He needs services to give him a robust and full life. Since June of 2019 when he left high school he has had 5 DSPs, and now another one is leaving for higher pay and benefits elsewhere. Each time there is staff turnover her son experiences stress, anger, and depression. There is no one trained to take her place. His employment and community care is jeopardized by the underfunding and immediate staffing crisis. The families are suffering and carrying the load. She focused on the 1,000 staff vacancies. She said it’s a hard job, you need trained and qualified individuals.

Senate Health & Welfare Receives Introduction to H.171 Update of Abuse and Neglect Statute

Rep Dan Noyes from the House Human Services Committee introduced H.171 on the Adult Protective Services statutes to the Senate Health and Welfare Committee. The statute was originally passed when vulnerable Vermonters mostly lived in institutional settings. He explained that it’s important to update the bill to address the choice of Vermonters to live in community settings. Many agencies use the abuse registry as part of their background check process.

Two key factors that are considered:

1. Is the individual a vulnerable adult?
2. Is there an allegation of abuse, neglect, or exploitation?

The Bill sets up two tracks of action by the Adult Protective Services team.

1. Assessment and proactive process which may lead to reparations or rehabilitation;
2. Full investigation which may lead to a placement on the abuse registry.

Legislative Counsel Katie McLinn reviewed the [bill](#) section by section for the Committee. She noted that the definition section is critical. There are significant changes to the definitions of abuse, exploitation, and neglect. Vermont Care Partners and other health care providers are concerned that the current version of the bill includes negligence in the definition of abuse. Testimony on the bill will be taken by the Committee this week.

Reducing Mechanisms for Suicide in Senate Judiciary Committee

Senate Judiciary took testimony on [H230](#), an act related to reducing mechanisms for suicide. The bill creates a penalty for storing firearms unlocked and/or loaded if the firearm is then used for the commission of a crime or displaying it in a threatening manner. It also expands who can apply for an Extreme Risk Protection Order to a family or household member and imposes a 72-hour waiting period for firearm purchases. The Committee heard from a variety of witnesses

that paralleled testimony on this bill in House Health Care, as summarized in the [VCP Legislative Update from March 1](#).

VCP Testifies on Revising the Warrant Statute in House Health Care

Legislative Counsel Katie McLinn walked the House Health Care Committee through S.47, a bill proposed by VCP, which covers transportation for people not yet in the care and custody of the DMH Commissioner. McLinn noted that this applies to people who are not involved in the criminal justice system. It is for when a family member or a treatment team member is concerned that a person is at risk of harm to themselves or others and is in need of treatment. They are either examined by a physician, or if a physician is not available, a judge can issue a warrant to allow them to be transported to the hospital for an examination by a psychiatrist—the second certification. Getting into the care of the custody of the Commissioner occurs after the second certification. If the psychiatrist examines the person and agrees that they are in need of treatment, there is a 72-hour window in which the person has to voluntarily agree to treatment, or the Commissioner files an application for involuntary treatment.

VCP Mental Health Services Director Dillon Burns, Team Two Coordinator Kristin Chandler, and Clara Martin Acute Care Director Kristen Briggs teamed up to provide [testimony](#) on the bill, along with pre-recorded testimony from First Call Assistant Director Brandi Littlefield. They emphasized that the current statute is over 50 years old and was written in the context of a different system. Confusion between providers in the field due to unclear language in the statute brought the network to create a stakeholder group and propose revised language. It is not intended to change people's rights or expand the scope for any partner, but rather to provide clarity to expedite access to care. Chandler emphasized that it is really a big deal to take away someone's rights. A warrant is a way to get someone some help when all other avenues for them to access care voluntarily have been exhausted. Challenges in the field have been going on for at least 10 years but have become increasingly difficult since the implementation of the Use of Force policy. Chandler noted the discrepancy between law and practice in the field for law enforcement, and that half of judges are new within the last two years.

Burns explained that this language allows only law enforcement to take someone into custody, and judges cannot order Qualified Mental Health Professionals [QMHPs] to transport. Briggs noted the complexity of transporting someone without support or training. It can feel unsafe and create liability. Rep Cina noted that he is a crisis clinician but not a QMHP. He reinforced that other avenues to access treatment voluntarily are exhausted before getting a warrant. He asked about changes in the Use of Force policy. He said it used to be that there would be a warrant, and police would take them to the hospital. Now, with Use of Force, it has changed a lot. Chandler said that now, in many counties, the police officer won't transport until the judge has issued the warrant. This process is a lengthy process—it can take 6-7 hours. The whole point of it is to get someone some help. "Our hope is that it is clear that officers can take people to the ED—that they won't have to wait."

Briggs noted that it's common that the warrant process happens at a barracks as well as an ED. Rep Houghton asked why the police barracks is included as a destination. Briggs said the ED can be a complicated place to go, given that there may be a lot of law enforcement and the person is among other people who are seeking care. If a person is not able to be safe, sometimes it's better not to be at the ED, if the warrant hasn't yet been approved. It's really common for this to be adjacent to criminal activity—sometimes it takes time for law enforcement and QMHP to tease out whether there will be charges or whether the person is in need of treatment.

Rep Houghton asked if there was consensus in the stakeholder group. Burns responded that the group was largely silent on the proposed language when it was sent out this fall, and VCP is now working with stakeholders on some consensus areas before they take more testimony. Chandler previewed that personal observation statute is a sticky wicket. Jack McCullough from Vermont Legal Aid is proposing a separate affidavit. Rep Demars noted that the ambulance workers are the first people who get called in his region due to lack of other first responder resources. In rural regions they rely on state police or sheriffs for transport. Most people with mental illness are not violent. Briggs has experience partnering with EMS when law enforcement wouldn't come on the scene. The testimony can be viewed [here](#).

UPCOMING EVENT

Disability Awareness Day “We Are Your Neighbors”

Online Forum Event, Wednesday, April 19 – 5:00 to 6:30 PM

[REGISTRATION LINK](#)

LEGISLATIVE RESOURCES

Vermont Care Partners Advocacy Fact Sheet

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

YouTube 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 and specialized developmental and mental health service agencies.