To: Senate Health and Welfare
House Health Care
Cc: Senator Ashe
Representative Johnson
Representative Hooper
Peter Sterling
Secretary Gobeille
Deputy Secretary Maksym
Paul Dragon
From: Commissioner Bailey
Date: March 14, 2017
Re: Committees' Questions and the Department of Mental Health Responses to Date – DRAFT

Please find below the updated legislative questions and the Department of Mental Health responses to date. We wanted to provide you the latest information and recognize additional questions may be forth coming. Please let us know if there are any additional questions o or are clarifications needed from the information provided below.

FACILITIES: Analyze data to determine current facility limitations

What are the geriatric psychiatric bed needs?

This question is best addressed to both DAIL and DMH given that geriatric psychiatric needs often include individuals who may have challenging behavioral presentations, like dementia. On average, DMH has a dozen inpatient admissions a year where disposition delays are attributable to nursing homes feeling unable to manage the clinical needs of referred patients. DMH and DAIL have been working with a couple of nursing homes to identify what is needed for consultation services, financial reimbursement rates that support the higher acuity long-term care services, and the type of program services and staffing needed to manage an aging psychiatric population.

What are the forensic psychiatry bed needs?

Both DMH and DOC have been working to identify the population, both in DOC custody and those not currently involved with DOC, who may benefit from forensic inpatient services. Generally, on an annual basis, the number is under 20 who both require inpatient hospitalization and mental health treatment. Court involvement, especially when court-ordered medication may be recommended, contributes to delays in timely discharge and taking acute care beds off-line. For individuals who are stabilized in hospital and still have pending legal resolutions, secure residential services may be appropriate. Currently, the DMH Commissioner does not have authority to transfer without court approval, which is at the discretion of a judge, and DMH does not have programmatic capacity to serve forensic individuals in an alternate secure treatment setting.

What are the long-term residential treatment bed needs?

DMH has developed a number of transitional, long-term, and secure residential beds prior to and following funding authorized und Act 79. Additional bed capacity may be beneficial to the system of care, but secure bed capacity is currently the least available option in the current residential bed continuum. In earlier reports to the House Corrections and Institutions Committee, DMH recommended at least 14 beds be created. DMH has also reported to this same committee the demands, implications, and challenges identified through Request for Information (RFI) responses to an RFI released in 2014. Most recently DMH released a Request for Proposals (RFP) with broad parameters of potential populations to be served and the management of the program or programs that might be created. Responses to the RFP are pending. With regard to long term residential and staff security needs, the response is contingent on the population to be served and level of secure containment determined to be both treatment focused and sufficiently secure that would assure safety for residents, staff, and community.

What are the child and adolescent facility bed needs?

DMH and DCF response indicated – it would take some time to analyze the system to identify exactly what is needed. We are in the process of working with DVHA to build 6 more bed capacity of hospital diversion in the southern part of the state. Additionally DCF and DMH have been working on “turn the curve” to reduce the use of residential care for children and build more community based and family based capacity, we would prefer to direct resources there.

What are the occupancy rates in crisis beds by locations? What is the distribution of crisis beds?

Breakdown of adult MH crisis beds: Number of beds for each program, location, and occupancy rate.

					FY16	FY17 Q1		FY17 Q2	
Program	**DA**	**Location**	**#Beds**	**% Occupancy**	**% Occupancy (less closed)**	**% Occupancy**	**% Occupancy (less closed)**	**% Occupancy**	**% Occupancy (less closed)**
Alyssum Inc	Alyssum	Rochester	2	84%	89%	81%	83%	65%	67%
Chris's Place	CMC	Randolph	2	80%	91%	65%	69%	69%	81%
Cottage Crisis Bed	CSAC	Middlebury	1	84%	84%	86%	86%	96%	96%
Assist	HC	Burlington	6	71%	73%	61%	66%	55%	55%
Alternatives	HCRS	Springfield	6	93%	93%	89%	90%	86%	92%
Oasis House	LCMH	Hyde Park	2	75%	81%	74%	75%	68%	68%
Maple House	WCMH	Montpelier	1	61%	61%	55%	55%	46%	46%
Bayview	NCSS	St Albans	2	88%	93%	90%	91%	84%	90%
Care Bed	NKHS	St Johnsbury	2	72%	75%	84%	84%	70%	70%
RMHS CSID	RMHS	Rutland	4	87%	91%	58%	95%	73%	82%
Second Spring	CS Corps	Williamstown	2	66%	66%	50%	50%	50%	50%
Battelle House	UCS	Bennington	6	53%	53%	44%	47%	28%	30%
Home Intervention (Adult)	WCMH	Barre	4	56%	58%	51%	52%	60%	61%
Total			**40**	**74%**	**76%**	**66%**	**71%**	**63%**	**66%**

What is DMH's expected occupancy rate for the crisis beds? If we have crisis beds that are consistently not meeting this rate, what are the reasons that this is happening? (e.g. closing beds due to staffing, acuity of clients, not enough referrals)

80% occupancy annually.

Breakdown of DA crisis programs by DA, region and whether or not the program is currently "mobile" (i.e. able to go into the community vs. having people meet them at the ER).

All DAs have crisis programs and all have indicated that they are mobile. One DA has indicated that they continue to have difficulty with nights and weekends due to staffing. Addison County is having the most difficult time being mobile. Orange, Lamoille, and Bennington Counties also struggle at times.

Latest report on ER wait times.

ATTACHMENT: Most recent information through January. See link below

Synopsis: On average, we have anywhere from 4-8 involuntary adults waiting per day and 30-50 involuntary adults total per month.

There was approximately 65 involuntary youth last year, according to our wait data.
https://app.resultsscorecard.com/Scorecard/Embed/14723

We do not get data on all voluntary waits at Emergency Departments. Some hospitals report, some do not and there is no consistency. DMH does not have statutory authority to require all reported voluntary waits including for Medicaid or private insurance.

Information on Team Two. How much funding does it get? Has funding increased in the past few years? Does current funding allow Team Two to respond to current need?

Funding was $83,334.00 in Year One and Year Two. Funding increased to $101,657.00 with financial participation from the Department of Public Safety. Additional funding would allow Team Two to reach more law enforcement and emergency responder groups and potentially offer longer training opportunities and/or refresher trainings where needed.

Does NH have a forensic psychiatric facility?

New Hampshire State Hospital has a 158- bed capacity for both civil commitment and forensic admissions, but not all forensic admissions are served by the hospital. The NH Department of Corrections (DOC) Medical and Forensic Services Division operates several treatment units

including the Secure Psychiatric Unit, Residential Treatment Unit, Wellness Units, and Focus Units. These modified therapeutic communities were established to treat inmates with mental health diagnoses and/or substance use disorders with the goal of helping them successfully transition into step down units or facilities to continue with their treatment needs. The state's Secure Psychiatric Unit (SPU) has 60 beds and the men and women here are typically dangerous. Some are civilly committed, some are deemed incompetent to stand trial, some are found not guilty by reason of insanity and others are violent inmates. New Hampshire is one of only a few states that places violent mentally ill people in a DOC setting. Media accounts indicate that a number of factors led to placing more behaviorally challenging or dangerous individuals in a DOC facility - assuring the safety of the staff and neighborhoods around the state hospital, the state decision to develop a new prison facility that could manage the population, and concerns for maintaining state hospital accreditation and Medicaid participation if challenging or dangerous individuals were placed with other vulnerable civilly committed adults with mental illness. The SPU has not sought certification, is not a hospital, and does not external oversight as it is located in a prison. There was a 2010 report recommending that the state build a new high security psychiatric facility on the grounds of the New Hampshire Hospital. Construction was estimated at more than $13 million, but identified as five times more expensive than placement in SPU. New Hampshire Hospital costs were identified as $1,350 a day versus $270 a day at the SPU.

It should be noted that a complaint, filed in August 2016 with the U.S. Department of Justice, claims: "The state of New Hampshire is systematically and intentionally violating the Constitution as well as the civil rights and civil liberties of a very vulnerable population." - The complaints alleges that the DOC SPU was designed to hold individuals involved in the criminal justice system due to mental health issues, such as those deemed guilty by reason of insanity or those awaiting certification as competent to stand trial. The complaint noted that it also houses patients who the state identifies as "too dangerous or disruptive to treat at the state hospital". - See more at: http://www.unionleader.com/health/Feds-asked-to-probe-mental-health-setup-at-State-Prison-08122016#sthash.q3r6DT7X.dpuf

WORKFORCE:

Analyze data to determine workforce limitations

This is a complicated topic and deserves discussion and input from multiple partners and the state. The AHS Secretary is convening two sub-workgroups focused on the inpatient and outpatient service needs. These questions have been separately queried by VAHHS and VCP for response. These questions will be addressed in more detail in the pending mental health bill if passed by involved providers.

- need for competitive salaries within the designated agencies
- rate of turnover

- number of vacancies.
- Lack of staff and underutilized existing resources (i.e. crisis beds)
- Trained personnel
- Nationwide nurse shortage, especially psychiatric specialization
- Psychiatry shortage
- Capacity if telehealth

Workforce Incentives:

- AHEC
- Loan forgiveness
- DOL
- Priority for dual enrollments pursuing health careers – dual credentialing (SA and MH) ?
- (Apply any new ed/recruitment/education incentives to drug counselors)

Ph.D. Psychologist prescribing privileges –

This is also the subject of pending legislation. DMH will need to do research on extent of utilization in other states and any professional limitations still required. It is premature to take a position on its feasibility or usefulness without additional exploration.

Can you tell me how much is spent on traveling nurses compared how much is spent on regular staff nurses? How many of each were used (most recent fiscal year 16 is probably fine).

In FY 16, DMH spent $2,102,299 on traveling nurses. The difference in traveling nurse vs staff nurse is between $21,732 and $42,532 per nurse (including salary and fringe). Temporary versus permanent nurses are roughly 35% - 40% vs. 60-65% respectively at present. The AHS/DHR workgroup on nursing salaries and subsequent salary adjustments have made compensation more competitive. The shortage of trained nurses, especially psychiatric nurses, is a primary reason for ongoing recruitment challenges. This has not changed and will not be immediately impacted by compensation changes without impacts to other healthcare environments experiencing shortages.

The average cost of a travel nurse vs a vacant staff nurse is approx. $30K. We have typically averaged 16, however, because of the market factor increases we expect to be able to reduce that to 12-14 in the coming months and further in FY 18. Using the average of 16 for FY 17, the additional cost would be approximately $510,000. Nurses are committed to a 13 week minimum, however, some nurses do extend their commitment. They cannot extend indefinitely, because that could change their traveler status.

Children and adolescents – Is there a short supply in terms of professional caregivers?

Further context or clarification is needed. Does this mean therapeutic foster care or other types of service professionals?

How is 24 hour hotline working? Now 8-12 hours. Data?

The Vermont Support Line (VSL) is one of the programs developed subsequent to the implementation of Act 79. This program provides statewide telephone peer support to prevent crisis and provide wellness coaching. VSL operates 365 days per year, seven days a week, and, with new funding from Vermont's Mental Health Block Grant, the line is now open an average of 10 hours per day. VSL is operated by full time and part time peer staff who have been trained using the Intentional Peer Support model, which uses a specialized curriculum developed expressly for support line workers. The Vermont Support Line took its first call on March 18, 2013 and has provided 22,638 individual instances of completed support through November of this year. FY16 surpassed FY15's completed call volume by 1,344 calls. Through November 2016, the Vermont Support Line has diverted 1,080 callers from emergency level services (crisis, emergency room, hospital, 911, etc.). In 2016, the support line has been able to increase the amount of incoming calls answered from 12.8% in 2015 to 20.6% (through November) of total incoming calls. So far in 2016, 82% of callers who answered the survey questions reported that the call was helpful.

Workforce growth/change overall in Mental health as relates to admissions/pts/clients

Data available annually. We can provide links or manually.

What is a mental health technician? What is training and Education like? Who pays for it?

VPCH employs Mental Health Specialists and have job descriptions and minimum training and education requirements as part of job specifications. These are state funded positions. VAHHS will need to respond to these questions regarding who are the employees at hospitals labeled as mental health technicians.

Crisis teams: how many? Distribution? Turnover rates? Where do they go? Why?

Each DA (10) has a crisis team in each catchment area. Turnover rates are within the 27% identified for DA's. VCP can respond to this question with regard to recruitment challenges and turnover.

Turn over rates at all levels (hospital and Das) where do they go?

Turnover as above for DA's. VAHHS can respond for hospitals

Turn over rates in EDs

VAHHS should respond to this question.

FLOW:

Define best practices for transitions (movement between levels of care) and establish responsibility for it

AHS sub-group working on this question

Develop immediate, short term and long term goals with bench marks, including funding

AHS sub-group working on this question

Who has been in level 1 beds and why

The majority of Level 1 patients are orders of emergency examination and have been determined to be a risk to themselves or others and require more than usual supports and services while inpatient. Level I definition has been contractually defined for nearly 5 years and expectation to have level 1 was set in statute during Act 79.

Who has been in crisis beds and where did they go?

Individuals stepped down from inpatient care when psychiatrically stabilized and individuals who could be served outside of an inpatient unit and determined by a physician to not require inpatient treatment. Individuals return to lesser levels of care much of the time (outpatient services, home with supports or independently, residential supported settings, no follow-up services). We do not have data to give specifics of where all individuals discharge to after crisis beds. Each individual DA may keep that data.

Who are possible populations to be served?

- Geri/psych – non offenders
- Old "feeble" offenders not to be mixed with others
- Act 248 - Developmentally disabled offenders
- Longer term secure psych facility – not (Level I) requiring hospital care

With the exception of Act 248 individuals, the recent DMH RFP attempted to address the needs of these populations and solicit potential interest from vendors in creating programs/facilities to serve these individuals in units or programs to meet their unique treatment needs.

Why can't we move patients in the system as needed? Care coordinators must have doctor permission; sometimes days to get it. Is there a protocol or model we can follow that allows more efficiency?

Movement within the system is determined by the qualifying clinical provider who has the legal responsibility for an individual's care, level of care and licensing requirements of the treating facility in which an individual is treated, and in full accordance with applicable state laws for either voluntary or involuntary care and transport. Only clinical providers operating within their scope of practice can make a disposition or transfer determination, and again the decision must comport with applicable state laws.

What percentage of people who are waiting in ER's for psych placements are current DA clients? Do we know anything else about where people are coming from before they end up in the ER's?

Our estimate is about 50% and the DAs estimate the same – however we don't have data on voluntary individuals this we know this estimate is not 100% accurate. We often hear about individuals de-toxing, some presenting from out of state (however a small number), people who are voluntary (if you need hospitalization and agree you are voluntary and therefore DMH does not necessarily know about you especially if you are not connected to a DA), we have heard some increased stories of individuals with high anxiety and psychotic delusions regarding Russians or spies and we have a number of individuals that are repeats because they are unwilling to engage in treatment options identified as appropriate for them.

Where are the geri-psych patients who are getting stuck at the hospitals coming from? Are they generally coming to the hospital from a nursing home or from some other type of community situation?

There is no specific setting accounting for elder wait times in ED's and wait time concerns are not limited to just geri-psych patients. Individuals may be coming from nursing home or community residential care home settings, individualized alternative care funded settings, or other home settings.

FUNDING:

Request: Provide the budget detail sheet and talking points

Provided on 2/10/17 via email from Jennifer Rowell.

Related to inpatient budget lines between DMH/DHVA - distinction between inpatient care that is DMH funded and that is DVHA funded? How those align with patients hospitalized under the care and custody of the Commissioner (or not.) What is status of plan underway that would bring funding and oversight into alignment?

We previously provided a chart within the system beds attachment (provided previously) that explains who pays for and manages which population. Additionally, DMH and DVHA has worked through the plan stated above, which was presented last session and completed in Summer 2016. A copy of the plan and findings were provided earlier this week. Please let me know if it was not received. (will attach again)

It appeared from budget slides that DMH funds all Level 1 beds? That was the only inpatient category identified in the budget chart. You believed that DMH also funded other involuntary inpatient care? I believe that hospitalization of CRT clients may be under the DMH budget (whether or not involuntary), but there was no apparent budget line; are they included under the CRT program budget/ case rate?

Commissioner Bailey stated that she was incorrect, and that Rep. Donahue was correct that DMH funds Level 1 hospitalizations and hospitalizations for Medicaid-funded CRT clients. The CRT inpatient figure is included in the CRT section of the pie chart. The inpatient costs are approximately $3.2 million, or 5.4% of the total CRT budget.

It would also be helpful to have the comparative per day cost for the VPCH, the other Level 1 beds, non-Level 1 inpatient, and the secure residential program.

- VPCH - $2,277 per bed per day
- BR - $1,425 per bed per day
- RRMC - $1,375 per bed per day
- MTCR - $1,272 per bed per day

If we supported the base of the system (DAs, crisis, step down, and level one system), would the system function as planned? The GMCB analysis of the Howard Centers budget suggested that they are underfunded and that waiting for the all payer model/ACO structures to take care of payments to occur may be a better approach rather than undertaking whole system change now. Is that correct?

Medicaid Pathways was launched as opportunities for both service and system reform, as well as payment reform. Continuation of this work or some future iteration of comparable work may yield recommendations that better respond to these questions.

Is there's more financial efficiency for the DAs? Some sources have suggest that where privates make money and hospitals break even on service/program offerings, DAs manage to lose money. If that's true, we don't want to be wasteful with the funding we assume we can find.

Generally, large health care providers/facilities can cost shift to consumers via insurers or carry the costs of less financially viable services on the backs of profit generating services to make overall services expenditures manageable for the organization. Also, consumers can generally "shop around" for the specialty care that they might be seeking, especially if they have private insurance. Also, health care facilities can customize the specialty care that is offered. Psychiatric care, even in a health care setting, typically does not generate profit as most health providers will attest to when questioned. DA's are required to provide core services on behalf of the state, and often to the state's most vulnerable and under or uninsured population (sliding fee-scale requirements) who have limited choices for care. Therefore,

ability to absorb losses in programs does not have the same fiscal flexibilities available. Opportunities to maximize or make profit are very limited and specialty or longer-term mental health care is often seen as an obligation of the state by insurers, especially when it begins to be cost prohibitive for for-profit or other entities that are afforded options to shift costs back to the state. Fund raising is an option for DA's, but also requires shifting personnel and time to this function for sustainability.

Costs to hospitals in present situation- ER construction, extra staff, sitters, mental health tech?

VAHHS should respond to this question

Sheriff costs in ED's

DMH allocation covers costs for sheriffs for both involuntary care transports and sheriff supervision in ED's.

For supervision only, costs were:

FY 15 - $719,441
FY 16 - $509,411
FY 17 through January 31, 2017 - $520,411
Total sheriff cost supervision and all transports (this includes all sheriff transports and is not just ED transports) Further breakdown would require manual sort and staff time spent in this activity

FY 15 - $894,771
FY 16 - $566,136
FY 17 through January 31, 2017 - $655,477

Costs to DA's for new hires resulting from high turnover?

VCP should respond to this question.

What do hospitals pay annually for patients stuck in the ED? How does that effect staff turnout in ED's? How are psych techs trained

and paid for in ED's? Capital investments? Law enforcement? Sitters? Untreated other people – who are those people? Quantify why they are there and involuntary medication?

VAHHS is most appropriate responder to these questions.

What is the cost of keeping geri-psych patients in higher levels of care than they need?

DVHA would be able to respond to this question for Medicaid population.

Do we need a geri/psych residence, how big (study)?

DMH and DAIL have been working with two long-term care facilities to consider more specialized care for elders with either psychiatric need or dementia related behavioral dysregulation. This work also include Division of Rate Setting for sustainable funding strategies and Division of Licensing and Protection given risk implications for long-term care facilities in accepting elders with higher acuity and other vulnerable adults who are also living in these environments.

Who are the people in the system that is way under paid? What are they paid?

VCP most appropriate to respond.

What could understaffed DA's stop doing?

This is a useful question and should include input from VCP as well. Likewise, it would be important to discuss what AHS and its Departments want DA's to provide and how are the expectations to be funded and sustained, especially as expectations fluctuate more than allocation levels to support the expectations. We know this discussion would result in push onto other systems and so it is important to identify what should possibly be stopped but also what the result of that may be.

What about moving developmentally disabled?

DAIL would best speak to this question. Not all DA's have DS programs. Also, most SSA's are small organizations, so separation may incur added system costs if not utilizing the existing DA infrastructure where available.

What do DA's pay for understaffing, in terms of turnover, retraining, morale, and quality?

VCP is probably best position to respond.

Can crisis teams bill other than Medicaid? What costs avoided with crisis teams? Should they be going out with police?

Individuals who have no insurance would have to be billed for services and are if information about service recipients is known. These individuals would also be subject to sliding fee scale payment. Qualifying clinicians can bill insurance, including Medicaid, if all patient insurance information is known and the service provided is a qualifying service under the insurance plan. Many crisis services may not qualify for reimbursement and some typical DA services do not qualify for third-party insurance reimbursement. There is historical difficulty in showing savings through "cost avoided" care, since the care and subsequent expense, has not been provided or incurred. The question of accompanying police is apart from billing. Capacity to accompany police would likely require additional funding as utilization of services would likely increase, but would not have a commensurate funding source to support the increased demand.

How much would it cost to expand the Support Line an additional 8 hours? (I'll get this info)

Pathways is estimating it would take $110K to $175K to expand the line by an additional 8 hours. Full 24/7 warmline coverage is estimated at an additional $240,000 annually.

What is the capacity funding detail for emergency services?

This is Medicaid investment dollars provided to the Designated Agencies for the costs associated with 24/7 triage, assessment, mobile outreach, short-term family stabilization and referral and screening for hospitalization or hospital diversion for children, youth and families. The investment goal is to increase the access of quality health care to uninsured, underinsured and Medicaid beneficiaries.

DATA/OUTCOMES/QUALITY:

What kind of data can we expect from Medicaid ACO re mental health care and outcomes. Transitions, case management. How will they monitor? Will we be able to learn from it for 2018?

One Care question

How will GMCB monitor mental health integration and results

GMCB question

Committee had requested information indicating total admissions, number of those that are involuntary/EE admissions, of those, how many result in commitment orders, and of those, involuntary medication applications/orders. It would be helpful to have that same set of numbers going back for several years.

Act 79 report highlights most of this information
http://mentalhealth.vermont.gov/sites/dmh/files/documents/reports/2017-ACT_79_Report_2017-02-22.pdf
http://mentalhealth.vermont.gov/sites/dmh/files/documents/reports/Memo_Correction_2017_Act_79_Report_2-22-17.pdf

Most recently available data on involuntary transport, with the breakdown on use of restraints by sheriff department.

Transports to Psychiatric Unit (July 1 2016 - February 24 2017)																
	ADULT Transports					MINOR Transports				Total						
Sheriff Dept.	metal	None	soft	(blank)		metal	None	soft		metal	None	soft	(blank)	Total	Soft/none %	None%
Addison Sheriff	1	4			**5**		1		**1**	**1**	**5**			6	83%	83%
Bennington Sheriff		3			**3**						**3**			3	100%	100%
Caledonia Sheriff	3	6			**9**					**3**	**6**			9	67%	67%
Chittenden Sheriff	9	11	6		**26**					**9**	**11**	**6**		26	65%	42%
Franklin Sheriff	5				**5**					**5**				5	0%	0%
Lamoille Sheriff		44	3		**47**		6		**6**		**50**	**3**		53	100%	94%
Orange Sheriff	1				**1**					**1**				1	0%	0%
Orleans Sheriff			1		**1**							**1**		1	100%	0%
Rutland Sheriff		5	1		**6**		5		**5**		**10**	**1**		11	100%	91%
Washington Sheriff	3	2	4		**9**	1	1	1	**3**	**4**	**3**	**5**		12	67%	25%
Windham Sheriff		2	17	2	**21**			4	**4**		**2**	**21**	**2**	25	92%	8%
Windsor Sheriff	2	8			**10**					**2**	**8**			10	80%	80%
Grand Total	**24**	**85**	**32**	**2**	**143**	**1**	**13**	**5**	**19**	**25**	**98**	**37**	**2**	**162**	83%	60%

Looking back on our data in the Act 79 report, we have had considerable success ensuring that transports are conducted in a safe and humane manner. Both transports to inpatient care for adults and youth have been conducted without restraint (neither soft nor metal) in a majority of cases since mid FY 2013. Additionally, transports to inpatient care that use metal restraints have consistently been under 20% of all inpatient transports.

For FY 2016, 12% of all adult transports and 11% of all youth transports were conducted with metal restraint. This is significantly lower than pre-Irene figures—a 2011 transport report indicated that 27% of all youth transports and 36% of all adult transports utilized metal restraint.

There are several factors that are contributing to this significant improvement:

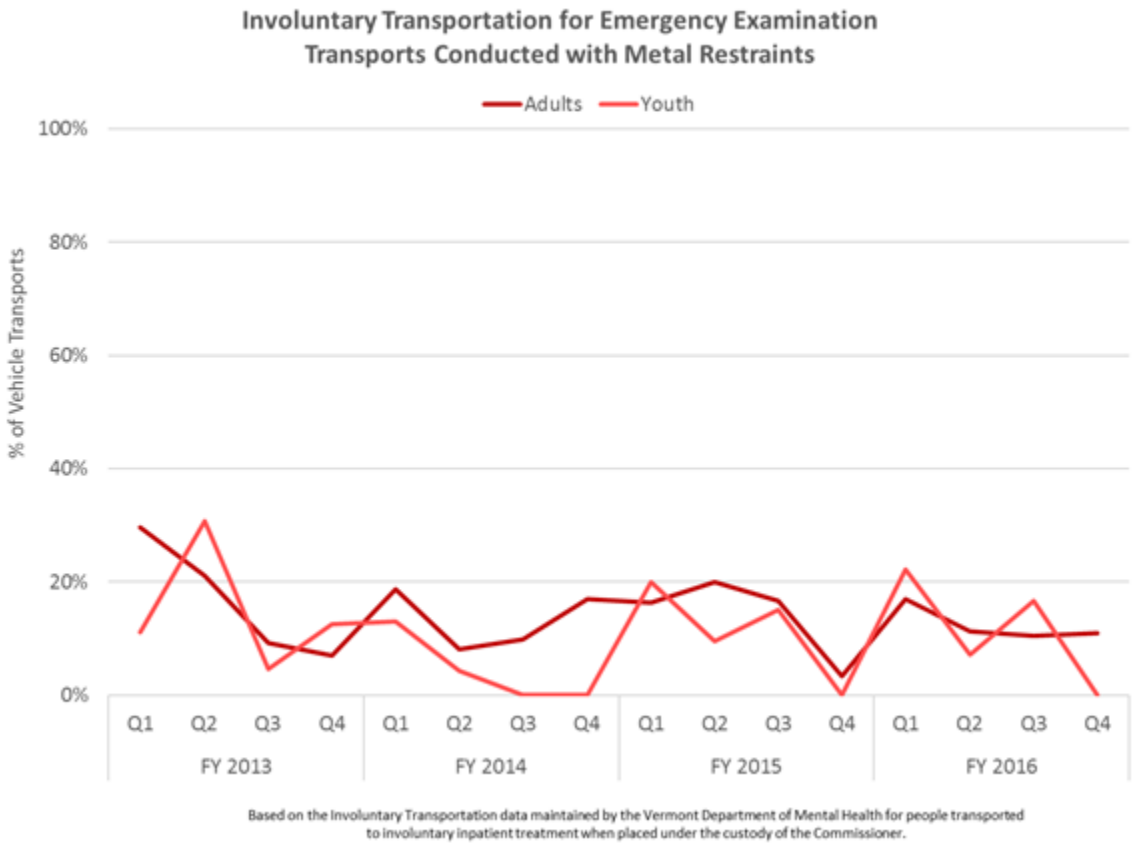
One, DMH has specific contracts with Windham and Lamoille Sheriff Departments that include mental health training and incentives for avoiding the use of metal restraint in transports. As you can see in the report previously provided, Windham and Lamoille conduct almost half of all involuntary transports.

Two, the raw number of transports for those in the custody of the commissioner has decreased significantly with the decentralization of the inpatient system of care. In 2011, there were 79 youth transports and 582 adult transports which is significantly greater than the numbers of transports in FY 2016 (37 transports for youth and 377 transports for adults). Smaller numbers allow a greater number of transports to be conducted by our DMH-specific contracts.

There are still areas for improvement. As you can see form the previous report, there are a few counties are still utilizing metal restraints in a manner more consistent with pre-Irene utilization (30% metal or greater). Of those, there are even fewer that are used frequently for mental health transport (Chittenden County). We continue to work with these Departments to change their use of restraint and their culture around mental health. Outside of these specific Departments, there are legitimate reasons to use metal restraints

Total MH discharges (2012 last number)	Total holds (EE and forensic) (2016)	Total holds placed inpatient (2016)	Total OH (2016)	Total IVM filings (2016)	Total ONHs (2016)
~4,900	679	597	90	96	261

ONHs include those as a direct result of a hospitalization and those that have been continuously renewed. DMH doesn't have a way to distinguish the two at the moment but we are working on it. We looked at general hospital discharge data from 2012 and there were 1961 discharges with a major diagnostic category of mental health and BR reported ~3,000 discharges for the same time period.



Based on the Involuntary Transportation data maintained by the Vermont Department of Mental Health for people transported to involuntary inpatient treatment when placed under the custody of the Commissioner.