VERMONT2019

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 79

January 15, 2019

Department of Mental Health
AGENCY OF HUMAN SERVICES
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Act 79 Reporting Requirements

18 VSA 174 § 7256. Reporting requirements

Notwithstanding 2 V.S.A. § 20(d), the Department of Mental Health shall report annually on or before January 15 to the Senate Committee on Health and Welfare and the House Committee on Human Services regarding the extent to which individuals with a mental health condition or psychiatric disability receive care in the most integrated and least restrictive setting available. The Department shall consider measures from a variety of sources, including the Joint Commission, the National Quality Forum, the Centers for Medicare and Medicaid Services, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration. The report shall address:

(1) use of services across the continuum of mental health services;

(2) adequacy of the capacity at each level of care across the continuum of mental health services;

(3) individual experience of care and satisfaction;

(4) individual recovery in terms of clinical, social, and legal results;

(5) performance of the State's mental health system of care as compared to nationally recognized standards of excellence.

(6) ways in which patient autonomy and self-determination are maximized within the context of involuntary treatment and medication;

(7) performance measures that demonstrate results and other data on individuals for whom petitions for involuntary medication are filed; and

(8) progress on alternative treatment options across the system of care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications. (Added 2011, No. 79 (Adj. Sess.), § 1a, eff. April 4, 2012; amended 2013, No. 96 (Adj. Sess.), § 101; 2013, No. 192 (Adj. Sess.), § 2; 2015, No. 11, § 19.)

Executive Summary: The Mental Health System of Care

The Vermont Department of Mental Health (DMH), with the Designated Hospitals (DHs), Designated Agencies (DAs), Specialized Services Agencies (SSAs) and other community and Agency of Human Services (AHS) partners, has continued to work throughout the past year to move the system of care forward within Vermont for people with mental health needs. The first Act 79 report (2013) addressed rebuilding a system of care in the time of crisis following Tropical Storm Irene. The second year (2014) focused on continuing to build capacity within the inpatient and outpatient systems, expansion of quality and evaluation activities, increased focus on the transitions of care, and internal changes and restructuring within the Department. The third and fourth year reports (2015, 2016) outlined the progress made to date in implementing the systems developed and discussed above. Coming into our fifth and sixth year reports (2017, 2018) DMH continues to highlight our key measures, emerging trends, and point out areas that are still in development.

Act 79

A system of care begins with availability of strong community support for people with mental health needs in the most integrated and least restrictive setting available. Act 79, passed in 2012 by the Vermont Legislature, moved to strengthen a well-respected community mental health system by bolstering supports and filling gaps to assist people living and receiving treatment in their communities. This included an increase in the capacity of case management services for designated agency outpatient clients and the enhancement of emergency outreach services in every community.

The array of peer support programs conceptualized in Act 79 continues to develop and expand their essential role in our system of care. These services include 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. Peers are also working within some Designated Agencies to provide supports to individuals awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services. Enhancement of these programs over the past year has included training and mentoring for peer staff using the Intentional Peer Support Curriculum, Wellness Recovery Action Plans (WRAP), and Wellness Engagement Training. The Wellness Workforce Coalition is also developing a Core Competency Training for peer support workers. Expansion of service outcomes is reported using the Results-Based Accountability framework.

Emergency services provided by the Designated Agencies are the initial point of access for crisis beds and, to some extent, hospital beds for psychiatric care throughout the state. Working closely with law enforcement is essential to this process. A statewide inter-disciplinary training program between law enforcement personnel and mobile crisis responders, known as “Team Two,” continues to grow and expand to include further training opportunities for a variety of community responders. This continues to be an area of need for further collaboration across many jurisdictions that are served by multiple law enforcement agencies. The Department welcomes the ongoing support of the Department of Public Safety in achieving the goal of integration of these services in the interest of quality mental health care and public safety. Additionally, work with towns, hospitals, and police departments to expand mobile outreach to target populations is underway in Chittenden County through a 2018 legislative

appropriation. Collectively, South Burlington, Colchester, Williston, Winooski, Essex and Shelburne came together requesting a Street Outreach expansion program. This new program targets unmet mental health needs of the residents of these towns with four full time staff. Developing ways to work together to address the unique situations in each town and through a "first response" type of manner will continue to be its focus.

The departmental adult care management system facilitates the coordination of admissions and aftercare services across the involuntary inpatient system at all Designated Hospitals and the Vermont Psychiatric Care Hospital. Care managers assist crisis services teams and providers to triage individuals into programs for admission, as well as facilitating the referral process for individuals to step-down programs, transitional housing programs, and supportive housing units when they are ready to return to the community. To accomplish this task, the team works closely with hospitals by holding weekly clinical team meetings regarding inpatient status, supporting discharge and aftercare planning, creating a bridge to community programming, and providing technical assistance when necessary. Acting as a managed care organization in partnership with the Department of Vermont Health Access (DVHA), a segment of the team performs utilization review for Community Rehabilitation and Treatment (CRT) clients and Designated Agency Adult Outpatient (AOP) clients receiving Medicaid benefits who are receiving inpatient psychiatric services. The utilization review care managers also review all Medicaid involuntary and Level 1 admissions, regardless of whether they are enrolled in any DA programs. In the Child, Adolescent and Family Unit (CAFU) the care managers play a large role in helping DAs access higher levels of care for children when needed. This includes residential treatment, both in-state and out-of-state as well as therapeutic foster care through intensive home and community-based services. The CAFU works in close collaboration with families and DAs/SSAs as well as education, child welfare, developmental disability services and early childhood.

Training throughout the community and hospital systems is an ongoing need. In addition to the training opportunities made available through statewide conferences, DMH has partnered with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) and other community partners to support numerous training, technical assistance and practice improvement initiatives for the clinical system of care. VCPI, now newly affiliated under the Northern Vermont University umbrella, is entering its fourth year of facilitating a statewide initiative to reduce seclusion and restraint in Designated Hospitals, using the "Six Core Strategies to Reduce the Use of Seclusion and Restraint ©"and is also developing and supporting training in the following clinical areas:

- Integrated Dual Disorder Treatment (IDDT) for Co-Occurring Mental Health and Substance Use Disorders;
- Core Orientation and Clinical Skills for Direct Care Staff;
- Dialectical Behavior Therapy;
- Open Dialogue (Collaborative Network Approach);
- Treatment of Early Episode Psychosis;
- Integrated Mental Health, Health and Wellness Interventions;
- Mental Health First Aid;
- Collaborative Mental Health and Law Enforcement Crisis Response (Team Two);
- Recovery Oriented Cognitive Therapy; and
- Children's Health Integration Linkage and Detection (CHILD) Grant

Ongoing

Current and future work continues to include stakeholder involvement. Over the past year, the Department has continued to host an Emergency Involuntary Procedures (EIP) Advisory Committee, which is comprised of a large cadre of stakeholders. Quarterly, this committee reviews data and receives updates from Designated Hospitals regarding their implementation of strategies to reduce seclusion and restraint. The committee also includes Disability Rights Vermont, who receives EIP Certificates of Need (CONs) for any involuntary patients in its capacity as Mental Health Ombudsman. The Department has also worked closely with the Designated Hospitals to further refine processes and to implement changes identified in the 2014 Act 192[1] legislation. These changes have included second certifications being completed while an individual is awaiting placement under an Emergency Examination order, seeking expedited hearings for non-emergency involuntary medications, and a notice of rights being provided to patients in the custody or temporary custody of the commissioner who are waiting in an emergency room.

During the summer and fall of this past year following passage of Act 200, DMH convened an Order of Non-Hospitalization (ONH) study committee to explore opportunities to improve ONHs, propose potential pilots for services to decrease ONHs, or recommend statutory changes to better support ONHs if any were identified. A full report of the ONH study committee and findings or recommendations was submitted to legislative committees of jurisdiction in early December 2018 and await legislative review and possible action.

Through its expanding focus on suicide prevention, the Department of Mental Health has partnered with the Center for Health and Learning and other AHS departments to continue implementation of the nationally-recognized Zero Suicide model. The model includes upstream "umatter" trainings for schools and Mental Health First Aid trainings for communities which promote awareness and build skills to identify those in need and refer them to help. The Center for Health and Learning/DMH partnership also provided training for clinicians in Chittenden, Lamoille and Franklin/Grand Isle counties on *Collaborative Assessment and Management of Suicidality* (CAMS), an evidence-based practice with good outcomes for treating suicidality. Together these practices will improve access to services and increase capacity for clinicians to deliver state-of-the-art care to those seeking help.

The Department, in collaboration with the Vermont Suicide Prevention Coalition, is also providing education to representatives from public health, education, state agencies, suicide prevention advocacy groups, youth leadership, mental health services and survivors throughout the state on effective approaches for populations at high risk for suicide, starting with a December 2018 panel discussion on LGBTQ population, new Americans, individuals with mental illness, and older Vermonters. Future populations to be addressed are teens and young adults, persons of color and veterans.

Current

Act 190 (2018) and the Big Bill (Act 11 [2018 Special Session]) provided $4.5 million in Capital Funds and $1.0 million from the Tobacco Litigation Settlement Fund to AHS through the Department of Buildings

[1] http://legislature.vermont.gov/assets/Documents/2014/Docs/ACTS/ACT192/ACT192%20As%20Enacted

and General Services to increase the state's Level I inpatient bed capacity at the Brattleboro Retreat. The funding provides for an additional 12 beds to increase statewide capacity by January 2020 while additional inpatient beds are further explored with the University of Vermont Health Network. A concept proposal was introduced late in the legislative session by the UVM Health Network recommending the development of additional inpatient beds on the campus of the Central Vermont Medical Center. Development of the concept proposal is ongoing and likely will be part of a longer-term inpatient bed replacement plan.

The Department continues to plan for the replacement of the current Secure Residential Recovery (SRR) program, the 7-bed temporary facility in Middlesex. Prior activities have included reports on the populations to be served and needs for the program, a larger bed capacity given referrals to the program for initial step-down aftercare services, a *Request for Proposals* to assess interest among community stakeholders in developing and/or operating a permanent secure recovery program, and planning across multiple AHS departments to assess how the mental health needs of populations being served by other departments might be addressed by future permanent program/s. Allocated funding is still required to develop a such a replacement plan.

A final component of work undertaken during the past year is the Department's payment reform initiative. The initiative represents a first step toward comprehensive change in both mental health service delivery and payments for those services. This effort is spearheaded by DMH in collaboration with the Designated Agencies (DAs), Specialized Services Agencies (SSAs), Vermont Care Partners and the Department of Vermont Health Access (DVHA). The Department sought to be an early adopter in payment reform with the hope of addressing program silos, reducing barriers to service access and/or limiting factors of program eligibility where possible for both adults and children receiving services in publicly funded community mental health programs. The resulting payment methodology is informed by both the Integrated Family Services (IFS), the Community Rehabilitation and Treatment (CRT) payment models and earlier Medicaid Pathway engagement and development work with community treatment providers. Using experience and lessons learned through each model and the combined payment and policy expertise of both departments, a new case rate framework and value-based payment model emerged. The DMH Child, Adolescent, and Family Unit also worked closely with early adopters of the Integrated Family Services model to align service reporting with the new model and the Department for Children and Families to incorporate funding for youth in custody who receive mental health services into the new case rate. Subsequently, annualized adult and child case rates were created, and expected caseloads projected based on currently available allocations and taking into account three years of prior payment and caseload history.

Throughout this process DMH worked closely with key stakeholders to keep all apprised of the opportunities inherent through this change process for services, revisions undertaken in the policy area, progress made, or milestones achieved in the approval process with the Centers for Medicare and Medicaid Services (CMS), and roll-out and technical assistance with providers. An overarching Steering Committee and several work groups were assembled for this planning and development process. Adult and Child Program State Standing Committee representatives were participants in Steering Committee meetings and progress updates were provided at regular state standing committee meetings. Engagement with the DAs and ongoing representative participation in review of policy, payment, and manual guidance revisions followed as payment methodology was crafted and finalized. Ongoing work and further refinement of process, as well as evaluation of improvements and outcomes achieved, will continue into 2019 and beyond. Other AHS Departments are also engaged in similar payment reform work involving DA's and the services provided. It is anticipated that other AHS Departments will align in

methodology, and where appropriate, may participate in an overall case rate payment methodology for services to other populations served by DAs over time.

Beginning 1/1/2019, an annualized case rate per DA or SSA will be divided into 12 equal monthly payments and paid monthly to each Agency. The new mental health case rates in Year 1 of this payment reform represents nearly $100 million dollars between both DMH and DVHA. As perspective on the significance of this payment reform initiative for mental health care services, the first year Medicaid payments through the Vermont Medicaid Next Generation Pilot Program were approximately $82 million dollars.

In addition to the payment reform initiative that had been underway, Act 11 (2018) authorized a DMH increase of $4.3 million to address an ongoing compensation gap for the DA workforce. New resources were targeted to direct service personnel to increase recruitment and retention of qualified, professional staff. Up to 20 percent of the approved funding was also authorized on an annualized basis to focus on value-based incentive payments to the DAs for quality and outcomes associated with the new payment reform initiative.

Future

The "Planning for the Future" section of this document outlines the path to move forward. The Department realizes that many of the new programs put into place require continual monitoring as to the outcomes we are aiming to achieve. The Department of Mental Health looks to the legislature, stakeholders, and their colleagues in the Designated Hospitals and Designated Agencies to continue to work together towards improving care and the quality of life for persons with complex mental health needs. As described in the Act 200 (2019) report submitted to the legislature, inpatient capacity must grow initially, but that additional capacity in community residential levels of care and expansion of integrated care approaches may alleviate the need for inpatient level of care over time. Prevention and health promotion activities should also help decrease the number of Vermonters who find themselves in need of such levels of care.

Accomplishments

The Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of Human Services (AHS) Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of

- Community Rehabilitation and Treatment (CRT) services for adults with severe and persistent mental illness;
- Adult Outpatient for adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions;
- Emergency Services for anyone, regardless of age, in a mental-health crisis; and
- Children, Youth, and Family Services, including children who have a serious emotional disturbance and their families.

The Department also contracts with several peer and family-run organizations to provide additional support and education for peers and family members who are seeking supplemental or alternative supports outside of the Designated Agencies in their catchment area. Peer and family-run organizations also help educate individuals and families to advocate for their needs within the Designated Agencies and across multiple service provider organizations.

The Department has made significant progress since the emergency closing of the Vermont State Hospital in late August 2011 following Tropical Storm Irene. Inpatient care is being provided using a decentralized system which includes one state-run hospital and five Designated Hospitals located across the state. Community services have been enhanced and support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for the level of care required. In many cases, treatment can be provided closer to individuals' homes.

However, providers within the mental health system continue to respond to growing demand and pressures to the best of their ability and within the current resources. Emergency departments continue to experience an influx of individuals seeking care and the system continues to experience challenges with flow between levels of care – transitioning individuals, when appropriate, to lower levels of care.

Under Act 79, which principally focused on adult services capacity, the Department continues its collaborative work to strengthen Vermont's existing mental health care system. This work has included the development of enhanced community services, including emergency/crisis responses, residential services and support, housing, and inpatient treatment capacity. Specific enhancements since the enactment of 2012 Act 79 include, but are not limited to:

- Hospital Services
  - 45 Level 1 beds with a total of 201 adult psychiatric inpatient beds across the system of care
  - Operating a 25-bed psychiatric hospital that is both CMS certified and TJC accredited
  - Operational capacity for Level 1 inpatient care at both Rutland Regional Medical Center and Brattleboro Retreat
  - Emergency Involuntary Procedure Rule-making process completed with Legislative Committee on Administrative Rules (LCAR)

    - Designation of the White River Junction Veterans Administration Medical Center to provide involuntary inpatient care
- Community Services
    - Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
    - Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs
    - Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
    - Increased and additional training for Team Two collaboration between law enforcement and mental health responders
    - Additional availability of soft-restraints for law enforcement transports for involuntary mental health hospitalizations
    - Resources to assist individuals in finding and keeping stable housing
    - Expansion of warmline hours
- Residential and Transitional Services
    - Soteria, a five-bed, peer supported alternative residential program opened in Chittenden County
    - Maintaining full occupancy at the secure residential recovery program, the Middlesex Therapeutic Community Residence, serving 7 individuals
    - Continued planning for permanent replacement capacity for the Secure Residential Program
- Performance and Reporting
    - Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts
    - Creation of a "VPCH Outcomes" scorecard to meet legislative reporting requirements
    - Creation of a "DMH Scorecard" using the RBA scorecard reporting tool
    - Migration of the "DMH Snapshot" and the "DMH continued reporting" report to the RBA scorecard reporting tool
    - Exploration of visualization tools to create more responsive reporting
    - Participation in development of the AHS Community profiles
- Regulation and Guidance
    - Revision of the Designated Hospital Manual and Standards to better reflect the scope of review and designation and creation of a designation protocol to efficiently manage the process
    - Creation of involuntary transportation manual to consolidate the expectations of the department into a single document
    - Revision of the emergency services standards
    - Revision and consolidation of the DMH Fee-for-Service Medicaid, the CRT Provider, and the Enhanced Family Treatment Manuals into a comprehensive, coordinated and policy aligned service provider reference manual for Payment Reform

- Launch of a Payment Reform initiative - a simpler, but accountable system that reduces the complexities of payment and allows a shift in focus of the providers and the department to outcomes and quality.

The Department is continuing to monitor the functioning of the clinical resource management system to "coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system" as written in Act 79. This system encompasses the following functions:

- Departmental clinical care managers provide assistance to crisis services clinicians in the field, Designated Agency case managers, and Designated Hospital social workers to link individuals with the appropriate level of care and services as well as acting as a bridging team for aftercare and discharge planning from hospital inpatient care to community services
- Departmental clinical care managers provide support to Designated Agencies and monitor care to individuals on Orders of Non-Hospitalization (ONH)
- An electronic bed board to track available bed space is updated regularly to enable close to real time access to information for individuals needing inpatient treatment, residential treatment or crisis bed services
- Patient transport services that are least restrictive have been developed and are coordinated through Admissions and Central Office
- Review and coordination of intensive residential care bed placement within a no-refusal system
- Access by individuals to a mental health patient representative
- Periodic review of individuals' clinical progress

The remainder of this report will provide more in-depth information about utilization, capacity, and outcomes of these programs within the Mental Health System of Care with a focus on adult services. For additional information about the children's system of care, the annual Act 264 System of Care Report can be found on the Integrating Family Services website at: https://ifs.vermont.gov/docs/sit. Measures with national rates are calculated from Substance Abuse and Mental Health Services Administration (SAMHSA) Uniform Reporting System Tables. A summary report is provided in the appendix.

Utilization of Services and Capacity

The Department of Mental Health, as part of the Agency of Human Services, has been working closely with the Legislative committees of jurisdiction and stakeholders to monitor and enhance the development of services to those requiring mental health care in Vermont as it works to improve the hospital and community-based system. This process is reflected in reporting on utilization of these services and is described below.

Inpatient Care

Vermont has a decentralized system of adult inpatient care, where people in need of hospitalization are provided treatment at either the state-run inpatient facility or one of six Designated Hospitals throughout the state. Designated Hospitals provide treatment to both voluntary and involuntary patients.

These beds provide three levels of service for adults:

- **Level 1 Involuntary**– involuntary hospitalization stays paid at-cost to contracted and state providers for people who are the most acutely distressed who require additional resources
- **Non-Level 1 Involuntary** – involuntary hospitalization stays for individuals who do not require additional resources
- **Voluntary** – voluntary hospitalization stays

Level 1 Involuntary care is provided at specific units across three hospitals for a total of 45 beds. These beds require admission and concurrent review by the Department utilization review and care managers. These beds are located at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and Vermont Psychiatric Care Hospital (25 beds).

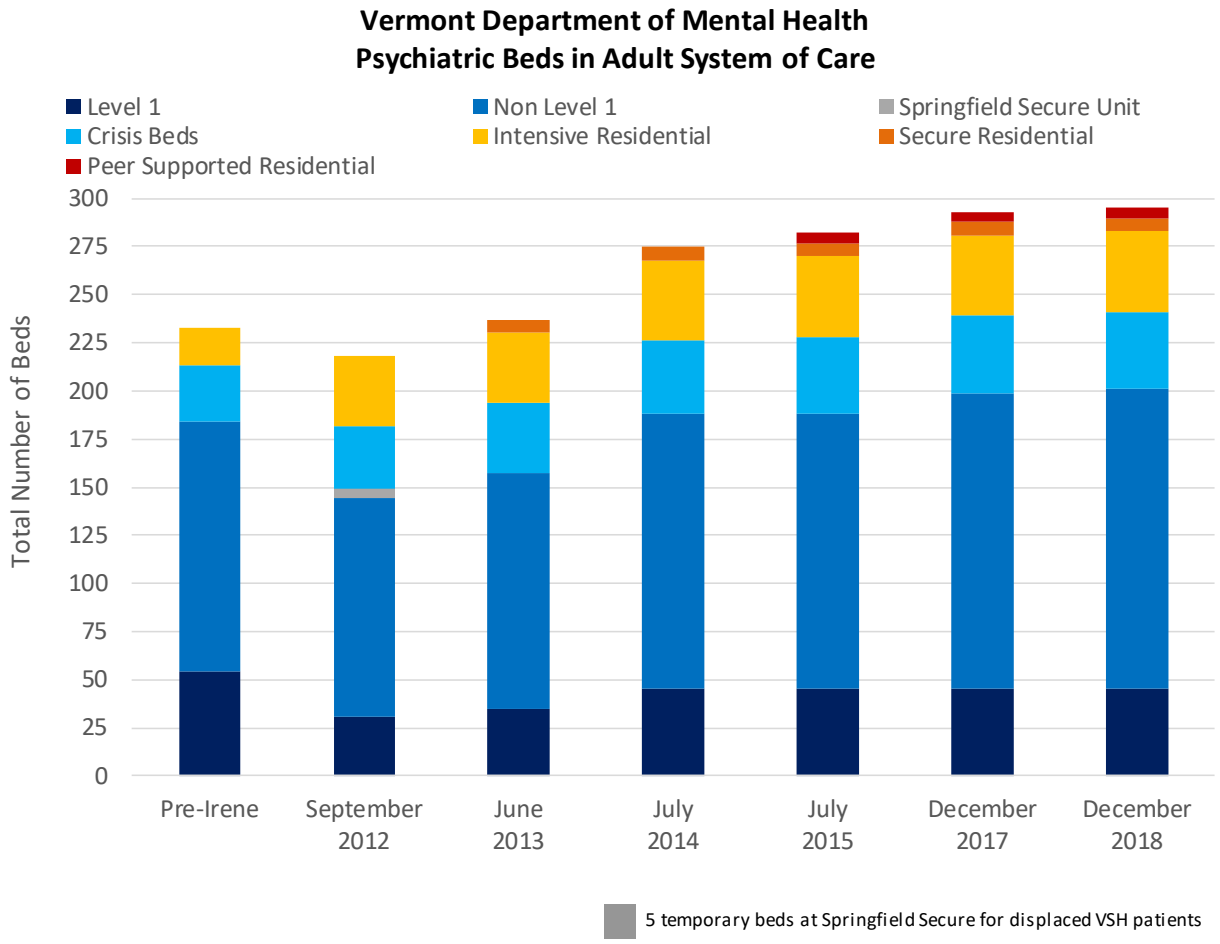
The remaining 156 beds are used for **Non-Level 1 Involuntary** and **Voluntary** inpatient stays. At our last estimation, approximately 80% of these bed days were used for **Voluntary** stays.

Hospital	Location	Total Adult Inpatient Beds
Brattleboro Retreat	Brattleboro, VT	89
Central Vermont Medical Center	Berlin, VT	14
University of Vermont Medical Center	Burlington, VT	28
Rutland Regional Medical Center	Rutland, VT	23
Windham Center at Springfield Hospital	Springfield, VT	10
Vermont Psychiatric Care Hospital	Berlin, VT	25
White River Junction VA Medical Center	White River Junction, VT	12*

**The VA Medical Center has 12 beds total for Veteran's psychiatric inpatient care. A subset of these beds (2-3) are allocated for involuntary care at the discretion of the Medical Center.*

An electronic bed board is updated daily to track capacity and facilitate placement of patients needing hospitalization or other crisis services in the system. Departmental leadership and care management staff work to resolve issues as quickly as possible. Emergency departments across the state have had to hold individuals needing inpatient psychiatric care while waiting for an open bed. This is disruptive to the emergency care setting and not a standard that the department regards as adequate for individuals requiring inpatient care.

Chart 1: Psychiatric Beds in the System of Care



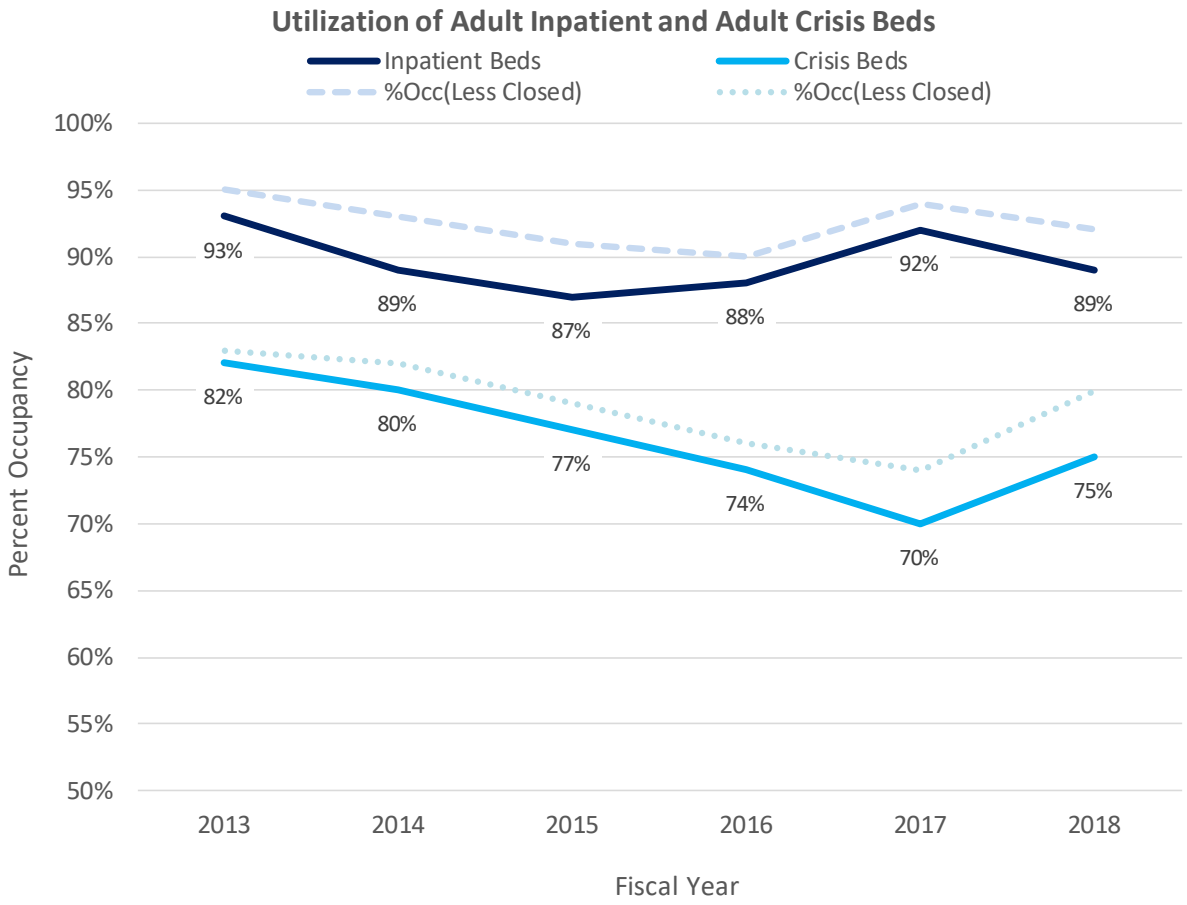
Vermont has increased its capacity for mental health care substantially since August 2011. Overall, the system capacity for psychiatric beds has increased by over 60 beds since August 2011. Vermont's adult psychiatric inpatient system has a total of 201 beds, which is seventeen (17) more than before tropical storm Irene closed the Vermont State Hospital. The Designation of White River Junction VA Medical Center added 10 adult inpatient beds to the system of care at last report. As of December 2018, the VA Medical Center increased to 12 psychiatric inpatient beds and continues to allocate two to three beds for involuntary care for Veterans.

At the same time, crisis and intensive residential beds have increased from 49 (Pre-Irene) to 87. Additional funding supported expansion of crisis beds for those persons not in need of hospital level of care and for persons needing step-down care; these beds are now available at all ten Designated Agencies. A number of these beds also provide access to peer support services, and the number of peer-supported residential beds has increased with the opening of Soteria House in Chittenden County. Middlesex Therapeutic Care Residence (the Secure Recovery Residence) continues to operate as a secure therapeutic community residential program in which individuals can continue their individual course of recovery.

Act 190 (2018) provided $5.5 million dollars for the development of 12 inpatient Level I beds at the Brattleboro Retreat. A construction agreement was completed between the Retreat and Department of Buildings and General Services (BGS) in December 2018. This additional inpatient bed capacity is currently anticipated to come online in early 2020.

The Department and other AHS agencies continue to work together to identify and develop permanent replacement capacity for the Secure Residential Recovery Program. The planning considerations of this collaborative work was outlined in the Act 84 AHS Major Facilities Report submitted in January 2018 to the House Committees on Appropriations, Corrections and Institutions, Health Care, and Human Services, and the Senate Committees on Appropriations, Health and Welfare and Institutions. To date, no funding has been allocated for either replacement or expansion of service capacity.

Chart 2: Percent Utilization of Adult Inpatient and Adult Crisis Beds



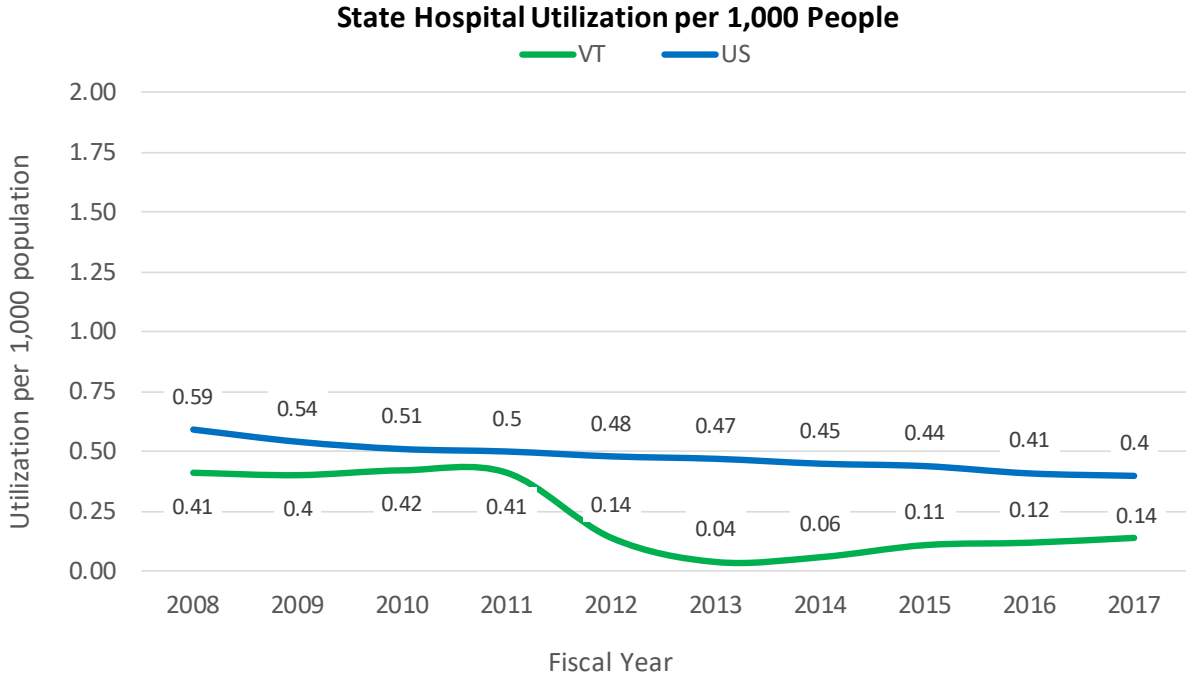
The Department calculates percent occupancy in two ways and both calculations are important to understanding bed utilization. The first calculation called "occupancy" is calculated using total bed days occupied by clients and total facility capacity. It helps the Department determine what percent of planned system capacity beds are occupied by clients. The second calculation called "occupancy (less closed)" is calculated using total bed days occupied by clients and available capacity, which is total facility capacity minus any closed beds reported to the Department. It helps the Department determine what percent of actual beds available are occupied by clients.

Occupancy of adult crisis beds declined consistently since FY 2013 and utilization was further impacted by hospital and community provider risk management concerns in the wake of the Kuligoski Supreme Court decision (2016). 2018 shows a slight increase though in utilization given more concerted effort between DMH care management and DA's to promote a crisis bed option, for clients assessed at lower risk, as an alternative to extended ED wait time. The department continues to explore voluntary alternative service or bed options that may better meet the needs of Vermonters experiencing a mental health crisis.

Adult inpatient bed occupancy has decreased slightly in 2018 but is not suggesting a decreasing need for inpatient capacity given the small percentage fluctuation. During FY 2018, involuntary inpatient lengths of stays was relatively unchanged. Readmission rates were also unchanged, a trend that remains below the national readmission rate trends. Additionally, more adults were being referred to involuntary inpatient care than in previous years.

The Department also compares the utilization of our system of care to national benchmarks. The following two charts provide information on Vermont utilization as compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMSHA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). FY 2017 is the most recent data available.

Chart 3: State Hospital Utilization per 1,000 people (in Vermont and the United States)

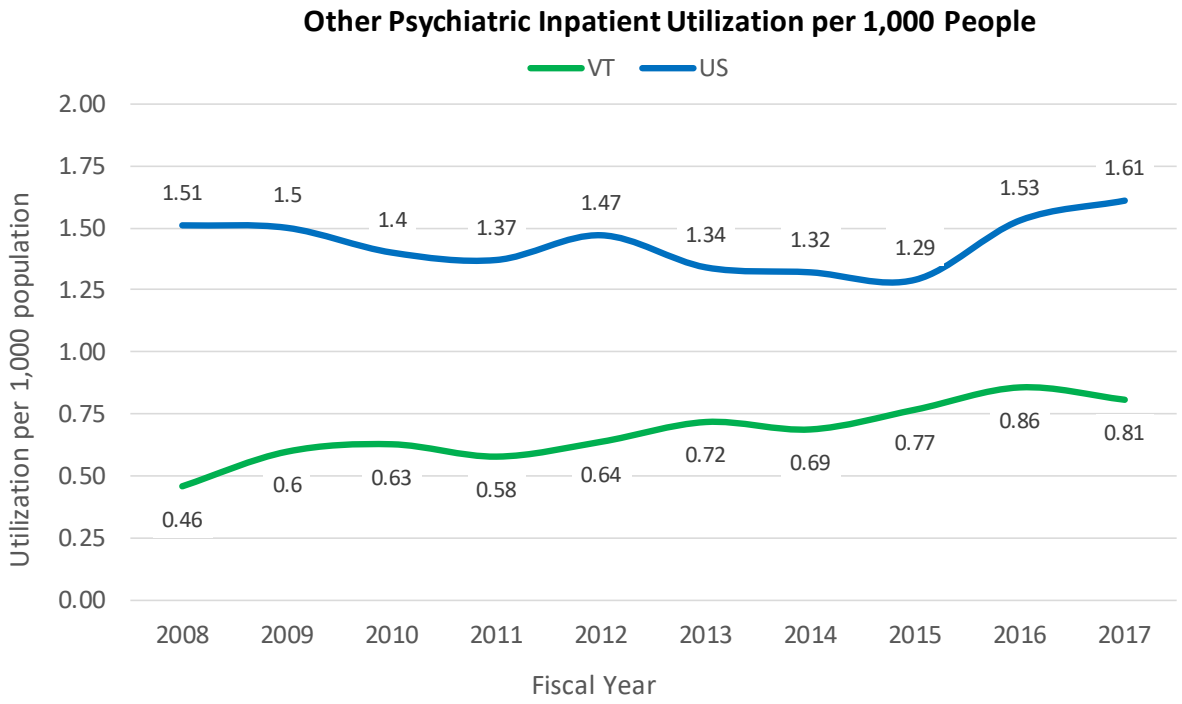


Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2017.

The national rate of state hospital utilization continues to decline year-over-year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August

2011. The Vermont hospital utilization data is showing a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing.

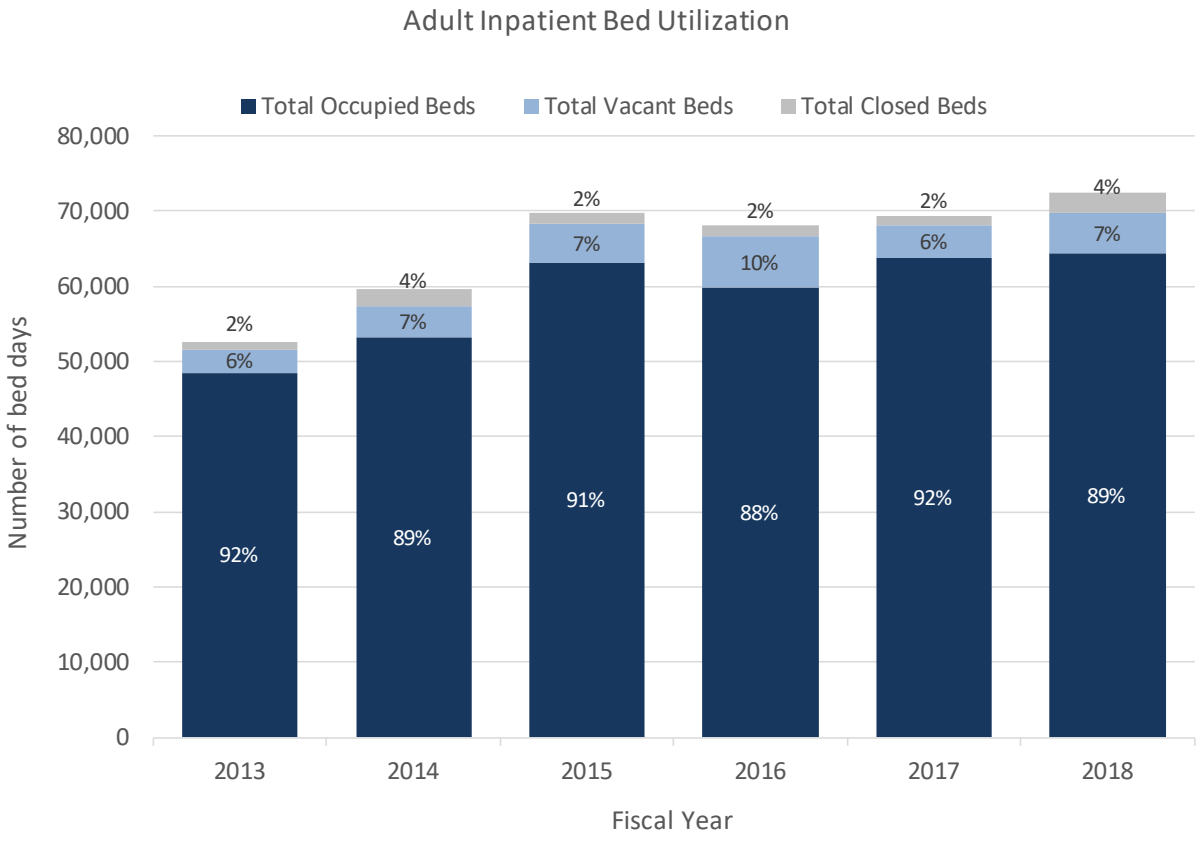
Chart 4: Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2017.

Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in chart above. The national rate of psychiatric hospital utilization since 2008 has generally declined year-over year through 2016 while Vermont's rate of utilization has increased. However, in both 2017 and 2018 there have been substantial increases in national utilization of psychiatric hospital beds. Vermont experienced a slight decline in 2017. Inpatient utilization is still below the national averages while rates of community services utilization in Vermont continues to be markedly higher than national averages (*Chart 24: Community Utilization per 1,000 Populations*).

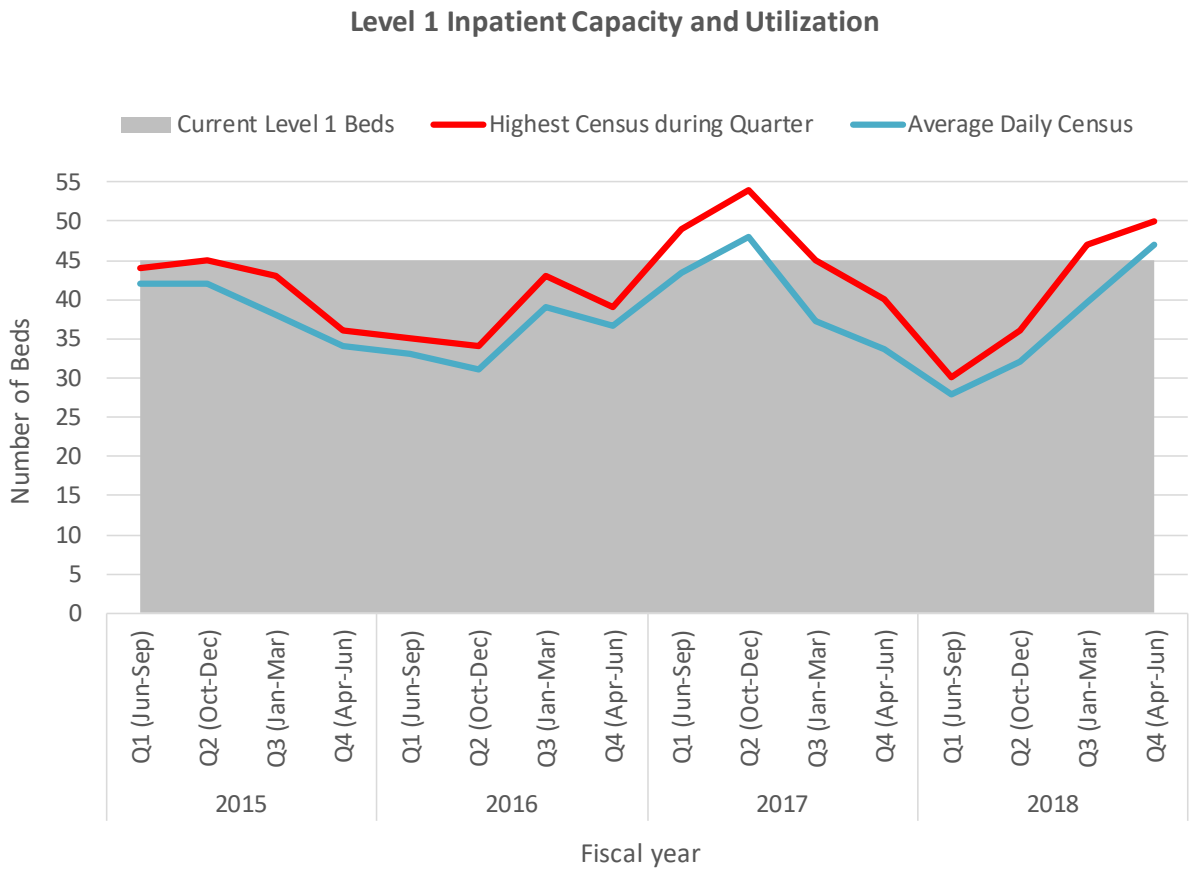
Chart 5: Adult Inpatient Utilization and Bed Closures



This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2018. The total bed day availability across the system has remained relatively constant in 2018 with only two additional beds added at the Write River Junction VA Medical Center. On average and in the most recent three years, approximately 2% of all available bed days were closed during each fiscal year. In 2018, bed day closures rose to approximately 4% throughout the system which may be due to room repairs, staffing, unit acuity, patient safety and care, or other causes. The Department, in concert with the Designated Hospitals, works to maintain the maximum compliment of beds and utilization of these beds through the bed board system.

Level 1 and Non-Level 1 Involuntary Inpatient Care

Chart 6: Level 1 Inpatient Capacity and Utilization

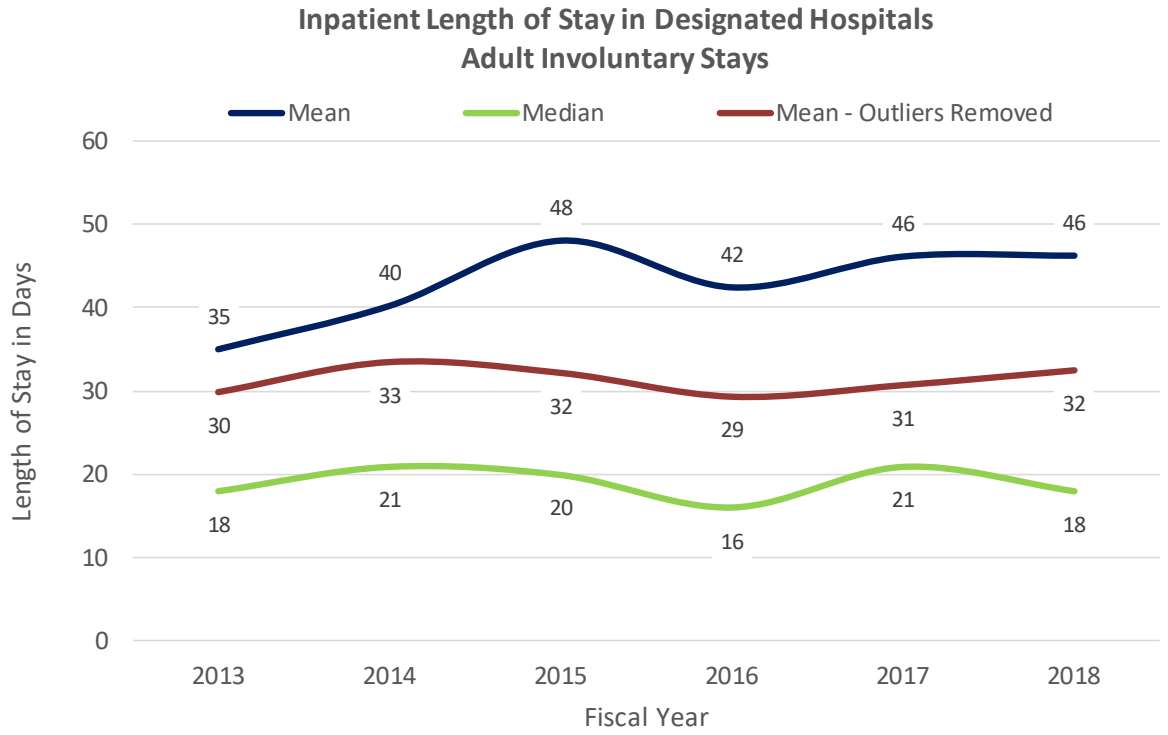


Level 1 patients require the highest level of care and services within the inpatient system. The chart above represents the average number of Level 1 patients receiving acute inpatient care in any hospital setting and the single combined one-day highest number each quarter. As a reminder, Level 1 involuntary inpatient care is a subset of all involuntary inpatient care conducted in Vermont.

The system's capacity is founded upon the need for balance in admissions and discharges across the Level 1 system. When the numbers are not equal, which is to say, when more admissions than discharges occur, over time this reduces the number of beds available in the system for new admissions.

Additionally, Vermont Psychiatric Care Hospital has 25 inpatient beds for Level 1 care, but the hospital is also part of a no-refusal system, meaning that the hospital admits people requiring involuntary inpatient care who are not Level 1, if another placement cannot be arranged. The Department is continually evaluating the application of Level 1 admission criteria across the Level 1 system to ensure that it is uniformly applied to admissions at Vermont Psychiatric Care Hospital as well as other Level 1 hospital inpatient units.

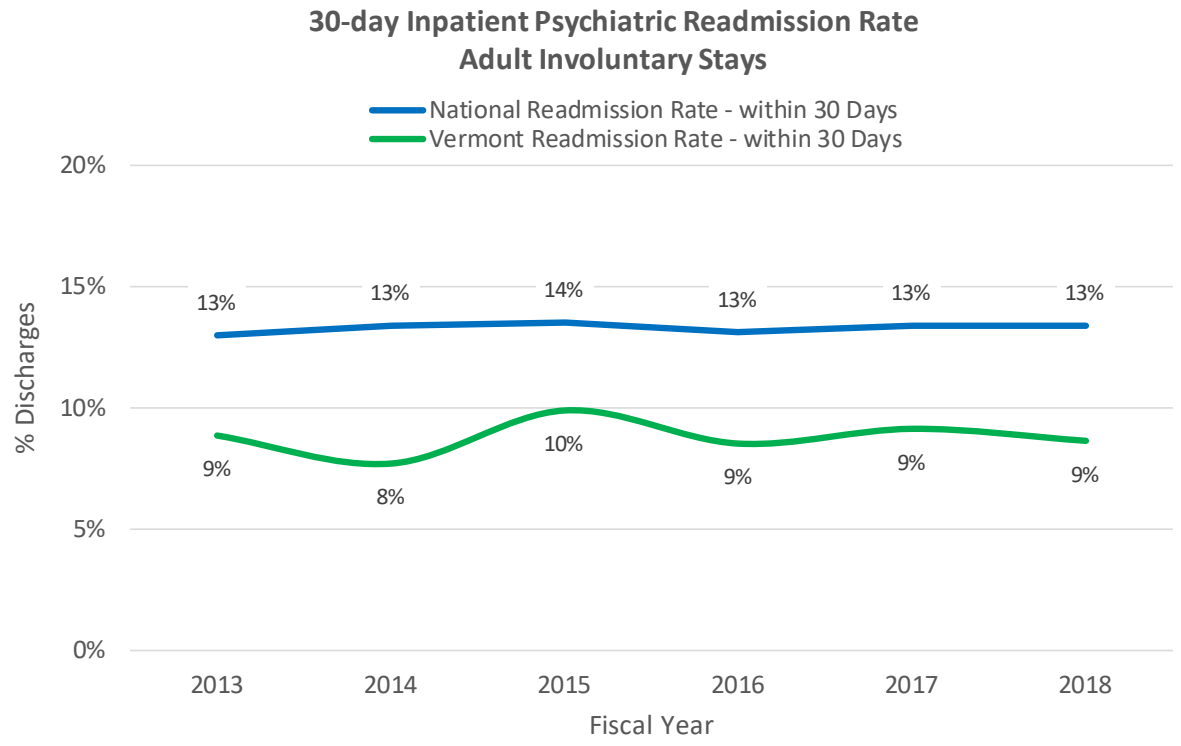
Chart 7: Inpatient Length of Stay in Designated Hospitals



This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients from FY 2013 through FY 2018. The trend indicates a leveling off in the most recent two year if the increased length of stay in hospital settings, from the highest average of 48 days in 2015 to an average of 46 days in both 2017 and 2018. Mean length of stay is also calculated by removing outliers, patients whose overall length of stay exceeds 180 days, which was two standard deviations from the average based on a five-year selection of inpatient stays. When removing outliers, mean length of stay is consistent at approximately 29-33 days. Addressing factors such as patient acuity, participation in treatment, and the availability of resources post-discharge are central to reducing length of stay.

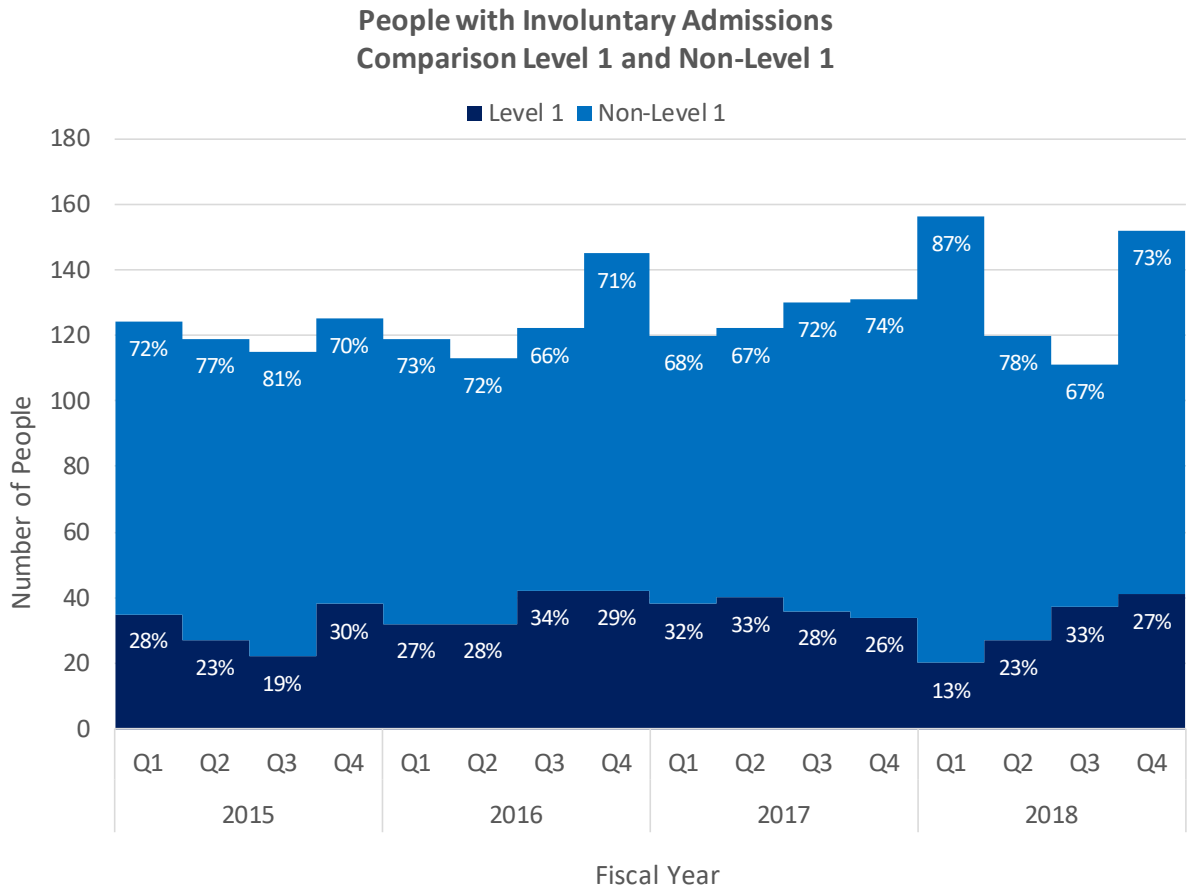
Additionally, this period also encompasses the introduction of the Level 1 system of care, which started in Designated Hospitals in FY 2013. From this initial start date, the system has seen an increase from 25 Level 1 patients per day (on average) to 45 Level 1 patients per day. Level 1 patients also have longer lengths of stay than non-Level 1 patients, which can also be a contributing factor to the overall increase in lengths of stay over the time-period.

Chart 8: Inpatient Readmissions in Designated Hospitals



Readmission rates within 30 days of discharge were calculated and compared to national benchmarks. More stability in readmission rates is seen in this six year look back period. This data continues to show that Vermont's rates at their highest were still lower than the average national rate presented in the National Outcome Measures (NOMS).

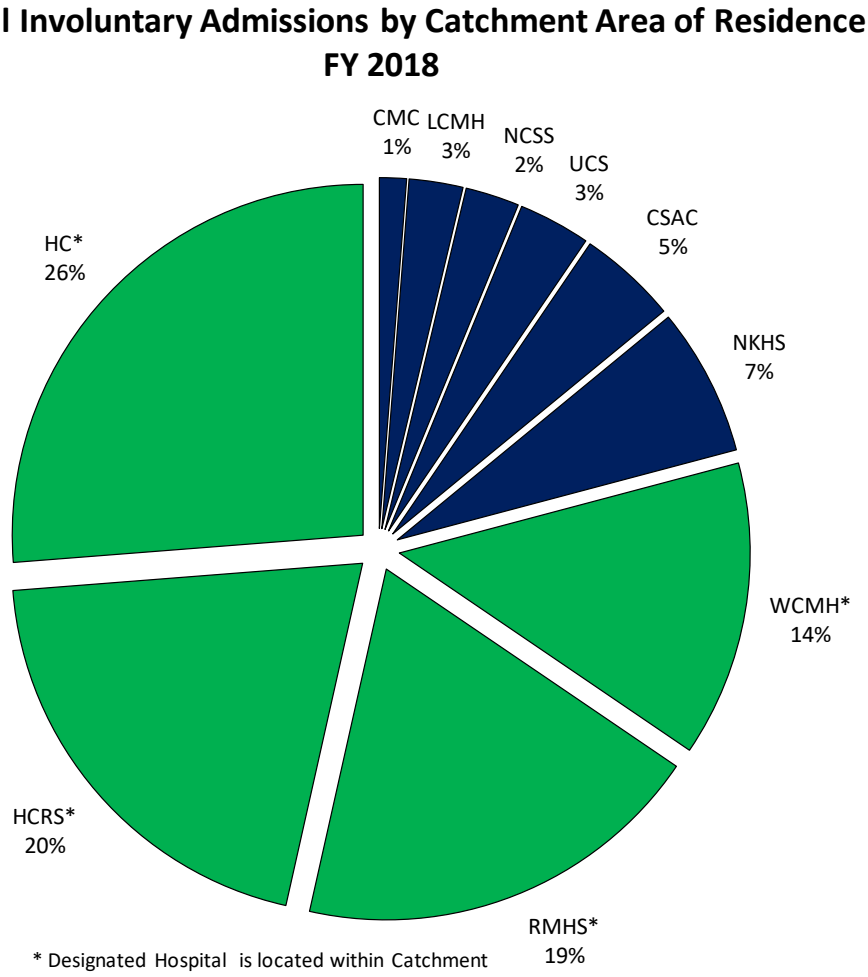
Chart 9: Involuntary Admissions – Comparison of Total Number and Level 1 patients



During the past three fiscal years, the number of people involuntarily admitted to inpatient care was at its highest in Q1 and Q4 of 2018, with only 13% and 27% of all people respectively being Level 1. Elevated numbers in Q1 and Q4 show significantly more, 87% and 73% respectively, being non-Level 1 admissions. As can be seen on this graph, the overall percent of patients admitted to psychiatric care with a Level 1 designation has been less than 34% of all adult involuntary patients. The actual numbers of people admitted has been relatively stable through FY 2015 to FY 2018, with exceptions of Q4 of FY 2016 and Q1 and Q4 of FY 2018.

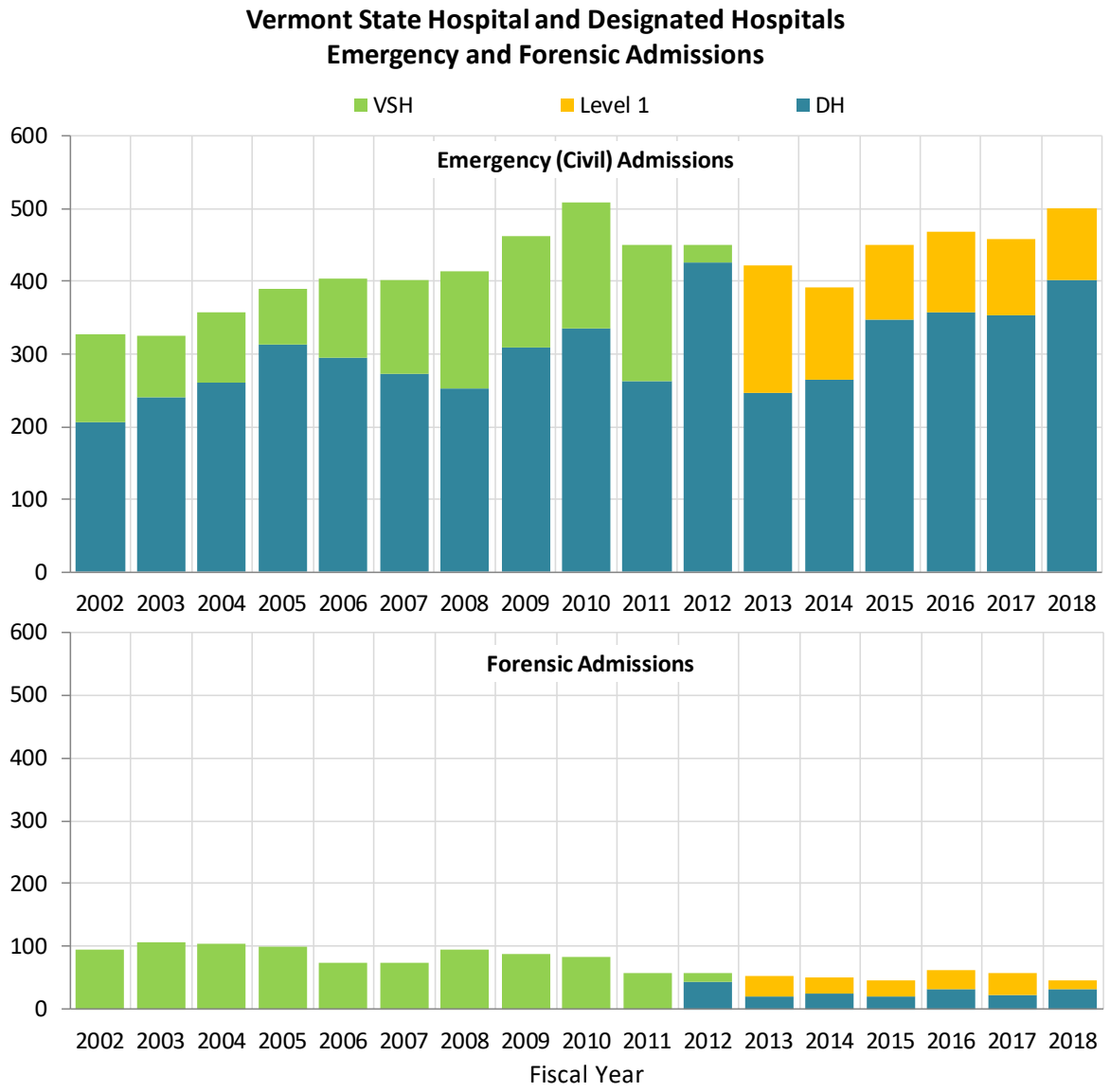
It is an expected result to see fewer people with the Level 1 designation since lengths of stay are longer than the non-Level 1 cohort. In other words, the capacity of the Level 1 system is limited by longer lengths of stay for the population, while the non-Level 1 system experiences more people moving through the system with shorter lengths of stay. The appearance of two quarters of significant increase in FY 2018 may suggest an increasing need for general involuntary psychiatric inpatient beds. Earlier quarters of information can be found in previous Act 79 reports.

Chart 10: Involuntary Admissions by Catchment Area of Residence



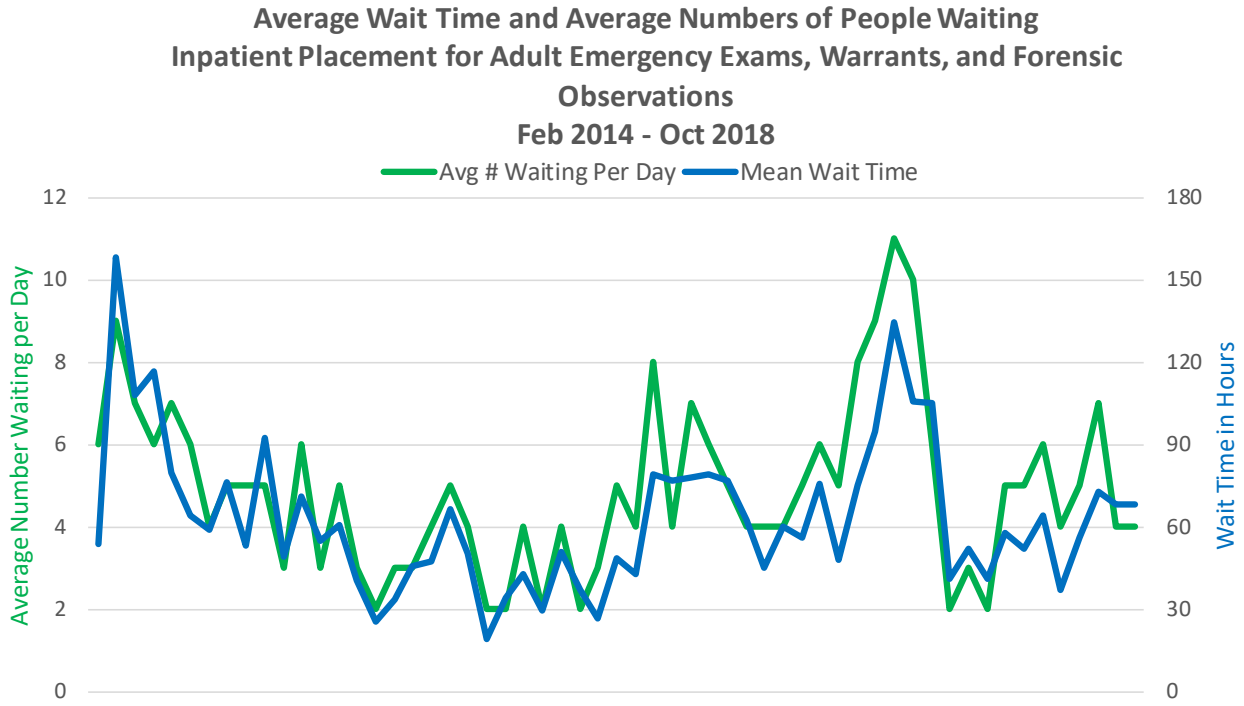
This chart provides information on the location of individuals who are admitted to an inpatient setting. As expected, larger agencies have a greater number of admissions as they are serving more individuals. This chart also suggests that the placement of hospitals in the decentralized system of care is appropriate to the population needs of adult Vermonters. A majority of admissions come from catchment areas which contain a Designated Hospital.

Chart 11: Emergency and Forensic Admissions



The number of emergency (civil) and forensic admissions increased overall in FY 2018, while seeing a slight decrease in forensic admissions. These numbers appear consistent with the elevated Q1 and Q4 admission numbers seen in 2018.

Chart 12: Average Number of People Waiting Inpatient Placement



The average number of adults per day waiting for admission to a psychiatric treatment bed is monitored monthly. Timely transition of people to inpatient care requires active management daily for individuals of all statuses in need of hospital care.

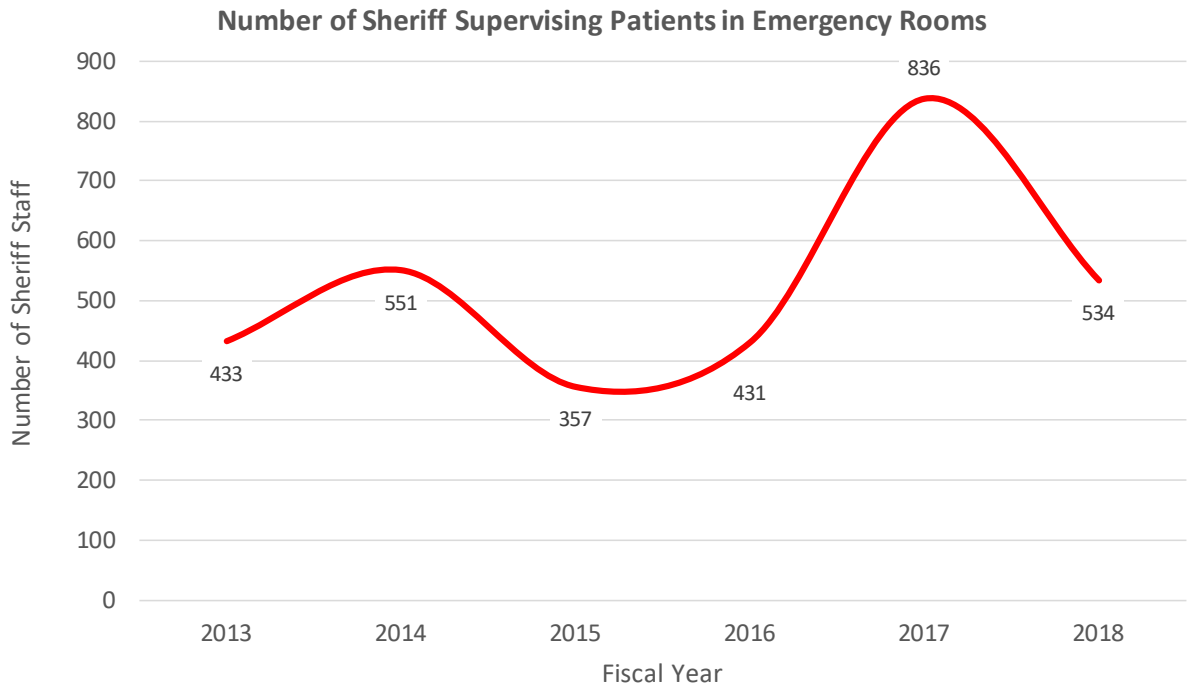
This chart reports the mean wait time and the average number of adults waiting per day from February 2014 to October 2018. The department's goal is to continue to place individuals in appropriate beds as soon as they are available. Sharp increases that periodically occur coincide with increases in adults presenting for admission during the same period. As context, in April-June 2016, the Department had almost 165 adults held via emergency exam or warrant, a 22% increase from the previous quarter and almost 20 more adults than any other quarter since March 2013. In July-September 2017, the Department had 177 adults held via emergency exam or warrant, almost 40 more adults than the average. Subsequently, the substantial spike in average number of individuals waiting in October 2017 steadily decreased through December 2017. The average number of individuals waiting per day and mean wait times also decreased; and while still subject to fluctuation, resumed a pattern more consistent with prior year reporting levels.

The Department of Mental Health has a cadre of experienced care managers in the care management team who work with each of the Designated Hospitals, the Designated Agencies emergency services teams, and the hospital emergency departments statewide. Their function is to track and coordinate individual case flow and support the relevant systems in moving people needing care through the system. The system is comprised of several points along a continuum which represent appropriate levels of care. As the acute mental health treatment system was decentralized, placement considerations became more complex and contingent on all service providers closely coordinating the different levels of care. The care management team also works on longer term planning for individuals needing more or

ongoing support and treatment services, monitoring availability of placements in various levels of community-based programs across the state.

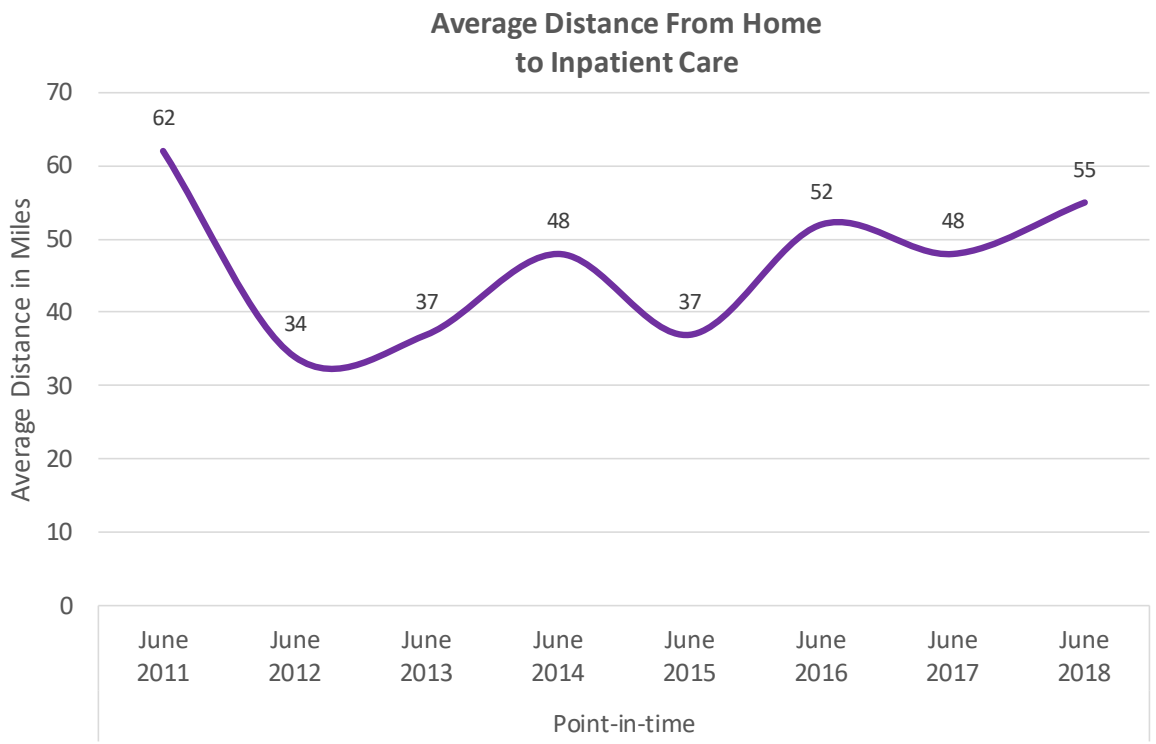
When patients are awaiting placement for treatment in a psychiatric hospital setting, available sheriff department personnel have been provided at the request of hospitals. This is a service paid through the department that is proposed for reduction; and the chart below illustrates utilization of sheriff supervision.

Chart 13: Sheriff Supervision in Emergency Departments



A hospital's ability to manage the dysregulated behavior of a patient who is waiting for an inpatient psychiatric bed varies from hospital to hospital. This may be due to the need to maintain a safe surrounding, availability of support resources, or security services at the hospital. Hospitals have continued to build psychiatric-specific supports in their emergency departments allowing reduced reliance on sheriff supervision, resulting in an overall decrease of sheriff supervising staff use in 2018. In support of this effort, DMH and DAIL's Division of Licensing and Protection, in conjunction with the Vermont Hospital and Healthcare Systems (VAHHS) met with hospital Emergency Departments in 2018 regarding the role of sheriff's in healthcare settings. Similarly, sheriffs were informed about the roles and responsibilities of the hospital health care provider during sheriff supervision. The department will continue to work with sheriffs, screeners and emergency department staff to use sheriffs only when clinically indicated.

Chart 14: Distance to Service for Involuntary Inpatient Admission



The closing of the Vermont State Hospital resulted in an increased use of beds in Designated Hospitals for involuntary psychiatric hospitalizations. The distance required to travel to an inpatient bed post-Irene, as demonstrated in the graph above, reflects the use of beds at nearby Designated Hospitals. While more regionalized care is available, the highest acuity hospital capacity are still located centrally and in the southern part of the state. The department considers timely treatment and treatment within one's community to be important factors in successful recovery. These two factors are incongruous when a hospital farther away from home is the most appropriate clinical alternative to remaining in an emergency department waiting for a closer bed.

The DMH care management team works to arrange patient transfers between hospitals if clinically appropriate, so that people can continue or finish their inpatient treatment nearer to their follow-up services and home community. The graph reflects the fluctuating distance to services pattern inherent in not having locally available beds for presenting psychiatric inpatient treatment needs. This is also reflected in *Chart 10: Involuntary Admissions by Catchment Area of Residence*.

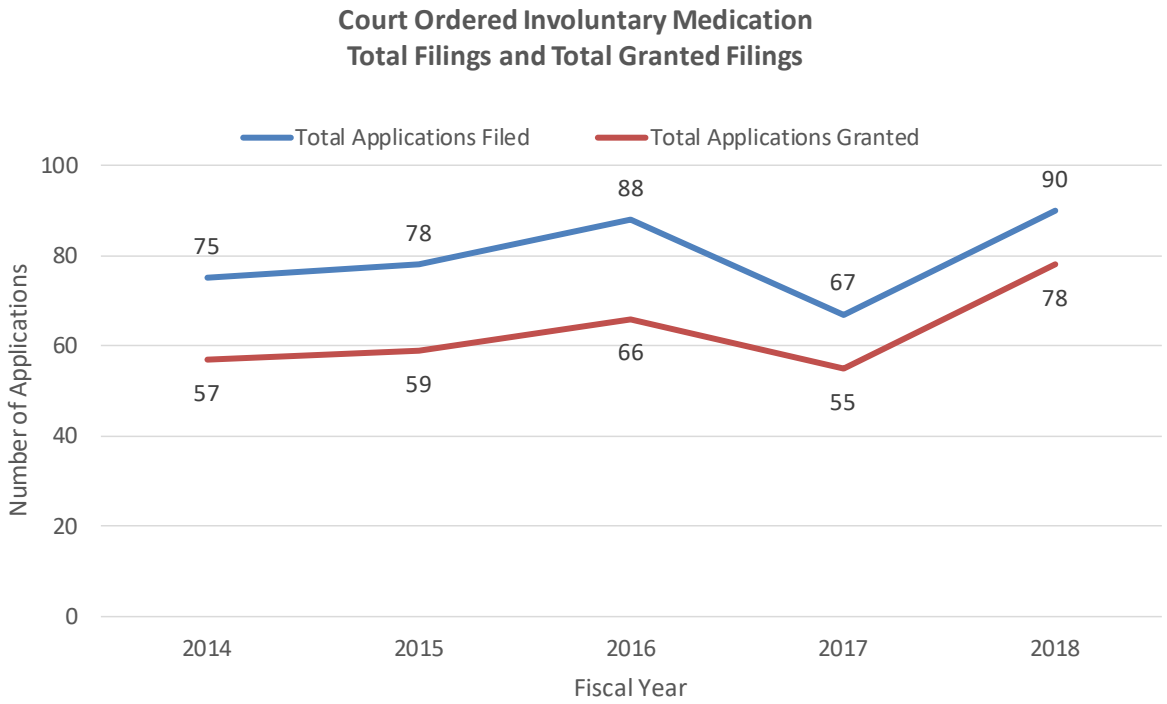
Involuntary Medications

The ability to care for those most acutely ill individuals may require the need for the Designated Hospital to seek the ability to provide medication to a patient against their wishes. This is an issue which has garnered state-wide attention by multiple stakeholder groups, the Administration, and the Legislature.

Act 192, an act relating to involuntary treatment and medication, was passed during the 2014 Legislative session, making significant changes to the laws governing petition and hearing processes for the determination of the need and Court order for involuntary medications.

The definition of involuntary medication for a patient requires that the individual meet criteria for the presence of a mental illness and clear evidence of needing treatment in accordance with V.S.A. Title 18 §7624-7627. Involuntary medication in a non-emergency situation may be administered to an involuntarily admitted person only through a court order. If a treating physician feels it is necessary, formal requests are made to the court.

Chart 15: Court Ordered Involuntary Medication, Total People and Total Filings



Total People, Total Filings, and Total Granted Filings

	Fiscal Year				
Court-Ordered Medication	**2014**	**2015**	**2016**	**2017**	**2018**
Number of people	57	60	73	61	79
Total Applications Filed	75	78	88	67	90
Total Applications Granted	57	59	66	55	78
% Granted	76%	76%	75%	82%	87%

This chart represents the total number of court-ordered involuntary medication orders filed, the total granted, and the total number of people with filings. The percent of filings granted varies from 75%-87%.

Long term trends (not shown in this chart) do indicate that the number of filings has increased substantially since the closure of the Vermont State Hospital in 2011, with more Designated Hospitals seeking involuntary medication orders. In the two most recent years, the trend has also indicated an overall increase in the number of orders being granted as well.

This application trend is explained by the expectations that inpatient care is both time-limited to the acute need and complimented by both best practice treatment approaches and active treatment interventions. In psychiatric hospitalization, duration of episode and intensity of treatment are influenced by services that can only be delivered in the inpatient setting. Acute interventions, stabilization, and medication management are generally the roles of hospitals with ongoing rehabilitation and recovery occurring in sub-acute and community-based treatment programs.

The most recent two-year trend of granting applications for court-ordered medication may be indicative of both recognition of lengthy inpatient bed utilization by individuals with complicated mental health needs where medication is clinically indicated but refused; and by the courts that must review and rule on the merits of applications for involuntary medication. Earlier, active treatment to stabilize and return individuals timely to their communities may also account for more recent leveling of length of stay in involuntary hospitalizations (Chart 7: Inpatient Length of Stay in Designated Hospitals). Future reporting will continue to examine these trends regarding court ordered involuntary medication filings.

Chart 16: Court Ordered Involuntary Medication, Mean Length of Stay

Court Ordered Involuntary Medication
Length of Stay for Discharged Patients

		FY 2015	FY 2016	FY 2017	FY 2018
Total Discharges	Overall	55	56	56	76
	Inp. Stays with One Filing	44	52	53	70
	Inp. Stays with Multiple Filings	11	4	3	6
Mean LOS (days)	Overall	191	103	161	136
	Inp. Stays with One Filing	155	98	150	130
	Inp. Stays with Multiple Filings	334	165	355	204

Chart 17: Court Ordered Involuntary Medication, 30 Day Readmission Rate

Court Ordered Involuntary Medication
30 Day Readmission Rate for Discharged Patients

		FY 2015	FY 2016	FY 2017	FY 2018
Total Discharges	Overall	55	56	56	76
	Inp. Stays with One Filing	44	52	53	70
	Inp. Stays with Multiple Filings	11	4	3	6
30 Day Readmission Rate	Overall	5%	5%	11%	1%
	Inp. Stays with One Filing	7%	6%	11%	0%
	Inp. Stays with Multiple Filings	0%	0%	0%	1%

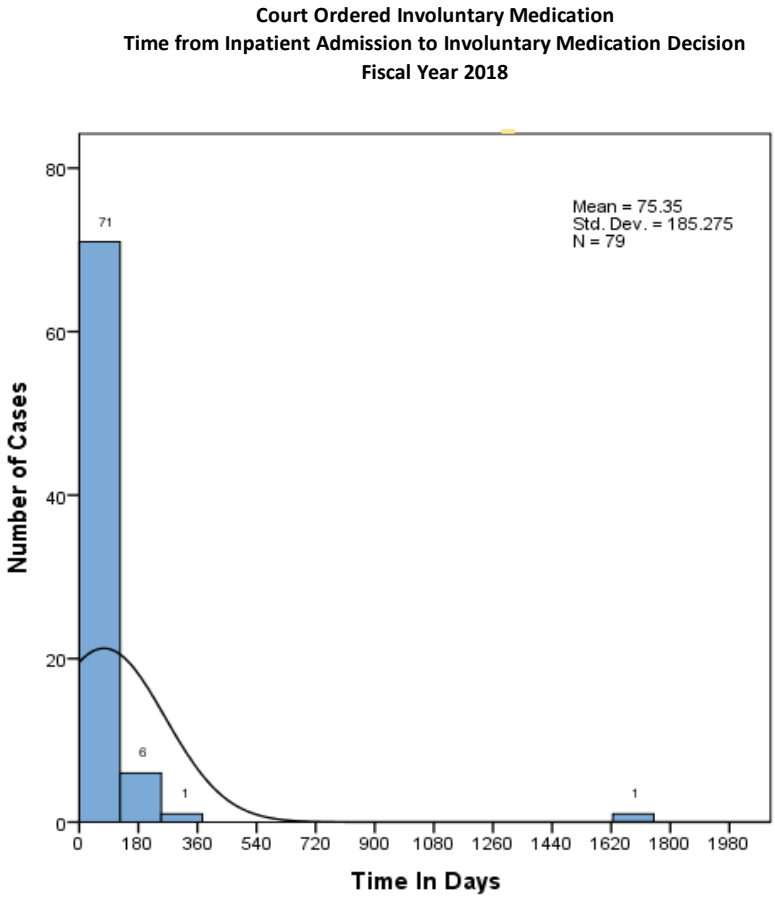
The Department has worked to provide lengths of stay and 30-day readmission rates for people that had a court-ordered involuntary medication filing at any time during their hospital stay and were discharged

in during the fiscal year. The number of people who have met these criteria have been consistent each fiscal year. Of those, the number with multiple medication filings decreased from 11 (20%) to 6 (7.9%) between FY 2015 and FY 2018.

Multiple filings can occur for a variety of circumstances: the court order has expired but the patient was not willing to continue medications; the patient agrees to take medications between hospital filing and the court date but is not willing to continue once the court process has been discontinued; or the medication ordered by the court is not effective and a new order has to be pursued for different medication.

When comparing these two groups of people, those with multiple filings had—on average—lengths of stays that were twice as long as those with one filing. When examining involuntary readmission rates, one individual with multiple filings in FY 18 was readmitted involuntarily within 30 days of discharge. The previous three fiscal years saw no individuals with multiple filings readmitted involuntarily within 30 days of discharge. The Department will continue to monitor this information going forward to identify trends.

Chart 18: Time in Days from Admission to Court Ordered Medication



This graph illustrates all initial cases (79) filed for involuntary medication in FY 2018. The average (mean) length of time between an admission to the hospital and to the medication decision is approximately 75

days, with only a small number of outliers on the longer end of the curve. The mean of 75 days in FY 18 represents 35 fewer days on average than FY 17 and 66 fewer days on average that FY 16. In FY 18, 79% of cases resolved in under 60 days and nearly 90% resolved in less than 120 days. Examining the time from admission to medication is only one way to assess the involuntary medication process, and important additional context can be gained by also examining the number of days that pass between when an Act 114 petition is filed and when a hearing is scheduled as well as the number of days between that hearing and the court's decision. Of note, however, is that 31% of medication applications (28 applications) took more than 10 days to render a decision and that only 15% of hearings (15 filings) took more than 10 days for a hearing to be scheduled.

The shortened period of time between admission and involuntary medication decision reflects that hospitals are actively pursuing medication applications when medication is clinically indicated for effective treatment and care of the patient. Additionally, increasing number of granted applications for court-ordered medication may be contributory to inpatient length of stay this fiscal year. It is also possible that clear guidance for court decisions or scheduling of hearings could reduce lengths of stay in some cases. DMH will continue to monitor in the upcoming fiscal year.

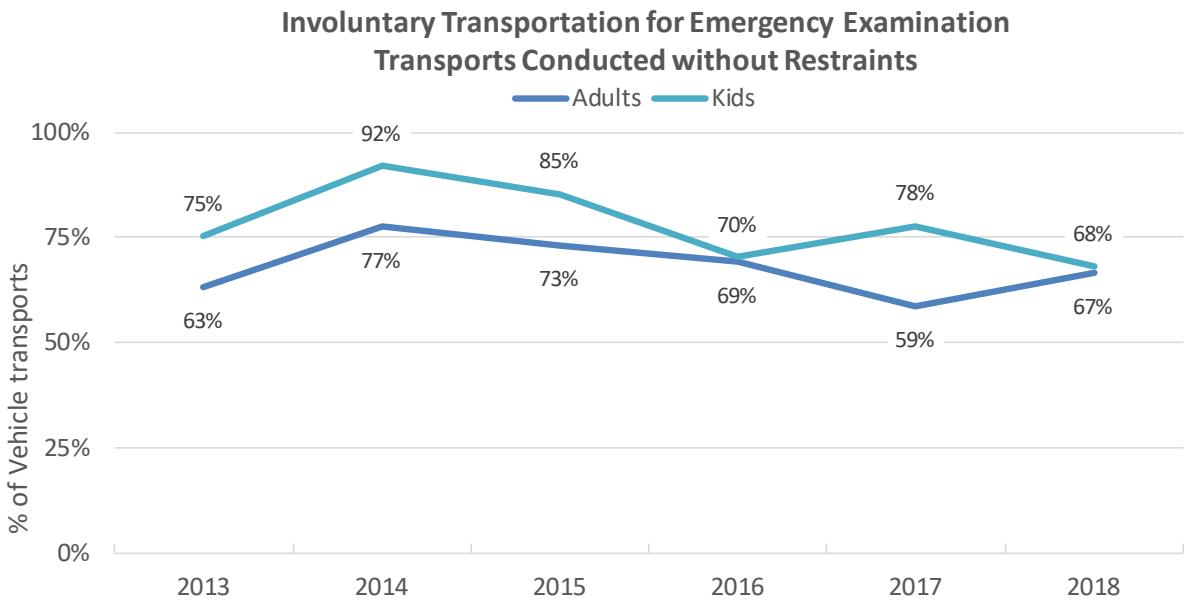
Transportation

Since April 2012, the Department has developed a more intentional implementation plan for changing the way individuals are transported to inpatient hospitalization with the goal of reducing metal restraints and providing options for transport whenever possible. For many years, secure transport was defined as a transport by sheriffs. Act 180, Title 18 §7511, recognized the need to take steps to reduce trauma for people who are found to need sheriff transport for involuntary psychiatric hospitalization. The current definition of secure transport is defined as the application of mechanical restraints, either soft or metal.

This change in terms evolved out the success of the involuntary transportation workgroup. Grants to support a pilot programs with sheriffs in Lamoille and Windham Counties using a least-restrictive approach by deputies in plain clothes with an unmarked van have continued throughout this period of time. Progression to some type of restraint is utilized only when a no-restraint approach fails.

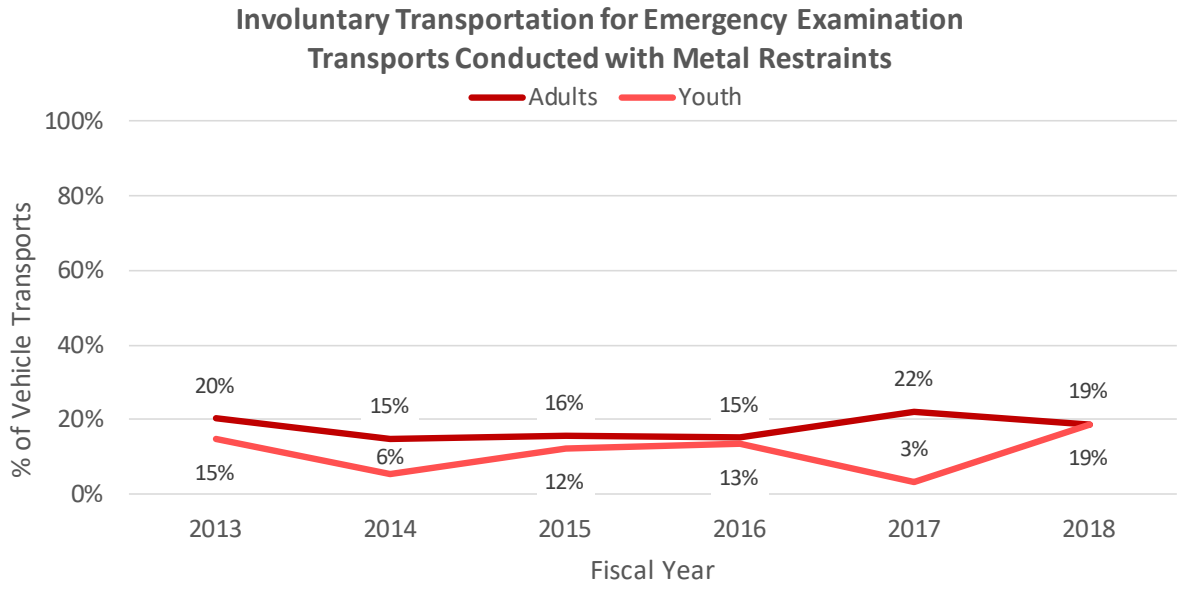
Subsequently the passage of Act 85 (2017), Section E. 314 required that any new or renewed contracts entered into by AHS with designated professionals or law enforcement officers for transport of persons pursuant to 18 V.S.A. § 7511 would include the requirement to comply with the Agency's policies on the use of restraints. During FY 19, Act 200 (2018) Section 6 as passed by the legislature requires the AHS Secretary to submit a written report in January 2019 describing specifications that support the requirements of Act 85 and provide oversight through expectations in its FY 19 AHS sheriff contracts for patient transports.

Chart 19: Involuntary Transports Conducted without Restraint



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

Chart 20: Involuntary Transports Conducted with Metal Restraint



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

A review of the data provided shows that a majority of transports are conducted without restraint for both adults and youth. When examining the use of metal restraints in FY 18, although there was a slight (3%) decrease in adult transport with mental restraint, there was a 16% increase in youth transport with

metal restraints. The 38% of adult and youth transport using metal restraints represents the highest percentage since 2013.

The Department is aware of differing practices that exist across law enforcement agencies; these differences are due in part to the need for more frequent training and monitoring of expectations from those who work in law enforcement. Until new AHS sheriff transport contracts are finalized, the Department continues to have specific contracts that monitor for predominant use of soft or no restraints during transport by two sheriff departments. Some sheriff departments have also already addressed reliance on metal restraints for transports prior to renewal of AHS transport contracts for mental health transports.

In response to current data and as a specification of new AHS sheriff transport contracts, the Department plans to collaborate with sheriffs from the pilot transport programs in the delivery of training to remaining sheriff departments that continue to have higher rates of metal restraint transports. The Department remains committed to creating a consistent law enforcement response and adherence with least restrictive transportation expectations outlined in its involuntary transportation manual.

Additional detail regarding adult and youth involuntary transports can be found in the subsequent graphs.

Chart 21: One-Year Overview of Adult Involuntary Transport

Vermont Department of Mental Health
Adult Involuntary Transportation for Emergency Examinations
Fiscal Year 2018

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	10	10	8	5	3	6	8	4	12	6	7	5	**84**
Non-Restrained	14	11	14	13	17	9	13	11	7	18	21	20	**168**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport													
None	14	11	14	13	17	9	13	11	7	18	21	20	**168**
Metal	1	3	2	3	0	5	4	2	7	4	5	3	**39**
Soft	9	7	6	2	3	1	4	2	5	2	2	2	**45**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	4%	14%	9%	17%	0%	33%	19%	13%	37%	17%	18%	12%	**15%**
Vehicle Used in Transport													
Ambulance	1	4	4	2	1	3	3	0	0	5	7	5	**35**
MH Van Alternative	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Private Transport	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Sheriff Alternative	7	8	5	5	11	5	6	8	8	10	13	11	**97**
Sheriff Cruiser	16	9	13	11	8	6	12	7	11	9	8	9	**119**
Other	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not Applicable ("Walk Up")	0	0	0	0	0	0	0	0	0	0	0	0	**0**
No Data	0	0	0	0	0	1	0	0	0	0	0	0	**1**
%Vehicle Transports that use Ambulance	4%	19%	18%	11%	5%	20%	14%			21%	25%	20%	**14%**
%Vehicle Transports that use MH Van Alternative												0%	**0%**
%Vehicle Transports that use Sheriff's Alternative	29%	38%	23%	28%	55%	33%	29%	53%	42%	42%	46%	44%	**38%**
%Vehicle Transports that use Sheriff's Cruiser	67%	43%	59%	61%	40%	40%	57%	47%	58%	38%	29%	36%	**47%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	23	17	18	16	19	11	18	15	19	19	21	20	**216**
TOTAL EE Transports	24	21	22	18	20	15	21	15	19	24	28	25	**252**

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Adult Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner.

Date of Report: 11/30/2018

Chart 22: One-Year Overview of Youth Involuntary Transport

Vermont Department of Mental Health
Youth Involuntary Transportation for Emergency Examinations
Fiscal Year 2018

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	1	2	0	3	1	0	0	2	2	1	0	0	**12**
Non-Restrained	2	2	2	2	3	0	2	0	3	3	4	3	**26**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport													
None	2	2	2	2	3	0	2	0	3	3	4	3	**26**
Metal	0	0	0	2	1	0	0	2	1	0	0	0	**6**
Soft	1	2	0	1	0	0	0	0	1	1	0	0	**6**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	0%	0%	0%	40%	25%	0%	0%	100%	20%	0%	0%	0%	**16%**
Vehicle Used in Transport													
Ambulance	0	1	2	1	0	0	0	0	1	0	3	1	**9**
MH Van Alternative	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Private Transport	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Sheriff Alternative	2	1	0	1	3	0	1	1	2	2	0	1	**14**
Sheriff Cruiser	1	2	0	3	1	0	1	1	2	2	1	1	**15**
Other	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not Applicable ("Walk Up")	0	0	0	0	0	0	0	0	0	0	0	0	**0**
No Data	0	0	0	0	0	0	0	0	0	0	0	0	**0**
%Vehicle Transports that use Ambulance		25%	100%	20%					20%		75%	33%	**24%**
%Vehicle Transports that use MH Van Alternative													**0%**
%Vehicle Transports that use Sheriff's Alternative	67%	25%		20%	75%		50%	50%	40%	50%			**37%**
%Vehicle Transports that use Sheriff's Cruiser	33%	50%		60%	25%		50%	50%	40%	50%	25%	33%	**39%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	3	3	0	4	4	0	2	2	4	4	1	2	**29**
TOTAL EE Transports	3	4	2	5	4	0	2	2	5	4	4	3	**38**

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Youth Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner.

Date of Report: 11/30/2018

Adult Outpatient Care and Utilization

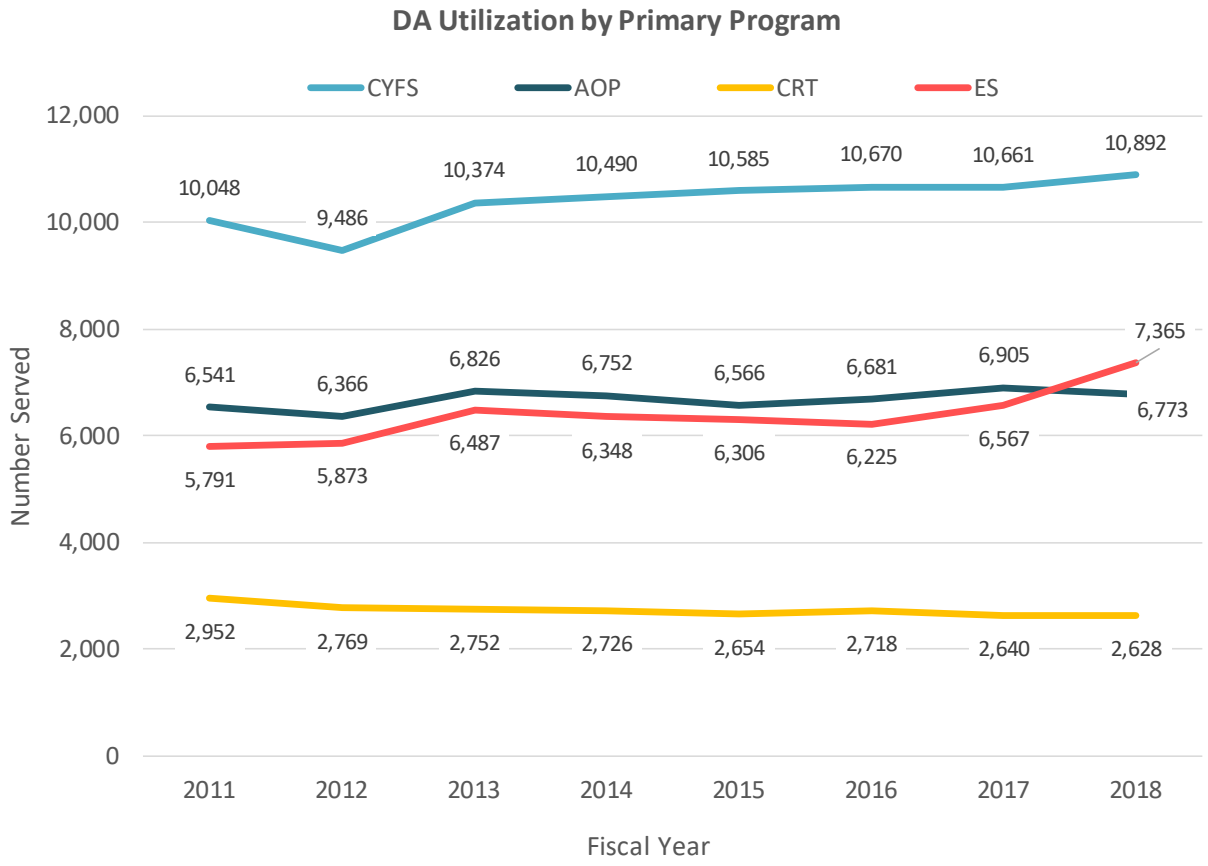
Outpatient services are provided through a system of care that includes the Designated Agencies, private practitioners, and other state and local social services agencies. The Designated Agencies provide comprehensive services to individuals through the Community Rehabilitation and Treatment programs, and they support and manage crisis beds and alternative services to hospitalization, intensive residential recovery beds, residential services, supportive housing, wrap-around programs, and peer services. In addition, Designated Agency services include Adult Outpatient counseling for individuals and families, case management and services to families with children experiencing a severe emotional disturbance. Availability of the continuum of outpatient services is limited geographically because of the rural nature of the state and by local resources.

To maximize utilization of limited treatment resources in both the community and hospitals, the Department developed a care management system that employs clinicians as key contacts and liaisons between Designated Agencies and Designated Hospitals, ensuring that people in need of treatment receive the appropriate level of care.

Community Rehabilitation and Treatment program staff within the Designated Agencies work with hospital staff to ensure a smooth transition to the community with a range of services in place as indicated by discharge and treatment plans for those clients being discharged from the inpatient setting as soon as possible. This period ranges from one hour to within one week of discharge. The Department expects that individuals are seen in the Designated Agency within one-week of hospital discharge, and case managers/social workers and others working with this population from both the community and the hospitals are required to work collaboratively to assure a timely follow-up visit.

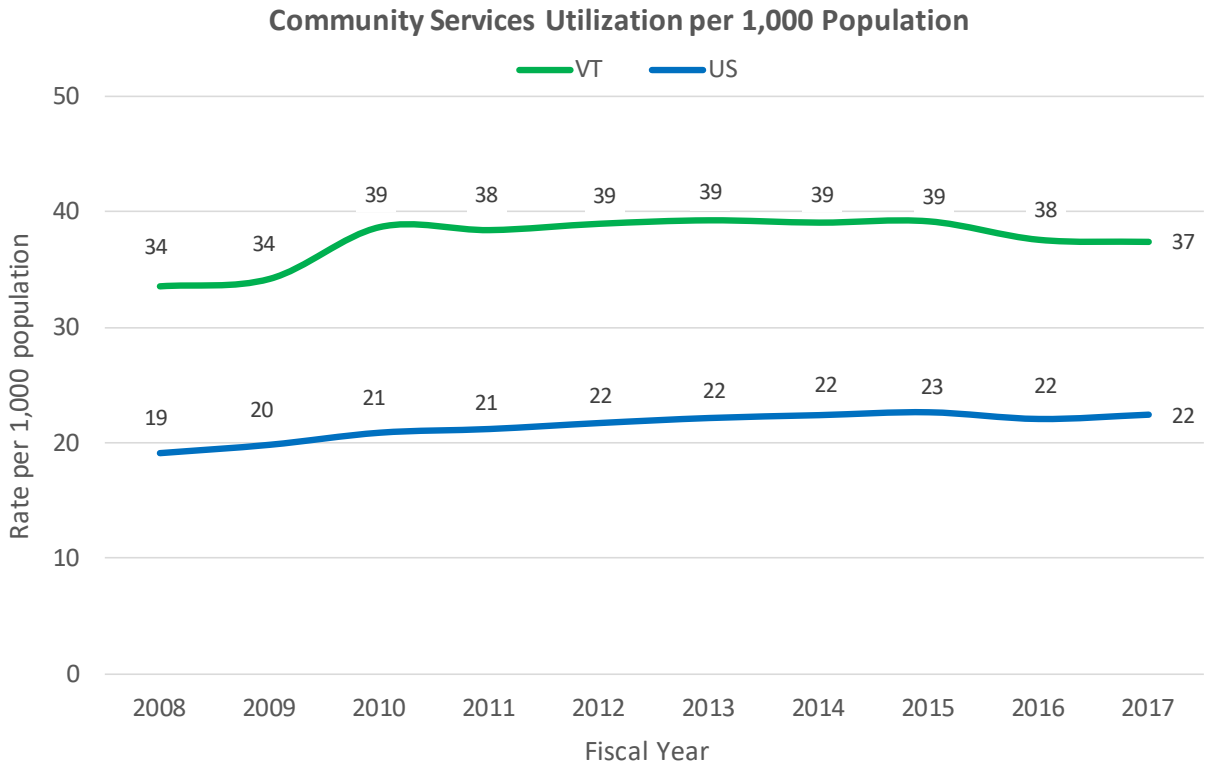
Although the Department provided enhanced community services funding through increased appropriations to key mental health programs in the community in FY 2013 and FY 2014, staff recruitment necessary to expand these service levels has continued to be a struggle. This past year, Act 11 (2018) provided an increase of $4.3 million to DA workforce targeting direct care staff and supporting DA recruitment and retention efforts to maintain a professional workforce. The payment reform initiative beginning 1/1/2019 has also been an effort to reduce barriers to access and promote more “needs” driven service delivery that can be more responsive to individuals seeking mental health services. The new payment reform methodology, more flexible service delivery, and value-based incentive payment framework focused on quality and outcomes supports a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Chart 23: Designated Agency Volume by Program



The highest number of persons served by a program offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. This program also reflects a slow upward trend over the most recent six fiscal years. The lowest numbers of persons served by a Designated Agency program continue to be those in the Community Rehabilitation and Treatment (CRT) programs. Adult Outpatient programs reveal a relatively stable trend over time. Between 2016 - 2018, Emergency Services programs have seen a slowly advancing upward trend for persons served by that program suggesting of a system that continues to be stressed in meeting urgent community mental health service demands. There is likely correlation between ongoing wait times for individuals in hospital emergency departments and the role of Emergency Services programs, which includes screening and follow-up for those awaiting inpatient hospitalization.

Chart 24: Community Utilization per 1,000 Populations

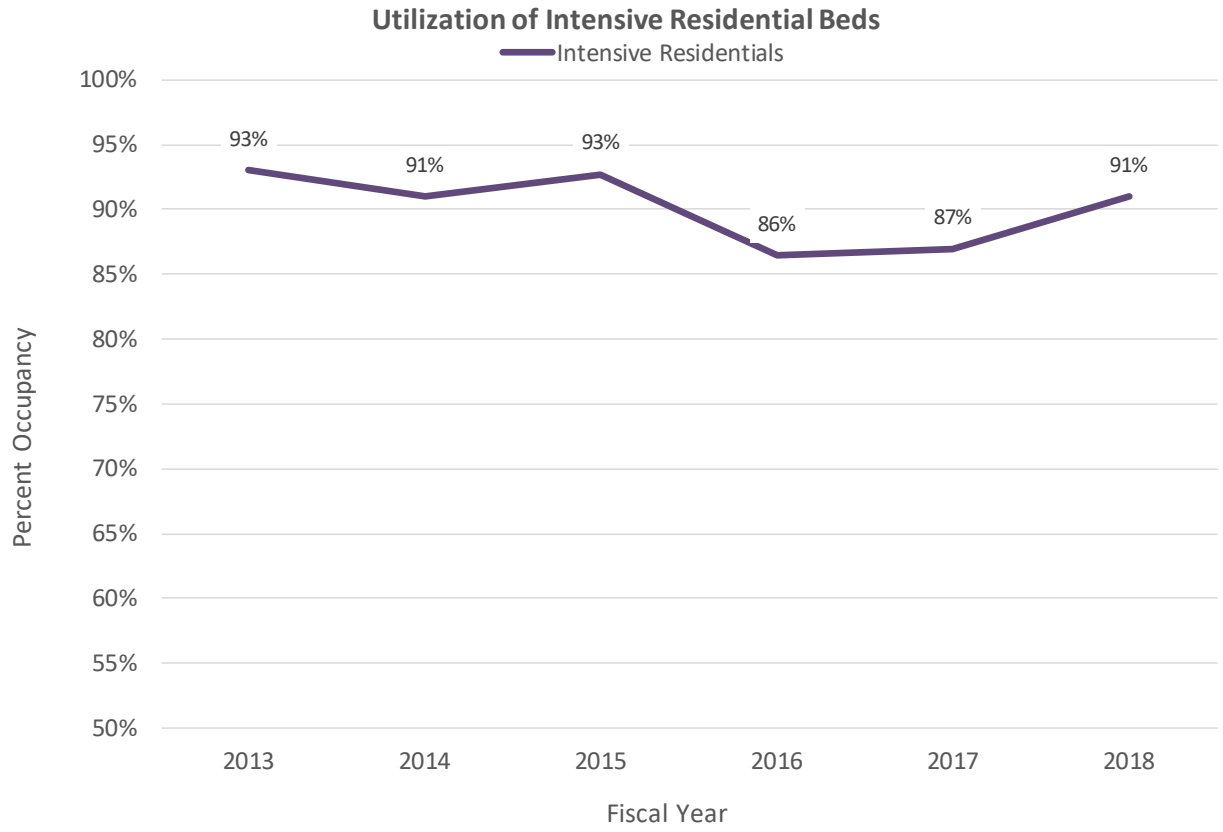


Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2017.

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national figure. These data show that Vermont has a strong and fairly consistent record of service delivery in community-based programs. While the progress appears to be static, data shown in *Chart 26: Non-Categorical Case Management* indicates that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care.

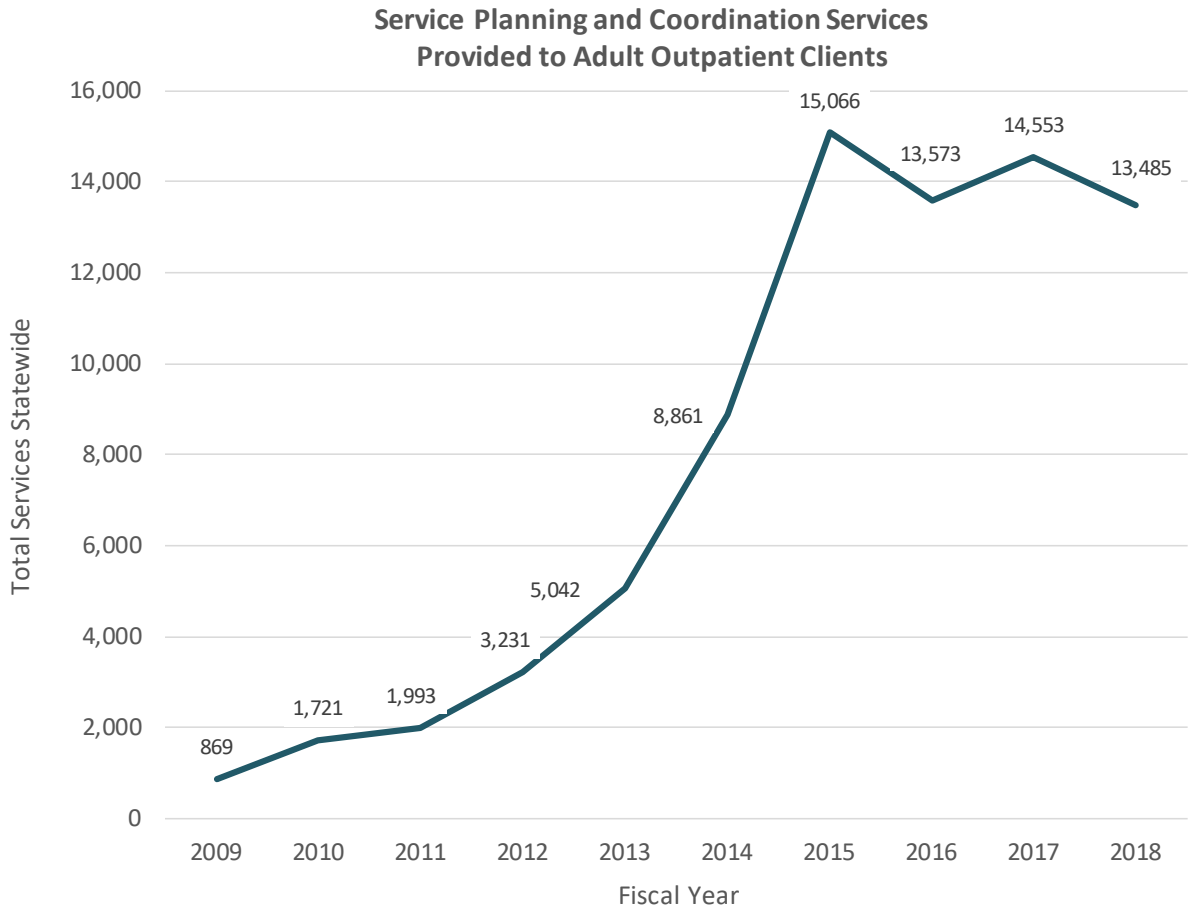
The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic illness this is more challenging, as they continuously require higher level of service needs within the system. For others, they enter and exit intermittently depending on their individual needs. The system must have the flexibility to meet the needs of the individuals and provide the necessary services.

Chart 25: Intensive Residential Bed Utilization



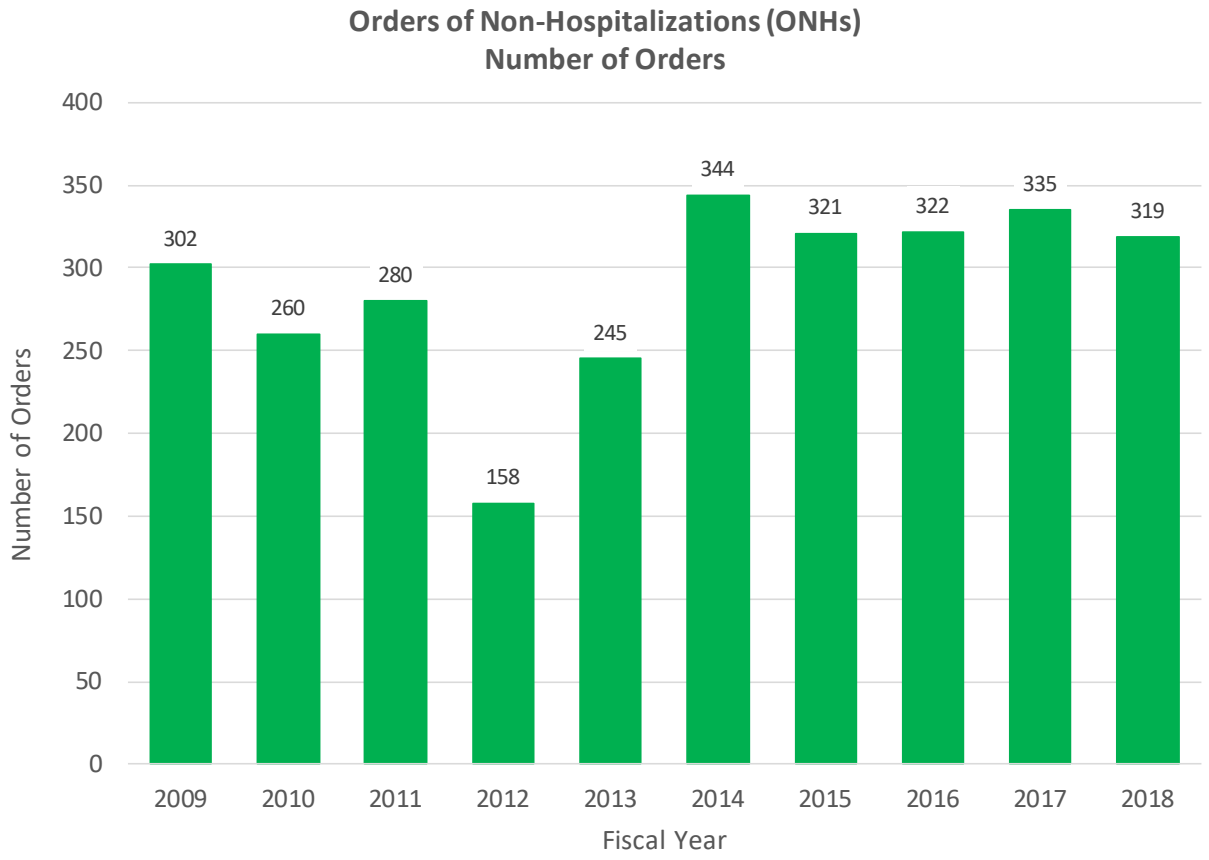
The Intensive Residential Recovery Programs (IRRs) are continuing to meet a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward independent living. The chart above illustrates the utilization of beds in these programs. FY 16 – FY 18 reflects a slow upward trend in utilization of IRR beds. There are seven programs in operation in Vermont. Soteria House opened in spring 2015, adding 5 beds. Maplewood opened in spring 2014, adding 4 beds for those needing a higher level of community care. Second Spring Westford and Middlesex Therapeutic Community Residence (MTCR) opened in February 2013. The programs provide both transitional and longer term supports, averaging residential program lengths of stay within a 12-18 month time frame for residents.

Chart 26: Non-Categorical Case Management



The support of non-categorical case management has led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services. It is worth noting here that the amount of services provided for service planning and coordination almost doubled in FY 2014, and again in FY 2015. This is a good indicator of the need for this level of case management to the adult outpatient population. The Department's overall payment reform starting in Calendar Year 19 continues to support the flexible delivery of adult non-categorical case management services.

Chart 27: Orders for Non-Hospitalizations



The number of Department of Mental Health Orders of Non-Hospitalization (ONHs) continues to hover around 324 in the four most recent fiscal years. Over that same period, the mean number of individuals subject to ONH's has also remained stable at about 262 people annually. Departmental legal staff members work closely with clinical staff and Designated Agency (DA) clinicians to monitor treatment compliance and maintain communication with providers. The Care Management Team monitors community care through the DAs which provide direct services in the community. Through this process, community service providers are required to provide clinical justification of the ongoing need and their efforts to engage individuals in the treatment planning process and in understanding and complying with community conditions imposed by the Court. The Department provides oversight and case consultation regarding options or resources that may be needed for more effectively serving individuals who are on ONHs. DAs closely coordinate with the care management team regarding requests for continuation or discontinuation of ONHs as well.

Enhanced Outpatient and Emergency Services

The impact of the enhancements allocated by the legislature in Act 79 has been significant in retooling some of the ways in which mental health services are delivered at the community level. All the Designated Agencies participated in developing additional services and enhancing those services that were already in place, to provide more timely access to and response for those in crisis. The list of

services covered by the changes was broad, with common themes and best practices identified and implemented across all the Designated Agencies.

Enhanced funds are utilized at Designated Agencies in various ways but fall into several major categories (listed in order of frequency):

- Evidenced-based and/or innovative clinical practices and/or treatment programs
- Expansion of Mobile Crisis Capacity
- Non-categorical Case Management
- Programs/Initiatives with Law Enforcement
- Peer Services
- Increased housing options for people at risk of hospitalization
- Expansion of Crisis Beds

At the end of FY 2018, Act 79 enhanced funding was supporting over 43 unique initiatives at Designated Agencies. Over 83% of initiatives are reporting that they are fully implemented and over 97% of initiatives are reporting that they have full coverage of the initiative across their geographical catchment area.

One example of an ongoing service capacity created through Act 79 is the START Team operating in Chittenden County. START (Stabilization, Treatment, And Recovery Team) is a community program within Howard Center Crisis Services that provides support to individuals ages 18 and older who are experiencing emotional distress and/or an increase in mental health symptoms. The goal of the program is to help prevent the need for higher levels of care services, such as the hospital or police.

The program relies on peers to provide face-to face contact and draws on the personal experiences of staff to connect with clients and work with them in their homes or in the community to develop the skills and receive the support necessary to maintain stability. START offers short-term services, typically between two to four weeks. The program also provides short-term case management services for individuals whose needs can be covered within two to four weeks

Law Enforcement and Mobile Crisis

Act 79 also calls for a reduction of law-enforcement intervention for people in mental health crisis. The primary vehicle for this reduction is through mobile crisis outreach. Outreach to people in mental health crisis is essential to recognition of the pressure points in the lives of individuals. Proactive mobile teams, perform outreach through Department grant initiatives, providing support in the community at such places as individuals' homes and in emergency departments. Joint interventions between law enforcement and mobile crisis teams have the potential benefit for service recipients in modeling de-escalation techniques. This collaboration has been viewed as enhancing the successful interventions in the community.

Each Designated Agency has developed mobile crisis teams to better respond to individuals experiencing psychiatric crisis and all programs have begun to perform crisis assessments and interventions in the community, as well as providing law-enforcement related crisis response. The capacity for this mobile outreach varies among the DAs due to ongoing recruitment and retention issues. At the end of FY 18, 75% of Act 79 funded mobile crisis initiatives are reporting full implementation and almost 92% are reporting full coverage in their geographical catchment area. In addition, the Designated Agencies are

providing increased services to patients waiting in emergency rooms for admission to psychiatric hospital care.

To continue these efforts successfully, standards and training for law enforcement personnel and crisis teams have been established. In FY 18, 61 law enforcement staff from local and statewide jurisdictions participated in the trainings. An additional 79 individuals (crisis workers, dispatch personnel, EMT staff, and other interested participants) attended Team Two training for a total of 140 statewide. Training will continue in 2019. A statewide communications protocol for deployment and safety between mobile crisis teams and law enforcement remains in place. An interdisciplinary training model developed by the Department and Public Safety has been delivered regionally through a collaborative effort between Vermont Care Partners, the Department of Public Safety, and the Department of Mental health using a train-the-trainers model referred to as "Team Two" Training. "Team Two" teams are established in 5 regions of the State:

- Central Team – Washington County, Orange County
- Southeast Team – Windham and Windsor Counties
- Southwest Team – Bennington, Rutland and Addison
- Northwest Team – Chittenden, Franklin Counties
- Northeast Team – Lamoille, Orleans, Essex and Caledonia Counties

The philosophy behind the Team Two training is one of collaboration, information sharing, and resource management for law enforcement and mental health crisis teams when responding to a situation from the legal, clinical, and safety perspectives. Training provides responders a clear understanding of the limitations and expectations of their fellow responders and evaluates the legal, clinical and safety aspects of the situation. "Train-the-Trainer" trainings have also been held to build capacity to maintain the learning and assure responders have the same interpretation of statutory issues. Currently, the Department of Public Safety is collaborating in funding additional trainings to adjunct emergency services staff, such as police dispatchers and statewide 911 call centers. Team Two has been recognized nationally as positive example of collaboration between law enforcement and mental health professionals.

Peer Services

Through Act 79 and other prior initiatives that were underway, the Department of Mental Health has been working to expand and improve services provided by individuals with the lived experience of mental illness (peers). The Department recognizes the value of peer support in promoting an individual's recovery from mental illness and has sought to expand both access to mental health peer services and improve the quality of those services. The focus has been twofold:

1. Increasing peer services for individuals with mental health and other co-occurring issues that need and desire additional recovery support from those with lived experience; and
2. Improving Vermont's infrastructure to ensure that individuals and organizations providing peer services are supported through training, continuing education, mentoring, co-supervision, technical assistance, administrative support, organizational consultation and development, and collaborative networking with peer and other providers.

The Importance of Peer Support in Vermont

The concept of "peer support" is not something that is unique to individuals with mental health and other co-occurring issues. In their 2004 article *Peer Support: What Makes It Unique?,* Shery Mead and Cheryl MacNeil write:

"Peer support for people with similar life experiences (e.g., people who've lost children, people with alcohol and substance abuse problems, etc.) has proven to be tremendously important towards helping many move through difficult situations (Reissman, 1989; Roberts & Rappaport, 1989). In general, peer support has been defined by the fact that people who have like experiences can better relate and can consequently offer more authentic empathy and validation. It is also not uncommon for people with similar lived experiences to offer each other practical advice and suggestions for strategies that professionals may not offer or even know about. Maintaining its non-professional vantage point is crucial in helping people rebuild their sense of community when they've had a disconnecting kind of experience."[2]

While there is great diversity in the ways in which peer support is provided for individuals with mental health and other co-occurring issues, Mead and MacNeil (2004) have identified core elements of mental health peer support that make it unique and an alternative form of support for individuals who have not been able to achieve recovery through traditional, professional services. These include:

- being free from coercion (e.g. voluntary),
- consumer run and directed (both governmentally and programmatically),
- an informal setting with flexibility, and a non-hierarchical, and non-medical approach (e.g. not diagnosing),
- the peer principle (finding affiliation with someone with similar life experience and having an equal relationship),
- the helper principle (the notion that being helpful to someone else is also self-healing),
- empowerment (finding hope and believing that recovery is possible; taking personal responsibility for making it happen),
- advocacy (self and system advocacy skills),
- choice and decision-making opportunities,
- skill development,
- positive risk taking,
- reciprocity,
- support,
- sense of community,
- self-help,
- developing awareness.[3]

[2] http://mentalhealthpeers.com/pdfs/PeerSupportUnique.pdf

[3] http://mentalhealthpeers.com/pdfs/PeerSupportUnique.pdf

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. As stated by the Substance Abuse and Mental Health Services Administration (SAMHSA), "evidence shows that consumer-operated services are supporting people in their wellness and recovery while also contributing to the entire mental health service system."[4] For these reasons, 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. The implementation of the programs described below is helping the Department move closer to this goal.

Implementation of Peer Services

Over the past year, the Department 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 of services 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. A full listing of adult peer programming supported by the Department of Mental Health is listed below.

Chart 28: Vermont Peer Services Organizations

Organization	Services Provided
Alyssum	Operates two-bed program providing crisis respite and hospital diversion and step-down.
Another Way	Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, employment and housing supports, and community meals. Specializes in serving individuals who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services. Another Way also partners with the Good Samaritan Haven as a center of support for people staying in Montpelier's emergency shelter.
Copeland Center	Supports training, mentoring and groups focused on the use of the Wellness Recovery Action Plan (WRAP) self-management and recovery tool among peer and professional service providers. Also offers training in Wellness Engagement.
NAMI-VT	Statewide family and peer organization providing support groups, educational and advocacy groups for individuals with mental health conditions and their families.
Northeast Kingdom Human Services Peer Cadre	Provides respite and peer support for individuals waiting in hospital emergency departments for inpatient psychiatric care.
Pathways –	Statewide telephone peer support to prevent crisis and provide wellness coaching.

[4] http://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/TheEvidence-COSP.pdf

Vermont Support Line	
Vermont Psychiatric Survivors	Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings.
Pathways Vermont Community Center	Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, employment and housing supports, exercise classes, and community meals. Specializes in serving young adults who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services.
Wellness Workforce Coalition	Provides infrastructure and workforce development for organizations that provide peer supports. Activities include: o Coordinating peer support trainings (e.g. Intentional Peer Support, WRAP, Peer Core Competency trainings) o Support for workforce development (e.g. recruitment, retention, career development) o Mentoring and co-supervision/reflection for peer support workers o Quality improvement: - organization development (e.g. financial management, board development) - reporting of service outcomes using the Results-Based Accountability framework. o Tracking of peer services and peer workers in Vermont o Communication and networking among peer organizations o Systems advocacy

Spotlight: Vermont Support Line

The Vermont Support Line (VSL) is one of the programs developed after the implementation of Act 79. This program provides statewide telephone peer support to prevent crisis and provide wellness coaching. VSL operates 365 days per year, seven days a week, and, with new funding from Vermont's Mental Health Block Grant, the line is now open an average of 15 hours per day. VSL is operated by full time and part time peer staff who have been trained using the *Intentional Peer Support* model, which uses a specialized curriculum developed expressly for support line workers. The Vermont Support Line took its first call on March 18, 2013. In FY 2018, 6,823 calls were completed. And 100% of all callers seeking support during non-call hours or when no staff were available were contacted within 24 hours of initial contact.

To support more Vermonters, VSL stopped taking out of state calls at the beginning of FY 2017. This allowed for our percentage of incoming calls answered to rise from 18% in FY 2016 to 22% in FY 2017, and 53.3% in FY 2018. In FY 2018, VSL diverted 232 callers from emergency level services. In 2018, 94% of callers who answered the survey questions reported that the call was helpful.

Spotlight: Alyssum

Alyssum opened its doors in November 2011 and expanded its capacity through additional Act 79 funding. The program offers a peer-developed approach to crisis support for individuals who are seeking an alternative to traditional DA crisis programs. Alyssum is a trauma informed program and staff make it a point to turn a crisis into an opportunity of growth and change. This year (FY2018) 96% of guests reported that trauma had impacted their lives in a significant manner. Many program guests reported more than one type of trauma: 57% reported psychosis/spiritual emergence, 55% provider system trauma, 88% physical and/or sexual trauma, 61% unsafe relationships, and 73% reported loss and grief. As one resident stated, "...*This place is amazing. They helped me open doors that had been slammed shut and locked up for years. I am going home with clarity and acceptance of all the trauma I have been through. The staff here are truly amazing….I feel like I am leaving with a clearer mind and never ending support…"*

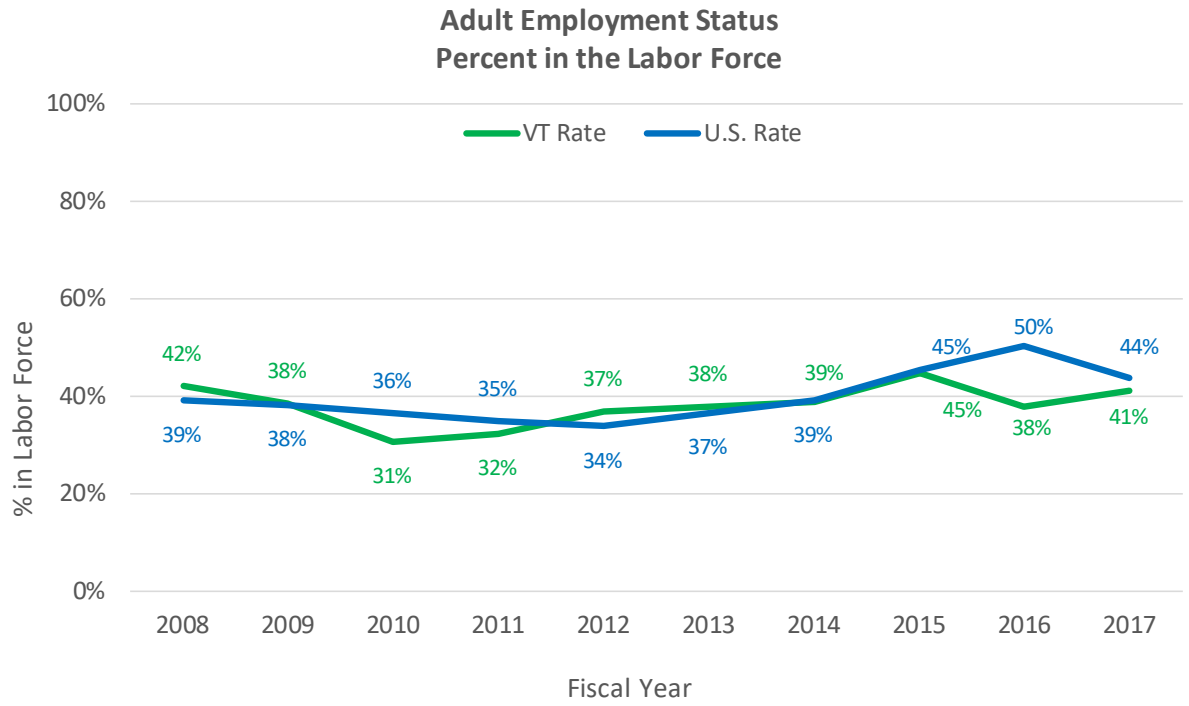
For FY 2018, Alyssum has had a total of 84 admissions and served 66 individuals (unduplicated). Over this period, Alyssum had an 92% occupancy rate and an average length of stay of 7 days. Demand for the program has been high—a total of 21 unique individuals were denied a bed due to full occupancy. This year Alyssum saw fewer calls than last year from individuals who did not meet intake criteria. 79% of admissions were for hospital diversion and 19% were for transition from a hospital (step-down).

The staff turnover rate at Alyssum is less than 10% (6% in FY 2018) annually. In FY 2018< guests reported 95% overall program satisfaction while at the program. Upon departure from Alyssum, 86% of guests self-reported feeling better, 12% say they felt the same, while 2% say they felt worse. Of the returning (repeat) guests at Alyssum, 89% reported reduced acute(crisis) service need reduction, citing both tools learned and support provided by Alyssum staff as a reason for this. Alyssum staff provided 1072 support calls this year.

Employment

Employment is an essential part of recovery for many individuals living with a mental illness. National data has shown that employment leads to decreased involvement with corrections, decreased hospitalizations, improved physical health outcomes, decreased substance use, and better community integration. Employment reduces a person's dependence on Social Security and has the potential to create significant savings to the system of care over time.

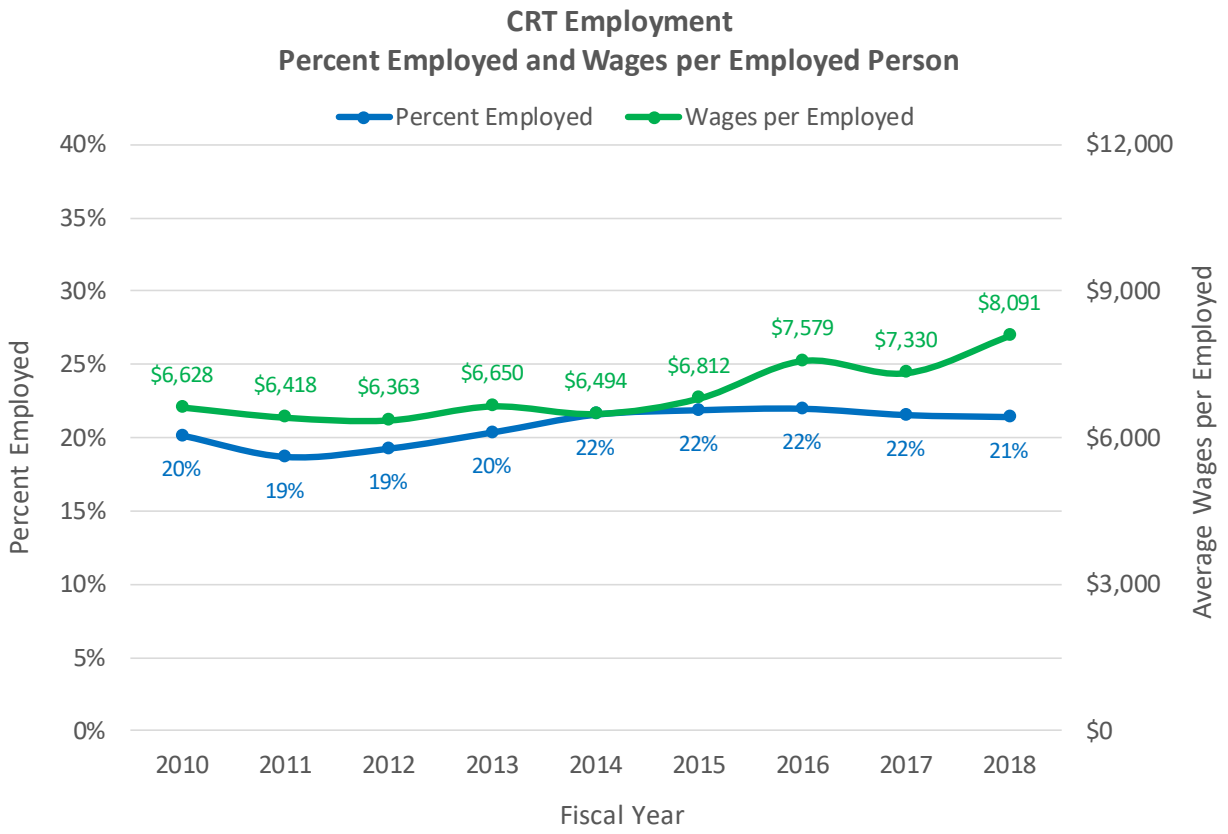
Chart 29: Percentage of All Adults with Mental Illness Employed in U.S. and VT



Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2017. Employment status for other mental health clients is based on case manager monthly service reports. Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2017. US totals are calculated uniquely based on those states who reported. Percentage in Labor Force includes all eligible adult mental health clients with SMI and is calculated as the percentage of those employed divided by the total number of adult clients (unemployed plus competively employeed). Workers who are excluded from DOL reporting are the self-employed,firm owners not incorporated and the following employee groups: elected officials, employees of nonprofit religious, charitable and educational organizations, unpaid family members, farm workers (with some exceptions), railroad employees, and individuals who work out of state.

The employment rate for all adults with mental illness in Designated Agencies—Adult Outpatient and Community Rehabilitation and Treatment combined—increased in 2017 in Vermont by 3% at the same time the national rate declined by 6%, moving Vermont's employment rate for adult with mental illness closer to the national average.

Chart 30: CRT Annual Employment Rates and Average Earnings



Analysis includes Community Rehabilitation and Treatment clients aged 18 - 64 who were active during any part of the annual reporting periods and includes all employment reported for the annual reporting periods.This report is based on analysis of the Department of Mental Health (DMH) and the Department of Labor (DOL) databases. DMH client data are submitted by Community Rehabilitation and Treatment Programs in conformance with contractual requirements. DOL data are submitted by employers in conformance with state and federal unemployment laws. Workers who are excluded from DOL reporting are the self-employed, firm owners not incorporated and the following employee groups: elected officials, employees of nonprofit religious, charitable and educational organizations, unpaid family members, farm workers (with some exceptions), railroad employees, and individuals who work out of state.

The chart above indicates a 1% increase in Community Rehabilitation and Treatment employment outcomes between FY 2012 and FY 2013. An additional 2% increase in FY 2014 held steady through FY 2017. Percent employed dropped 1% in FY 2018. Wages that slowly grew between FY 2011 – FY 2016 dipped slightly in FY 17, but have rebounded in FY 2018 despite the slightly lower employment percentage. Community Rehabilitation and Treatment programs continued to support individuals with their employment goals despite continued challenges within the system of care. Individuals, on average, earned $8,091 per year (*15 hours per week for full year at Vermont's current minimum wage of $10.50 per hour*).

Individual Experience and Recovery

A significant aspect of the intent of Act 79 was to improve the care and the experiences of those receiving mental health services in the State of Vermont. The Department routinely surveys consumers of mental health care and staff who provide the services as part of its Agency Review process.

Additionally, the Department also surveys consumers and families annually using a nationally developed survey. These surveys are one measure of individual experience and recovery, and the results are summarized in the following charts.

Person-centered care is focused upon the individual needs and movement towards stabilization and recovery. The individual needs of clients are the focal point at all the levels of care in the system. The Department of Mental Health tracks clinical, social and legal measures to assess experience and recovery. There are many measures used to quantify individual experience and recovery including employment information, consumer surveys, housing, and other metrics.

In addition to supporting people to obtain employment, which is one of the most effective interventions for improving recovery and reducing stigma, the Department currently supports and continues to expand several other non-medical interventions for the management of and recovery from distressing symptoms associated with mental illness. Interventions such as *Wellness Recovery Action Planning, Wellness Engagement*, *Open Dialogue,* and the *Hearing Voices* curriculum support individuals in reducing or eliminating the negative effects of their psychiatric symptoms. These approaches may, in some cases, give the individual an opportunity to work with their physician to reduce the medications that are being taken to manage those same symptoms. These types of interventions are available to a varying degree at the Designated Agencies and are an essential component of the peer service program described above. Currently, across the state, there are many initiatives underway to expand the availability of several of these interventions.

The Department has continued to support options for individuals seeking to avoid or reduce reliance on medications through funding of the residential program *Soteria – Vermont*, which provides specialized treatment and support for individuals experiencing first break psychosis who are seeking to avoid or reduce their reliance on medications. This program, which opened in the spring 2015, includes care from a psychiatrist to support withdrawal from medications. The intensive residential program *Hilltop,* which has been in operation since 2012, also provides treatment and support for young adults transitioning to the community from hospital level of care.

The current MHBG budget still calls for 10% of the funds to be allocated to evidence-based practices for early interventions for Early Serious Mental Illness (ESMI). Current research indicates that early intervention and treatment of individuals who are first experiencing psychosis could prevent or reduce long-term disability, and in some cases, reduce long-term reliance on psychotropic medication.

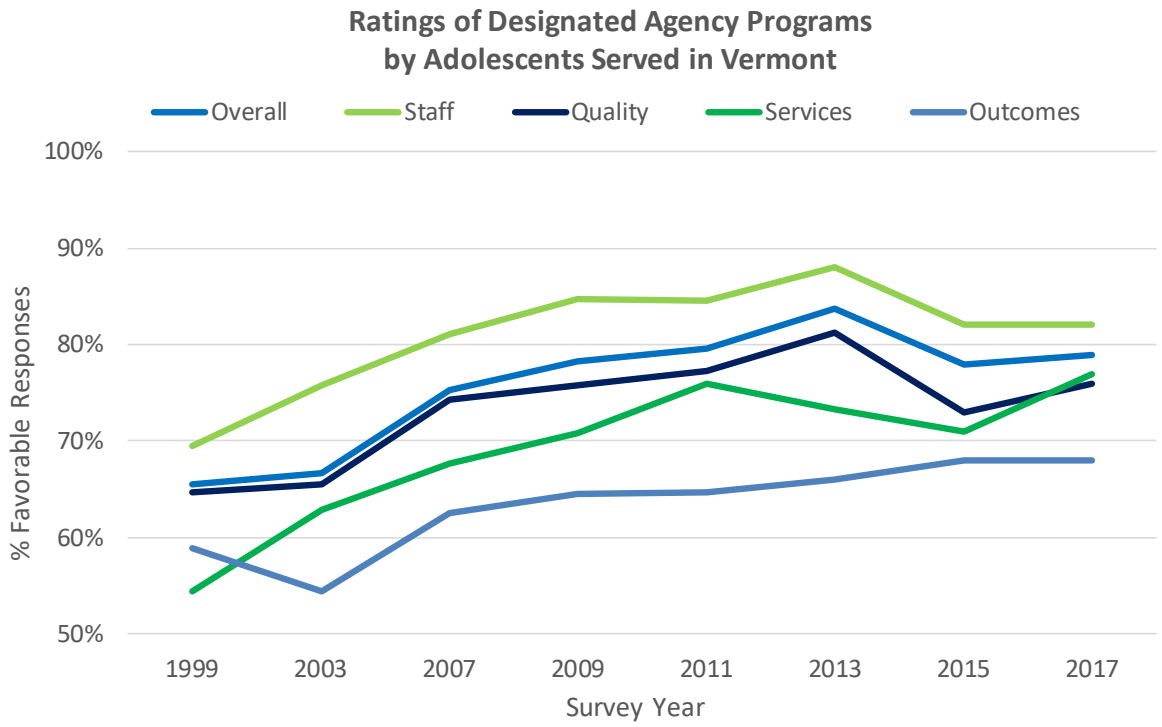
In 2015, the DMH began working with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) to identify and promote evidence-based practices for this population. A multi-stakeholder Advisory Committee reviews practice recommendations and funding allocations.

Vermont is using these MHBG funds to support implementation of Open Dialogue (Collaborative Network Approach in Vermont), which is a promising evidence-based practice supported by SAMHSA. VCPI has and continues to provide training and consultation to staff from several DA's including residential programs, Pathways Vermont, Vermont's Psychiatric Care Hospital, and Middlesex Secure Residential Program on Open Dialogue.

Perception of Care Surveys

The Department conducts consumer surveys to evaluate Community Rehabilitation and Treatment Services and Children and Family Services provided by the ten designated agencies in Vermont. The survey for children and families includes parents of children and adolescents with a severe emotional disturbance as well as youth in services. The full survey reports can be found online at: http://mentalhealth.vermont.gov/reports/consumer-surveys. The surveys focus on five areas with a resulting overall score constructed from responses to the survey questions.

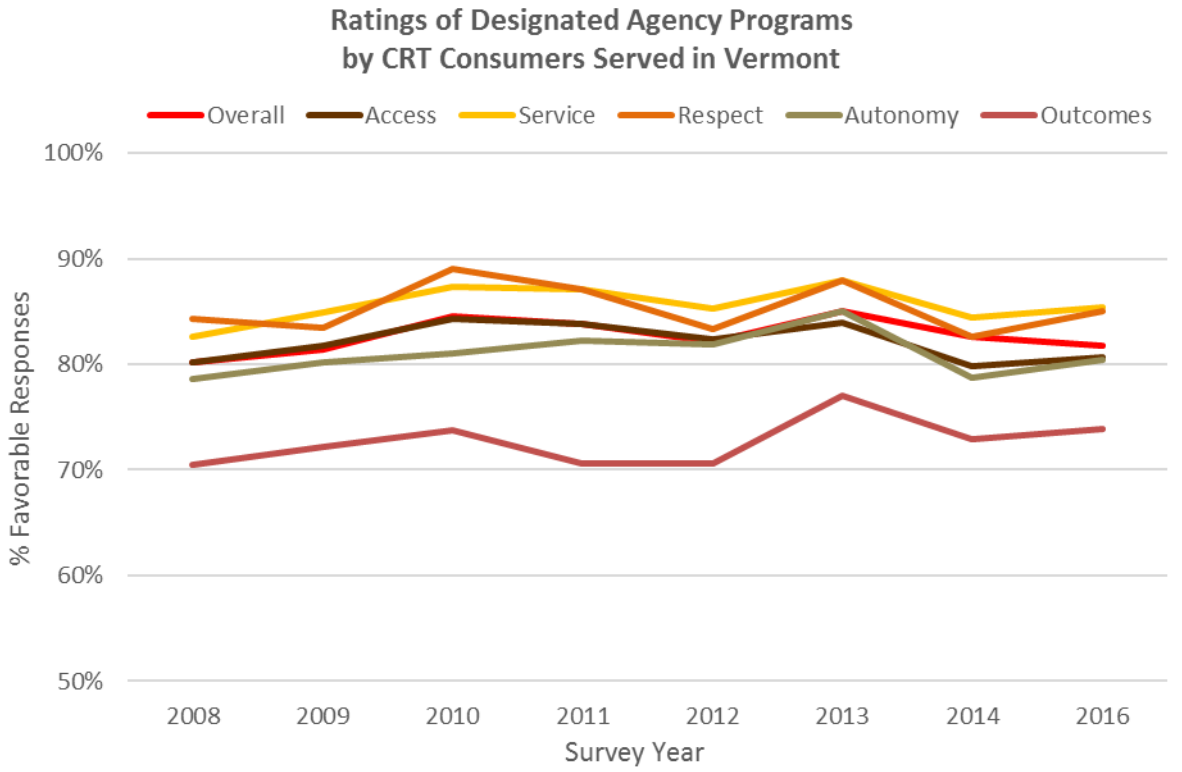
Chart 31: Ratings of Child, Youth, and Family Services Programs by Adolescents Served



Analysis is based on responses to surveys of children served by Vermont's Department of Mental Health regional community-based child and adolescent mental health programs. Responses of "agree" or "strongly agree" are considered positive, compared to "no opinion", "disagree", and "strongly disagree".

Overall satisfaction in Child and Adolescent Mental Health Programs has increased over the years. In 2015, the percentage of responses decreased in all areas with the exception of outcomes favorability. In 2017 survey responses, the areas of staff, outcomes, and overall favorability remained relatively unchanged from 2015 levels. Favorable response percentages rose for services and quality of services in 2017.

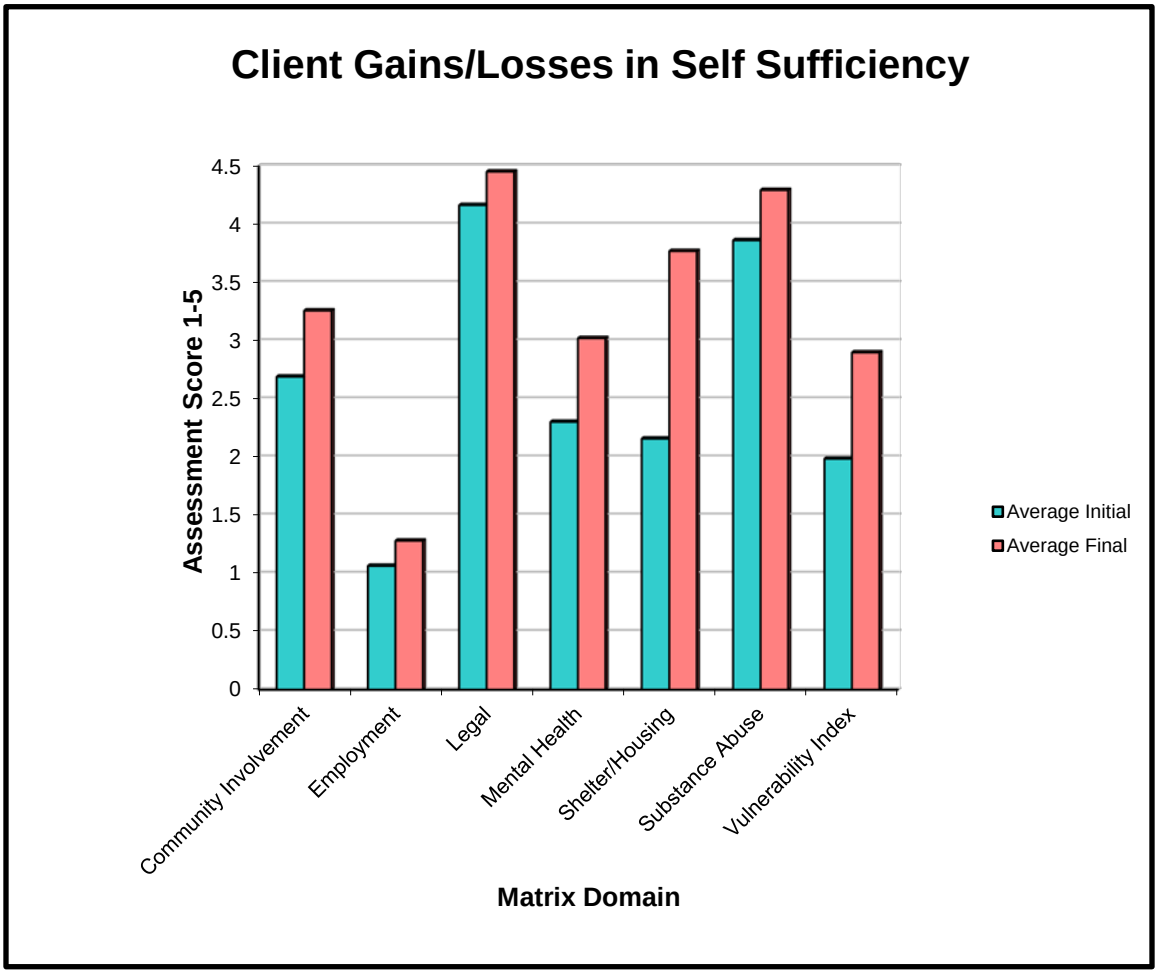
Chart 32: Ratings of CRT Programs by CRT Consumers



Analysis is based on responses to surveys of children served by Vermont's Department of Mental Health regional community-based CRT mental health programs. Responses of "agree" or "strongly agree" are considered positive, compared to "no opinion", "disagree", and "strongly disagree".

Satisfaction with Community Rehabilitation and Treatment programs has shown less improvement, but remains close to the eightieth percentile for all domains, except for the outcomes domain. Survey results vary widely by Designated Agency. Information from surveys is used in the designation process and when working with Designated Agencies to improve care. Final CRT perception of care survey outcomes are pending for 2019.

Chart 33: Housing



Since its creation in December 2011, a total of 222 persons who were homeless, mentally ill, and needing an acute care bed have been allocated a rental assistance subsidy and have subsequently been housed with community supportive services *as part of the Department's Housing Subsidy & Care Program*. Of those served, more than 73% (161/222) were literally homeless or temporarily housed, meaning on the streets, in emergency shelter, or staying in temporary housing such as acute care hospitals or jails.

A total of 44% (97/222) were chronically homeless in places not meant for habitation or emergency shelter prior to entering the Housing Subsidy & Care. Of the 222 housed since the program began, 100 have exited. 26 of that number have transitioned to other affordable housing and 11 are deceased.

The performance indicator the department seeks to achieve is a one-year housing retention or 365 days. The average length of stay in housing since the program began in December 2011 is 1,199 days with the median stay being 1,252. Thus, these numbers significantly exceed the housing retention target.

The Vermont State Housing Authority continues in its role as the Department's collaborating partner verifying client income, setting rent payments, and working with participating landlords. The effort continues to insure ongoing availability of housing to individuals who are homeless and severely and persistently mentally ill, who are in acute care settings.

DMH continues the focus of efforts with Community Mental Health Center and Pathways to Housing collaborations with local not-for-profit housing developers.

The Self Sufficiency Outcome Matrix is required as part of a subsidy allocation. All self-sufficiency outcome measures recorded demonstrate improvement for the individuals participating in the Housing Subsidy & Care program (Chart 33 above). The improvements overall and in legal, housing, mental health, substance abuse and community involvement identify client gains over initial scores.

All ten Designated Agencies and the Department's adult Specialized Service Agency (Pathways) are service providers for housing subsidy and care, as well as the participating providers listed below:

- Another Way
- Brattleboro Area Drop-In Center
- Community Health Center of Burlington
- Helping Overcome Poverty's Effects
- Northeast Kingdom Community Action
- Homeless Prevention Center

Planning for the Future

The landscape of the Mental Health System of Care has been changing and evolving as new system resources are implemented within community-based care or inpatient care settings. We have seen an ongoing demand for the limited number of inpatient beds to serve individuals with acute mental health needs. The increase in intensive residential recovery, secure residential, and crisis beds have continued to support a system in recovery as new inpatient hospital beds were opened. At all times, the Department's daily work continues to be one of assuring that individuals are cared for in the least restrictive setting, that wait times for admissions continue to be actively managed, and that services throughout the system are of high quality.

The Department of Mental Health continues to work diligently with the Designated Hospitals and Designated Agencies to develop the capacity to care for this vulnerable population of Vermonters, implement process and outcome measures to assure value to the system of care in terms of quality and cost, and collaborate with partners including the Courts, Law Enforcement, Disability Rights Vermont, Department of Corrections, Department of Vermont Health Access, and the Blueprint for Health. The Department will continue with these efforts in the coming year and beyond.

DMH is also in the process of launching two new Federal Grant initiatives focused on early childhood development and school age youth. A Health Resources and Services Administration (HRSA) grant through the Vermont Department of Health (VDH) for Screening, Treatment and Access for Mothers and Perinatal Partners (STAMPP) is underway. In partnership with the VDH Maternal Child Health Division, effective screening, intervention and treatment of maternal depression and related behavioral disorders will be the focus of the 5-year, $627,525 federal cooperative agreement. The second is a 5-year Substance Abuse and Mental Health Services Administration (SAMHSA) award for up to $1,582,371 to the Agency of Education (AOE) for Project AWARE Vermont. This initiative is also being launched in partnership between AOE and DMH. The Child, Adolescent, and Family Unit of DMH will be working to increase awareness of youth mental health issues; enhance wellness and resiliency skills for school age youth; and support system improvements for school based mental health services. Grant funding for both initiatives exists through September 2023.

The Department of Mental Health is working with other AHS Departments, including Vermont Health Access (DVHA), Children and Families (DCF) Family Services Division, and Aging and Independent Living (DAIL) Developmental Disabilities Services Division to explore mobile response and support services (MRSS) for the child, youth and family system of care. Representatives from these departments/ divisions, along with representatives from a family advocate organization and a Designated Agency participated in a state-to-state peer learning and technical assistance event in December 2018 to hear about the experience of other states who have implemented MRSS.

In the National Association of State Mental Health Program Directors report, Making the Case for a Comprehensive Children's Crisis Continuum of Care (2018), it notes that "[i]n 2013 the Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Medicaid and CHIP Services (CMCS) recognized Mobile Crisis Response and Stabilization Services as "not only clinically effective but cost effective as well.""

MRSS differs from traditional crisis services in that it's more upstream. A mobile face-to-face response is provided to a family-defined crisis to provide support and intervention earlier for a child/youth and

family before emotional and behavioral difficulties escalate. An MRSS response has been shown in other states to "avert unnecessary" higher levels of care in settings such as emergency departments, inpatient psychiatric care, or residential treatment (NASMHPD 2018).

Examining the Mental Health System of Care

In response to challenges arising in the mental health system of care, the Vermont legislature passed Act 82, an act relating to examining mental health care and care coordination. This act tasked the Department with identifying many of the challenges and opportunities within the current mental health system of care. The Department approached the directives of Act 82 with an emphasis on stakeholder input and ideas and held two all-day meetings and numerous stakeholder sub-committee meetings to engage with stakeholders and providers. DMH embraced stakeholder perspectives as pivotal to the work, provided leadership and directing efforts, and provided reports to the Vermont legislature (https://legislature.vermont.gov/assets/Legislative-Reports/) and on the Department's website (http://mentalhealth.vermont.gov/reports/legislative-and-budget).

In 2018, Act 200 relating to systemic improvements of the mental health system was also enacted requiring a number of analyses and follow-up evaluation and development work to continue into 2019. The Act explicitly cited for focus and review:

- Need for additional inpatient bed capacity and facility planning
- Replacement of the Middlesex Secure Residential Recovery Program
- Creation of an Order of Non-Hospitalization Study Committee and report
- Renovations at the Brattleboro Retreat
- Progress in transporting of patients for mental health care
- Collection of information on persons seeking mental health inpatient treatment
- Heightened review and scrutiny of rates of payments to DAs and SSAs to retain its workforce
- The Institutes of Mental Disease (IMD) phase down impacts
- Integration, coordination and overall parity for mental health services as a component of health care

Many of the Act 200 (2018) reports to the legislature build on prior efforts under Act 82 (2017) and require analyses of complex and evolving issues. These reports and activities are intended to inform a long-term vision for the future of the mental health system as a part of a holistic and integrated health care system.

The information described in this report, as well as the content outlined in each of the Act 200 (2018) reports, reflect the work and dedication of the Agency of Human Services, Department of Mental Health, to continuously improve the state's mental health system of care.

Appendices

Appendix A: DMH Snapshot

Appendix B: DMH Continued Reporting

Appendix B: NOMS (National Outcome Measures) Data Sheet Summary

APPENDIX A: DMH MONTHLY SNAPSHOT

This is a sample report of the DMH Snapshot RBA Scorecard. RBA Scorecards are available via the links below for the most up-to-date information and is posted to the DMH website.

http://mentalhealth.vermont.gov/reports/results-based-accountability

DMH System Snapshot

		Time Period	Actual Value	Current Trend
P	Snapshot **Adult Inpatient Hospitalization**			
PM	How_Much % occupancy of adult inpatient hospital units	FYQ1 2019	91%	→ 1
PM	Snapshot # of closed adult inpatient beds per day (average)	FYQ1 2019	8	↗ 1
PM	Snapshot % of all adult inpatient bed days used for involuntary care	FYQ3 2018	40%	↘ 1
PM	Snapshot # of EE applications for adults (18+)	FYQ1 2019	150	↘ 1
PM	Snapshot # instances where involuntary inpatient placement was unavailable, and adult was held in the emergency dept.	FYQ1 2019	74	↘ 1
PM	Snapshot # of requested Court-Ordered Forensic Observations	FYQ1 2019	21	↘ 1
PM	Snapshot # of screenings Court-Ordered Forensic Observation resulting in an inpatient order	FYQ1 2019	10	↘ 1
P	Snapshot **Level 1 Inpatient Care**	Time Period	Actual Value	Current Trend
PM	How_Well % occupancy of Level 1 adult inpatient hospital units	FYQ1 2016	87%	↘ 2
PM	How_Much # Level 1 admissions	FYQ1 2019	52	↗ 4
P	Snapshot **Youth Inpatient Hospitalization**	Time Period	Actual Value	Current Trend
PM	Snapshot % occupancy at youth inpatient hospital units	FYQ1 2019	81%	↘ 2
PM	Snapshot # instances where inpatient placement was unavailable, and youth was held in the emergency dept.	FYQ1 2019	10	↘ 1
PM	Snapshot # of closed youth inpatient beds per day (average)	FYQ1 2019	1	↘ 1
PM	Snapshot # of EE applications for youth (0-17)	FYQ1 2019	14	↘ 1
P	Snapshot **Community Services**	Time Period	Actual Value	Current Trend
PM	How_Much % occupancy of Designated Agency adult crisis bed programs	FYQ1 2019	79%	↗ 2
PM	Snapshot % occupancy of Designated Agency youth crisis bed programs	FYQ1 2019	58%	↘ 2
PM	How_Well % occupancy of adult intensive residential beds (including MTCR)	FYQ1 2019	94%	↗ 2
PM	Snapshot # people enrolled in housing subsidy + care program to date	FYQ2 2017	121	↗ 1

			Time Period	Actual Value	Current Trend
P	Snapshot	**Court-Ordered Involuntary Medications**			
PM	Snapshot	# applications for court-ordered involuntary medications	FYQ1 2019	20	↘ 1
PM	Snapshot	# of granted orders for court-ordered involuntary medications	FYQ1 2019	15	↘ 1
PM	Snapshot	Mean time from filing date to decision date in days	FYQ1 2019	12	↗ 1
P	Snapshot	**Suicide**			
PM	Snapshot	# of suicide deaths	FYQ4 2018	30	↗ 1
PM	Snapshot	# of suicide deaths who were served by a DA within the previous year	FYQ4 2018	3	↗ 1
P	CareMgmt	**Involuntary Transportation**			
PM	How_Much	# of transports to inpatient psychiatric care	FYQ3 2018	64	↗ 1
PM	How_Well	% of transports to psychiatric inpatient care without using physical restraint	FYQ3 2018	56%	↘ 1
PM	Snapshot	# of transports for adults to inpatient psychiatric care (18+)	FYQ3 2018	55	↗ 1
PM	Snapshot	# of transports for youth to inpatient psychiatric care (0-17)	FYQ3 2018	9	→ 2
PM	Snapshot	% of transports for adults to psychiatric inpatient care using metal restraint	FYQ3 2018	24%	↗ 2
PM	Snapshot	% of transports for youth to psychiatric inpatient care using metal restraint	FYQ3 2018	33%	→ 1

APPENDIX A: DMH Continued Reporting

This is a sample report of the DMH Continued Reporting RBA Scorecard. RBA Scorecards are available via the links below for the most up-to-date information and is posted to the DMH website.

http://mentalhealth.vermont.gov/reports/results-based-accountability

DMH Continued Reporting

		Time Period	Actual Value	Current Trend
P	ContinuedReport Total Adult Involuntary Inpatient Care			
PM	ContinuedReport # admissions	FYQ4 2018	155	↗ 1
PM	ContinuedReport # of discharges	FYQ4 2018	148	↗ 1
PM	How_Well Length of stay (LOS) for discharged clients	FYQ4 2018	37	↘ 2
PM	Better_Off 30 day readmission rate for discharged clients	FYQ4 2018	9%	↘ 1
P	ContinuedReport Level 1 Inpatient Care	Time Period	Actual Value	Current Trend
PM	ContinuedReport Average daily census for Level 1 services	FYQ1 2019	49	↗ 4
PM	How_Much # Level 1 admissions	FYQ1 2019	52	↗ 4
PM	ContinuedReport # Level 1 admissions to non-Level 1 units	FYQ1 2019	9	↗ 1
PM	ContinuedReport # Level 1 discharges	FYQ1 2019	52	↗ 2
PM	ContinuedReport Highest level 1 census during time period	FYQ1 2019	52	↗ 4
PM	ContinuedReport % of people admitted involuntarily that are Level 1	FYQ4 2018	28	↘ 1
PM	ContinuedReport % of involuntary bed days that are for Level 1 stays	FYQ4 2018	65	↗ 3
P	ContinuedReport Adults Waiting for Involuntary Inpatient Care	Time Period	Actual Value	Current Trend
PM	How_Much # of adults waiting per day for involuntary inpatient placement (average)	Nov 2018	3	↘ 1
PM	How_Much # of adults waiting for involuntary inpatient placement (total)	Nov 2018	42	↗ 1
PM	How_Much # hours of wait time for adult involuntary inpatient admissions (average)	Nov 2018	47	↘ 1
PM	ContinuedReport # hours of wait time for adult involuntary inpatient admissions waiting more than 48 hours (average)	Nov 2018	120	↗ 1
PM	ContinuedReport # hours of wait time for adult involuntary inpatient admissions waiting less than 48 hours (average)	Nov 2018	14	↗ 1
PM	ContinuedReport # of individuals requiring sheriff supervision in emergency departments	Mar 2018	7	↗ 1

APPENDIX C: National Outcome Measures

The National Outcome Measures (NOMS) report can be found in its entirely-for Vermont and other states—on SAMHSA's website: http://www.samhsa.gov/data/ under "State and Metro Reports"

Vermont 2017 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per 1,000 population	7,524,119	37.55	23.00	58
Community Utilization per 1,000 population	7,318,598	37.41	22.37	58
State Hospital Utilization per 1,000 population	131,633	0.14	0.40	54
Other Psychiatric Inpatient Utilization per 1,000 population	446,562	0.81	1.61	39

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	699,316	41.0%	43.8%	57
Employed (percent with Employment Data)**	699,316	27.8%	20.9%	57

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	70.7%	78.7%	49

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	62.7%	73.1%	46

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	6,829	7.0%	8.3%	50
State Hospital Readmissions: 180 Days	15,719	12.3%	19.2%	52
State Hospital Readmissions: 30 Days: Adults	6,323	7.1%	8.6%	49
State Hospital Readmissions: 180 Days: Adults	14,441	12.5%	19.6%	51
State Hospital Readmissions: 30 Days: Children	450	0.0%	6.3%	16
State Hospital Readmissions: 180 Days: Children	1,158	0.0%	16.1%	20

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,115,700	85.4%	82.7%	58
Homeless/Shelter	210,479	3.5%	4.2%	54
Jail/Correctional Facility	86,943	0.1%	1.7%	53

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	89,414	-	3.0%	35
Supported Employment	62,596	25.1%	2.0%	41
Assertive Community Treatment	74,032	-	2.1%	41
Family Psychoeducation	35,658	-	2.8%	15
Dual Diagnosis Treatment	237,513	-	11.7%	28
Illness Self Management	318,831	-	20.0%	22
Medications Management	554,087	83.6%	34.6%	22

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	9,728	-	1.2%	21
Multisystemic Therapy	26,180	-	3.8%	17
Functional Family Therapy	24,574	-	4.6%	15

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	67.8%	78.8%	48
Child/Family Improved Social Connectedness	-	87.2%	46

*Denominator is the sum of consumers employed and unemployed.
**Denominator is the sum of consumers employed, unemployed, and not in labor force.

SAMHSA Uniform Reporting System - 2017 State Mental Health Measures

STATE: Vermont

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	23,432	37.55	7,524,119	23.00	58
Community Utilization per 1,000 population	23,344	37.41	7,318,598	22.37	58
State Hospital Utilization per 1,000 population	88	0.14	131,633	0.40	54
Medicaid Funding Status	15,548	69%	5,053,378	71%	56
Employment Status (percent employed)	2,574	28%	699,316	21%	57
State Hospital Adult Admissions	70	0.80	99,174	0.82	51
Community Adult Admissions	6,318	0.46	9,475,004	2.07	50
Percent Adults with SMI and Children with SED	2,595	11%	4,950,127	66%	57

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	61 Days	79 Days	49
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	46 Days	79 Days	49
Percent of Client who meet Federal SMI definition	19%	72%	54
Adults with Co-occurring MH/SA Disorders	23%	25%	56
Children with Co-occurring MH/SA Disorders	-	7%	51

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	79%	88%	49
Quality/Appropriateness of Services	83%	90%	49
Outcome from Services	71%	79%	49
Participation in Treatment Planning	78%	86%	49
General Satisfaction with Care	84%	90%	49

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	82%	88%	46
General Satisfaction with Care	76%	88%	48
Outcome from Services	63%	73%	46
Participation in Treatment Planning	85%	89%	48
Cultural Sensitivity of Providers	87%	93%	47

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	17,403	85.4%	4,115,700	82.7%	58
Jail/Correctional Facility	22	0.1%	86,943	1.7%	53
Homeless or Shelter	712	3.5%	210,479	4.2%	54

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	4	7.0%	6,829	8.3%	50
State Hospital Readmissions: 180 Days	7	12.3%	15,719	19.2%	52
Readmission to any psychiatric hospital: 30 Days	-	-	27,805	13.4%	20

State Mental Health Finance (2017)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community Mental Health*	$85,551,700	-	$19,948,114,782	76.9%	57
State Expenditures from State Sources	$45,287,765	52.9%	$11,142,374,361	42.9%	48
Total SMHA Expenditures	$85,551,700	-	$25,945,022,406	-	57

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	74,032	2.1%	41
Supported Housing	-	-	89,414	3.0%	35
Supported Employment	628	25.1%	62,596	2.0%	41
Family Psychoeducation	-	-	35,658	2.8%	15
Integrated Dual Diagnosis Treatment	-	-	237,513	11.7%	28
Illness Self-Management and Recovery	-	-	318,831	20.0%	22
Medications Management	2,094	83.6%	554,087	34.6%	22

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	9,728	1.2%	21
Multisystemic Therapy	-	-	26,180	3.8%	17
Functional Family Therapy	-	-	24,574	4.6%	15

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	-	-	27,291	3.9%	33
Juvenile Justice Contacts	217	2.7%	6,885	3.1%	35
School Attendance (Improved)	-	-	14,973	33.4%	24

* Includes primary prevention, evidence-based practices for early serious mental illness, and Other 24-Hour Care