



Replacing the Vermont State Hospital with Humane Community-based Recovery — and Saving Millions of Dollars for Vermont Taxpayers

December 2007



An Ethan Allen Institute Report

“Don’t Send Me to Waterbury!”

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CONTENTS

Dark Old Days at Waterbury	2
Executive Summary	3
Treating Mental Illness in Vermont: A Brief Chronology	4
Who Does the Vermont State Hospital Serve?	6
The Case for Building a New Vermont State Institution	7
The Case Against Building a New State Institution	10
Managing the Forensic Patient Population	12
Serving the Non-Forensic Population	12
Useful Models of Recovery in Community Settings	12
Recommendations for Action	16
Treatment	17
Service Providers	18
Facility Locations	18
End Notes	19

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Cover photo courtesy Vermont Historical Society Library.



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The Dark Old Days at Waterbury

Hazel was washing dishes in her mother's kitchen when she heard that her fiancé had died in a tractor accident. "Mother said, 'If you don't stop crying, I'm sending you to Waterbury.'"

Hazel couldn't and her mother did. Hazel stayed more than 20 years. When she finally got out, her family was all gone. She had no skills or friends. She died in a run-down board and care home, robbed of her life.

Five members of Bill's extended family died within a year, and Bill fell apart. "They sent me to Waterbury," he recalled. "They pulled all my teeth and let me go after 16 years." Bill was discharged in the 1980s, leaving with his few clothes in a garbage bag. Occasional dish washing jobs proved too stressful for the 60 year old man who lived in poverty on 16 medications. He died, with no family at his side, in a Northeast Kingdom nursing home,

Their mother was a hooker, and Florence and Julia were underfoot. At ages 2 and 4 they were sent off to the Brandon Training School. The sisters were released when their mother died 24 years later. Neither young woman had any skills for community living. Florence could only defecate and urinate when others were in the room, having been herded with a group to a row of toilets all her life. Julia didn't know her favorite color, food or music. Neither knew the difference between loitering and window shopping at the mall. Both had been given hysterectomies when they started menstruating. And all of their teeth were pulled, too.

Overwhelmed by life outside the institution, Florence was sent to the Vermont State Hospital in the 1940s. Julia found a job as a housekeeper for a blind man in a one room cabin with a dirt floor. The sisters lost touch.

Forty years later, Florence surprised everyone at VSH when she announced that she wanted "out of this damn bug house!" State mental health officials refused her request, claiming she couldn't manage on the outside. Florence won her appeal to the Vermont Supreme Court, and moved out with little more than the five-foot stack of her medical records. She lived 12 more years in her own apartment. She enjoyed wearing many watches, the sign of power in the state institutions. One of her prized possessions was the letter she received while living at the state hospital, informing her of her father's death. Florence and Julia were eventually reunited after a 50-year separation. They died a few years apart, in different nursing homes, alone.

Traumatized at home and institutionalized for life, these four Vermonters are testimony that institutional living does not promote recovery. Surely, Vermont can do better.

Bethany Knight knows these personal stories through her work with Washington County Citizen Advocacy, as a long term care ombudsman, and eventually as guardian to the elderly sisters. Bill, Florence and Julia are all buried on her farm, at their request. She doesn't know what happened to Hazel.

“Don’t Send Me to Waterbury!” – Executive Summary

For the past 25 years there have been repeated calls for the closure of the Vermont State Hospital, with its dark history of often horrific treatments. A major policy question facing the 2008 Legislature is whether the inmates of the 110-year old Hospital will move to community settings, or to one or more costly new state institutions.

That question must be informed by a modern awareness of the nature of mental illness, and the efficacy, expense, and humanity of various alternative methods and settings for treatment and recovery. Perhaps most importantly, public policy and practices must be shaped in close partnership with the dedicated community of Vermonters who have lived experience with mental health crises, rather than shaped by the preferences of bureaucrats, clinicians, and the employee labor union.

Today VSH houses approximately 42 men and women on any given day, at about \$20 million state dollars a year. Virtually all of these Vermonters are involuntarily admitted and eligible for Medicaid, but Medicaid funds cannot be used to pay for their care because the Federal government has, for the third time, decertified the hospital.

Vermont now has the opportunity to fully develop a mental health care system where three-fourths of the present Hospital’s population can find support and healing in small, safe, secure and far more cost-effective community settings. Those patients who have committed crimes should be treated within the correctional system.

This report recommends that

- **The operative policy for Vermont’s seriously mentally ill population ought not be removal from society, but recovery in community.** Vermont’s mental health system should be centered on community-based services, not built around a centralized psychiatric facility.
- **The Department of Mental Health should abandon its relentless quest for the construction of new high-cost state-owned mini-VSH facilities,** whether in Waterbury, the FAHC Burlington campus, or elsewhere.
- The DMH and designated agencies should **welcome new private providers of services,** such as residential recovery housing (Fairweather Lodges), and faith-based and peer-run drop-in centers. Every temptation to secure a monopoly, so damaging to the interests of consumers, must be stoutly resisted.
- Community hospitals must evolve to holistically address the physical and mental health of the people in their communities, and address the issue of forced medication as a serious question of medical ethics.
- **Designated agencies should employ peers** and give them authority to serve creatively, not simply direct new workers to provide old models of care. Providers should seek compassionate staff members who like people and are not looking for opportunities or evidence to punish clients.
- **Building an enormously expensive new replacement facility for VSH, at the urging of a state bureaucracy and its employee union allies, over the objections of the Public Oversight Commission and most advocates for the mentally ill, will create a large and unnecessary burden for a generation of Vermont taxpayers, while offering inadequate recovery services for Vermonters with mental illness.** It is not sound public policy.



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Treating Mental Illness in Vermont: A Brief Chronology

On August 8, 1891, a train from the south pulled into the Waterbury station on the Central Vermont Railroad. Twenty-five prisoners had arrived from the Brattleboro Retreat; the first inmates of the new Vermont State Asylum for the Insane.

Like hundreds of Vermonters who would follow them, a move to the Hospital meant beginning a long sentence of hard work and often frightening treatments. For the next 65 years, the “insane” performed the hospital’s housekeeping and custodial chores, staffed the laundry, kitchen, and boiler rooms, as well as tended the grounds, gardens, graveyard, piggery, hennery, slaughterhouse, dairy farm and acres of crops.

In those days – and right into the 1960s – insanity and its more modern and inclusive name, mental illness, were a mystery to medicine. Treating a mystery is a challenge. The Vermont State Hospital staff had no clue about the crises and traumas that brought people to their hospital. They had even less of a clue about what treatment or support would help people recover. Consequently, early treatment of inmates was greatly influenced by the preferences of the Hospital’s superintendents and doctors. Often selected for the convenience and comfort of the staff, services involved extreme experimental practices and punitive quarantining on locked wards with subhuman conditions.

In the 1930s, the accepted “best practice” for disruptive patients was a colonic irrigation, lying strapped to a table. The “best practice” for epileptics was wearing a nightgown 24 hours a day, tied to benches with arms tied behind their backs during daylight hours. The “best practice” for “acutely disturbed female patients” was hydrotherapy, immersion in cold water baths.

In 1950, “best practices” included an electroshock treatment called the Blitz, administered to women without muscle relaxants, leaving many with broken bones. If the Blitz produced no results, “best practice” put patients in 60 full insulin comas over a 90-day period.

In 1950 the Medical Building opened and became the dubious site for 22 years of surgery, including lobotomies, abortions, sterilizations and hysterectomies.

In 1958 the first experimental halfway house was established in Montpelier to receive VSH patients deemed ready to adjust to community life.

In 1960, 1,240 Vermonters lived on the Waterbury campus, and more than 160 died.

With the establishment of Medicare and Medicaid, and the expansion of disability insurance, housing assistance and other Government programs, hospital discharges surged in the 1966-80 period. Federal funding stimulated the growth of nursing homes and community residential programs, making it easier to place patients outside of hospitals; moreover, the transfer of patients to nursing homes and community residences allowed fiscally stressed state administrators to capture federal money not available for patients in state mental institutions.

Looking back at 1968, a former VSH director of nursing, Marsha Kincheloe, wrote, “Success had changed the very nature of the institution. The 15 years of rehab effort had resulted in the discharge of most of the patients who provided useful labor at the Hospital. This was good for them, but up to 1954 two-thirds of all the work in the hospital was performed by unpaid patient labor. The loss of nearly 90 percent of this labor force meant that as the hospital grew smaller, it became more expensive to run as people had to be hired to perform functions that had once been done for free.”¹

In 1971, the VSH dairy farm closed and the cows were dispersed to farms in other towns.

In 1984, “As the community mental health centers continued to grow so did their ability to provide rehabilitation and alternatives to hospitalization...the hospital census dropped to 150 patients. The Legislature was faced with declining federal funds, Community Mental Health Centers in great need of more money, and a small expensive hospital that was going to require an even greater investment to pass JCAHO [accreditation] standards,” Kincheloe recalled.²

In 1986, the federal government decertified the Hospital for poor care. Certification, essential to make patients eligible for federal funds, was eventually restored when the state reconfigured part of the facility as a nursing home.

In 1987, researchers led by a former Vermont commissioner of mental health published an article entitled, “A State Mental Health System with No State Hospital: The Vermont Feasibility Study.” This visionary report concluded, “Developing comprehensive regional community support and rehabilitation services to replace the state hospital for all public mental health clients except forensic patients was both feasible and desirable since it would result in better services at a roughly equivalent cost to the state. The team also developed recommendations for optimizing the success of regionalization.” The study covered the feasibility and the desirability of operating a state mental health system without a state hospital, except for a small forensic facility. Feasibility was examined in terms of client needs, service system capabilities, financing, human resource requirements, legal and rights protection issues, and political considerations.³

In 1995, the state negotiated a community mental health Medicaid waiver that drew down federal money for services. Some of the new funds were used to cover nearly two-thirds of the cost of running the VSH.

That same year Trinity College Professor Paul Carling wrote, “We are on course in Vermont, of phasing and closing our only state hospital in favor of a completely community-based service system. It is simply not clear at this point how far the state hospital census will decline....It may, in fact, be wise to take the position that no one can know exactly how much hospitalization any system will require in the future, because an excellent system should need very little – certainly much less than is currently used. Moreover, many of the state hospital beds we now have in Vermont can be replaced by using non-hospital alternatives and by using the services of other hospitals closer to home.”⁴

Also in 1995, a 30-plus year follow-up study of individuals who once resided at the Vermont State Hospital showed former patients had very successfully adapted to community life (more productive, fewer symptoms and better overall functioning) when offered accompanying social, residential and work-based rehabilitation services.⁵

In 1999 the U.S. Supreme Court held in *Olmstead v. L.C.*⁶ that the unjustified isolation of individuals with disabilities is properly regarded as discrimination based on disability. The Court held that unjustified segregation in institutions is discrimination, not only because it perpetuates unwarranted assumptions that people with disabilities are incapable or unworthy of participating in community life, but also because confinement in an institution severely curtails everyday life activities, such as family relations, social contacts, work, educational advancement and cultural enrichment.⁷ Vermont’s plan for implementation of the *Olmstead* decision was finalized in February 2006.

In 2000, the Vermont Commission on Psychological Trauma reported a concern about whether facilities like the state hospital caused more trauma than healing. “Certain practices, such as physical restraint, involuntary medication and the housing with privacy typically associated with inpatient settings also result in retraumatization for victims of sexual and physical violence, by recreating the emotional and physical conditions of the original trauma event.”⁸

In 2003, the federal government again decertified the Hospital for poor care, following two patient suicides. The certification was again eventually restored.

Joining the national movement to shift from mental health treatment to recovery, in 2003 the Veterans Administration Action Agenda recommended that the VA adopt a consumer-centered, re-

covery-oriented model in place of a model that simply manages symptoms and accepts long-term disability.⁹ The VA group further recommended that consumers be significantly involved in everything from planning to choosing providers to delivering services.¹⁰

In 2004, the U.S. Department of Justice issued a condemning report on the Vermont State Hospital, calling it “dehumanizing” and “prison-like.” The report found that VSH staff used restraints when the patient was in no immediate danger to self or others, as a first resort, longer than the incident warranted, without appropriate rationale, and for the convenience of staff. Further, the DoJ found Vermont’s use of restraints was far above the national average for like settings.¹¹

Later that year the General Assembly created the Vermont Futures Planning Advisory Group and instructed the Secretary of Human Services to consult with it to create a strategic plan for the replacement of the Vermont State Hospital.¹²

In 2005, the federal government decertified the Hospital again for poor care, after two patients ran away. Because VSH remains decertified, Medicaid funds can not be used to cover the treatment of VSH patients. Vermont taxpayers are thus paying more than \$20 million a year to support fewer than 50 VSH patients a day. The average number of individuals served annually at VSH is 225, with an average length of stay of less than 70 days.¹³

In 2006, the Futures Group released its Vermont Futures Plan. Echoing recommendations heard since the 1980s, the Group called for the final closure of VSH by 2012. The plan further recommended locating new in-patient programs in collaboration with existing tertiary, community and specialty hospitals and developing a new array of in-patient and out-patient community and rehabilitation services.

In 2007 the FY08 Appropriations Act included language changing the Futures Planning Advisory Group into the Advisory Council for Transformation of Mental Health Services (the “Transformation Council”), which met for the first time in September 2007.¹⁴ Members of the council were appointed by the commissioner of mental health and include consumers and their family members. The purpose of the council is to seek input on mental health program options and policies and ensure that such programs and policies are consistent with goal of ensuring consumers have access to comprehensive and adequate continuum of mental health services.

By 2011 the 110-year old Vermont State Hospital almost certainly will have closed. Whether the inmates, like the cows at the hospital farm, will move to community settings, or to a costly new state institution, is a major policy question facing the 2008 Legislature. **That policy must be informed by a modern awareness of what constitutes mental illness, and the efficacy, expense, and humanity of various alternative methods and settings for treatment and recovery.** Perhaps most importantly, state policy and practices must be shaped in close partnership with the dedicated and experienced community of Vermonters who have lived experience with mental health crises, rather than driven solely by clinicians or bureaucrats.

Who Does the Vermont State Hospital Serve?

The VSH today serves an average of 42 patients on any given day. Virtually all of these persons are involuntarily admitted and eligible for Medicaid. Sixty percent are diagnosed with a co-occurring substance abuse disorder.

VSH conducts about 100 in-patient forensic evaluations each year, usually within 30 days. These are conducted for persons sent to the Hospital by a court for a determination of their sanity at the time of the alleged offense, their mental state associated with the offense, and their competence to stand trial. If persons are found incompetent to stand trial, they are, after a hearing, involuntarily committed.

On any given day, around 15 of the Hospital's patients have a history of violence towards staff and others, requiring a high level of security. Department of Mental Health (DMH) officials also state that community placements have not and do not work for this subset of the patient population. Many observers claim that community placements don't work because these individuals have spent too much of their lives in state facilities. Generally middle aged and older men and women, these 15 or so people typically require one or two staff at all times, and are suffering more from the disability of long term institutionalization than their original diagnosis. The Legislature's consultants propose that this particular subset of the VSH population be addressed first, through construction of a non-acute, secure care residence on the VSH campus in Waterbury.¹⁵

The remaining 30 or so patients are men and women labeled as having severe and persistent mental illness. When deemed by a physician and a designated mental health agency and subsequently found by the Court as in need of Emergency Evaluations (EE), they stay at the examining facility between two to 12 months. Most EEs are conducted in community hospitals, to determine whether a person needs treatment, a change in service or medication, or a change in housing.

Persons undergoing an EE must have been refused admission by all Vermont hospitals before going to VSH. In 2004, 252 Emergency Evaluations were conducted in the five Vermont hospitals designated for that purpose, and 95 at VSH. The median length of stay at VSH of patients undergoing EEs is two months and the mean length of stay is 21 months.¹⁶

Over the past 40 years there has been a clear and pronounced trend toward deinstitutionalization. In Vermont today there are 14 community hospitals, 11 designated community mental health agencies, and numerous peer-supported recovery programs. A wide array of psychotropic medications make it possible for many people with mental illnesses to live normal lives. None of these factors existed when the VSH was created, or indeed until it was into its sixth decade. With some medical and social support, thousands of persons once thought to be "hopelessly insane" have been able to learn to live peaceably and productively outside of an institution.

The Legislature of 2008 will debate two models: the old state-controlled institutional model that removes people from the community, and the newer community model not operated by the state, which stresses recovery in a homelike setting. Each ought to be judged on criteria of efficacy, safety, cost, and humanity.

Legislators need to ask: what is the reason behind the astonishingly high cost preferences of the Department of Mental Health – and whether there is some way of promoting recovery among mental patients that is both more successful and less expensive for taxpayers.

The Case for Building a New Vermont State Institution

The case for replacing the obsolete VSH with a new and improved (and very expensive) institution is based on five arguments:

First, inertia. For 110 years the state has had a state hospital for the mentally ill. That is the historic benchmark – even though dramatic changes have taken place over those years, from the era of electroshock, hydrotherapy, blitz, and indentured servitude, to modern medications and community recovery models.

Second, it is an undeniable truth that there must be a secure facility to house the criminal and potentially violent patient, who society cannot allow to remain at large. This case, however, only argues for housing about a dozen such persons, a fairly stable number over the past several years. Vermont still must deal with the small but very real concern that Rep. Donald Grout of Stowe identified in 1881 when he introduced the legislation to create the Waterbury asylum to, "provide for the care, custody and treatment of the insane criminals of the State." A large hospital or rehabilitation center may well be not what they need.

Third, Vermont's community hospitals endorsed the Department's Certificate of Need application, as the DMH's proposed solution would not require the hospitals to make significant changes. They argue that Vermont's community hospitals lack the beds and trained staff needed to accept additional patients now resident at the VSH, patients who would be primarily Medicaid enrollees. The unspoken reality here is that thanks to the state's major expansion of Medicaid in the 1990s without adequate funding to support it, that program has become a serious money-losing proposition for Vermont hospitals.

These are understandable concerns, but the arguments for making an historic and humane change in Vermont's mental health system are far more compelling.

When Vermont's nursing homes were asked to begin admitting complex, skilled nursing patients in the 1990s, few facilities felt prepared. Saying "No" to this unwanted change was a common initial response. Previously, most of the 3,000 plus nursing home patients were mentally alert and needed fairly straightforward custodial care. In those days, nursing home admissions directors shied away from accepting Alzheimer's patients. Now, the majority of Vermont's nursing home residents has dementia or requires care that was once the exclusive domain of hospitals.

In the mid-1990s, when the nursing home at the state hospital was closed, private facilities balked at admitting former VSH patients, claiming, "Patient acuity was too high to manage". After being offered free staff training in caring for people with a psychiatric diagnosis and significant admission bonuses, facilities finally agreed to admit long-term VSH patients. Patients were accepted on a "no-reject" policy and successfully integrated into the state's nursing homes. Union House in Glover was one of the most open to such a population, and has had no significant problems with offering quality care.

Receiving care close to home is a fundamental principle of the Vermont health care system. With additional support, training and funding, Vermont can serve the non-forensic population needing mental health services in community hospital psychiatric wards, when hospital care is the preferred setting.

In 1994 the Department of Mental Health started this exact process, entering into partnerships with five designated hospitals to shift patients involuntarily admitted to VSH to community hospital settings. The designated hospitals still have the right to refuse an admission if they "do not feel they can safely treat," due to patient acuity or behavior.

Significantly, when the VSH daily census approaches 50, designated mental health agencies and hospitals must admit the "overflow". This proved that, when required, community hospitals can treat non-forensic patients from VSH.

There are six hospitals in Vermont with such expertise: Central Vermont, Springfield, Rutland, VA in White River Junction, Fletcher Allen and the Brattleboro Retreat. All but the VA serve both voluntary and involuntary patients. The VA only handles voluntary admissions.

In 2002 these six hospitals and the Vermont State Hospital had a combined 5,031 mental health admissions, far above the national average. Incredibly, the fewest admissions – just 217 – occurred at the VSH. The remaining admissions breakdown: Central Vermont 530; Springfield 626; Rutland 506; VA 376; Fletcher Allen 691; and the Brattleboro Retreat 2,085. By law, VSH is the only hospital with a "no-reject" admissions policy, meaning, unlike their colleagues in the six other hospitals, the VSH psychiatrists can't refuse admissions. Also by law, the VSH is also the only hospital that can forcibly medicate patients.

Vermont has about 200 licensed psychiatric beds, (56 at VSH) not counting children's beds.¹⁷ Out-of-state hospitals with mental health wards, such as the 21 beds at Dartmouth Hitchcock Hospital in Lebanon, NH, provide nearly 10 percent of the mental health inpatient services received an-

nally by Vermonters. These beds are not part of this calculation, as the law currently does not permit the court to order Vermonters to go to another state.

In a February 2005 report to AHS secretary Charles Smith, the then Division of Mental Health used a formula based on VSH census trends and determined the state needs a psychiatric bed capacity of 101 psychiatric beds.¹⁸

If even more capacity is needed, seven of Vermont's 14 hospitals licensed as critical access hospitals could each also add up to 10 psychiatric beds: Copley, Gifford, Grace Cottage, Mt. Ascutney, North Country, Northeastern Vermont Regional and Porter Medical Center. The other critical access hospital in Vermont, the Windham Center at Springfield, already operates a 10-bed psychiatric unit.

The state's six general hospitals can also add up to 10 psychiatric beds each without danger of complications in federal funding. (Absent a waiver, hospitals that become predominantly mental hospitals lose eligibility for Medicaid payments for mental patients.) Three of the six already have psychiatric units: Central Vermont (17 beds), Fletcher Allen (28 beds), and Rutland Regional (19 beds). The others are Northwestern, Southwestern Vermont Health Care, and Brattleboro Memorial.

Fourth, it is possible that mental health clinicians support a new VSH because VSH is the only facility where it is legal to administer forced medication. If clinicians want this power and control in a new setting, a controversial public debate would have to be opened to amend Act 114 of 1998.

For close to 100 years, until 1985, patients could be forcibly drugged at VSH without a due process hearing. In 1984 Vermont State Hospital patients filed a class action lawsuit claiming violations of their due process rights when receiving forced non-emergency medication. The following year the court approved the now famous J.L. consent decree, in which the Hospital agreed that patients could not be forced to take psychiatric medications (often through injection) without first having a hearing with representation.

In 1990 the state unsuccessfully sought to have the court dissolve the decree. In 1998 Vermont enacted Act 114 to put the provisions of the decree into statute. Again in 2002, the state asked the state Supreme Court to vacate the decree, and this time the decision was overturned and the decree was vacated.¹⁹

Fifth – and perhaps most politically significant – the Vermont State Employees Association (VSEA) strongly supports creation of a new multi-million dollar hospital in Waterbury. The union currently represents some 200 employees at VSH and ardently opposes anything resembling “privatization”. A VSEA representative, participating in discussions around the planned closure of VSH, said, “The whole process has been tremendously flawed and we believe it is nothing more than an attempt by the Administration to wash their hands of the mental health system through privatization.”²⁰

Transferring all or most of the current VSH patients to community settings, supervised by designated agencies whose employees are not state employees, would diminish the VSEA's breadth and reach, i.e. membership base and dues. Many VSH employees are second and third generation employees.

The permanent “temporary” on call crew of the Hospital, brought in on an “as needed” basis, consists of about 45 state employees living in the Waterbury area.

The FY 2007 Capital Bill includes this provision, lobbied for by the VSEA: “Staffing shall include demonstrated due diligence in support of the statement in the Vermont futures strategic implementation plan of July 11, 2005 that the ‘expertise and experience of the current VSH staff is a valuable resource’ by identifying potential avenues that would enable current qualified staff to maintain their status and contractual benefits as Vermont state employees.”²¹

VSEA's website has conducted a poll, asking the question, "How has the state done on the Vermont State Hospital Relocation?"²²

Working with friendly politicians, the VSEA can be expected to mount a fierce campaign to build the new facility in Waterbury, at whatever cost. Legislators will need to keep in mind the interests of mental patients and of their taxpayer constituents when the VSEA presses for its special interest in preserving state employee jobs.

The Case Against Building a New State Institution

The opposition to building a new state hospital comes primarily from groups working in the interests of civil rights, those with mental illness and legislators responding to taxpayers.

The first group believes that when people are sick, traumatized or troubled, the remedy is safety, security, kindness, understanding and human relationships. By their very design, institutions set up an us-them paradigm. The persons managing the institutions tend to view the patient as a helpless and defective object, whose capacity to work out of crisis into recovery is limited or nonexistent. They see their role as doing things to patients – the "best practices".

In years past, mental health policy centered on removing the troubled from the community. Over the last 30 years, a community-based, peer supported movement has developed a low profile but highly successful model of recovery across the country. People previously labeled as violent and/or a danger to themselves and others have found comfort and recovery in low cost, small residential settings. Remaining connected to the community – not removed -has proven to be the cornerstone of true rehabilitation and recovery.

Patient and peer advocates are particularly opposed to institutions that habitually engage in forced or involuntary application of drugs, seclusion and restraints. In 2006 VSH documented 366 episodes of patient seclusion, ranging from 11 to 60 episodes per month. That same year, a four-point or five-point restraint bed was used 254 times, from one to three hours each time. Forced medications were given a total of 293 times.²³

"The federal government, Joint Commission on the Accreditation of Hospital Organizations (JCAHO), consumer and family organizations, professional organizations, and state mental health authorities are all invested in the reduction and elimination of seclusion and restraint as a practice within treatment settings."²⁴

Patients often speak of being frightened, becoming increasingly angry, and feeling abused and violated, while thinking that the staff seemed happier to have them restrained, making them less of a management problem.

VSH staff leads all state employees in on the job injuries, logging in more incidents than corrections guards or the Vermont National Guard, many of whose members are serving in a war zone. Such a haunting statistic is yet another reason why Vermont must no longer practice the primitive technique of restraint. When a person is doing something to another person that is not humane, the consequences are clearly not humane for either party.

In 2004, Vermont Protection and Advocacy staff concluded "It is the staff's perceptions and fears that the patient may injure themselves or others, or that the staff will lose control over the situation, that dictates the use of seclusion and restraint and the violence associated with those measures."²⁵

The psychiatry unit within Salem Hospital in Salem, Oregon, has six years of experience with nearly eliminating the use of locked seclusion and mechanical restraint. Unanticipated benefits include increased patient, family, staff, and physician satisfaction, reduction of patient and staff injury, and improved recruitment of staff and physicians. By focusing on respect and dignity, the environ-

ment has become one of participation and healing. Staff time is used more efficiently and the program has improved financially.²⁶

In 2004, the Vermont Mental Health Performance Indicator Project noted, “Restraint and seclusion, which are currently accepted methods of management of psychiatric consumers in this country, meet DSM-IV definition of human-induced traumatic stressors. Both exert violent and absolute control while engendering utter helplessness and fear.”²⁷

In the winter of 1999-2000, Vermont’s then Commissioner of Mental Health Rodney Copeland issued a report identifying the need to “... eliminate the coercion experienced by our most vulnerable citizens.”²⁸ The report described the Department’s plan to provide a “... significant increase in our efforts to eliminate coercion from our systems of care.”²⁹

Following the achievement of Vermont’s private nursing homes more than 15 years ago, mental health facilities need to finally become restraint-free. Nursing homes in Vermont virtually eliminated the use of restraints in 1991, after determining more than 30 percent of their patients were physically restrained in 1987.

State officials should closely consult with Vermont Psychiatric Survivors (VPS), the operators of Safe Haven (see p. 13), to work out creative alternatives to the use of restraints. Even seclusion affords an individual more dignity.

Patient advocacy groups like VPS are concerned that a new state facility for mental patients will eat up available funds that might be far better employed through community-based services. Many involuntary admissions to VSH are already occurring because of underfunded and unavailable community services. The construction of a new facility could prevent the transfer of VSH patients into far less expensive and far more suitable community settings. An underutilized new state institution will put pressure on its administrators to get more patients into more beds, regardless of the interests of those patients.

Advocacy groups believe that after years of being tested in state and nationally, community-based organizations offer a far more humane, recovery-centered and cost-effective method of serving Vermonters with mental illness.

Opposition – rather unorganized – to a new VSH also comes from stressed-out taxpayers. In its January 2007 report the Public Oversight Commission said, “...discussion of costs by the Applicant [Department] during the conceptual CON phase suggests a capital expenditure approaching \$100,000,000. This amount seems beyond the fiscal capability of the State of Vermont if the overall components of the Futures Project were to be implemented and adequately funded....An acute care solution which detracts from necessary funding of the community care components undermines the overall objectives of the Futures Plan.”³⁰

The level of state capital construction bonding for FY 2009 is \$54.6 million. The cost of debt service for a new \$86 million VSH facility will significantly impact this budget. In doing so, the VSH project will be in competition with other state capital construction needs, local water and sewer projects, and school construction projects.

There are, fortunately, more attractive alternatives.

Managing the Forensic Patient Population

Persons – mostly men – who are awaiting charges, charged with, or convicted of a crime, should receive mental health and substance abuse services within Department of Corrections facilities or designated community hospitals. Many are already held in correctional facilities, awaiting trial.

Those who must, for public safety, remain in a Corrections facility, should remain in a designated separate unit for those with medical illness. The Department of Corrections has separate units for those inmates who are non-predatory and are susceptible to being manipulated or abused by others. They are housed in an 18-bed unit in the Northwest State Correctional Facility (St. Albans) and a 28-bed unit in the Northern State Correctional Facility (Newport).

Within the corrections system, mental health services are provided in a 24 bed unit at the Southern State Correctional Facility (Springfield) a secure 10-bed unit in the Southern State Correctional Facility (Springfield) for special needs cases who require secure housing and 14 beds at the Dale II unit (Waterbury) for women with special needs. For close custody, designated units are at St. Johnsbury (8 beds), Newport (10, proposed as future housing for civil commitment), Springfield (32) and St. Albans (10). Inmates can be segregated in the following units: St. Johnsbury (8), Newport (8), Springfield (16), Marble Valley (4), Chittenden (4), and St. Albans (10).³¹

In the past five years, much has improved according to Department of Corrections officials. Corrections mental health care has received more funding; contracts have been signed with new service providers, with new, built-in oversight by a combined Quality Council of the state Departments of Corrections and Health.

The small number of permanent criminally insane inmates housed at the present VSH can be accommodated in a special unit at a regular corrections facility or transported out of state to an appropriate state or federal facilities.

Serving the Non-Forensic Population

The great majority of VSH patients are not in the custody of the Department of Corrections. These persons can be accommodated in one of several models.

The Futures Report calls for “Building peer support capacity and employing blended peer / professional models of care are important in promoting resilience and recovery from mental illness. This plan recommends a grant capacity and the solicitation of proposals from peer support organizations and from peer/professional collaborative groups for building up the evidence-based peer-support resources of our continuum of care.”³²

Eight of the state’s ten designated mental health agencies are using peers to work with patients. Peers with lived experience are a real asset to a community program, for they will make certain that other staff will be “trauma informed,” i.e., will avoid actions that will aggravate the traumas that are the cause of so many mental illnesses.

Useful Models of Recovery in Community Settings

Safe Haven is a Randolph-based peer/professional-supported living collaboration between Vermont Psychiatric Survivors and the Clara Martin Center, the local designated mental health agency. Now in its tenth year of operation, Safe Haven houses six people discharged from VSH. The mental health agency contracts through VPS so that peers are actually employed by VPS, limiting the designated agency’s liability exposure.

Funded by a HUD program for the homeless and some investment from Clara Martin, Safe Haven is “the cheapest program” in Vermont, noted for “good successes,” according to VPS executive director Linda Corey. Former patients often return to college, get degrees in the field and come back to work in recovery programs.

Just one peer staffer is on duty at the unlocked residence at any given time. No professional mental health workers are present; when residents want such attention or treatment, they go to the Clara Martin Center.

Some residents come to Safe Haven from VSH on an Order of NonHospitalization (ONH) from the courts, meaning that they are discharged with conditions. Conditions might include staying at Safe Haven, taking medications or contacting support staff regularly. The Order is a court document the patient also signs. If a resident on an Order decides to leave Safe Haven, the peer worker tells them he or she will report the departure to the Clara Martin Center staff.

Safe Haven residents are often considered the tough VSH discharges, cases “no one else wants.” Many have long histories with Corrections and Mental Health. Safe Haven informs the Randolph police whenever such a resident moves in.

Staying an average of two years at the home, residents are taught basic skills before they find their own living situation nearby. Senior housing and private apartments are common transition housing.

A cost analysis prepared by Safe Haven of six guests who stayed there during 2006-07, found that savings to the state totaled more than \$2 million.

One guest stayed 230 days for \$7,360. Had this patient been at VSH, the bill would have been \$241,500.

Other stays resulted in equally dramatic savings, on guests staying 62 days, 273 days, 307 days, 488 days and even 22 months. In all cases, the cost savings were based on a charge of \$32 a day, as opposed to a VSH charge of \$1,050.

What makes the Safe Haven model and costs even more remarkable is that the program routinely accepts patients from VSH that have no home to return to. It is also noteworthy that each of these guests successfully transitioned to the community from Safe Haven, to either senior housing or a private apartment.³³

Second Spring in Williamstown, a community-based residence for recovery and treatment, serves up to 11 discharged VSH patients, and is staffed by peers and nonpeers. Former patients come on a voluntary basis to learn how to live again in the community, something impossible to learn in a hospital setting. With only eight months of operation on the books, firm budget figures are not yet available. Second Spring’s monthly charge to an SSI client is approximately \$611. The program is supplemented with another \$1,050 by Medicaid, totaling more than \$1,600 a month.³⁴ DMH Commissioner Michael Hartman estimates the full cost of running Second Spring is closer to \$750 a day – expensive, but still less than VSH’s \$1,050 daily rate.

Home Intervention in Montpelier, sponsored by Washington County Mental Health, is described by some as “a user-friendly alternative voluntary hospital diversion program” for up to six people. An unlocked acute psychiatric crisis residence staffed by peers, HI offers healthy, home cooked meals and a chance to rest. Ex-patients say that at VSH, they aren’t “allowed to lie down during the day.” Treated with respect, HI participants can smoke, stay in touch with community supports and have their own room.

No programming or programs are offered at HI, a feature designed to encourage participants to go into the community and find the doctors and other supports they need. HI emphasizes independence, not dependence. Unlike community hospital psychiatric wards where patients are expected to go to as many as five therapy group sessions a day, participants at HI don’t join any in-house programming. HI usually has a waiting list.

During the CON application process, both the Public Oversight Commission and the BISHCA Commissioner clearly directed planners to look at good models in other states, the best practices of both medical and non-medical services and supports: “The CON must explore and consider those al-

ternative solutions for an inpatient psychiatric facility which provide a satisfactory and appropriate balance of the priorities of the Health Resource Allocation Plan and achieves the least capital and operating costs... The CON must include sufficient research and analysis of systems in place or planned in other states to permit assessment of the effectiveness and efficiency of the CON's preferred alternative."³⁵

One such outstanding model operating in many other states is the **Fairweather Lodge**. An intentional community that provides housing, employment and social support for people with psychiatric disabilities, the Lodge was conceived in 1968 by psychologist George W. Fairweather and launched with a grant from the National Institute of Mental Health.

Fairweather believed that people with severe and persistent mental illness could create meaningful lives, living and working in middle class neighborhoods. The first of what has become 19 Lodges was opened in 1970 in Minnesota, sponsored by a nonprofit called Tasks Unlimited. More are planned in Minnesota, due to long waiting lists. People seeking a home, support and a job enter a training or orientation Lodge to determine if they are willing candidates for membership. Training Lodges are licensed as residential care homes and staffed 24 hours, as the effort involves helping former patients, criminals and the homeless to learn the skills of successful daily living.

Lodge members who graduate from training Lodges move into a standard Lodge. One Lodge member said of his move there, "When I went there, I didn't have a home, job or support system. When they answered the door, I had all three. And when I need help, or someone to talk to, I talk to one of the other Lodge members. I don't call professionals." He added, "I work my hours for my money."

Private homes in residential neighborhoods, Lodges are sometimes purchased with HUD mortgages. Six to eight Lodge members live as a group and manage their home, with an average of two hours a week of paid staff support. Staff primarily focuses on benefits counseling. Tracking long term outcomes, "in all categories (days of hospitalization, rates of employment, gross earnings, living situation) the lives of Lodge members improve tremendously, compared to life prior to joining the Lodge... Statistically, their standard of living, social status and even their sense of control over their own lives is dramatically higher and relatively permanent."³⁶

Days of hospitalization averaged 66 per person per year prior to moving to a Lodge. After five years at a Lodge, the average dropped to less than three days. Prior to joining, 16 percent of Lodge members were working. After five years those working are more than 92 percent.

Prior to joining the Lodge, most residents were in high dependency living situations, such as hospitals and treatment programs: 44 percent in hospital, 24 percent in residential psychiatric programs, and 18 percent in residential care homes. Five years later, 69 percent reside in Lodges and 28 percent in unsupervised apartments, with just three percent in residential psychiatric programs. The largest group of Lodge members is individuals with criminal records. Seventy percent of the members have substance abuse problems.

Different from a group home, the Minnesota Fairweather Lodges are member run, with members making and enforcing rules. Lodges are open, with members free to come and go.

Members have an average length of stay of eight years, longer than Americans in the general population live at one address. Members who do move go to private apartments. All members are employed, except those elderly members who have retired. One third of Lodge members have quit the SSDI program and become self supporting taxpayers.

Reflecting on how Lodges interact with the mental health system in Minnesota, Tasks Unlimited executive director John Trepp observed that, "The [mental health] professionals react in horror to people going off disability. They don't tend to believe in recovery or employment."

A few years ago, a movement began in Minnesota to close the Lodges down, because they didn't employ staff to teach independent living or nursing staff to manage the dispensing of medications. "It is difficult for the state to get their heads around the Lodge operations," Trepp said. The Lodges survived the threat of closure and have prospered.

Lodge members participate in community volunteering, such as Habitat for Humanity, and routinely enjoy vacations (such as fishing trips to Alaska), at their own expense. Lodge members repeatedly stress that their lives are "the farthest thing from a program," noting that programs make them feel different and separated from the rest of the community.

From a financial standpoint, Lodge members earn 10 times more than they earned prior to joining, and close to three times more than the Minnesota average for disabled workers.

All members are covered by Medicaid, with Lodge members paying half of the premiums, and Tasks Unlimited paying the remainder. Monthly Lodge costs per member are typically \$245 for rent, \$255 for food and utilities, \$100 for Medicaid buy in, and \$100 for a programming fee that covers benefits counseling. Most members earn \$1,600 after taxes a month, and have between \$500 and \$1,000 a month in discretionary income.

Tasks Unlimited operates several businesses, including janitorial, construction and building rehabilitation, and all of the associated tasks such as bookkeeping, equipment repair, driving, and inventory control. Staffed entirely by Lodge members, TU's annual payroll is \$3.5 million. TU proudly points to the fact that the state subsidy it receives (\$8 a day per member in supported employment funds) totals \$883,447 annually, while the TU payroll tax is a roaring \$846,281! In other words, the Lodges achieve close to a break-even proposition for taxpayers. Further, Lodge members routinely choose to earn money rather than receive SSDI.

Lodge members often speak of the isolating nature of individual or supervised apartments, the preferred housing model promoted by mental health agencies and professionals. Living as a self-directed group and managing their own household (grocery shopping, cooking, cleaning, all tasks), members find new meaning in their lives. They move beyond dwelling on their schizophrenia, bipolar disorder and depression, at virtually no expense to the government. The stability and meaning of Lodge life makes criminal and other socially unacceptable behaviors extremely rare.

Lodge members elect an executive council that makes decisions on who moves in, what vehicles will be purchased, and what business contracts will be pursued. In their 37 years of operation, the Minnesota Lodges report there has been no violence ("two, one-punch fights") and only one suicide. Each Lodge has its own unique identity; one is a home only for convicted murderers.

Rose House in Milton, New York and **Stepping Stone** in Claremont, New Hampshire are peer crisis respite centers that welcome people without expecting or requiring them to take psychotropic medications. Those who find medications useful are responsible for their use. Considered one of the most developed models of its kind, Rose House can accommodate up to five people at one fifth the cost of a psychiatric hospital stay. It provides outreach to private homes and a "warm line," a telephone support service where people can call before they reach crisis, i.e. time for "hotline."³⁷

One of the unique features of Stepping Stone is that consumers must establish a relationship with the facility when they are not in crisis, almost like a membership. After completing such an interview, individuals are told, "come when you need us." Like Rose House, it costs a fraction of a stay in a psychiatric ward.

The Stepping Stone home, open for ten years, has two private, single bedrooms, one full and one half bathroom, a kitchen, and a TV room. Other rooms offer space for peer support groups and creative activities. Some of the current ongoing center activities available to respite guests, include t'ai chi and mediation, music, drumming, art, peer support skills, and groups focused on empowerment,

recovery and wellness. “Guests are free to come and go from the center, cook their own food or participate in the cooking, and have 24 hour peer support available to them.”³⁸

Soteria House in Anchorage, Alaska, is designed for the newly diagnosed individual with severe mental illness, as a non medical alternative to hospitalization. Rather than being retraumatized by an institutional stay, up to eight individuals can stay in a homelike environment, and make their own decisions about what they need.

Staffed by peers, Soteria does not require residents to take antipsychotic medications. A study that tracked Soteria residents from 1971 to 1983 compared 97 patients treated in a conventional hospital with 82 treated in Soteria. At the end of two years, Soteria residents had fewer hospital readmissions, higher employment levels and more were living independently or with peers.³⁹

New York City’s **Pathways to Housing** has an unusual strategy of offering housing before any other support for people with a mental health crisis. It serves homeless people who suffer from psychiatric disabilities by providing housing without requiring participation in treatment or sobriety.

Since 1992, Pathways has worked with homeless people turned away by other programs because of active substance use/abuse, refusal to participate in psychiatric treatment, histories of violence or incarceration, or other behavioral problems. More than 500 people live in permanent housing and receive services through this nonprofit, in Queens, Brooklyn, East Harlem, West Harlem and Mt. Vernon, NY.

Pathways boasts that 85 percent of all clients served have not returned to homelessness. Once into housing, clients can choose clinical services that include psychiatric and substance abuse treatment, comprehensive health care, supported employment services, art and photography workshops, and family reconnection on a twenty-four-hour, seven-day-a-week basis. One of the most cost-effective solutions to ending chronic homelessness, Pathways provides individual apartments and services for \$22,500 per client per year, while a bed in a New York state psychiatric hospital costs \$175,000 per client per year.⁴⁰

Recommendations for Action

Vermont has a commendable history of recognizing when it is time to close a state institution.

The state’s only facility for the mentally retarded, the Brandon Training School, was phased out and finally closed in 1993. Various parties fiercely fought closure, using many of the very fear-based arguments being used today against closing VSH. Fear that severely retarded people could live nowhere but a state institution was a commonly held belief. Of course, virtually all residents were safely and successfully relocated to community housing throughout the state. DMH Commissioner Hartman reports that a few of the 12 to 15 VSH patients labeled unable to reside in the community came out of Brandon.

Governor Richard Snelling called for the closure of the Weeks School for Juvenile Delinquents in Vergennes. That was accomplished in 1979. A small facility, Woodside, was subsequently built in Essex for short term housing of this troubled population.

The operative policy for Vermont’s seriously mentally ill population ought not to be removal from society, but recovery in community.

Wise care in a community setting, aided by peers, must be guided by the basic principles of human dignity, worth, and the value of caring human relationships. Care in a forbidding mental health institution can often become a terrifying dehumanizing ordeal, as referenced in the 2003 suicide note left by VSH patient Chris Fitzgerald: “No more lies, no more pain! Today’s assault is the last degradation I can endure...”

The Institute recommends that the General Assembly keep three features in mind when shaping a \$140 million post-VSH system of recovery-based, trauma-informed services:

I. Treatment

- Vermont’s mental health system should be centered on community-based services, not a centralized psychiatric facility. The greatest emphasis should be placed on avoiding costly hospitalization. “It is likely that general erosion in availability of outpatient services increases the demand for more costly emergency and hospital-based care,” the Department of Mental Health itself admits.⁴¹
- Community and designated hospitals should address the perceived need to involuntarily medicate people as first and foremost a medical ethics question. Treating physical and mental health with parity, hospitals must ask, “What can providers properly do for people who lack the capacity to make a decision about needed immediate medical treatment, be it for a physical or mental condition?”
- With additional and proper support, training and funding, mental illness patients (other than those who are part of the forensic population) can and should be served in our community hospitals, when hospital care is the preferred setting. Placement decisions should factor in funding constraints, as anticipated by the Futures Report: “... it is safe to say that the more integrated, physically, clinically and operationally, the replacement facility is with a general facility, the greater the likelihood that the facility will not be deemed [by the federal government to be] an Institute for Mental Disease and will receive Medicaid reimbursement for services provided to eligible patients.”⁴² The world has changed in the past 50 years, with more and more Americans needing mental rather than physical health care. Community hospitals must evolve to holistically address the physical and mental health of Vermonters, and deal with the question of involuntary medication through its medical ethics committee.
- Providers of mental health services should permanently abandon the use of restraints in Vermont. Within a supportive environment, competent staff can prevent the escalation of confrontational situations. Creative options for regaining stability must be developed, such as calm rooms with music and aromatherapy, and tactile comfort zones.
- The Department should ensure that substance abuse services are made available in all settings.
- Programs should be created to fit to people, not people to programs. The Vermont Peer Support Workgroup, a subcommittee of the Futures Group, has and is making solid proposals worthy of adoption, particularly, “...an holistic crisis model will be created for people who dealing with a psychiatric crisis who do not want to take medications.”
- The forensic population should be dealt with in corrections facilities, with mental health services made available. Community hospitals can bid on contracts to offer timely on-site court ordered forensic evaluations.
- Forensic patients will be the only population transported by sheriff’s departments to mental health and hospital services. All other transport of mental health clients will be contracted with trained, compassionate individuals, a model Washington County Mental Health is now testing.

II. Service Providers

- Designated agencies should embrace and fund a statewide peer specialist training and certification program.
- Providers should employ peers at all appropriate levels of the system. In its follow-up investigation of a 2003 VSH suicide, Vermont Protection and Advocacy recommended that, “VSH should reach out and support augmented peer support and outside community participation for patients at VSH. The aggressive promotion of peer support and recovery programs that utilize

outside, non-VSH staff resources will help bring both a sense of hope and connection to patients that desire such contact. In addition, the presence of outside support people will assure that circumstances inside the hospital are observed and remedial action taken before a crisis situation develops.”⁴³

- Designated agencies should employ peers and give them authority to serve creatively, not simply have new workers deliver old models of care. Providers hiring should seek staff members who like people and are not looking for opportunities or evidence to punish clients.
- Notwithstanding the reemployment language pushed into Act 147 of 2006 by the VSEA, providers should avoid automatically hiring former VSH staff members for patient care positions. Anyone who has been a part of the dehumanizing seclusion, restraint and forced drugging investigated by the U.S. Department of Justice and others ought to seek other types of employment.
- Community hospitals should, where practicable, use peers, particularly in emergency rooms, to calm and support mental health patients in crisis.
- The DMH and designated agencies should welcome new providers of services, such as private faith-based and peer-run drop in centers. Every temptation to secure a service monopoly, always damaging to the interests of consumers, must be stoutly resisted.

III. Facility Locations

- The Department should abandon its relentless quest for the construction of new high-cost state-owned mini-VSH facilities, whether in Waterbury, the FAHC campus or elsewhere.
- If need is demonstrated, designated agencies should create specialized programming residences, more like Safe Haven than Second Spring. Second Spring combines features of medical and non-medical residences. The 11-bed residence in Williamstown, has been open from March of this year, and costs about \$750 a day. Safe Haven is distinctly a nurturing home, with no programming or treatments offered on site. A six bed residence that has operated for 10 years, Safe Haven costs \$32 a day. These models, designed for people recovering from severe and persistent mental illness transitioning from the Vermont State Hospital and ultimately back home, are worth replicating
- If need is demonstrated, the Department should phase in two small (five bed) state operated, non-medical units, one in the north, one in the south, for patients who need temporary high security environments. These recovery residences will employ VSEA staff and utilize plenty of peer supports. By developing these modest options, the state will continue as the mental health provider of last resort.
- Individuals declared criminally insane and unable to stand trial should be housed in a specialized forensic wing of existing correctional facilities, or be tuitioned out to other state or federal settings. Vermont is a small state, and cannot provide all services for all situations, but it can contract for them when needed.
- Community hospitals should increase staff and security measures to achieve the capacity to serve Vermonters in crisis.
- The Department should encourage private residential recovery housing, like Fairweather Lodges, to open in Vermont. Vermont’s practice of using publicly funded therapeutic residences is very expensive. The more such options can be privately operated, the better for residents and taxpayers alike. Some of the most troubled long term residents of VSH, those 12 to 15 individuals referenced earlier, may well find a welcoming home at a Fairweather Lodge.

With designated agencies claiming that even an eight percent annual increase in funding is insufficient, the Legislature should encourage the development of proven less costly models and providers of care.

- The Legislature should create incentives for increasing the stock of private, affordable housing available to people leaving mental health residences. True community based recovery includes the availability of private housing options within cities and towns.

Vermont's diverse population of people with mental health problems needs a variety of humane, affordable, community-based supports. Ultimately, like all consumers, users of mental health services will shape the system by what services they choose. As Michael Allen, senior staff attorney at the Bazelon Center for Mental Health Law in Washington, DC., said, "Putting mental health dollars and decision making in the hands of people with mental illnesses makes good public policy sense."⁴⁴

Building an enormously expensive new replacement facility for VSH, at the urging of a state bureaucracy and its employee union allies, over the objections of the Public Oversight Commission and most advocates for the mentally ill, will create a tremendous and unnecessary burden for a generation of Vermont taxpayers, while offering inadequate recovery services for Vermonters with mental illness. It is not sound public policy.

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The Ethan Allen Institute, founded in 1993, is Vermont's independent, nonpartisan, free-market public policy research and education organization – a “think tank” for issues facing Vermonters.

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