PROPOSED DMH RECOVERY RESIDENCE

Sarah Squirrell, Commissioner
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VERMONT
DEPARTMENT OF MENTAL HEALTH

AGENDA

- History of Middlesex Therapeutic Community Residence
- System of Care Needs, Capacity Analysis & Costs of Care
- Future Recovery Residence
- Clinical Perspectives
- Design of the Future Recovery Residence
- National Content Experts: Systems and Clinical Perspectives
- Next Steps

HISTORY OF THE MIDDLESEX RESIDENCE

- Act 79 (2012) The State of Vermont committed to build a permanent secure residential program
- Created the Middlesex Therapeutic Community Residence (MTCR), a seven-bed secure residential program
- Built using Federal Emergency Management (FEMA) funds
- Step-down facility for those who are no longer in need of inpatient care, but who need intensive services in a secure setting
- Involuntary legal status under the Care and Custody of the Commissioner of Mental Health
- Requires an Order of Non-Hospitalization indicating by the court that the individual requires a secure setting

Current Middlesex Secure Residence

The temporary facility has outlived its lifespan and needs to be replaced

Site has poor drainage and is difficult to maintain

No permanent foundation

Frost and moisture issues require constant repair to structure, ramps and fencing

SYSTEM OF CARE NEEDS

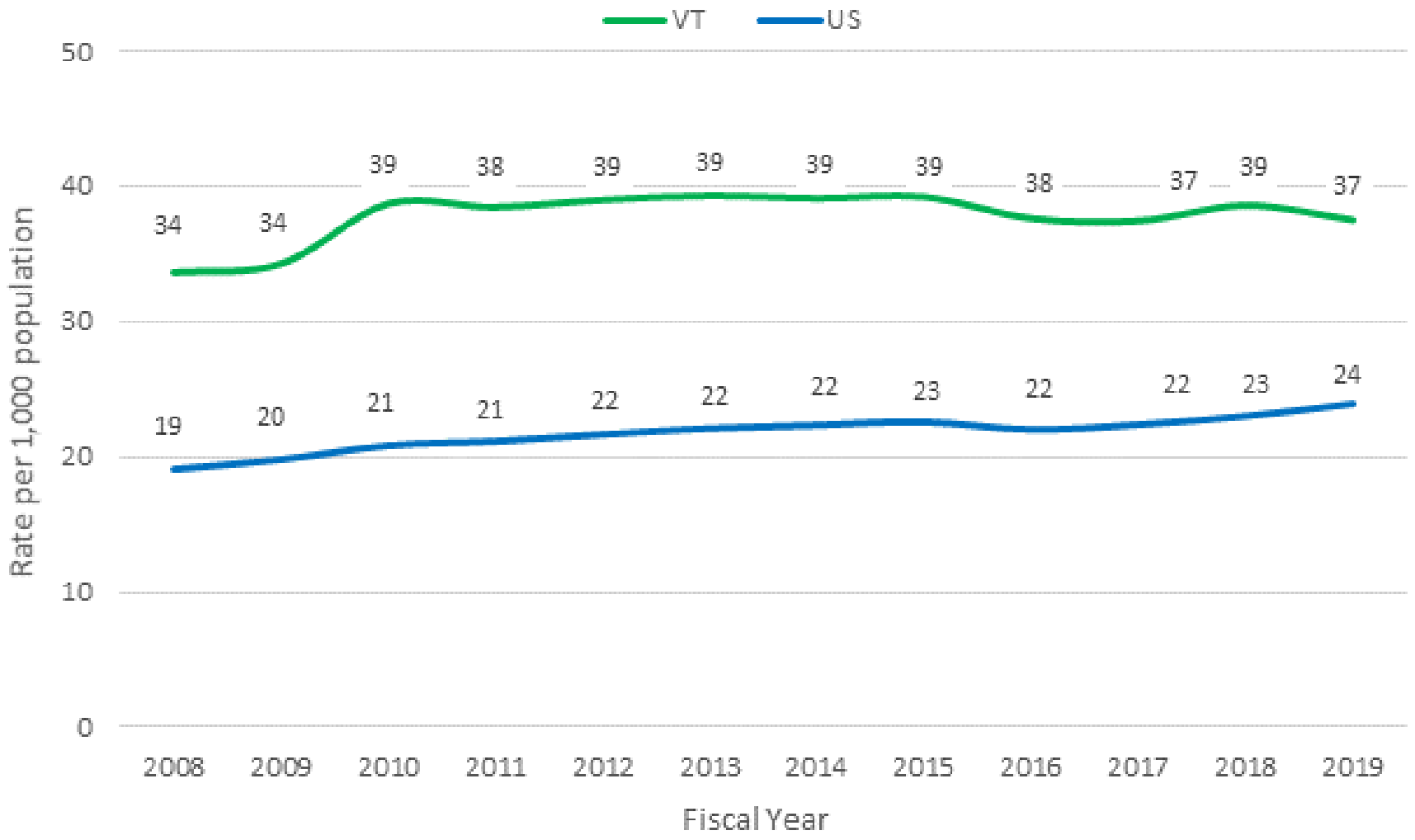
- In order to provide the best care possible for Vermonters, a robust continuum of step-down treatment programs must be available
- Increasing our step-down capacity in the system of care has been identified as a critical need
- A permanent secure program is a key component in Vermont's system of programs available to individuals needing 24/7 treatment and support services.
- The replacement and expansion of the of the current Middlesex Therapeutic Residence is an essential and smart solution in addressing systemic challenges
- Long wait times in Emergency Rooms are symptomatic of inadequate flow in our system which is our ability to support individuals effectively with minimal delays as they move through stages of care and recovery

CURRENT MIDDLESEX DATA

- 95% of referrals to the secure residence are from Level 1 units across the state
- 53 individuals served since opening
- Average Length of Stay (LOS) is 8 – 10 months
- 65% of residents have stepped down to less restrictive settings or independent housing
- Occupancy Rates

FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
90%	94%	82%	92%	88%	91%	95%

Community Services Utilization per 1,000 Population

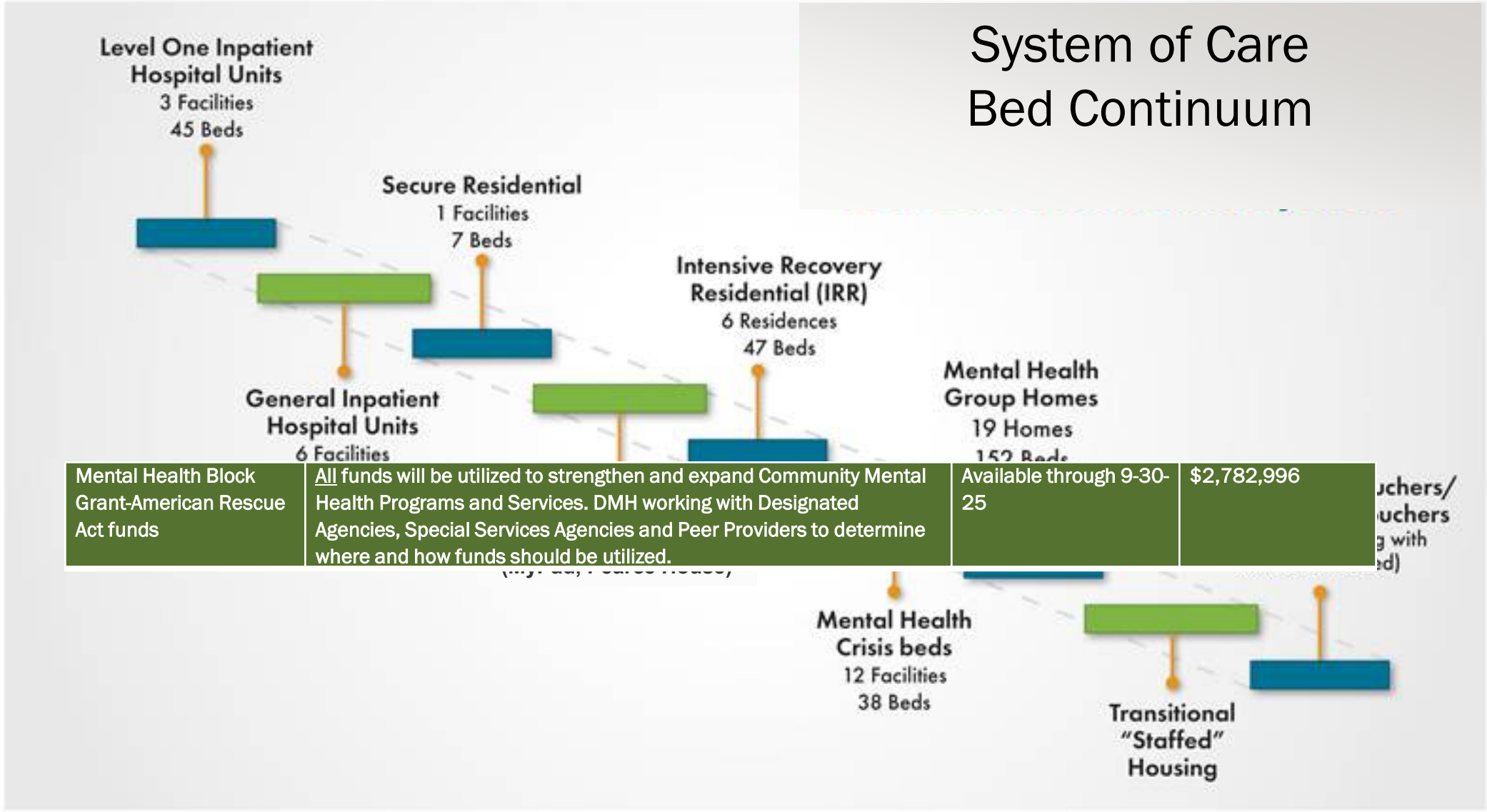


Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2019.

SUPPORTING COMMUNITY-BASED CARE

Funding Source	Focus of Funds	Spending Timeframe	Amount Funds
Mental Health Block Grant	Community Based MH Programs and Services	10/2020 – 10/2021	**$1.2M**
Mental Health Block Grant – COVID Supplement	Community Based MH Programs and Services	Current – 3/2023	**$1.4M**
Mental Health Block Grant – American Rescue Act	Community Based MH Programs & Services	Current – 9/2025	**$2.78M**
SAMHSA COVID Emergency Grant	Community Based MH Emergency Services Programs & Supports	4/20 – 8/2021 (extension likely)	**$1M**
SAMHSA COVID Emergency Grant Supplement	Community Based MH Emergency Services Programs & Supports	2/21 – 5/31/22	**$1.4M (Full amount is $2.8M, DMH/ADAP split)**
			Approximately $7.8M

System of Care Bed Continuum

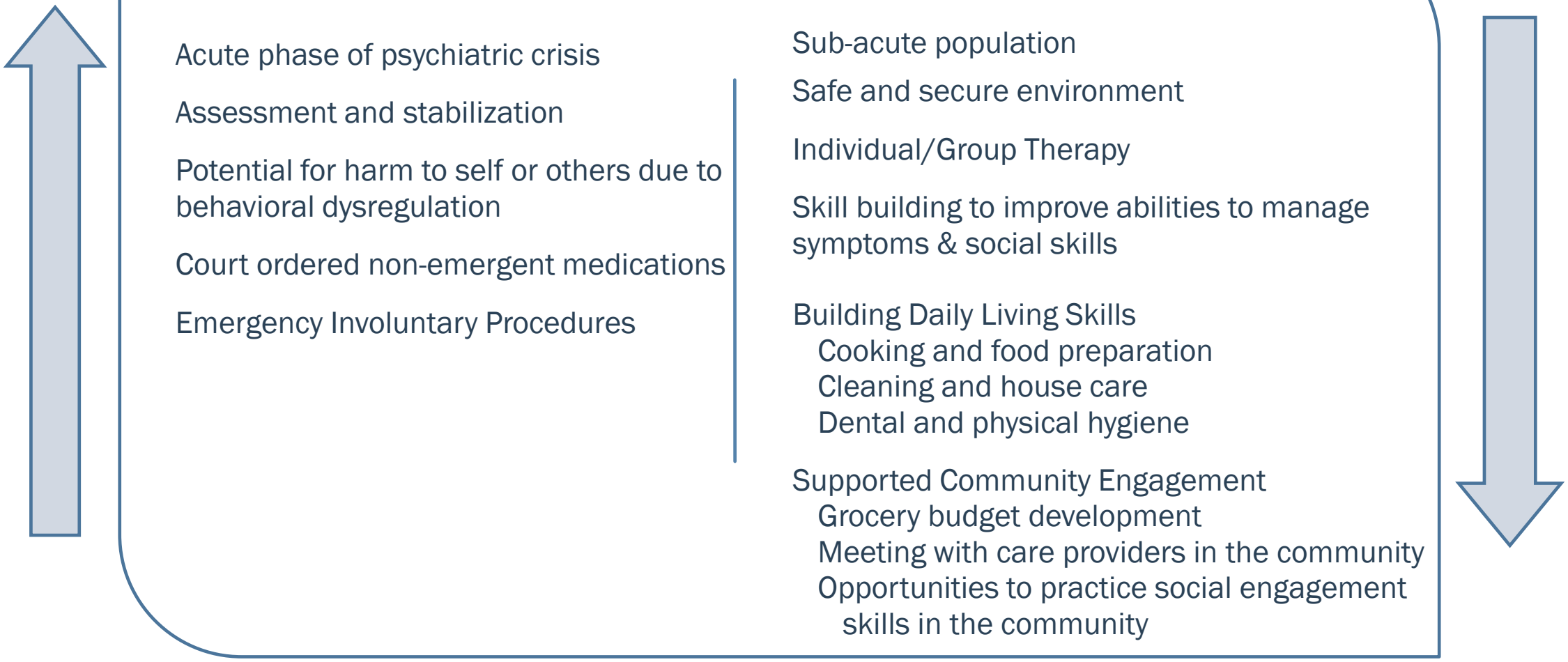


Mental Health Block Grant-American Rescue Act funds	All funds will be utilized to strengthen and expand Community Mental Health Programs and Services. DMH working with Designated Agencies, Special Services Agencies and Peer Providers to determine where and how funds should be utilized.	Available through 9-30-25	$2,782,996

LEVEL 1 CRITERIA

- Patient poses significant danger to self (either imminent or strongly suggested by patient history) such that significant and more than usual resources are needed to manage the patient's care; or,
- Patient poses significant danger to others (either imminent or strongly suggested by patient history) such that significant and more than usual resources are needed to manage the patient's care; or,
- Patient poses significant disruptive behaviors such that significant and more than usual resources are needed to manage the patient's care; or,
- Great difficulties caring or protecting for self that are significant and more than usual resources are necessary to manage the patient's care.

LEVEL OF CARE ATTRIBUTES



Inpatient Level of Care

Acute phase of psychiatric crisis

Assessment and stabilization

Potential for harm to self or others due to behavioral dysregulation

Court ordered non-emergent medications

Emergency Involuntary Procedures

Secure Step-Down Level of Care

Sub-acute population

Safe and secure environment

Individual/Group Therapy

Skill building to improve abilities to manage symptoms & social skills

Building Daily Living Skills
- Cooking and food preparation
- Cleaning and house care
- Dental and physical hygiene

Supported Community Engagement
- Grocery budget development
- Meeting with care providers in the community
- Opportunities to practice social engagement skills in the community

COSTS OF CARE

Level of Care	Facility or Program	Approx. Annual Operating Cost	Approx. Daily Operating Cost
Level 1: Intensive Inpatient Care	Vermont Psychiatric Care Hospital (25)	$23.6M	$2,610/day
	Level 1 beds at Brattleboro Retreat (14)		$1,776/day*
	Level 1 beds at Rutland Regional (6)		$2,063/day
Non-Level 1 Inpatient	Central Vermont Med. Center (14) Rutland Regional Med. Center (17) UVM Medical Center (28) Windham Center (10) VA Medical Center (12) Brattleboro Retreat (75)		$1,771 /day
Secure Residential	Middlesex Secure Residential (7)	$3.1M	$1,200/day
	New Secure Residential (16)	$9.1M**	$1,565/day**
Intensive Residential Recovery Programs	Second Spring North	$12.37 M average	$842/day average
	Second Spring South		
	HCRS: Hilltop		
	HCRS: Meadowview		
	RMHS Maplewood		
Community-based Residential Recovery	Soteria House	$1.0	$550/day
Intensive Supported Housing	Howard Center My Pad CSAC My Pad	$628.5k average	$574/day avg.

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*Based on most recent cost settlement.
**Pending final staffing structure.

FUTURE RECOVERY RESIDENCE

- Replace the current physically secure Middlesex Therapeutic Community Residence with a 16-bed physically secure recovery residence that provides the highest quality of care, ensures the safety of residents in an environment of care that is recovery oriented and promotes rejoining and rebuilding a life in the community
- Individuals who are sub-acute and ready to discharge from inpatient hospitals but have higher treatment needs, risk factors that impact public safety and exceed the capacity of community providers
- Require enhanced transitional support to successfully step down from inpatient level of care to a safe and stable environment
- Enhances equitable access to appropriate, timely and high-quality care and treatment
- Capable of serving individuals with forensic needs and increased risk

FUTURE RECOVERY RESIDENCE

- The secure recovery residence serves the highest acuity population of individuals who are ready to discharge – 100% of referrals come from Level 1 units from across the state
- Replacing the current residence and expanding capacity will greatly improve the movement of patients through our system, This will support timely discharge and inpatient bed availability in the system of care, relieving pressure through-out the system.
- The right thing for Vermonter's and the system of care, without it we will be doing a disservice to those individuals who are ready to step down from hospital level of care, need transitional support and require a safe and secure setting as they work towards recovery
- Collaboration & partnership are key tenets of advancing this urgent and important capacity in our system of care

DATA SUPPORTING EXPANDED CAPACITY

- Over nearly 7 years of operation, the 7-bed, temporary, secure residential program in Middlesex has successfully transitioned many individuals with complex needs from inpatient care back to local communities or less intensive support programs and services.
- Impact of the pandemic on escalating mental health needs – demand for high intensity services is not decreasing
- 95% - 100% occupancy in Level 1 beds – long lengths of stay this cohort of individuals
- Improved environment of care of the new design enhances program treatment capacity
- Occupancy Rate of current Middlesex Residence – Average occupancy 90% over the past 5 years
- Analysis of Residential Bed needs found that point in time data surveying inpatient facilities indicate that at any given time 7 – 10 individuals could step down to a physically secure recovery residence
- Vermont's 10-year vision to decrease inpatient bed capacity
- Centers for Medicaid Services requirement to phasedown IMDs

CLINICAL PERSPECTIVES

DR. ALISSON RICHARDS

VERMONT
DEPARTMENT OF MENTAL HEALTH

GRETCHEN

Gretchen* is a 38 year old woman with history of long inpatient stays. Her hospitalizations include a history of court ordered non-emergent involuntary medications. Her response to medications is seen as marginal and she remains psychotic at baseline.

During her hospitalizations, Gretchen regularly has dysregulated moments where she will destroy property or assault others at a frequency of about once every 4 to 6 weeks. Other than these episodes, even though she remains psychotic, she is behaviorally stable.

Due to the ongoing episodic nature of her behavioral dysregulation, none of the community providers feel that she is appropriate for their programs as they can not guarantee the safety of the other residents under their care.

*fictitious person

RANDY

Randy* is a 45 year old man, who has been charged with murder and has been found Incompetent to Stand Trial due to his mental illness. He has refused medications and due to his stable presentation while at the hospital, court ordered non-emergent involuntary medications, have been denied by the courts.

He remains delusional and psychiatrically under treated. Due to public safety concerns and history of extreme violence when untreated, no community providers feel comfortable that they could safely treat him in the community while he remains under-treated.

*fictitious person

GREG

Greg* is a 40 year old man with a history of numerous psychiatric hospitalizations as well as placements at various group living settings. His length of stays at the group living situations range from a matter of days to a few months with the transition resulting in re-hospitalization.

His hospitalization history includes need for non-emergent involuntary medications, and he traditionally stops taking medications in the community. He has resided at several of the Intensive Recovery Residences where he has either eloped from or has assaulted others and is no longer seen as a person they feel they can safely serve. He stabilizes in a hospital setting with medications and currently when no longer needing hospital level of care none of the community providers (DAs, SSAs, and Peer run programs) feel they can safely manage this person's ongoing risk of violence.

*fictitious person

FUTURE RECOVERY RESIDENCE

DEPUTY COMMISSIONER MOURNING FOX

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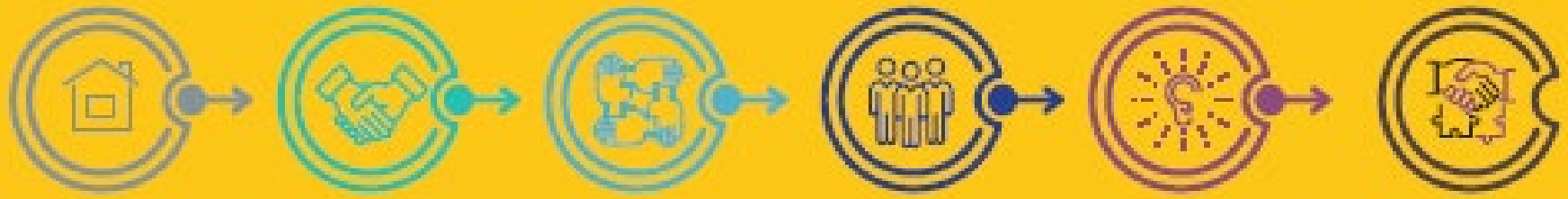
MOVEMENT
PEOPLE
GIVING
MEANINGFUL
OPTIMISM
INTERACTION

OVERVIEW: GUIDING PRINCIPLES

6 Guiding Principles To A Trauma-Informed Approach

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:



1. SAFETY | **2. TRUSTWORTHINESS & TRANSPARENCY** | **3. PEER SUPPORT** | **4. COLLABORATION & MUTUALITY** | **5. EMPOWERMENT VOICE & CHOICE** | **6. CULTURAL, HISTORIC/ & GENDER ISSUES**

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

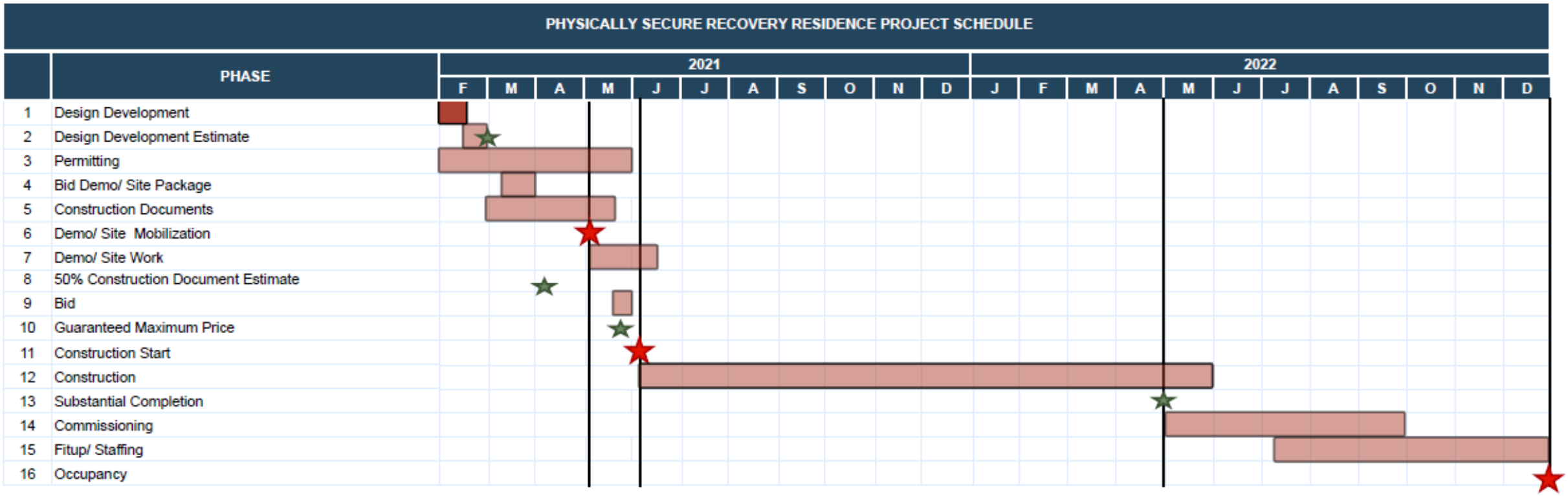
NATIONAL CONTENT EXPERT PERSPECTIVES: SYSTEMS & CLINICAL

DR. KEVIN HUCKSHORN

DR. JANICE LEBEL

NEXT STEPS

PHYSICALLY SECURE RECOVERY RESIDENCE PROJECT SCHEDULE



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