

VERMONT2017

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 82, Sections 3 and 4

December 15, 2017



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I. Summary of Report Expectations: The Mental Health System of Care

This report is submitted to satisfy requirements of Act 82¹, Sections 3 and 4 of the 2017-2018 legislative session.

These sections require that the AHS Secretary collaborate with the Commissioner of Mental Health, the Green Mountain Care Board, providers, and persons who are affected by current services, in order to submit an action plan to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services.

The action plan is required to be informed by an analysis of specific issues, including, but not limited to:

1. Data requirements
2. Causes of ED referral and self-referral including the following:
 - a. Circumstances of the individual
 - b. Factors impacting length of waits
 - c. Emergency examinations that do not result in inpatient hospitalization
 - d. Short and long-term trends in inpatient length of stay and readmission rates
3. Services: availability, regional accessibility and gaps
4. Resources necessary to staff Designated and Specialized Agencies (DAs and SSAs)
5. Care coordination- regional development and current Department of Mental Health (DMH) accountability
6. Crisis diversion evaluation including existing and potential new models.
7. Diversion models
8. Implementation of Act 79
9. Mental health access parity
10. Geriatric psychiatric support services*
11. Forensic psychiatric support services or residential care*
12. Units or facilities for use as nursing or residential homes or supportive housing*
13. Emergency Services

* These items will be addressed in the Act 84, Section 31 report due on January 15, 2018.

**Links referenced throughout the document are subject to change. A complete version of this report with attachments will be posted on the DMH website.

¹ <http://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT082/ACT082%20As%20Enacted.pdf>

II. Executive Summary

This report is in response to directives of Act 82, Sections 3 & 4, and addresses many of the challenges and opportunities of the current mental health system of care. Many of the report's identified needs for the system represent expanded ideas and responses that have been worked on for some time prior to the enactment of Act 82. What is different today are the numbers of individuals and families presenting with needs which speaks to the need for bed capacity but also robust and effective community based services.

DMH has approached the directives of Act 82 with an emphasis on stakeholder input and ideas. DMH embraces stakeholder perspectives as pivotal to the work while simultaneously providing leadership and directing efforts. Perspectives were shared from across the system of care from:

- Peers and individuals with lived experience
- Family members
- Emergency room and hospital staff
- Providers
- Police
- Attorneys
- DMH and other AHS Department staff

In the end, not every contributor has agreed to every recommendation or how to prioritize. DMH understands that the task at hand is to move forward, recognizing there will be areas of disagreement. DMH's role is to lead and provide strategic direction in order to start addressing serious and timely systemic challenges.

Key findings of this report include:

- DMH is actively developing and implementing integrated and “whole health” delivery system approaches and has made significant progress implementing evidence based best practices. (Section V)
- DMH collects a variety of data and each data collection effort is unique. Effective analyses are limited by data quality, data scope, and analytical resources. (Section VI)
- There are many reasons for increased referrals and self-referrals to hospital EDs including an increase in overall need. (Section VII)
- Wait times for all levels of response are longer for people seeking psychiatric care than non-psychiatric. (Section VII)
- ED wait time themes *not* supported by available data – “longer stays in inpatient hospitals reduce availability to those who are waiting,” and “[there is an] increase in acuity of patients presenting to EDs.” (Section VII)
- DMH recommends a change to state statute to allow parents and guardians to consent to inpatient treatment for children under age of 12. (Section VII)

- The system is experiencing increased success through the use of intrastate transfers from high acuity beds to general units either in a person's home community if appropriate or to the general unit of the current hospital. (Section VII)
- Currently, there is no in-between resource in Vermont that meets the needs of high acuity individuals who require a safe and contained setting with intensive services. (Section VIII)
- The current capacity of 40 statewide crisis beds has seen a decline in overall utilization for each of the past four fiscal years.
- DMH supports the development and evolution of well-designed mental health courts that are part of a coordinated effort to reduce the number of individuals with mental health challenges needlessly entering the criminal justice system. (Section VIII)
- The total available workforce is not sufficient. A basic increase in wages to staff of DAs and SSAs, while desirable, may not equate to increased access to care for Vermonters across the system of care if the size of the total available workforce does not increase. (Section VIII)
- The % of all VT adults with any mental illness is 20%, which is higher than national avg., the % of all VT youth with serious emotional disturbance is 6%, consistent with national avg., and the % of all VT adults getting treatment is 58%, also higher than national avg. (2015). (Section IX)
- DMH recommends further development of peer resource capacity. (Section XII)
- Most inpatient and residential service providers identify the ongoing scarcity of bed resources in each level of care as a contributing factor to lack of access and long wait times for services. (Section XII)
- Stakeholder groups support all current service options available and recommend more be developed at all levels of the service system with consumer and service provider involvement. (Section XII)
- Vermont has defined expectations for mental health service parity, however, there is little to no agreement across a diverse constituency of stakeholders in how or what achieves true parity and whether or not such parity exists for individuals presenting with mental health conditions. (Section XIII)

III. Section 3(c) Report

All planning and proposals related to forensics, units, facilities or geriatric psychiatric capacity will be included in the in the Act 84, Section 31 report due on Jan 15, 2018.

The following action items from the September 1, 2017 status report described in the next section will also be covered in the Section 3(c) report:

1. Increase the secure residential capacity to at least 16.
2. Create a forensic unit which could be in a corrections facility, a stand-alone facility or a new hospital.
3. Additional level 1 or VPCH type beds – assuring a “no refusal²” system.
4. Continue to explore or build geriatric psychiatric capacity.

IV. September 1st Status Report - Sec. 3(a)(2)

On September 1, 2017 the Department of Mental Health (DMH) submitted a status report to the Senate Committee on Health and Welfare and the House Committees on Health Care and Human Services. This report described the progress made in completing the analysis required within Act 82 and produced a corresponding action plan. The status report included immediate action steps the Agency was able to take to address the hospital emergency department (ED) crisis that did not require additional resources or legislation. This report was created after two public meetings that included a variety of participants representing varying views of the system and its needs.

For a copy of this status report and more information please visit:

<http://mentalhealth.vermont.gov/news/act-82-working-meeting>

http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Act82_Working_Meeting_2017-08-17_FINAL.pdf

After the September 1st status update, work continued to develop themes that were identified during the public meetings. Additionally, the Jeffords Institute for Quality hosted three meetings to focus specifically on the system and flow challenges in Washington County. The findings of that effort echo findings of previous work and is available for review on the DMH website.

² A common understanding of what “no refusal” means in relation to federal law and the Center for Medicaid and Medicare Services (CMS) was agreed to between Vermont Psychiatric Survivors, VAHHS and DMH.

V. Long-term Vision - Sec. 3(a)(1)(A)

DMH is striving to build a holistic system of prevention, treatment, recovery, and support services to promote resilience for all Vermonters affected by mental illness, to prevent mental illness and build mental health³. For this system to be effective, DMH is focused on the following vital strategies:

- Integration across service sectors, including medical, substance abuse, justice and other human services
- A “whole health in all policies”⁴ framework that recognizes social determinants of health
- Strong leadership, active partnerships
- A strengths-based approach to empower individuals, families, and communities
- Use of evidence based and promising practices
- Results Based Accountability
- Innovation and flexibility in funding and program development

DMH believes that integration is most effective if it transcends beyond the doctor’s office and includes a strong focus on prevention. In order to slow the rate of incidence of poor mental health and the cost of services to individuals, we must balance the current intense focus on a medical care model of treating individuals who already have a diagnosis, with increased focus on a public health model of promoting health and preventing problems for the entire population.

DMH has modeled integrated approaches through its Child, Adolescent & Family Unit (CAFU). CAFU has led cross-departmental work in areas such as wellness, suicide prevention and transition age youth, including integrated approaches to care such as continuing to build off the Integrating Family Services. CAFU models a public health approach to:

- Promote mental wellness for all children, youth, families, and communities
- Provide prevention services to reduce risk factors and increase resilience and protective factors for children and youth, at risk for serious mental health needs, and their families
- Provide intervention and treatment services to children and youth with known serious mental health needs and their families to reduce the symptoms of mental disorders and increase competencies and functioning

³ Please see attached for a description of the children, adults and family Systems of Care, a map of designated providers and a description of Community Programs.

⁴ Whole health in all policies is based on the recognition that our greatest health challenges—for example, chronic mental illness, health inequities, climate change, and spiraling health care costs—are highly complex and often linked. Promoting healthy communities requires that we address the social determinants of health, such as transportation, education, access to healthy food, economic opportunities, and more. This requires innovative solutions, a new policy paradigm, and structures that break down the siloed nature of government to advance collaboration.

DMH is committed to a public health approach that is based on whole-person population health. An important part of this commitment involves healthcare reform, with an emphasis on integration. Examples of this work include integrating children and family services in partnership with the Department for Disabilities, Aging and Independent Living (DAIL) and the Department for Children and Families (DCF) and new efforts toward delivery system and payment reform that will be detailed in the annual Act 113 Section 12 report due on January 15th. DMH's leadership dedicates a significant portion of their time, to all aspects of healthcare reform. To assist its work in this area, DMH hired a Director of Mental Health & Health Care Integration for the first time in 2013. In 2014, the director began a "Visioning Process" with leadership to identify the key steps and processes necessary to move the department in this direction, even while maintaining the critical daily functions of overseeing the state's System of Care.

Through the Visioning Process, DMH detailed strategies to accomplish goals for children, adults and families. Many of these strategies are being implemented today:

1. *Becoming a Strengthening Families State* - The Strengthening Families Framework™ is supported by AHS and is actively being implemented by DMH, the Department for Children & Families' (DCF) Child Development Division, the Vermont Department of Health (VDH) and many of AHS's partner organizations.

The Strengthening Families Framework is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. A Strengthening Families approach engages families, programs, and communities to build five "Protective Factors":

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete support in times of need
- Social and emotional competence of children

More than 30 states use the Strengthening Families Framework to guide policy and practice to increase the focus on strengthening protective factors for children and families. More information about the Strengthening Families Framework can be found at:

<https://www.cssp.org/reform/strengtheningfamilies/about/body/Vermont.pdf>

<https://www.cssp.org/young-children-their-families/strengtheningfamilies/about>

AHS has implemented the Strengthening Families Framework in accordance with Act 43 of the 2017 session. AHS convened an interdepartmental team and reviewed 750 community provider grants and then ranked them according to how many of the Strengthening Families Framework Protective Factors the grant supports. AHS views this as the first formal agency-

wide step to creating a work plan to increase cross-agency awareness of trauma as a fundamental issue in our work and to support the intentional use of the Protective Factors framework to guide Agency programs and services.

Building Flourishing Communities - In the past year, DMH has led the implementation of a state-wide, evidence-based public health approach to prevention of early childhood adversity and promotion of thriving through the Building Flourishing Communities initiative. The initiative is implemented primarily through 26 Master Trainers located around the state who are helping to facilitate culture change regarding prevention and treatment of childhood trauma via a community-based, interconnected, public health approach of sharing science-based information and education.

DMH has established a steering committee of experts from across the state to help guide this work. The 26 Master Trainers are working through-out Vermont presenting information about the neuroscience, epigenetics science, the Adverse Childhood Experiences study and resilience science to community members and organizations interested in effecting change in their communities. The Master Trainers periodically meet with one another for professional development and to ensure fidelity to the model.

Building Flourishing Communities is a lifespan approach—from pre-natal to elders—to prevent illness of all kinds and help create flourishing communities where children, their families, and other adults have access to an interlocking system of social supports. More information about evidence-based public health approach (Self-Healing Communities) that Building Flourishing Communities is implementing, can be found at:

<https://www.rwif.org/en/library/research/2016/06/self-healing-communities.html>

2. *Supporting Workforce Development* – DMH is committed to development and support of a health care workforce that can promote and provide integrated health, mental health, and substance use treatment and care. This has become a key element in DMH grant applications and underlays collaboration with DVHA on the All-Payer Accountable Care Organization Model implementation and support of Blueprint for Health Community Health Teams.

Most recently, DMH has been awarded a 5-year grant through SAMSHA to start in February 2018 that promotes full integration and collaboration in clinical practice between primary care and mental health treatment in order to improve the overall wellness and physical health status of children with a serious emotional disturbance. The grant promotes integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases. SAMHSA expects that a continuum of prevention, treatment and recovery support services

will be offered to individuals within the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant program.

3. *Mental Health Care Access within Primary Care* - Primary care will have quick access to social emotional promotion, prevention services, and other mental health services and treatment to promote healthy development of the population across the lifespan. Significant strides have been made to embed mental health clinicians within primary care practices and continues to expand through efforts such as Blueprint for Health Community Health Teams, which supplement services available in Primary Care Medical Homes (PCMH) and link patients with social and economic services that make healthy living possible for all Vermonters.
4. *Mental Health of Seniors* - Support an intentional strategy for a life-course development approach in all relevant state policies. DMH is concerned with mental health across the lifespan, but recognizes that different approaches and foci may be needed at different life stages. Elders are served in all inpatient and adult community programs funded through DMH. In addition, DMH collaborates with DAIL on the Elder Care Clinician Program – included in all DA Adult Outpatient Programs - which provides clinical treatment for mental health and co-occurring substance use disorders to homebound Vermonters age 60 and older.
5. *Zero Suicide* - Suicide is preventable. In addition to building a sustained mental health promotion campaign, DMH works to ensure that Vermonters are aware of the resources available to those at risk of suicide as well as family and friends who may be concerned about a loved-one's risk to harm self, and to further ensure that those experiencing suicidal behaviors understand that seeking help is encouraged. More information about Zero Suicide can be found at: <http://mentalhealth.vermont.gov/suicide-prevention/implementing-zero-suicide>
6. *Housing First and Supported Employment* - DMH supports the Housing First approach: to rapidly connect individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment, or service participation requirements. More information about Housing First can be found here:
<https://www.pathwaysvermont.org/what-we-do/our-programs/housing-first/>.
7. *Employing Evidence-Based Practices for Adults*

DMH is committed to using all available resources to provide evidence-based, best, and promising/emerging practices when supporting adults receiving publicly funded mental health services. The policy framework for choosing these practices includes ensuring the practice is aligned with the AHS's values; legislative intent; input and collaboration with individuals, family members, and providers; and the practice meets the following requirements:

- demonstrates strong evidence of efficacy and usefulness
- clearly delineates steps
- responds to individuals' choices,
- facilitates integration and community inclusion
- has minimal negative side effects and many positive effects
- has excellent long-term durability
- is affordable
- is relatively easy to implement and sustain
- has well-defined steps for oversight and accountability
- is adaptable to diverse individual groups and communities

Training and support for evidence-based practices is provided by DMH staff and through collaborative efforts with the Vermont Cooperative for Practice Improvement and Innovation (VCPI), which was established in 2013. DMH staff provide the primary oversight and accountability for evidence-based supported employment because competitive employment has been shown through research to positively impact many of the legislative goals outlined in Act 82.

The community adult mental health programs are currently providing the following evidence-based, best, and promising/emerging practices to varying degrees:

- Evidence-Based Supported Employment Services (called Individual Placement and Support)
- Dialectical Behavioral Therapy (DBT)
- Six Core Strategies for Seclusion and Restraint Reduction
- Integrated Dual Diagnosis Treatment (IDDT)
- Open Dialogue/Collaborative Networks Approach
- Motivational Interviewing
- Seeking Safety
- Wellness Action Recovery Planning (WRAP)
- Intentional Peer Support for Peer Staff
- Open Dialogue Treatment of Early Episode Psychosis
- Housing First
- Cognitive Behavioral Therapy (CBT)

The following are practices that DMH would like to implement soon:

- Strength-Based Case Management
- Person-Centered Treatment Planning
- Recovery Oriented Cognitive Therapy
- Intentional Peer Support *for Providers*

Initiatives currently supported by DMH:

- Suicide Prevention (described at number 6, above)
- Team Two Training
- Trauma Informed Care
- Integration of Primary Care and Mental Health Care (described at number 4, above)
- Permanent Secure Residential Planning
- Mental Health First Aid (for Adults and Youth)
- Culture of Wellness

9. *Employing Evidence-Based Practices for Children and Families*

DMH provides supports and services to children and families in the community at settings such as at child care centers, schools, primary care offices, teen centers, home, etc., to reach people wherever they are in their daily lives. Children's mental health improves when people surrounding the child, such as parents, teachers and coaches, are grounded in social-emotional development. The more children are exposed to these positive messages across settings and developmental stages, the healthier they will be through their development.

Any successful service system must meet needs at different developmental stages of early childhood, school-age, and young adults transitioning to adulthood. Children and families living with financial, food and/or housing insecurity, and who may be exposed to adverse experiences at home, in their community, or at school, are at greater risk for developing mental health issues and therefore need increased attention.

All supports and services are provided within the framework and principles of the System of Care⁵. These include providing services in a way that is child-centered and family-focused, individualized to meet the child/family's needs, culturally competent, strength and community-based, and collaborative between and among families, agencies and community.

Effective treatment for a child's identified mental health condition also serves to prevent further difficulties for the child and the child's family, while also reducing the future likelihood of adverse experiences for the child. Effective treatment of the child today is prevention of mental health problems for future generations.

⁵ http://mentalhealth.vermont.gov/sites/dmh/files/documents/ABOUT1_0.pdf

Below are some of the activities our mental health system performs to address Adverse Childhood Events and build resiliency. These approaches are evidence-based, evidence-informed or promising practices. We implement these approaches through strong partnerships.

Promotion for All:

- The Parent Home Companion guide⁶ includes a half-page ad for all parents of newborn and young children. The ad describes that being a parent is not an easy job and there are mental health supports in their area that parents can rely on.
- DMH works in conjunction with UVM's Vermont Center for Children, Youth and Families to promote the Vermont Family Based Approach⁷, "a strategy that explores how environmental factors influence genetic function, and ultimately brain development, psychopathology and wellness." The model focuses on healthy activities, family relationships, screening and assessment, and access to supports and services when necessary.

Prevention for Those at Risk:

- Collaborate with schools, through school-based clinicians, to implement Multi-Tiered System of Supports⁸ to create a healthy school environment for students to learn and where clinicians can address the needs of students at risk.
- Provide consultation and education to early care and education providers on healthy social-emotional development and effective strategies for emerging behaviors.
- Provide child psychiatry consultation to primary care providers so they can meet the needs of pediatric patients and their families.
- Young Adult Leadership training at teen centers to strengthen youth and young adult voice in creating a community and system that understands and supports their needs as they transition into adulthood.
- Mental health workers located in and consulting with primary care offices to identify and prevent mental health issues.

Intervention for Those in Need:

- There is a Resource Parenting Curriculum being offered for foster, adoptive, and biological families parenting children/youth who have experienced trauma. The curriculum is intended to educate the caregiver about impacts of trauma and effective

⁶ <https://pcavt.org/assets/files/3-16-2017%20PCAV%20Home%20Companion%20for%20web.pdf>

⁷ <http://www.med.uvm.edu/vccyf/vermont-family-based-approach>

⁸ <http://education.vermont.gov/student-support/multi-tiered-system-supports>

parenting strategies. Implementation is underway and is expected to be available statewide within the next year.

- The Vermont Federation of Families for Children’s Mental Health provides workshops for families on family leadership and empowerment within the Vermont System of Care.
- Mental Health First Aid is an educational workshop for community members to understand how to respond to someone in a mental health crisis.
- The U-Matter⁹ campaign works with communities to prevent suicide and develop youth and community leadership on the topic.
- Family respite offers a break to families caring for a child with mental health challenges.
- Mobile crisis services respond to child and family crises in all settings to address immediate needs and prevent further distress or complications. Responses may be individualized or geared toward a community, such as a post-intervention response for a school community following a student’s death by suicide.

Treatment for Those in Need:

DMH, often in collaboration with a sister department, has promoted evidenced-based practices (EBPs) for effective treatment with children, youth, and their families. The following approaches directly address the impact of trauma and adverse family experiences:

- Attachment, Regulation & Competency Framework for children and youth who have experienced complex trauma.
- Child-Parent Psychotherapy is a dyadic attachment-based treatment for young children exposed to interpersonal violence with the goal to strengthen the relationship with the primary caregiver.
- Parent-Child Interaction Therapy is a dyadic behavioral intervention for children (ages 2–7 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship.
- Trauma-Focused Cognitive Behavioral Therapy for children and adolescents impacted by trauma and their parents/caregivers.
- Child and Family Traumatic Stress Intervention (CFTSI) is a brief (5-8 session), evidence-based early intervention for children 7 to 18 years old that reduces traumatic stress reactions and the onset of Post-Traumatic Stress Disorder (PTSD). CFTSI is implemented within 30-45 days following a traumatic event or the disclosure of physical or sexual abuse.

⁹ <http://vtspc.org/about-vtspc/umatter/>

The Following EBPs Address Building Resiliency:

- Zero Suicide, also mentioned at number 6 above, is a pathway to prevent suicide and includes evidence-based practices such as Dialectical Behavior Therapy (DBT), Counseling on Access to Lethal Means (CALM), and Collaborative Assessment & Management of Suicidality (CAMS).
- Intensive treatment for the small percentage of children/youth who need short-term intensive interventions such as High-Fidelity Wrap around Services.

In collaboration with other departments and agencies, DMH participates in the following Evidence-based practices:

- Positive Behavior Intervention and Supports (PBIS) and Multi-Tiered System Supports (MTSS) with the Agency of Education
- Strengthening Families and Youth Thrive with The Department for Children and Families
- Applied Behavioral Analysis with the Department of Disabilities, Aging and Independent Living

VI. Data - Sec. 3(a)(1)(B) & Sec. 3(a)(1)(E)

DMH collects a variety of data on community and inpatient services for mental health. Each data collection effort is unique. The Department relies on various authorities provided in statute, grant, or contract to collect data. Most data collection efforts include a basic level of demographic information—including name, date of birth, zip code, etc.—for the Department to match data to other sources to develop measures. Data collection efforts can also include clinical data, service-level data, survey data, or incident data. Data is also collected using a variety of different capture methods, each with varying levels of data quality. Due to a lack of technological resources, most data efforts are captured using spreadsheets. Other data collection efforts are captured using data warehouses with strict data upload requirements. An example of warehoused data can be found within the Monthly Service Report (MSR) Submission Specifications for the Designated Agencies, which are included on the DMH website: <http://mentalhealth.vermont.gov/manuals>

There are several hindrances to effective analysis at DMH: data quality, data scope, and analytical resources. All these pieces of data collection and its use are limited by resources of staff and technology available.

Data Quality

While capturing data in a spreadsheet is flexible to changing data needs and low cost, data quality is not as high as capturing data using established databases. Established databases have rules that accept or reject data based on complexity and accuracy, and safely store data to prevent accidental

corruption or deletion. Our lack of quality databases compromises the quality of our data. We use the spreadsheets as effectively as possible by establishing data definitions and data input processes, but data could be of higher quality with advance collection and analysis tools.

Data Scope

While DMH utilizes its authority to the maximum extent possible to collect data, there are significant data gaps that prevent DMH from fully analyzing issues with the current system of care. Several examples are included below:

- For hospital emergency department (ED) wait times for inpatient care, DMH only receives usable data on those who are being held involuntarily.
- For adult inpatient hospitalization, DMH only receives usable data on those being held involuntarily in the custody of the Commissioner, those funded by Medicaid, or those in the Community Rehabilitation and Treatment (CRT) program. These data sources are not stored in databases or data warehouses and are stored in separate locations (due to the different authorities that collect them). These factors introduce data error and prevents more sophisticated data collection.
- DMH only receives incident-based data on inpatient and outpatient services. We receive a record that describes demographic variables, start and end dates, and other basic information, but not enough to information to assess intensity or clinical improvement.
- For many sources of data, DMH only receives the resulting data from another process—such as data capture from a medical claim—rather than data collected explicitly to evaluate quality or performance. Many medical claims contain only a basic level of information that allows the Department to quantify number and duration, but not quality nor transition.

Analytical Resources

The lack of technological resources for data collection means that more analytical time is spent querying and cleaning data than developing complex analysis. Also, all data questions—regardless of complexity—must be routed to the research and statistics division for analysis, and each permutation of the initial question takes additional analysis time. DMH is evaluating the use of a data analytics platform to develop dashboards of basic information on inpatient and outpatient care.

During the Department's all-day public meetings on the mental health system of care, there were several themes that emerged during the discussion:

- DMH needs data to evaluate the quality of services delivered by providers,
 - DMH needs data on all emergency department waits and inpatient stays, and
 - DMH needs data to understand why the numbers of people needing inpatient care have increased.

Essentially, the Department needs data that will enable it to assess system performance, evaluate the quality of services, evaluate outcomes for clients served, and examine the origins of why Vermonters need high-intensity mental health services.

Preliminary Solutions

1. Additional Data

DMH needs data to thoroughly examine the effectiveness of the current System of Care. To accomplish this goal, DMH needs data for:

- All psychiatric inpatient hospitalizations, regardless of legal status or insurer. This must include enough information to establish a unique identifier for each individual, basic demographic information, basic stay information, days a person may be hospitalized when they no longer clinically meet inpatient criteria, and disposition.
- All residential placements in mental health programs. This must include enough information to establish a unique identifier for each individual, basic demographic information, basic stay information, barrier days, and disposition. (DMH currently receives service hits in MSR, but not enough information to evaluate system health.)

DMH is working with the Vermont Association of Hospitals and Health Systems (VAHHS) to identify avenues for data collection and partnership over analytics. DMH is also working with the Emergency Room Wait Times Data Subgroup (a multi-stakeholder group including VAHSS, Vermont Care Partners (VCP), providers, the National Alliance on Mental Health Vermont (NAMI Vermont), and Vermont Psychiatric Survivors (VPS) to identify data gaps.

2. Information Technology

Through the Agency of Human Services, the DMH is working to procure IT resources to develop more robust systems to capture data and provide quality of services. As part of the Agency of Human Services, DMH is working with the Agency of Digital Services (ADS) to ensure that IT resources are strategically deployed for maximum benefit across state government.

The Department is also examining other IT-related solutions to ease the strain on analytical resources. We are working with ADS to pilot business analytics software to create dashboards designed to visually display frequently asked basic data questions. Quality Management at DMH has been working extensively over the past several years to streamline process and reporting so that resources and staff time are more efficiently used, in alignment with Governor Scott's Program to Improve Vermont Outcomes Together (PIVOT) initiative.

VII. Emergency Department Referrals - Sec. 3(a)(1)(C) & Sec. 3(b)

There are many reasons for increased referrals and self-referrals to hospital EDs and a variety of experiences that follow. This section includes:

1. An overview of the “no refusal” system
2. A discussion regarding age of consent for inpatient hospitalization for children
3. Examines causes of families and children in crisis

4. Shares information regarding ED wait times collected by partners at NAMI, VPS and VAHHS
5. Reviews quality metrics available regarding ED wait times

The “No Refusal System”

With the closure of the Vermont State Hospital following Tropical Storm Irene in 2011, the State of Vermont enacted a new decentralized system of involuntary mental health treatment¹⁰. The intent of the legislation was to recreate a system of decentralized care that replicated, to the extent possible, the number of beds available at the former Vermont State Hospital. The system of care envisioned by the legislation required the Commissioner of Mental Health to establish a “no refusal system by entering into contracts with inpatient and outpatient residential treatment facilities to provide mental health treatment. 18 V.S.A. § 7252(8). With respect to inpatient facilities, the Commissioner was to enter into contracts with providers to provide “high intensity services” and eligibility criteria for those services as “established by the Commissioner in contract.” Id. To effectuate the purposes of the statute, the Commissioner entered into contracts with several “participating hospitals” for what have become known as “Level 1” beds.

Level 1 beds include 25 beds at the Vermont Psychiatric Care Hospital (VPCH), 6 beds at the Rutland Regional Medical Center (RRMC), and 14 beds at the Brattleboro Retreat. In addition to these Level 1 beds, the Brattleboro Retreat and RRMC, as well as other Vermont hospitals with psychiatric units (known as designated hospitals pursuant to 18 V.S.A. § 7401(3)-(6)), may admit non-Level 1 patients who have been placed in the Commissioner’s custody and care. The Commissioner does not have the authority to force a designated hospital, or even VPCH, to admit a patient. This includes admission to Level 1 beds contracted and paid for by the State of Vermont.

Despite the legislature’s attempt to establish a “no refusal system,” federal law prohibits non-medical professionals from making determinations around hospital admissions and discharges. Psychiatric hospitals that accept federal Medicare payments are required to comply with Conditions of Participation for Hospitals set out in federal regulation. See 42 C.F.R. Part 482. 42 C.F.R. § 482.12(c)(2) provides that patients may be “admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.” As such, for a hospital to comply with the Conditions of Participation, and thereby maintain access to much needed Medicaid funds, clinical staff must be responsible for making admission determinations. The fact that the Commissioner, a care manager, or even a judge may want a person hospitalized does not supersede this condition.

Care managers have limited authority and actual ability to create a desired outcome. That includes admission to inpatient psychiatric units from EDs or Corrections; or discharge from a hospital or Corrections to a particular residential placement. This is due to many factors outside of the control of the DMH, including but not limited to:

¹⁰ See Act No. 79. An act relating to reforming Vermont’s mental Health System (2011 Adj. Sess).

- Hospitals place their licenses and accreditations at risk if they admit someone onto their unit that they are not able to manage safely or who impact the safety of the other patients.
- Needs of the individual awaiting treatment (e.g. if the person has medical needs that limits which hospital he/she can go to. The Brattleboro Retreat and the Vermont Psychiatric Care Hospital are stand-alone facilities that do not have the medical oversight that other units at general hospitals have, so people with complex medical needs are unable to be admitted safely to these facilities);
- Willingness and ability of a hospital to treat a particular individual based on current or historical presentation – hospitals refuse admission for some individuals based on their recent or distant histories of unmanageable behavior that the unit(s) feel they cannot safely manage;
- Limited availability of appropriate discharge placements based on an individual's specific needs (an example of this is people who no longer require inpatient level of care and require long term care with skilled nursing but due to their mental health symptoms or history of aggression are not considered for admission by these facilities) and long wait lists for virtually all group homes and Intensive Residential Recovery programs.

Even though hospitals (the Brattleboro Retreat and RRMC) have entered into contracts with DMH to treat Level 1 patients, they all have at times refused admissions due to their assessment that they cannot serve the person safely or maintain the safety of the other patients. Other facilities in the “no refusal” system, such as the Intensive Residential Recovery programs, have similarly denied admission to patients seeking to step down from hospitalization, if the patient’s acuity is believed to be too high for the milieu. Such decisions are consistent with CMS regulations and Joint Commission standards, in that the final decision to admit an individual, whether for inpatient or outpatient treatment, rests solely on clinical staff. With the term “No Refusal” many are confused why it appears that hospitals and other facilities are allowed to refuse admission to some individuals. The facilities in the “No Refusal” system receive higher payments for their services, in order to enhance their staffing and facility to mitigate, as best as possible, their feeling that they cannot safely manage a new referral’s presentation.

In addition, all services in the community are voluntary in basis, and the individual to be served has to agree to participate in those services. If an individual refuses to engage in the services being offered, that can negatively impact the patient’s ability to discharge in a timely fashion. There is one community placement that is facility secure, the Middlesex Therapeutic Community Residence (MTCR), and all residents there have to go under an Order of Non-Hospitalization (ONH). These ONHs are generally always stipulated and not contested in court. A patient who is in a hospital and being referred to the MTCR has to agree to go there voluntarily. This is done because staff cannot engage in any Emergency Involuntary Procedures at MTCR and if a patient were to be forced to reside there, the likelihood of the resident become aggressive and/or assaultive is high. Responding to aggressive behavior may place the MTCR at risk in regard to its license and its mandate to insure the safety of the other residents as well as the new resident.

Potential solution: Intra-state Transfers

When the state of Vermont decided to go with a decentralized system of inpatient psychiatric beds the understanding and belief was that individuals who needed inpatient care could receive treatment in or near their home community. The DMH Care Management team considers this when triaging and transferring patients around the state. However, the system as a whole will need to continue maturing in order for this to come to fruition in its entirety.

One area of the system experiencing increased success over the last year has been the use of intra-state transfers from high acuity beds to general units either in a person's home community if appropriate or to the general unit of the current hospital. RRMC and VPCH both have utilized the transfers between other hospitals and general units over the past year successfully. This creates flow within the system and allows for patients to essentially step down to a general unit from the highest acuity unit and then discharge when appropriate. This approach is similar to medical patients transferring from ICU to a med surge unit and seeks to align inpatient mental health treatment with inpatient medical treatment.

Inpatient Hospitalization for Children

There are ongoing concerns related to age of consent for inpatient hospitalization for children. DMH recommends a change to state statute to allow parents and guardians to consent to inpatient treatment for children under age of 12. For children ages 12 or older, the law will remain unchanged, (the child has authority to consent without additional parent consent).

Under current law, young children are required to provide consent to voluntary inpatient psychiatric treatment. This current policy is inconsistent with general health care and represents a lack of parity between mental health and health care law, as parents or guardians may consent to a child's being hospitalized for other health care issues (even if the child opposes hospitalization). Changing this statute would achieve the following:

1. Clarify the age of consent for providers and families.
2. Avoid unnecessary use of Emergency Exams, staff time, and resources for involuntary hospital admission for children who do not consent to hospitalization.

Children and Families in Crisis

There are more children in crisis in Vermont than ever before. This is evidenced by the increase in the number of children both 0-3 and 6-11 coming into DCF custody. One of the age groups at greatest risk is children ages 0-3 which includes newborns who have been exposed to substances. The biggest spike occurred between 2013-2015, when for the first time the number of children 0-5 surpassed the number of older youth in custody. The two main drivers for this increase are believed to be the systemic impact from two child deaths in 2014 and the current opioid epidemic. The rise in Vermont's poverty rate (15% from 9.9% in 1990) may also play a role in this change.

To address these issues, the DMH and the Family Services Division of the Department for Children and Families has been working together around issues that impact the safety and well-being of

children. This collaboration is also exploring gaps within our local system of care around early childhood mental health which has resulted in the implementation of the following models:

- Parent-child interaction therapy (PCIT) - is an evidence-based treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT. Most of the session time is spent coaching caregivers in the application of specific therapy skills. The Howard Center, Family Services, the Department of Mental Health and UVM are working together to implement this training over the upcoming year. The training will be originating in Chittenden County, with a goal to train clinicians around the state in this evidenced-based program that has been shown to reduce abuse and neglect. There is a momentum of interest in getting more clinicians trained in PCIT in Vermont which would result in significant benefit to victims of child abuse or those who have experienced trauma. Currently there are five designated mental health agencies who are working collaboratively to train staff on PCIT.
- Child-Parent Psychotherapy (CPP) – Northeastern Family Institute (NFI) VT in collaboration with Easter Seals VT, has sponsored a learning collaborative of 40 clinicians statewide to train in CPP, an evidence based model for treating parents and children 0-5. CPP examines how trauma and the history of the caregivers' relationship with the child impact the caregiver-child relationship and the child's developmental trajectory. A goal is to support and strengthen the caregiver-child relationship to restore and protect the child's mental health. The clinicians in the learning collaborative are participating in an 18-month training commitment sponsored by DCF, DMH, and the UVM Child Welfare Training Partnership which began in the spring of 2017.
- Building Flourishing Communities - (described in section V).

Attention is being paid to the challenges that exist for both the mental health and child protection system through increased funding (for the Designated Agency system through the legislature in 2017) and by additional resources in the child protection system. The fact remains, however, that there continues to be an increased demand that has outpaced the ability of both systems to meet the needs of children, youth and families faced with poverty and by the opioid crisis and therefore developmental trauma.

[NAMI Survey](#)

National Association of Mental Illness (NAMI) Vermont implemented a survey regarding ED Wait Times. The survey results are available at:

https://docs.google.com/document/d/1u_rqRZZEKWvrTGKNw-ri3Ef1jeukd7A-EmCCvUHSxcM/edit?usp=sharing

Below is a summary of the findings from the survey issued by NAMI Vermont:

- There were 25 respondents (including 17 family/friends/significant others, 7 individuals with a mental health challenge, and 1 mental health provider).

The general thoughts from this group as to why there is an “increase in the number of people with mental illness experiencing long waits in the ED, what services or supports are lacking or inaccessible that could prevent an ED crisis?”, “What alternatives should we explore to alleviate the long wait in the ED?” and participants provided a list of services, supports, treatments, and strategies that have helped in their (or loved one’s) recovery process include:

- Shortage of beds for treatment including long-term secure residential, supervised housing and group homes focusing on least restrictive settings
- Lack of prompt treatment to de-escalate and mobile crisis response, 24/7 drop in facilities or walk in clinic at DA
- Insufficient professional resources (psychiatrists, other mental health professionals, crisis workers) with standardized, statewide competencies, training, intake protocols, personalized planning, trauma-informed counseling skills and therefore access to outpatient treatment
- EDs are ill equipped to treat mental illness which can escalate symptoms having a space or room in the ED that is quieter and more humane with less of an isolation feel would help
- Local police need to be educated in mental health crisis
- A legal system that allows patients to be treated with appropriate medication involuntarily in outpatients including changing to the judicial system.
- Current laws set bar too high for admission to hospital and crisis staff under pressure not to admit due to no beds
- Increase in Peer Support including use of Peer Access phone services
- Education/training for Caregivers for children and adult

The last piece of the survey addressed factors that may have escalated a situation in the ED. The following themes emerged:

- Fear of being "locked up", door guards/sitters/security 24/7
- Uniformed police officers' presence, conversations, behavior, not being able to leave, all other patients in the ER can escalate symptoms
- Need different environment, anticipation of secure transport, put alone in a small observation room in a johnny (clothes and bag taken away) with a window wall to be watched by someone on a gurney

VAHHS- ED Wait Times

VAHHS also spoke with Emergency Department doctors to get their perspective on what is contributing to ED wait times. Their response is based on their experience, and in many cases, matches other identified contributors.

- Lack of beds

- Increased referrals from schools
- Increased referrals from police
- Increase in geri-psych population
- Increasing prevalence of serious psychiatric disease in general and in adolescents in particular; This is further compounded by the psychiatric effects of our increasing drug and alcohol abuse in VT.
- Court orders to ED
- Lack of community resources/preventive care

Themes of the comments from the ED doctors included concerns regarding changes in resource availability post Tropical Storm Irene and loss of the VT State Hospital, shorter time of hospitalizations therefore people cycle back more frequently, not enough beds, patients are discharged from inpatient and bouncing back at an unprecedented rate, usually the very next day. The ED doctors believe these reflect the fact that while there may be downstream issues, beds are required. They also don't believe robust outpatient resources would avert the ED bounce-back within 24 hours and do not seem to have an impact on recidivism for the most acute patients. They believe needs of elderly Vermonters is a rapidly increasing problem and there are still few, if any, resources such as placement options in VT to address that. They are also seeing an increased number of individuals from nursing homes and very few inpatient or outpatient options for these patients. For pediatric patients they feel as if they are seeing an increased number of students sent from school for behavioral issues/threats to staff and students.

Lastly, they feel police are recognizing mental health and the importance of treatment more and more and get quite a few referrals directly from police.

Quality Metrics on ED Wait Times - Sec. 3(a)(1)(E)

During the working meeting on August 17, 2017, Vermont Psychiatric Survivors (VPS) presented research they were working on based on a literature review of Emergency Department Wait Times. VPS Executive Director Wilda White did an extensive review of the national literature to help us understand the trends and themes. The full presentation can be found on the DMH website at:

http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Literature_Review_of_ED_Waits_Presented_Aug_17_2017.pdf

In summary, the findings include:

- There are about 65 million ED visits a year nationally and about 6% of those are related to psychiatric needs
- The most prevalent presentation for adults are: alcohol related, anxiety, and then suicide attempt or self-harm
- Wait times for all levels of response are longer for people seeking psychiatric care than non-psychiatric

	Psychiatric	Non-Psychiatric	Difference
Observation	23 hours	9 hours	14 hours
Transferred	12 hours	6 hours	6 hours
Discharged	8 hours	6 hours	2 hours

- The most prevalent presentation for children are: depression, anxiety and disruptive behavior or ADHD
- Factors that are predictors of prolonged adult ED waits include: Medicaid/uninsured, age, reason for visit such as suicidal or homicidal ideation, cognitive disorder or personality disorder, use of restraints or sitters, history of aggressive behavior, experiencing homelessness

Factors that are predictors of prolonged child ED waits include: living in northeast, south or metropolitan area, 6-13 years of age, intentional self-injury, autism, developmental and intellectual disabilities, weekend, and months without school vacation.

Additional themes supported by the data:

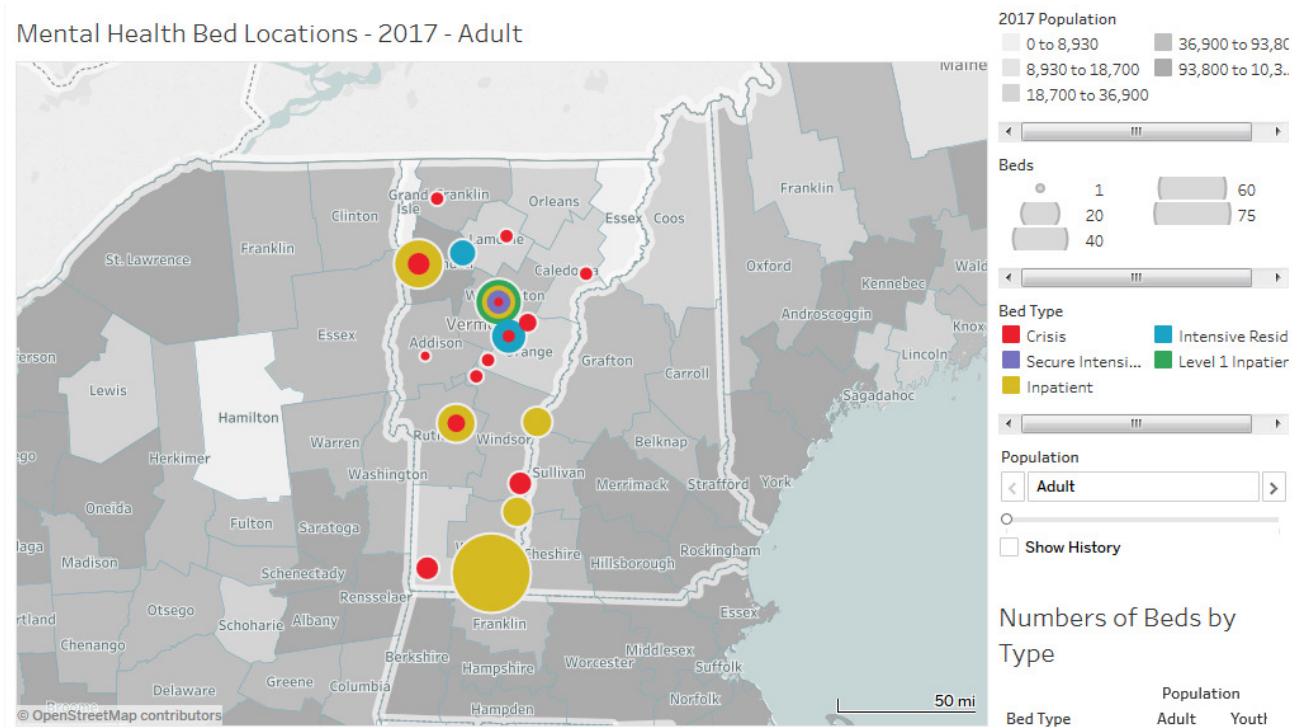
1. More people are presenting to EDs
 - Between 2002 – 2011, 30% increase in total ED visits
 - Psychiatric visits as a percentage of total visits increased by 18.5%
 - Total number of psychiatric visits increased by 55%
2. Client presentation (past and present) impacts willingness of providers to accept patients
3. Homelessness; use of restraints and sitters; history of aggressive behavior; diagnosis; age, all affect length of stays (LOS) in the ED
4. Workforce issues (variation in staff experience, undertrained ED nursing staff) impact ED LOS
 - Undertrained staff may increase need for restraints, sitters, involuntary emergency procedures, all of which lead to prolonged ED waits
 - Undertrained staff may misinterpret patient behavior, which may lead to prolonged ED waits

Themes *not* supported by the available data:

1. Longer stays in inpatient hospitals reduce availability to those who are waiting
 - Prolonged ED waits driven also by characteristics of patients, rather than solely lack of in-patient beds
2. Increase in acuity of patients presenting to EDs
 - Psychiatric diagnoses in ED, by prevalence, have remained constant over last 15 years; nationally, alcohol-related disorders; anxiety; and suicide or intentional self-harm are most prevalent psychiatric diagnoses in ED

VIII. Gaps in Service - Sec. 3(a)(1)(D)

Resource Availability and Regional Accessibility



<https://public.tableau.com/profile/emma.harrigan2032#!/vizhome/DMHMentalHealthSystemofCare-BedsbyTypeandLocation/Dashboard>

Utilization Trends – Use of Crisis Bed Resources

The current capacity of 40 statewide crisis beds, with programs ranging in size from 1 bed to 6 beds, has seen a decline in overall utilization for each of the past four fiscal years. An average statewide utilization in FY 14 of 80-82% occupancy, consistent with anticipated crisis bed utilization per funding agreements, has progressively declined to an average utilization in FY 17 of 70 -74%. First quarter FY 18 shows a higher utilization, but quarterly trends have fluctuated in the same manner in the previous fiscal years as well.

There are a number of issues that may be contributing to this lower utilization over time. As additional crisis bed program capacity emerged following Act 79, DA crisis bed providers initially met the clinical support needs of individuals who could be effectively treated in a voluntary crisis bed program. Fast forward to current demand and the challenges to existing inpatient bed capacity due to long lengths of stay for a small cohort of patients with significant mental illness, longer length of

stay for patients who disagree or resist best practice treatment approach delaying effective treatment or stabilization, and long lengths of stays for individuals with complicating forensic issues.

These individuals presenting to Emergency Departments may be no less acute than other ED admissions and may not be appropriate for crisis bed programs. However, they also cannot access inpatient care if a hospital determines they cannot acutely treat the individual and does not admit them to inpatient level of care, or, lacks the bed capacity.

Crisis bed programs larger than two beds are subject to licensing and regulatory oversight as residential providers and are unlikely to accept individuals, who may be receptive to alternative services, but continue to present at potentially higher risk of harm to self or others.

Individuals waiting for voluntary admission are also free to decline alternative resources, but hospitals are unlikely to discharge individuals who clinically meet criteria for inpatient care unless an individual is amenable to an aftercare plan.

Contributing to this lower utilization are individuals who may not require hospitalization any longer, but refuse treatment recommendations and still present with behavioral dysregulation or unwillingness to voluntarily engage with crisis bed alternative services. The hospitals are not willing to accept the risk of prematurely discharging a patient who is not fully stabilized psychiatrically, nor are the crisis bed programs willing to accept the risk of admitting a person with fluctuating clinical acuity to a less resourced crisis bed program.

Hospital Emergency Departments, psychiatric inpatient units, and outpatient providers are highly sensitized to engaging individuals presenting through high profile events, given the media coverage and examination that such incidents engender, beyond the initial emergency triage and transfer of care. Current delays in transfer to the right level of care are often viewed as the result of a system that does not have the right amounts of treatment resources available, adequate numbers of well compensated treatment providers available, and services that people need and want to access. These areas can undoubtedly be improved upon and more voluntary crisis bed utilization is appropriately offering alternative service to a cohort of people who would otherwise be added to the current numbers waiting in emergency departments.

There are also voluntary crisis bed models offering greater staffing intensity, peer support resources, and more therapeutic space as earlier service options that would benefit a cohort of individuals in the community who are at risk of hospitalization. All discussions suggest that this resource is not for high acuity individuals who require a safe and contained setting with intensive services. A bed in a hospital may suggest safety and containment, but if unable to offer acute treatment services, is not an effective use of that resource either. Currently, there is no in-between resource in Vermont that meets the needs of this cohort of individuals with serious mental illness that would be offset with federal financial participation.

Supportive Housing

Supportive housing is a widely used term and, simply put, combines and links permanent affordable housing with flexible and voluntary support services designed to help the individual tenant stay housed and build the necessary skills to live as independently as possible. A *supported housing* model identifies types of and necessary service components of housing for individuals who may find it difficult to manage in their own home and are in need more supports. The different types of supported housing offer different levels of support as well.

Some of the types of supported housing include:

- support in an individual's own home,
- others include supported housing or group living situations,
- shared housing with support workers, or
- short term stay supported housing, such as clinician supported or crisis housing

Supports can be tailored to the individual with all housing types and include:

- benefits education and counseling,
- budgeting skills development,
- supports for maintaining tenancy,
- life skills development; and
- assistance in accessing care, local activities, education, employment/training or advocacy.

The DMH and its community mental health system is currently challenged by several factors that have converged to place the Department in an unenviable position.

- Budget pressures, current and forecast, make innovative supportive housing responses difficult to consider or implement.
- High acuity individuals who utilize substantially more service and supports than others, requiring concentrated efforts that seem to increase cost initially, but may reduce costs if well targeted with supportive housing/rental assistance.

The Department is undertaking an analysis to optimize efforts in these difficult budgetary times. Complicating matters is the fact that many high cost and homeless users of DA resources may not be eligible for CRT program services in the absence of a severe and persistent illness diagnosis. Some individuals served in adult outpatient programs, who would benefit from the full array of case management and community support services, may still have disabilities and a myriad of psychosocial stressors that are equally or more-costly to local communities. Housing resources for this population remains a gap as individuals served in adult outpatient programs are not eligible for CRT Housing Support Funds. Existing CRT housing resources have capacity limits and must prioritize supports for individuals with the most significant mental health needs. In Budget year 2014, the DMH Housing Subsidy and Care program was also reduced by \$500,000.00 further constraining its availability to the CRT population.

It remains essential to improve affordable housing units and supports in the community. In some instances, smaller clusters of congregate housing and supports may be viable, such as provided through Pathways Housing First model and in some DA CRT support services configurations. These approaches have contributed to success in providing housing and supports for individuals served. However, these services are not statewide.

There have been no increases to Designated Agencies to make community housing via housing subsidy a more viable option since 2012. Annual market rent increases continue to shrink the value of this line item for those DMH serves, and the number that it could potentially serve.

Housing development is a viable alternative to subsidy and Department staff have worked with designated agency staff to coordinate local efforts with the not for profit housing development sector. Vermont's Housing Revenue Bond is expected to generate roughly \$34 million dollars for the creation of homes and apartments over the next three years. Roughly 10% of bond proceeds are targeted to the development of Supportive Housing, some of which has already been awarded to projects. Supportive Housing is generally targeted to people who have experienced chronic homelessness and been unsuccessful in other housing programs which offer fewer services or time-limited residency.

Supportive Housing typically requires the pairing of rental units, on-site services customized to the needs of residents, and rental subsidy to bridge the gap between operational costs and what a tenant can afford for a monthly rent. Because of the bond mechanism, Supportive Housing funding through Vermont's Housing Revenue bond will pay only for capital costs for construction or rehabilitation only. Full realization of Supportive Housing will therefore be contingent on local partners accessing rental subsidy (typically through a housing authority or AHS program) and leveraging new or underutilized service capacity in the community through programs.

Current efforts underway to respond to the Supportive Housing need include three Designated Agencies: Clara Martin Center, and Lamoille County Mental Health and Washington County Mental health. They all have projects "in the pipeline". These projects will produce twelve units of housing in these catchment areas. These units are part of the DMH coordinated response to reduce cost and increase opportunity for persons prone to emergent care when homeless, and for those caught in a sub-acute care status unable to exit a needed bed, due to lack of affordable housing in the community.

Peer Supports

Peer support can take many different forms such as self-help and mutual support groups, peer crisis respite, warm lines, inpatient peer services, wellness planning and skill development, peer-driven housing supports, peer drop-in and community centers. This support has been shown to be effective in supporting recovery. It is the goal of the Department of Mental Health to make a variety of peer supports available to anyone in the state struggling with mental health and other co-occurring issues.

Working toward this goal, DMH has focused primarily on improving and refining Vermont's expanded array of peer services, many of which were developed or enhanced following the passage of Act 79. This expanded array includes community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support.

Priorities for further developing peers supports, according to Pathways Executive Director Hilary Melton, include:

1. A PEER RUN Community Center (like Another Way/Pathways Vermont Community Center) in every county
2. PEER RUN crisis beds in every county (like Alyssum)
3. Housing vouchers and supportive services (Housing First peer approach model) available in every county
4. Peer support presence in every ER (there is a work group looking at the Living Room model that looks promising)

More information regarding implementation of peer supports can be found in Section XII of this report.

Mental Health Treatment Court

Mental health courts (MHCs) started in the late 1990s and were created to reduce the number of defendants with significant mental health challenges in the criminal justice system where it is costly and almost impossible to provide evidence-based and recovery-focused treatment. Drug courts influenced the design of MHC programs, including the incorporation of core features of multidisciplinary treatment teams, treatment plans with related services and goals, accountability, rewards and sanctions, and regular statutory hearings. MHCs require significant collaboration and commitment among many partners including the state's superior court, attorney's office, public defender's office, court administrator's office, and community mental health and substance use disorder providers.

In 2003, when the rest of the nation only had a few dozen mental health courts, Vermont established its first MHC in Chittenden County where it continues to successfully operate. The latest outcomes indicate that 50-60% of participants graduate from the program and 60-65% of those individuals remain conviction free a year later compared to only 35% of those who did not graduate. In 2009, Windsor County initiated the Sparrow Project with the goal of meeting the challenges of defendants with mental illness and/or substance use disorders. The Sparrow Project was not a formal MHC program and ended in July 2017. Currently, there are no additional mental health courts in Vermont. There are two adult drug courts that offer a co-occurring track in the regions of Washington and Rutland Counties.

Research on MHCs is limited to a few rigorous evaluative studies. These studies indicate that MHC defendants have lower rates of recidivism, improved mental health treatment engagement and fewer days of incarceration. Vermont's outcomes mirror these findings. Therefore, it is not surprising that stakeholders would recommend an expansion of mental health courts as a way to divert individuals from involvement in the criminal justice system.

Planning and implementing an additional MHC program requires the commitment and involvement of a local court judge, judicial staff and non-judicial court staff, including technology and security staff, as well as input from key community stakeholders, such as representatives from the State's Attorney's office, the Defender General's Office, law enforcement, local service providers, the Department of Corrections, the Department of Mental Health, and/or local municipal partners. Success requires a community effort, significant resources, a detailed plan and proposal, and a population size that substantiates the cost and effort of establishing a mental health court in the suggested county. There needs to be sufficient court resources and alignment among the proposed specialty docket and the judiciary system's goals. Lastly, all proposals are dependent upon the approval of the Vermont Supreme Court.

DMH supports the development and evolution of well-designed mental health courts to the extent that they are part of a coordinated effort to reduce the number of individuals with mental health challenges needlessly entering the criminal justice system. A well-designed MHC would include recovery-focused, evidence-based practices from the fields of mental health, substance use disorders, and criminology. The mental health courts need to be regularly monitored to ensure court program practices safeguard the needs and rights of participants, adhere to fidelity of evidence-based practices, and demonstrate positive participant outcomes.

A viable alternative to mental health courts, especially in a rural state like Vermont, may be increased community mental health services that focus on employment and education, strengthen the relationship between local law enforcement and mental health programs, and the design of a diversion model that utilizes regular statutory hearings in conjunction with existing specialty dockets.

Staffing Resources - Sec. 3(a)(1)(G)

Two reports were produced in 2016 that discuss the DA and SSA workforce, compensation and corresponding impacts on the system of care, as follows:

1. Vermont Care Partners white paper brief:

[https://vermontcarepartners.org/pdf/files/139_VCP%20workforce%20white%20paper020516s%20\(2\).pdf](https://vermontcarepartners.org/pdf/files/139_VCP%20workforce%20white%20paper020516s%20(2).pdf)

2. Act 113, Section 11 Report:

<http://legislature.vermont.gov/assets/Legislative-Reports/Act-113-Sec-11-Medicaid-Pathway-Report-12-30-16.pdf>

Information provided by Vermont Care Partners for the Act 113, Section 11 report estimated that "raising the DA and SSA direct care workers compensation up to the level of state employee

compensation would require an investment of over \$43 million to the \$385 million system of care.” Additionally, Vermont Care Partners describes in its white paper that “Adding to the recruitment problem is the lack of availability of prospective employees. Vermont’s unemployment rate was the fourth lowest in the country in 2004 at 3.4%. In August 2015, Vermont had the third lowest unemployment rate at 3.6%. (2004 PHPG Report, page 4-1; August 2015 Unemployment and Jobs Press Release, Commissioner Annie Noonan) The lack of candidates for our job openings forces us to compete to hire people who are already working elsewhere at higher compensation levels. This has made recruiting for positions extremely challenging.”

These issues are complex. Of particular concern is that the total available workforce is not sufficient. A basic increase in wages to staff of DAs and SSAs, while desirable, may not equate to increased access to care for Vermonters across the entire system of care if the size of the total available workforce does not increase.

Mental Health Profession Data

In 2016, the Vermont Health Care Innovation Project Health Care Workforce Work Group commissioned the information services firm IHS Markit to develop projections of current and future demand for health workers and to help monitor changes in demand over time. The study used a microsimulation approach to project the demand for health care services and health professions. The demand projection model has been used for health workforce modeling for federal and state governments, for trade and professional associations, and for health systems. Study findings can be found here:

<http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Vermont%20Health%20Care%20Demand%20Modeling%20Final%20Report%206-17%20FINAL.pdf>

In the past three years, several mental health-related professions have been surveyed by the Health Department: Mental Health Counselors (2017), Clinical Social Workers (2016), Master’s- and Doctoral-Level Psychologists (2016), Psychiatrists (2014), Advance Practice Registered Nurses (2015). Detailed reports on each profession can be found at <http://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/health-care-workforce>.

Profession surveys are a census of providers, as all providers are intended to respond to the survey and the Health Department follow-ups with non-respondents. The final response rate is usually above 99%, however there are several years where this rate was not achieved for mental health professions. The data presented includes practitioners who actively provide patient care in Vermont and excludes providers who maintain Vermont licenses but do not practice. Because many professionals in Vermont hold more than one professional licensure, some of the FTE availability might be a double-count of a single provider.

Of the major mental health professions examined, there are more clinical social workers (1020 licensed, 794 active) than any other mental health profession, followed by mental health counselors (725 licensed, 618 active), Master’s and Doctoral-Level psychologists (591 licensed, 486 active),

Psychiatrists (179 active), and Psychiatric Advance Practice Registered Nurses (64 active). Total FTE availability of each profession also varies and is described in the table below.

	Mental Health Counselors 2017	Clinical Social Workers (2016)	Psychologists (2016)	Psychiatrists (2014)	Advance Practice Registered Nurses (2015)
Total Licenses	725	1020	591		
Total Inactive	101	220	104	179	64
Total Active	618	794	486		
Total Active FTE	423.4	635.5	355.9	116.6	41.5
% Response Rate	99.2%	99.40%	99.8%		

There are some noticeable trends that emerge when examining the availability of Psychologists, Mental Health Counselors, Clinical Social Workers, and Psychiatrists across Vermont. The geographical areas served by Northeast Kingdom Human Services (NKHS) and Northwestern Counseling and Support Services (NCSS) have the lowest rates of FTEs per capita for Clinical Social Workers, Psychiatrists, and Master's- or Doctoral-Level Psychologists. The NKHS geographical does have more advance practice registered nurses than other parts of the state, but not enough to make up for the absence of psychiatrists. The geographical areas served by Howard Center (HC), Health Care and Rehabilitation Services of Vermont (HCRS), and Washington County Mental Health Services (WCMH) have the highest rates of FTEs per capita for mental health counselors, clinical social workers, psychologists, and psychiatrists. The geographical area served by Rutland Mental Health Services (RMHS) has the highest rate of FTEs per capita for psychiatric advance practice registered nurses.

The Health Resources and Services Administration (HRSA) does establish designations for underserved areas, but there are no current standards for how many mental health care professionals are needed. Additionally, the HRSA categorization of core mental health professionals does not include mental health counselors, which are the second highest represented profession for mental health.

Another contributing factor to workforce challenges specifically for Licensed Clinical Mental Health Counselors and Licensed Marriage and Family Therapist may be the process for individuals to either become newly licensed in Vermont or licensed in Vermont after having moved here from another state where they were already licensed. DMH has begun work with the Office of Professional Regulation (OPR) and the Allied Mental Health Licensing Board to review the requirements for licensing both new and currently licensed practitioners from another state, as well as any challenge related to maintaining a clinical license. We are hopeful that in working with OPR they will be able to have draft legislation for this upcoming session.

IX. Demographic Trends - Sec. 3(a)(1)(F)

DMH reviewed current Vermont demographic information and found:

- Overall VT population is static but slowly decreasing
- Less youth under age 18, more adults over age 65
- % of all VT adults with any mental illness is 21%, which is higher than national avg of 18.7%. (2016)¹¹
- % of all VT youth with serious emotional disturbance is 6%, which is consistent with national avg. (2015)¹²
- % of all VT adults getting treatment is 58%, which is also higher than national avg. (2015)¹³

Vermont's aging demographics has also steadily surpassed what was a comparable median age of 33 years for both Vermont and the U.S. in 1990. Between 1990 and 2014, the median age of Vermonters has risen to 42.4 years in sharp contrast to the median age in the U.S. of 37.5 years. Since the 1970s, Vermont's median age has advanced by 16 years whereas the U.S. median age has only advanced by 9.5 years. Vermont's Community Rehabilitation and Treatment Program cohort, individuals who have severe and persistent mental illness also reflects the same aging demographic, as evidenced in the most recent FY 2016 Statistical Report, with 69% of active clients falling in the 35-64-year-old age range. This same age cohort, using the services of the Vermont Psychiatric Care Hospital (VPCH), also accounts for 68% of all patient days at VPCH. Age and longest lengths of stay for VPCH patients also correlates with the 50 year and older cohort with mean stays of 7-9 months. According to Vermont's Agency of Commerce and Community Development, the aging demographic of Vermont is only expected to continue to increase through 2030 with nearly 30% of its population exceeding 65 years and older by that time. Undoubtedly, this cohort will be a greater utilizer of long-term care services going forward. Appropriate in-home and facility-based care services addressing both physical, as well as, mental health and other psychiatric care services will be necessary to adequately support individuals with treatment needs.

Toward this end, DMH and the Department of Disabilities, Aging and Independent Living (DAIL) have been exploring collaborative augmentation of in-home services and supports and facility-based rehabilitation services for individuals unable to be managed in their own homes or require transition planning supports while longer-term living situations are developed. Working with existing long-term care providers, determining the mental health support services needed to support facility providers,

¹¹ <https://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2016/NSDUHsaePercents2016.pdf>

¹² <https://wwwdasis.samhsa.gov/dasis2/urs.htm>

¹³ ibid

and determining a financing model to sustain appropriate and quality services are underway; but will require additional resources currently and as demand increases over time.

Compounding the aging issue is also co-occurring health complications found in this population from long-term psychotropic medication use. It is recognized that people who experience significant mental illness experience greater morbidity and live 10-25 years shorter than the general population. This is attributed to a number of variables including social consequences of the illness, lifestyle factors, and side effects of antipsychotic medication use. Antipsychotic medication can indirectly cause weight gain, lipid abnormalities, and unregulated blood sugar, through a combination of reduced activity due to sedation and increased appetite, leading to higher rates of cardiovascular disease and diabetes. Further these medications can include negative physical health effects, such as stigmatizing and harmful extra-pyramidal side effects.

Another Vermont anomaly is the disproportionate rate of suicide, placing it as the 8th leading cause of death in Vermont and at an average age of 46.3 years. The number of Vermont suicide deaths and suicide death rate has hovered at 12.0 per 100,000 or greater since 2005. Alarmingly, Vermont vital statistics for 2015 placed the suicide death rate per 100,000 at 14.3, down from the previous two years by 16.9 in 2013 and a high of 18.7 in 2014. This is in comparison with a rise nationally from 10.5 to 13.0 per 100,000 over the same time period. Veterans in particular are overly represented in the suicide death rate for the 18 – 34-year age range at 57.7 per 100,000. Post-traumatic Stress Disorder and other contributory factors for this cohort further exacerbates the need for mental health treatment services. Current suicide rates, suicidal ideation and verbalization of potential self-harm with access to means are contributing factors to demand for inpatient capacity and resources. Efforts such as the “zero suicide” initiative, the crisis text line, and the GunShop Project in Vermont require ongoing support to bend the curve on this public health crisis.

The prevalence of co-occurring substance abuse and rapidly increasing impact of opioid use in Vermont, like many states, is also compounding mental health treatment needs and demand for both inpatient and outpatient dual disorder treatment services. At the ED level, the need for treatment services during a crisis presentation may be poorly differentiated given ever present interplay between mental health conditions and substance addictions and the immediacy of resolving the acute need and offering a timely disposition. While Vermont is not alone in facing this public health crisis, inpatient psychiatric beds, residential substance abuse treatment beds, and varying levels of outpatient treatment expertise, especially for a complicated co-occurring group, are in high demand and short supply. For the foreseeable future, additional capacity is needed in all these levels of treatment services. More information can be found at this link:

http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Opiod_Handout.pdf

X. Care Coordination

Regional Care Coordination - Sec. 4(1)

The Central Vermont region is examining a model for a regional resource and referral “hub” for mental health and substance abuse treatment in order to help alleviate consequences of inadequate mental health follow up care. These consequences can include: exacerbation of symptoms; challenges in work/home life; higher risk of chronic medical conditions/decreased life expectancy; high drop-out rates from school; readmission; and suicide. Lack of proper follow up can also result in return visits to emergency rooms, hospital admissions and readmissions. In order to determine the need for this resource, data was examined across all payers regarding follow up post-hospitalization at 7 and 30-days and it was determined that there is room for improvement to access for care.

At present, the region is examining resources needed and subsequent costs to expand the current WCMHS navigation system to include evaluation of psychiatric needs, schedulers for private counselors, and provision of urgent brief treatment, as needed.

Development of the model is continuing and includes exploring web-based schedulers, IT agreements, and resource needs to fully operationalize the model. They hope to have a final model by February and can continue to update the committees on this work.

http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Collaborative_and_Hub.pdf

http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/VCP_Presentation_on_Regional_Navigation_Regional_Care_Coordination.pdf

DMH Care Coordination Accountability - Sec. 4(2)

The Adult Care Management team is currently comprised of four care managers with the specific focus of supporting the movement of consumers through the different systemic levels of care. The structure of the care management team has evolved over time as DMH meets the needs of the state System of Care. The care managers provide direct DMH support to hospitals, Designated Agencies and other community partners for individuals who are accessing all the levels of mental health care the state offers.

Understanding the effectiveness of care management is particularly complex due to the perceived, versus actual power any individual care manager has to move people through system. Although the care managers have the weight of DMH behind them to help facilitate timely admissions and discharges to and from hospitals, they do not have the ability to admit or discharge any individual. This final decision lies solely with the medical director of the unit or hospital.

When looking at effectiveness, it is important to consider the scope of the work being done. Care managers have managed 2100 involuntary admissions and 2000 discharges over the past four years. This work is accomplished by four individuals that work with hospitals and community partners throughout the entire state. This provides a statewide perspective as to the pressure points within the system. Having this statewide view also allows for accurate triaging of individuals who need inpatient psychiatric treatment.

In looking at data over the past three years related to number of people waiting for inpatient beds and their length of stays in an ED, the pattern has fluctuated over time. In August 2017 there was an average of 9 people waiting for involuntary hospital admission in EDs throughout the state, with an average wait time of just under 100 hrs. In comparison, March 2014 also had an average of 9 people waiting but their average wait for a bed was about 160 hours. It is possible that this is an indicator of the effectiveness of the Care Management team to help people move through the system of care. However, other variables impact the ability to confidently say this is directly the result of the care management work. VPCH, the new state hospital, was just starting to open in 2014, so it is also possible that the lower length of time in an ED in 2017 could be the result of the opening of the beds at VPCH.

Historically, there has not been the ability to track and document when a hospital declines a referral for admission. Care Management often includes leadership from DMH in conversations with community partners and hospitals when a referral has been made for inpatient care and the potential receiving hospital declines admission. These high-level conversations help the department to understand the hospital's rationale for the decision. Currently the department is working with the hospitals who have contracts with DMH (Level One facilities) to provide written documentation outlining the "refusal" in order to have a better understanding of the specific challenges a case or unit exhibits. Per CMS, admission privileges belong to the admitting physician who makes the final decision. It is the hope that expecting written documentation of "refusals" will increase the accountability of the hospitals and increase transparency.

In addition to this, it is important to note that different inpatient units serve different populations; a bed is not a bed. At times, it has been perceived that a hospital has refused a patient admission and that this is a discriminatory practice. Units around the state serve varied populations. This is because not all patients require the same type of treatment, at the same level, or in the same environment. Of the 192 beds throughout the state, 45 are Level 1 (highest acuity), 96 are general psychiatric unit beds which is a mix of voluntary and involuntary patients, 14 are for transition age (18-25), 15 beds are for LGBTQ, 22 beds are for co-occurring disorder patients. What might be perceived as discrimination may be related to the proposed patient not being compatible with the unit that has a bed available.

DMH Care Management Statewide Responsibilities- The Care Management team follows the treatment of individuals with identified mental health needs who need involuntary hospitalization. This includes individuals who are waiting for inpatient psychiatric treatment in connection with an inpatient psychiatric examination order issued by the Criminal Division of Vermont Superior Court, those who have been hospitalized through the Emergency Examination process, as well as person's who have had their Orders of Non-Hospitalization (ONH) revoked and are awaiting inpatient treatment. With respect to individuals with inpatient orders for psychiatric examinations, they may be waiting in hospital EDs or in Corrections if bail has been set. The care manager assigned to coordinate hospital admissions communicates daily with EDs, Corrections staff, community mental health crisis screeners, psychiatric inpatient units, the Assistant Attorneys General in the DMH Legal

Unit to ensure that timely and accurate information is shared and that individuals are able to access treatment efficiently.

The two care managers who are assigned to follow individuals who are currently inpatient collaborate with their inpatient and outpatient teams to identify their clinical needs for success in the community and support development of discharge plans. These two care managers participate in weekly clinical status calls with all designated hospitals and maintain documentation of their contact with the inpatient units and summaries of the individuals' clinical status on a weekly basis. The care managers also communicate with the Designated Agencies for the counties from which patients arrive on the unit to ensure that necessary clinical information is shared, appropriate referrals for outpatient treatment are made, and to direct residential placement referrals as needed. Additionally, they facilitate conference calls with inpatient and outpatient providers to address discharge needs including mental health and residential. They collaborate closely with DMH Legal to ensure that legal requirements for discharge are met.

If the individual returns to the community on an Order of Non-Hospitalization (ONH), then the assigned care manager communicates regularly with the Designated Agency who provides treatment to ensure that he/she is receiving adequate treatment and engaging in services and following conditions of the ONH. If the individual is not following the conditions of the ONH, then the care manager collaborates with the Designated Agency and DMH Legal on whether to revoke the ONH and supports initiation of this process as needed, in addition to working with the agency on possible strategies to intervene and support this individual in remaining stable in the community. This care manager also follows the care of individuals in Corrections who are designated Seriously Functionally Impaired (SFI) and supports Corrections in discharge planning as the individual is ready to return to the community.

XI. Crisis Diversion Evaluation and Diversion Models - Sec. 4(3)(A)-(B)

DMH asked a subgroup from the ED wait times data group to explore different options related to crisis bed or crisis response. Many ideas were discussed during the legislative session and we allowed this topic to change organically and through a more peer lead process in order to really understand what may work best for those experiencing a mental health crisis.

During the initial all day public meetings the information at this link was presented:

<http://mentalhealth.vermont.gov/news/act-82-working-meeting>. In the following months there was further development of the options by a workgroup with the following membership: Linda Simoneaux, Amos Meacham, Curry Murphy, Ward Nial, Ann Burzynski and Ed Paquin. The options explored include:

The following information is from the *Alternatives to Emergency Departments Group*:

The Alternatives to ED bed group formed to develop approaches to decrease wait times in hospital emergency departments. We believe people in emotional distress deserve access to the level of care they need. In our initial presentation to DMH, we recommended that more options to access support and treatment be made available for people in psychiatric distress, outside of the hospital setting.

- “Psychiatric Urgent Care Walk In clinic ”
- Psychiatric Emergency rooms
- Dedicated “Emergency Evaluations Beds” within existing psychiatric inpatient units
- These ideas have merit and deserve further exploration and development. They were determined by this group to be creating freestanding “mini-psych units” and expanding psychiatric beds in the state.

We explored the idea of a “23 hr bed” that would provide an alternate site from a hospital for involuntary assessments. This option would require a change in law in order to hold involuntary individuals and could be based on similar programs in Delaware and CA. It would require information and more understanding about existing state and federal laws in order to implement and there are some concerns about possible consequences to human rights due to the involuntary nature.

The group established a subcommittee to develop a “*Living Room*” model which is a peer support program that would provide another option in the existing continuum of care and potentially reduce use of hospitals and reduce wait times for people by providing an alternative structured staffed setting with immediate access, time limited stay and a “hub” for connecting people with services. This would not be a step down from inpatient hospitalization as it is viewed that existing crisis programs fill that role. It could provide a place for persons to go after emergency treatment and stabilization in a hospital emergency department. It would be based on programs that currently exist in other states, which include varying levels of medical/clinical/peer support integration and be adapted to the unique needs of this rural state with a small and scattered population.

Additionally, persons on Emergency Examination status can receive support from trained Living Room staff but cannot be housed at the Living Room site without legal changes. This model would provide trained staff to do outreach and provide support to persons on extended waits in emergency departments through peers and therefore providing meaningful employment for qualified persons who identify with lived experience.

The group determined that data currently unavailable is required to identify the specific problem of why people are waiting in EDs and who they are and to develop relevant solutions. We recommend that the following data be gathered for careful study before implementation of new programs:

- Number of voluntary boarders. Current data gathered by DMH is for involuntary only
- Number of unique persons related to total bed days. For example: do 3 people account for 15 bed days at 5 days per person, or do 15 people account for 1 bed day apiece?
- Reason people are not being admitted into a hospital bed: such as no bed available, bed available but hospital refuses admission, person is not accepted based on diagnosis (DS, ASD, for example)
- Number of High Users of Services: number of people who board in ED multiple episodes (not the same as multiple days)

Implementation of any new program or approach would have to consider the needs of a specific community and local existing resources, so that services are not being duplicated and that services that people will not use are not put into place.

- Educate people seeking services and care community partners how to access new services
- Enlist ED reception staff to redirect people to a different site
- Adapt programs to meet the needs of community: assess need through surveys, research, focus groups, collaborate with designated agencies, police, hospitals, clients, consumers, patients, advocacy groups

Creating a free-standing program with adequate staff to provide two (2) staff on site twenty-four hours a day, seven day a week (24/7), with a Program Coordinator and one (1) additional staff for dedicated outreach and off-site support, with sufficient ongoing training which may include clinical consult, would cost between 550,000 to 700,000 dollars, depending on building expenses and scheduling ratio.

My Pad

Over the last several years, the Howard Center has implemented a stabilization and recovery team or START team that complimented existing emergency services with a modified Assertive Community Treatment team model that better meets the needs of individuals who require more intensive service support to remain stable and independent in the community. Through the extension of service hours and the inclusion of peer support providers, the ability to monitor, engage, and intervene earlier with individuals who may be struggling has proven effective for the cohort served.

Extending this outreach and engagement model further, Howard Center increased service capacity to a few high-end service utilizers who are residing in permanent and supported housing, with a constellation of professional and peer providers available 24/7 in clustered “My Pad” apartments. If adequately funded for replication for other individuals awaiting discharge and who are at high risk for decompensation and rehospitalization, such an intensive model of service delivery could effectively divert a rapid recycling of higher cost inpatient levels of care.

DMH is currently working with Howard Center to identify and reallocate resources to replicate and pilot an additional “MyPad version 2.0” for three high service utilizers who are best supported in individualized housing following hospitalization, but rapidly decompensate without 24/7 support services. Benchmarking success of reduced need for inpatient hospitalization, increased autonomy coupled with engagement in treatment services, and improved outcomes for persons served will better demonstrate overall cost effectiveness through this type of financial investment.

Alternatives to Emergency Department for Children

New Northeastern Family Institute (NFI) Crisis Diversion Beds - Regions in the Southern part of the state have high rates of child psychiatric hospitalization per capita (.0093 as opposed to .0030 for the rest of the state). To address the need for children and youth to stay close to their community, NFI has created a new program in the southern region that will:

- Allow children and youth to have access to a hospital diversion program versus having to be hospitalized in a psychiatric facility, and
- Provide a step down from hospitalization when needed

The Southern Hospital Diversion Program will use the current successful NFI model. It will provide co-ed (male and female), staff secure (locked to the outside but open to those inside), programming, and room and board for up to six youth from age 10 to 18 years old. This program will also work closely with the Brattleboro Retreat to ensure a collaborative relationship around planning and serving children and their families.

The Hospital Diversion program in southern Vermont plans to open in November 2017 in Brattleboro, Vermont. The 6-bed, 10-day facility plans to divert significant numbers of the voluntary admissions away from the Brattleboro Retreat. DMH will create incentives for the program to maintain a maximum 10-day stay, 95% of clients going to a lesser level of care, and an 80% occupancy rate.

XII. Implementation of Act 79 - Sec. 4(4)

In response to requests, the Department developed a crosswalk of legislative requirements and consultant recommendations from 2012 Act 79 in order to educate interested readers on the progress of implementation: <http://mentalhealth.vermont.gov/reports/legislative-and-budget>.

Summary of Act 79

(4) Implementation of Act 79: address whether components not fully implemented are necessary and whether the components implemented are adequate. Priority is determining need to fund 24-hour warm line, 8 intensive residential recovery beds and whether other models of supported housing needed. If implementation or expansion needed, the action plan shall identify the initial steps needed to design, plan and fund.

The majority of the 2012 Act 79 requirements have either been met or continue to be addressed through ongoing development efforts, data collection and evaluation, and additional activities required in this Act 82 report.

- The Clinical Resource Management System has supported active movement of individuals in and out or “flow” of the current mental health system of care with active involvement and collaboration with inpatient and community-based treatment providers.
- Areas such as workforce outreach, mobility, training, and capacity that allows for prompt response to need and turnover continues to have geographic variation around the state. This too is a recognized component for workforce examination and development focus within sections of this report.
- Even though Act 79 funding greatly expanded crisis beds, intensive residential recovery beds, and more community housing supports and services options, continuing demand and calls for expansion of these valued resource options remain.

Regardless of current investments in all areas of service capacities, more choices for services to engage individuals at every level of care or need are recommended by stakeholder groups.

As with any system of care considering modifications, rigorous review must also be introspective; so, re-examination of service delivery and payment models is also a component of this report.

Opportunities to deploy evidence-based or promising practices that better integrate physical and mental health care services, effectively address the coordinated care needs of each person served, and move incrementally toward improved interventions across provider types and better individual outcomes, must continually be reviewed.

Two remaining areas for development under Act 79 are further developing and expanding peer resource capacity through 24/7 operation of the statewide “warm line”, ample community-based peer supports across all areas of Vermont including inpatient access to peer services, and peer-run transportation services. All peer service components will require additional funding beyond what was allocated in Act 79 to be a reality.

Likewise, seven Intensive Residential Recovery (IRR) beds, outlined in Act 79 but never funded, have not materialized given lack of consensus about what type of beds would have the most impact for step-down needs from higher acuity care beds. Also, consistent with recommendations for development of more options, most inpatient and residential service providers identify the ongoing scarcity of bed resources in each level of care as a contributing factor to lack of access and long wait

times for services. These unfunded beds, and the potential need to develop new additional beds or facilities, is rolled into this Act 82 report.

Consensus among stakeholder groups exists for additional mental health system resources at all levels of the service system, more workforce capacity to deliver the services, and greatest flexibility in recognizing individual choice for any new services developed. Stakeholder groups support all current service options available and recommend more be developed with consumer and service provider involvement. Expansion of existing capacity requires increased financial funding to address the gap between need and access. If funded adequately, there will also be no wait times in the mental health system of care.

XIII. Mental Health Access Parity - Sec. 4(5)

While Vermont has defined expectations for mental health service parity, there is little to no agreement across a diverse constituency of stakeholders in how or what achieves true parity and whether or not such parity exists for individuals presenting with mental health conditions. Even though the scope of examination is defined as evaluation of processes for individuals presenting at hospitals, the polarized factions quickly emerge and the discussion of barriers to access begins well before presenting to hospitals.

The working conceptualization of mental health parity is that no access or service differentiation exist in the manner that individuals are received regardless of whether presenting with psychiatric or other health condition. However, preliminary discussions with health care providers over the course of several months of focused discussions around service access remains slow moving with regard to when and how individuals may experience barriers depending on where they may be presenting or from what referral source. This component of the report remains under-developed and requires ongoing preliminary analysis and dialogue with providers and stakeholders to achieve some level of consensus before review of processes outlined within the evaluation take place.

As an example of one issue of parity, health care providers in hospital emergency department settings envision that their treatment capacity is principally triage, stabilization, and transfer. While there is no disagreement on these general service boundaries, the majority of individuals presenting with primary physical health care needs are served emergently, desire or need services, and have capacity to provide the necessary consents (or have others to emergently speak on their behalf if they are not able to do so). Conversely, mental health patients do not always want what is recommended or actively resist what is recommended.

In the above instances, individuals are frequently viewed as needing the services of the State and are expected to transfer immediately to a facility that will manage to assuage the individual by alternative means. The belief continues that a health care facility has an obligation to provide the clinical treatment that is believed to be the most effective for the presenting illness. In the absence of being able to adhere to these service parameters, there is early identification that the person has

been sufficiently triaged and stabilized to the extent necessary to affect an appropriate transfer. This extends to the inpatient psychiatric setting as well, where there is a preference that this cohort of individuals should be classified as Level I patients and attributed to the State's responsibility.

Additional access parity concerns emerge for individuals presenting to hospitals under order of the court or during incarceration that further differentiates them from individuals accessing the hospital for physical health care. Aftercare plans and criteria for services in the community whether outpatient or long-term care in nature also beg further examination of parity for individuals with mental health conditions.

DMH strives to find common ground with others on parity issues but the involuntary nature of treatment and state's obligations for capacity falls squarely on the state versus the system of inpatient healthcare providers. While controversial and a point of contention within hospitals with both emergency departments and inpatient psychiatric units, it may be reasonable to consider that parity must include some level of access and no refusal of inpatient psychiatric admission at these hospitals. This likely carries cost for hospitals that have not made such investments in renovations beyond the walls of their emergency departments, but such requirements of health care providers do exist in other states. Criteria for transfer to a state facility bed could more closely parallel specialty care, when treatment trajectory is clearly exceeding an acute episode of illness, and after such treatment attempts have been made. At present there is not a statutory expectation of hospitals with psychiatric inpatient units to receive and admit any patient presenting for psychiatric care. Also, there is not state bed capacity to accept all the individuals who represent the cohort that hospitals currently indicate they do not have capacity or resources to appropriately treat.

XIV. Emergency Services - Sec. 4(9)

Emergency services includes screening, assessment, support, referral, and crisis beds. Emergency services are funded as a separate service and as part of CRT. Funding for emergency services includes Global Commitment Investment capacity payments (70%) and fee-for-service payments (30%) (varies slightly depending on DA) and DAs can bill DMH or DVHA for this state plan service depending on the individual being served. There has been little additional funding over time although Act 79 added some capacity payment in FY13. One challenge is that the majority of current DMH funding for this service is provided through a capacity payment and the state has little flexibility to increase funds in that category. The DAs also report challenges with third party billing, so working with the Green Mountain Care Board and Department of Financial Regulation to address this is necessary.

DMH is developing payment reforms with the DAs and is brainstorming how emergency services may be addressed. A report out on progress to date will be found in the Act 113, Section 12 report due by 1/15/2018.

DMH is also working with some specific regions and with the DAs, Town Managers or Mayors, police, hospitals and other interested parties to increase these resources. The models will vary depending on regional need but will be either Street Outreach Workers, additional crisis staff in communities or additional crisis staff/screeners at the emergency departments. We are just beginning the work and at this point have shared funding commitment from Chittenden Co. leadership.

XV. Next Steps

Updated action steps from the September 1, 2017 status report are summarized as follows:

1. Data identification and analytics:
 - a. The ED Data subgroup has identified what data is needed from the EDs as well as other data elements that will help provide a full picture of current ED, inpatient and other flow related issues. The work from this point forward is to establish data definition, process for collection, assure high data quality and establish procedures for data review and use. This work will continue as needed.
 - b. This subgroup will be engaged to further understand reasons for referrals to EDs. As we learn more about the reasons from both the ED Data subgroup and other direct collection of information from individuals accessing the ED we will continue to find themes regarding reasons and therefore actions that should be taken.
 - c. This subgroup will work with hospitals to complete a current data survey. This work is in process.
2. Data Collection:
 - a. VAHHS and DMH will implement prospective collection of data as it relates to reasons for referral to EDs, need for inpatient and barriers to discharge including gaps in services (and in connect to ED Data subgroup). This work has begun and will continue to inform decisions and system improvements.
3. ED Options:
 - a. The ED subgroup will explore alternatives to EDs, develop budget and identify statute or regulation changes needed.
4. Workforce:
 - a. AHS is bringing together multiple health care workforce efforts and aligning them with Governor Scott's broader workforce initiatives. This work is currently in process.
5. Facilities: Refer to the Act 84, Section 31 Report due January 15, 2018 in order to finalize recommendations on-
 - a. forensic capacity
 - b. inpatient capacity
 - c. crisis alternatives
 - d. secure residential
 - e. Nursing facility capacity and options to serve geriatric individuals.

6. Regional Navigation:
 - a. Use the current work in Washington Co. to further develop framework for regional navigation, budget and plan needed to implement state-wide and if that will have any impact or identify changes needed from DMH Care Management Teams. Washington Co. and Vermont Care Partners have continued to develop this model and this report includes their findings.
7. Mobil Crisis, Supportive housing and other Community Based Services:
 - a. Create workgroup to further explore expanding mobile crisis, supportive housing needs and other community based services needed.
 - i. DMH has been working with individual communities to build capacity for crisis response including expanded use of street outreach workers.
 - ii. The need for additional supportive housing was identified in various workgroup meetings and DMH has been working to grow that resource within current allocations.
 - iii. There continues to be strong reoccurring support for a strong preference for community based services and not just facilities as a response to the current stressors.
8. Involuntary Treatment: refer to work and information from Section 5 of Act 82 report regarding involuntary treatment.

Next steps identified for the intensive level system of care described below. This is not an exhaustive list nor in priority order:

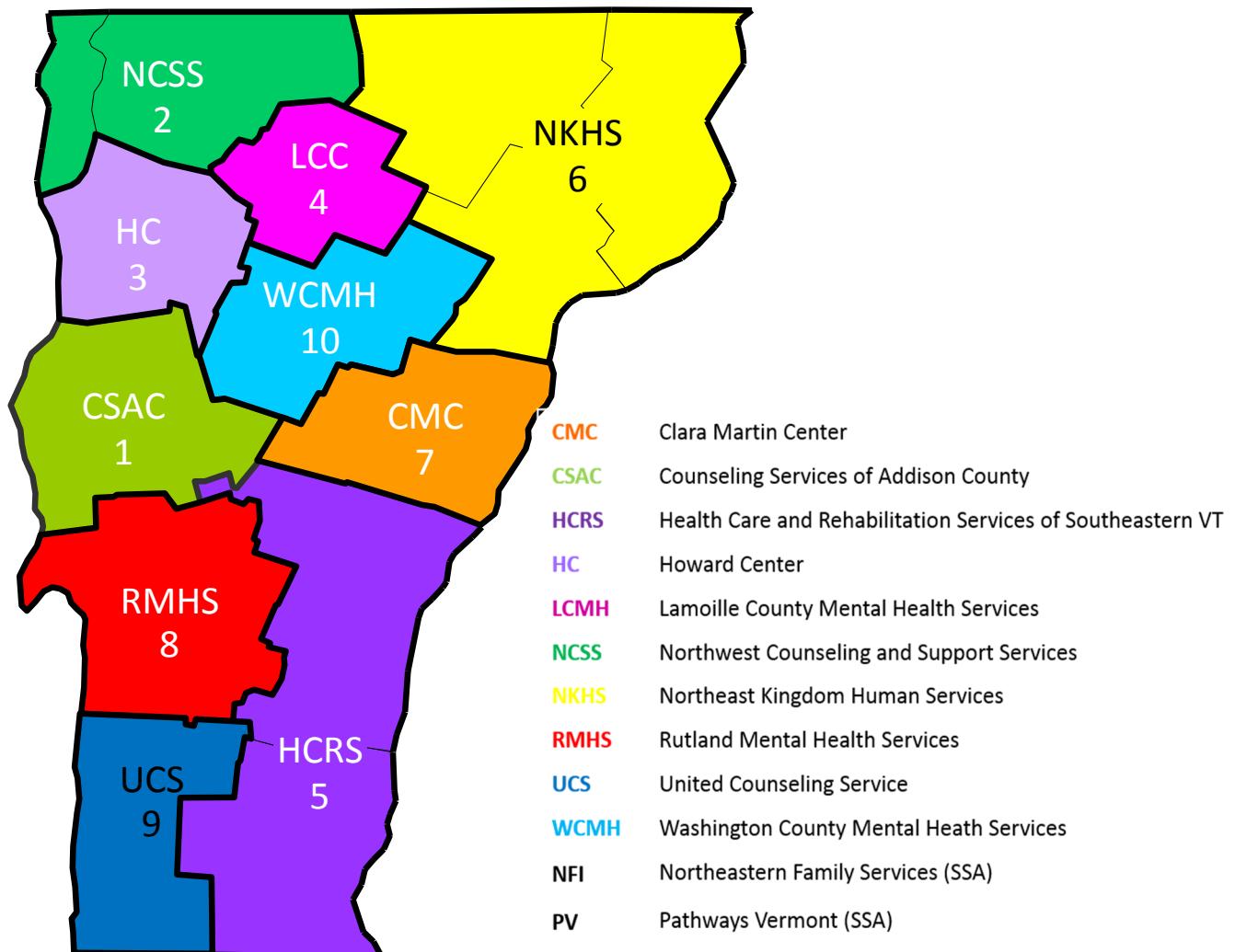
1. Further examination of licensing and rules regarding emergency involuntary procedures (EIP).
2. Further exploration of intensive residential programs treating and maintaining individuals with aggressive behavior.
3. Fully utilize crisis beds¹⁴ and continue to explore alternatives that people may be more willing to access.
4. Continue to expand mobile crisis outreach (including street outreach workers) to appropriately address crisis in community so individuals can be diverted, when appropriate, from the ED.
5. Address the strong conflicting opinions of involuntary treatment. Is there a middle ground to be found? More information will be found in the Act 82, Section 5 report.
6. Provide supportive housing that can adequately support people coming out of inpatient or prevent some individuals needing inpatient or crisis services.
7. Add more resources to assure training in evidence based practices. DMH works with VT Cooperative for Practice Improvement and Innovation to expand access to training in evidence based practices and grants to support training.

¹⁴ The crisis beds that currently exist were utilized at a high rate in the last quarter, but it is unclear if this is a new trend.

8. Sustain and expand peer services.
9. Expand mental health treatment court capacity.

XVI. Vermont Mental Health System of Care

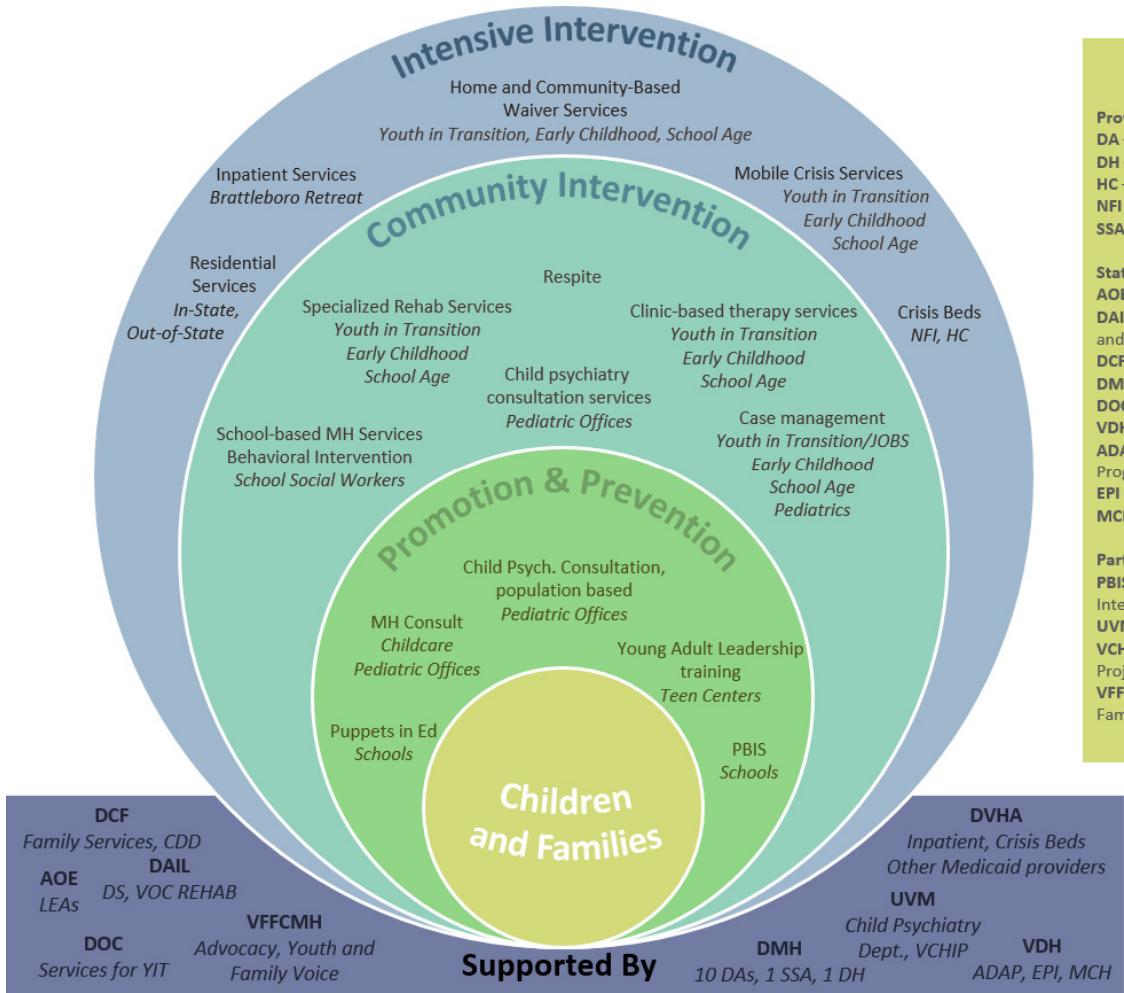
Designated Providers



Community Programs

<i>Program</i>	<i>Description</i>
Adult Outpatient (AOP)	Provides services for adults who do not have prolonged serious disabilities but who are experiencing emotional, behavioral, or adjustment problems severe enough to warrant professional attention
Community Rehabilitation and Treatment (CRT)*	Provides services for adults with severe and persistent mental illness
Children and Families (C&F)*	Provide services to children and families who are undergoing emotional or psychological distress or are having problems adjusting to changing life situations.
Emergency Services	Serves individuals who are experiencing an acute mental health crisis. These services are provided on a 24-hour a day, 7-day-per-week basis with both telephone and face-to-face services available as needed.
Advocacy and Peer Services	Broad array of support services provided by trained peers (a person who has experienced a mental health condition or psychiatric disability) or peer-managed organizations focused on helping individuals with mental health and other co-occurring conditions to support recovery

Children's Mental Health System of Care



Acronyms

Providers

PROVIDERS
DA – Designated Agency
DH – Designated Hospital
HC – HowardCenter
NFI – Northeastern Family Institute
SSA – Specialized Service Agency

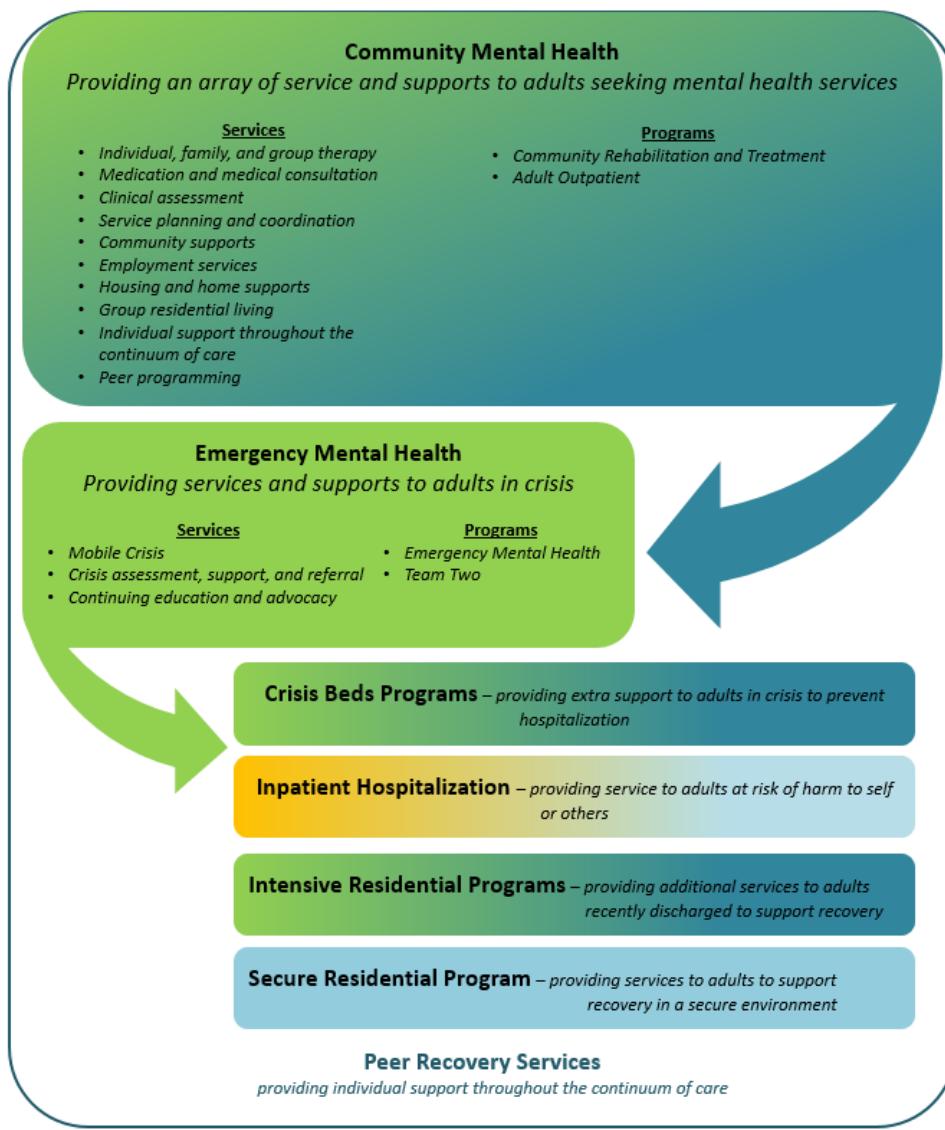
State Government

AOE – Agency of Education
DAIL – Dept. of Disabilities, Aging, and Independent Living
DCF – Dept. for Children and Families
DMH – Dept. of Mental Health
DOC – Dept. of Corrections
VDH – Dept. of Health
ADAP – Alcohol Drug Abuse Programs at VDH
EPI – Epidemiology at DMH/VDH
MCH – Maternal Child Health at VDH

Partners and Programs

PBIS – Positive Behavioral Intervention and Supports
UVM – University of Vermont
VCHIP – Vermont Child Improvement Project
VFFCMH – Vermont Federation of Families for Children's Mental Health

Department of Mental Health Adult Mental Health System of Care



Color Legend

Department of Mental Health (DMH)

Designated Agencies

private, non-profit service providers that are responsible for ensuring needed services are available through program delivery, local planning, service coordination, and monitoring outcomes within their geographic region.

Specialized Services Agencies

private, non-profit service providers that provide a distinctive approach to service delivery and coordination or provide services that meet distinctive individual needs.

Private Providers

Psychiatrists, Psychologists, Nurse Practitioners, Social Workers, Physician Assistants, Licensed Mental Health Clinicians, Community Hospitals

XVII. Glossary

ADHD	Attention-deficit/hyperactivity disorder
ADS	Agency of Digital Services
AHS	Agency of Human Services
CAFU	Child, Adolescent & Family Unit Childe
CALM	Counseling on Access to Lethal Means
CAMS	Collaborative Assessment & Management of Suicidality
CBT	Cognitive Behavioral Therapy
CFTSI	Child and Family Traumatic Stress Intervention
CMS	Centers for Medicare & Medicaid Services
CPP	Child-Parent Psychotherapy
CRT	Community Rehabilitation and Treatment
DA	Designated Agency
DAIL	Department of Disabilities, Aging and Independent Living
DBT	Dialectical Behavioral Therapy
DCF	Department for Children & Families
DMH	Department of Mental Health
DVHA	Department of Vermont Health Access
EBP	Evidence Based Practice
ED	Emergency Department
EIPs	Emergency Involuntary Procedures
ER	Emergency Room
FFP	Federal Financial Participation
FTE	Full Time Equivalent
FY	Fiscal Year
GF	General Fund
HC	Howard Center
HCRS	Health Care and Rehabilitation Services of Vermont
HRSA	Health Resources and Services Administration
ICU	Intensive Care Unit
IDDT	Integrated Dual Diagnosis Treatment
IMD	Institution for Mental Disease
IRR	Intensive Residential Recovery
IT	Information Technology
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LOS	Length of Stay
MCO	Managed Care Organization
MH	Mental Health
MHC	Mental Health Court

MSR	Monthly Service Report
MTCR	Middlesex Therapeutic Community Residence
MTSS	Multi-Tiered System Supports
NAMI	National Alliance on Mental Health
NCSS	Northwestern Counseling and Support Services
NFI	Northeastern Family Institute
NKHS	Northeast Kingdom Human Services
NYC	New York City
OHN	Order of Non-Hospitalization
OPR	Office of Professional Regulation
PBiS	Positive Behavior Intervention and Supports
PCIT	Parent-child interaction therapy
PCMH	Patient Centered Medical Home
PHPG	Pacific Health Policy Group
PIPBHC	Promoting Integration of Primary and Behavioral Health Care
PIVOT	Program to Improve Vermont Outcomes Together
PTSD	Post-Traumatic Stress Disorder
RMHS	Rutland Mental Health Services
RN	Registered Nurse
RRMC	Rutland Regional Medical Center
SAMSHA	Substance Abuse and Mental Health Services Administration
SFI	Seriously Functionally Impaired
SSA	Specialized Service Agency
START	Stabilization, Treatment, and Recovery Team
TCR	Therapeutic Community Residence
UVM	University of Vermont
VAHHS	Vermont Association of Hospitals and Health Systems
VCP	Vermont Care Partners
VCPI	Vermont Cooperative for Practice Improvement and Innovation
VDH	Vermont Department of Health
VPCH	Vermont Psychiatric Care Hospital
VPS	Vermont Psychiatric Survivors
VT	Vermont
WCMHS	Washington County Mental Health Services
WRAP	Wellness Action Recovery Planning