Analysis of Need: Residential Mental Health Beds

ACT 26, SECTION 2 (2019) REPORT TO THE VERMONT STATE LEGISLATURE

Agency of Human Services

DEPARTMENT OF MENTAL HEALTH | WWW.MENTALHEALTH.VERMONT.GOV

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Legislative Requirement

This report fulfills the requirements of Act 26, Section 2 of the 2019 legislative session.

Sec. 2. REPORT; ANALYSIS OF RESIDENTIAL MENTAL HEALTH NEEDS

(a) The Department of Mental Health shall evaluate and determine the mental health bed needs for residential programs across the State by geographic area and provider type, including long-term residences (group homes), intensive residential recovery facilities, and secure residential recovery facilities. This evaluation shall include a review of needs in rural locations, current and historic occupancy rates, an analysis of admission and referral data, and an assessment of barriers to access for individuals requiring residential services. The evaluation shall include consultation with providers and with past or present program participants or individuals in need of residential programs, or both.

(b) On or before December 15, 2019, the Department shall submit a report to the House Committees on Appropriations and on Health Care and to the Senate Committees on Appropriations and on Health and Welfare containing its findings and recommendations related to the analysis required pursuant to subsection (a) of this section.

Section 1: Overview of the Current System

This report presents information and analysis of residential settings serving individuals with mental health treatment needs in Vermont. The report gives an overview of each type of residential setting and describes the categories of analysis required by the legislation. This report does not include an overview or discussion of non-residential individual living arrangements such as supportive housing, which include provision of mental health treatment services in tandem with individual housing vouchers that allow a person to live in their own apartment in the community.

Adult Residential Settings

GROUP HOMES

19 HOMES 151 BEDS

Group homes are living arrangements for three or more people. Group residences are owned and/or staffed full-time by employees of a provider agency and the provider agency is responsible for management of group home resources primarily for Vermonters residing within their catchment area.

PURPOSE

These arrangements are designed to provide individualized, recovery-oriented treatment plan services in either transitional or longer-term residential rehabilitation settings.

REQUIREMENTS

Group Living arrangements are licensed facilities and individuals are afforded resident rights and protections before transitioning to more independent living arrangements in accordance with their treatment plan.

INDIVIDUALS SERVED

Group Homes are available to individuals enrolled in the Community Rehabilitation and Treatment (CRT) program of a Designated Agency on both a voluntary and involuntary[1] basis. Referrals to the group homes are decided by the Designed Agency's CRT program with regards to the current milieu and level of care appropriateness.

Individuals served in Group Homes require more intensive treatment than those living independently in the community. Services and supports include skill-based training to increase independence in the community; activities of daily living support such as meal preparation, grocery shopping and housekeeping; and treatment supports such as medication management and supportive counseling for appropriate socialization.

STAFF SECURE: INTENSIVE RECOVERY RESIDENCES (IRR)

6 RESIDENCES, 47 BEDS

This residential treatment setting consists of specialized group arrangements for three or more people and are staffed full-time by employees of a provider agency at a higher staff to resident ratio than found in group homes. This level of care includes the peer-run Soteria program.

PURPOSE

Recovery-oriented and treatment-focused programs for individuals frequently stepping down from hospital level of care with an anticipated length of stay between 6 and 18 months.

REQUIREMENTS

IRR arrangements are licensed facilities and individuals are afforded resident rights and protections before transitioning to more independent living arrangements in accordance with

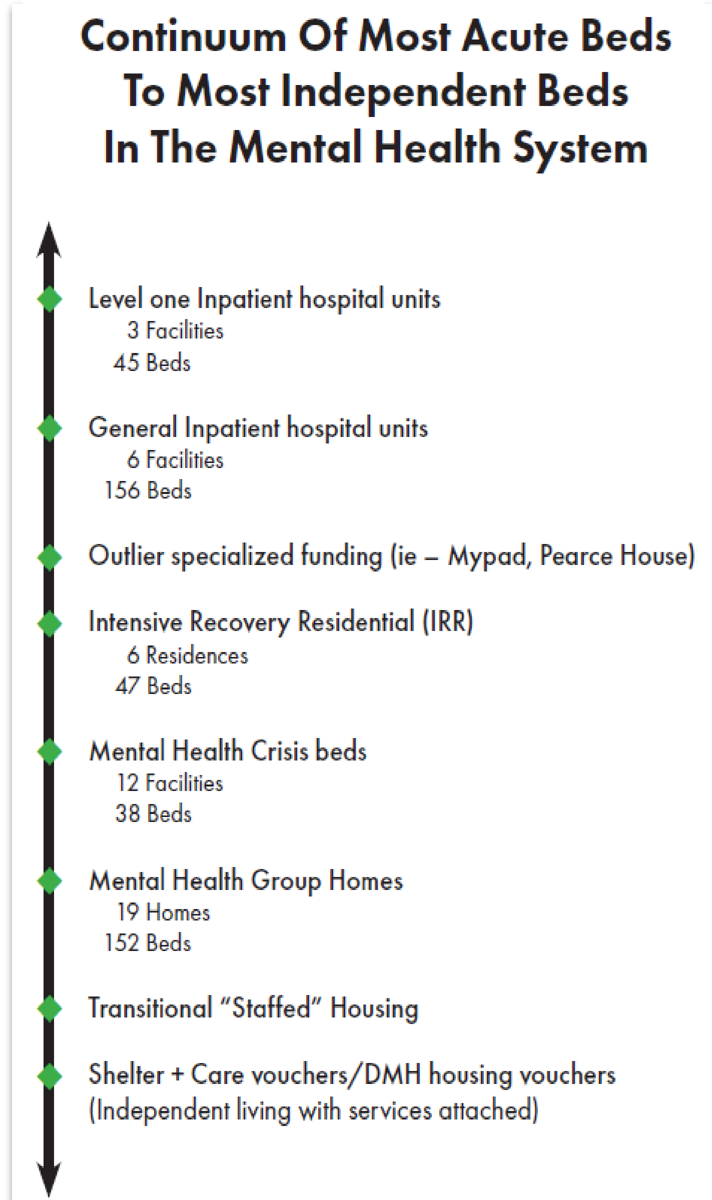
[1] Individuals on an "Order of Non-Hospitalization" have an involuntary status.

their treatment plan. IRRs are a statewide resource, regardless of what catchment area a person may have lived in prior to residing in the IRR.

INDIVIDUALS SERVED Eligibility thresholds for entrance to these transitional support and treatment programs anticipate individuals enrolled in CRT who continue to require ongoing supervision by skilled mental health staff and in an environment focused on safety and further harm reduction and mitigation work as part of aftercare in the community and access to more permanent, stable living options. These individuals are primarily served with an involuntary status.

Referrals to the IRRs are made through the DMH Adult Care Management Team based on the clinical readiness and acuity of the individual. The referrals are managed by this team because of their centralized view and coordinating role in managing this state-wide resource, their role in determining readiness for admission to an IRR from inpatient settings and their knowledge of the history of an individual's previous placements.

Figure 1: Continuum of Bed Care



PHYSICALLY SECURE RECOVERY RESIDENCE (MIDDLESEX)

1 FACILITY, 7 BEDS

This residential treatment setting has the same clinical characteristics as an Intensive Recovery Residence except that it is physically secure as well as staff secure. This facility, in contrast to other Intensive Recovery Residences, is surrounded by a 14- foot fence that is climb resistant. All the exterior doors are locked, and the entrance to the residence has two looked doors with a sally port between them to help ensure that residents are unable to leave without staff accompanying them.

PURPOSE

The Middlesex Therapeutic Community Residence (MTCR), was designed to be a temporary facility, using Federal Emergency Management (FEMA) funds until a long-term replacement could be obtained and/or built. The seven-bed secure residential program, temporarily sited in Middlesex, was created from Act 79 in 2012. The intent of the legislature in creating MTCR was to create a step-down facility for those who were no longer in need of inpatient care but continued to need intensive services involuntarily in a secure setting.

REQUIREMENTS

The MTCR is licensed as a Therapeutic Community Residence and individuals are afforded resident rights and protections before transitioning to more independent living arrangements in accordance with their treatment plan. MTCR is the only physically secure residential recovery facility in the State of Vermont and is therefore a statewide resource, regardless of an individual's originating catchment area.

INDIVIDUALS SERVED

In order to be placed at MTCR, an individual needs to be in the care and custody of the DMH Commissioner on an Order of Non- Hospitalization (ONH). While many individuals receive services in the community under an ONH, in order to be placed at MTCR, a judge needs to specifically find that the clinically appropriate treatment for the patient's condition can only be provided safely in a secure residential recovery facility.

Referrals to MTCR are managed by the Adult Care Management team in the same manner as the referrals to IRRs with a lens toward an individual's needs for a secure residence.

EXPANSION OF PHYSICALLY SECURE

Funds to support the planning and development of a larger, permanent facility were included in the FY20 Capital Bill of the Vermont Legislature. This development is a priority for AHS and a better permanent facility design and footprint can be created in a next generation secure residential facility.

A state run physically secure 16-bed residential facility with capacity to perform Emergency Involuntary Procedures (EIP's) will provide critical capacity within the mental health system of care and contribute to reducing barriers to discharge from Level 1 inpatient beds across the state. Added benefits of the proposed 16-bed physically secure residential include building from the existing clinical and staffing assets of the current secure residential facility in Middlesex. Maintaining staff familiar with the residents and operations, will afford better continuity for programming and will build on existing capacity and clinical expertise. From an operational and staffing level, a centralized, 16-bed facility leverages economies of scale as well.

Section 2: A Review of Needs in Rural Locations

Figure 2: DMH Residential Bed Locations 2020

Individuals served in residential settings

Below is a count of individuals served in residential settings and their hometowns. Pathways is a Specialized Services Agency and does not operate any group homes. Rutland County Mental Health and Northeast Kingdom Human Services do not have group home beds. More analysis will need to be completed to determine if IRR usage is impacted by the fact that a county does not have any group home capacity.

Figure 3: Individuals in Residential Settings by County

Individuals Served in Residential Settings By County/Designated Agency					
County of Origin/Designated Agency	CRT Clients Served	Individuals in Intensive Recovery Residential	Percent in Intensive Recovery Residential	Individuals in Group Homes	Percent in Group Home
Addison	175	1	0.6	15	8.6
Franklin/Grand Isle	225	1	0.4	11	4.9
Chittenden	632	9	1.4	58	9.2
Lamoille	137	0	0	23	16.8
Windham/Windsor	397	17	4.3	13	4.5
Caledonia/Orleans/Essex	241	1	0.4	0	0
Orange	180	2	1.1	4	2.2
Rutland	290	3	1.0	0	0
Bennington	156	1	0.6	6	3.8
Washington	335	6	1.8	16	4.8
Pathways (Statewide)	47	4	8.5	0	0
Total	**2815**	**45/54***	**1.6%**	**146/151***	**5.2%**

**9 beds are available at IRRs and 5 beds are available at group homes. Each of the IRR beds and Group Home beds have referrals and the admission process is continuously occurring. This number also includes the 7 beds at MTCR.*

CRT programs across the state serve approximately 2,815 adults with serious mental illness. Of those clients, only 1.6 %, or 45, of those individuals reside in an Intensive Recovery Residence (IRR) and 5.2%, or 146 individuals, reside in a group home within their county of origin. The above data shows that:

- Individuals served in the Windham/Windsor counties have the highest rate of IRR usage
- Lamoille County has the highest rate of individuals living in a group home

Figure 4, below, shows data that is a point in time count of individuals served by Intensive Recovery Residential programs, based on county of origin and reflects individual placement in each area of the state. Many individuals that need an IRR leave their County of origin to further their treatment.

DMH will need to explore the minimal use of IRRs from the counties that currently do not have group homes in their area. There was an initial belief that IRRs would be used more frequently by agencies that do not have group homes, however, this does not appear to be supported by the data.   On occasion, an individual served through an IRR will remain in that new area and will continue their treatment with the new Designated Agency.

Figure 4: County of Origin for the IRR Residents

County of Origin for Intensive Recovery Residents							
COUNTY OF ORIGIN	Second Spring North (Westford)	Second Spring South (Williamstown)	MTCR	Meadowview (Brattleboro)	Maplewood (Rutland)	Hilltop (Westminster)	Total
Chittenden	2	2	1			3	**8**
Addison	1						**1**
Franklin/ Grand Isle					1		**1**
Lamoille							**0**
Caledonia/ Orleans/ Essex			1				**1**
Washington		5	1				**6**
Windham/ Windsor	3	5	1	4	1	3	**17**
Orange		2					**2**
Rutland				1	2		**3**
Bennington			1				**1**
Other			2				**2**
TOTAL BEDS FILLED ON 11/18/19	**6**	**14**	**7**	**5**	**4**	**6**	**42**

The table below, Figure 5, illustrates that the highest number of individuals involuntarily hospitalized are from the Chittenden County area. There are several reasons for this higher number which includes population density, larger transient community, higher education institutions as well as a centralized transportation hub.

Figure 5: Involuntarily Held Individuals by Location

Involuntarily Held Individuals by Year and Originating Location				
Designated Agency	**involuntary hospitalized CY 2016**	**involuntary hospitalized CY 2017**	**involuntary hospitalized CY 2018**	**involuntary hospitalized CY 2019 (6 months)**
Orange County	13	14	8	5
Addison County	22	25	19	9
Chittenden County	135	135	139	92
Windsor/Windham County	68	69	60	38
Lamoille County	17	13	14	9
Franklin County	19	28	25	16
Northeast Kingdom Counties	46	41	34	20
Rutland County	104	88	81	45
Bennington County	17	25	17	6
Washington County	52	63	77	23
Pathways (Statewide)	3	21	15	2
Not from a specific area of the State	40	38	51	13
Total	**536**	**560**	**540**	**278**

Secure Residential Capacity

As of the date of this report, all 7 beds at MTCR are filled. At any given time, there are approximately 6-10 individuals who could be referred to a secure residential program that has the capacity to perform occasional EIPs. This cohort of individuals occupy significant inpatient hospital bed days and cannot be appropriately served at the Middlesex secure residential program (MTCR) due to current regulations for Therapeutic Community Residences, the facility's design, and the staffing pattern. **95% of referrals to the secure residential facility are from Level 1 units across the state.**

Since its opening, MTCR has been operating consistently at or near 100% capacity.

Analysis clearly affirms that the level of care s with high demand and currently unavailable in the mental health system of care is a Physically Secure Residential with the capacity to perform Emergency Involuntary Procedures (EIPs), thus supporting the State's intent to build a 16 bed physically secure residential with the capacity to perform EIP's. A temporary alternative facility to the physically secure Middlesex Residential facility is not determined to be needed at this time and DMH will continue to work with BGS on an expedited plan to build the new 16 bed physically secure residential replacement that will have the capacity to perform EIPs.

Section 3: Current and Historic Occupancy Rates

Group Homes

Group Home average occupancy for the first 6 months of FY20 is 91%. This number runs between 95-100% for most of the homes. The average is decreased to 91% due to one group home with 10 beds that runs at 70% due to the specialized population that it serves.

Individuals who are aging are more likely to stay in place due to the lack of access to appropriate nursing facility and other long-term setting options for individuals with mental health needs.

Community care homes (level 3) are also closing due to low reimbursement rates - these are privately owned residences that provide meals, med management, and psychosocial supports. Treatment is not typically provided within a Community Care Home. Mental Health treatment is provided by the local Designated Agency.

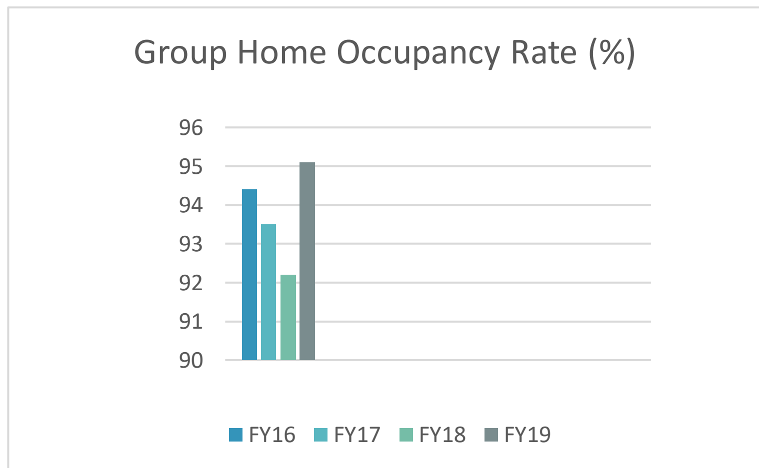


Figure 6: Group Home Occupancy Rates by Year

Intensive Recovery Residences-including the State's Physically Secure Recovery Residence (Middlesex)

INTENSIVE RECOVERY RESIDENCES CAPACITY

Figure 7 indicates that five of the six IRRs run between mid-80% to low 90% occupancy rate which is consistent with national standards of an 85-90% occupancy rate. One IRR, Maplewood

in Rutland, has consistently been well over 90% occupancy which indicates that Maplewood could benefit from expanding its number of available beds from four to six.

Figure 7: Occupancy for Intensive Recovery Residentials

Annual Occupancy for Intensive Recovery Residentials				
	CY 2016	CY 2017	CY 2018	CY 2019 (Partial)
Hilltop Recovery Residence	88%	85%	77%	84%
Maplewood Recovery Residence	94%	96%	95%	91%
Meadowview Recovery Residence	95%	97%	88%	97%
Soteria House	92%	86%	89%	88%
Second Spring - Westford Program	83%	95%	89%	91%
Second Spring – Williamstown Program	79%	84%	95%	88%

Individual Outliers/Enhanced Funding Plans

There are individuals who require unique living arrangements and an enhanced service delivery model in order to live safely and successfully in the community. The Department has seen an increased demand for this type of exceptional programming as shown in the chart below. An example of this type of programming are the MyPad and Pearce House models. During the 2019 legislative session, additional funds were appropriated to expand this type of programming. The number of outliers declined during 2017 due to two long-term hospitalizations and the death of an individual that had been served as an outlier for many years.

Figure 8: Outliers by Year

Outliers by Year			
2016	2017	2018	2019
13	10	15	18

Figure 8 shows the need for outlier funding, which allows for certain individuals to live in a setting outside of an inpatient psychiatric hospital, is on the rise. In the future this population may be served in a physically secure recovery residence with the capacity for emergency involuntary procedures.

SECTION 4: ANALYSIS OF ADMISSION AND REFERRAL DATA

As noted above, referrals to the Intensive Recovery Residences are made through the DMH Adult Care Management Team based on the clinical readiness and acuity of the individual. The referrals are managed by this team because of their centralized view and coordinating role in determining readiness for discharge from inpatient settings and the history of the individual's previous placements.

Figure 9: IRR Admissions from Involuntary Hospital Stay

Calendar Year	Individuals admitted to an IRR from an Involuntary Hospitalization stay
2016	6.1%
2017	7.1%
2018	5.9%
2019 (6 months)	3.9%

Figure 9 illustrates the percentage of individuals who are admitted to IRRs from involuntary hospitalization stays. DMH wanted to know the percentage of clients that went to IRR from an involuntary hospitalization compared to how many individuals were hospitalized involuntarily, which is noted in Figure 5. These figures also show a decline in both actual number of admissions as well as a decrease in the percentage of admissions from involuntary hospitalizations, while occupancy rates remained high. This indicates that this level of care either requires more capacity, or individuals are unable to transition to the next lower level of care which would be either group home living of independent living situations.

Figure 10: Admissions to IRR

Admissions to Intensive Recovery Residences by Year				
	CY 2016	CY 2017	CY 2018	CY 2019 (6-mo)
Maplewood	2	8	0	2
Meadowview	4	4	7	2
Hilltop	3	3	5	1
Second Spring (N&S)	16	20	13	5
MTCR	8	5	7	1
Total	**33**	**40**	**32**	**11**

REVIEW OF LEVEL OF CARE NEEDED UPON DISCHARGE FROM INPATIENT SETTINGS

In order to evaluate the Residential Bed needs for the mental health system of care it is critical to analyze the level of care needed upon discharge from hospitals providing mental health inpatient care. The access and referral pathways for the residential system of care is multi-faceted. Individuals may be accessing residential level of care directly from a community level of care or may be discharged from inpatient level of care and serve as a step-down program.

Across the state, hospital inpatient treatment teams were asked, "what does the involuntary client need upon discharge to be successful in the community?" Below is a 6-month (July – December 2019) review of the answers given by the inpatient treatment team.

Figure 11: Level of Care Needed Upon Discharge- July

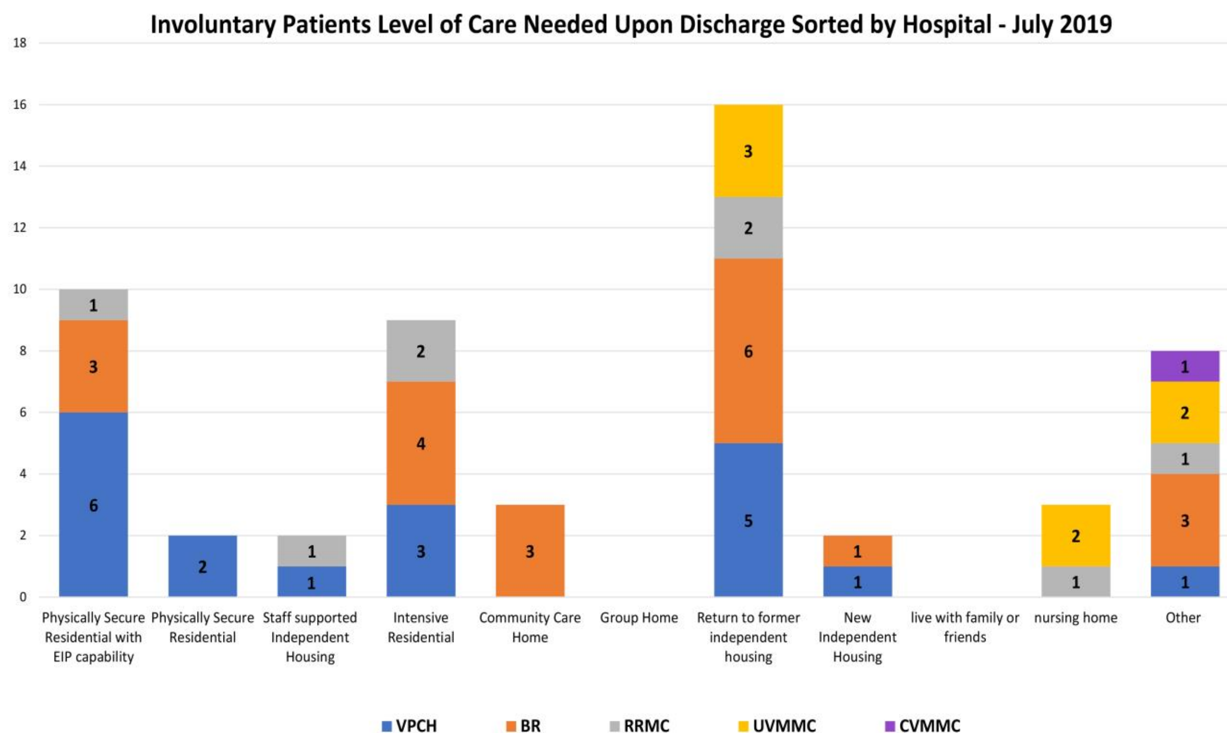


Figure 12: Level of Care Needed Upon Discharge- August

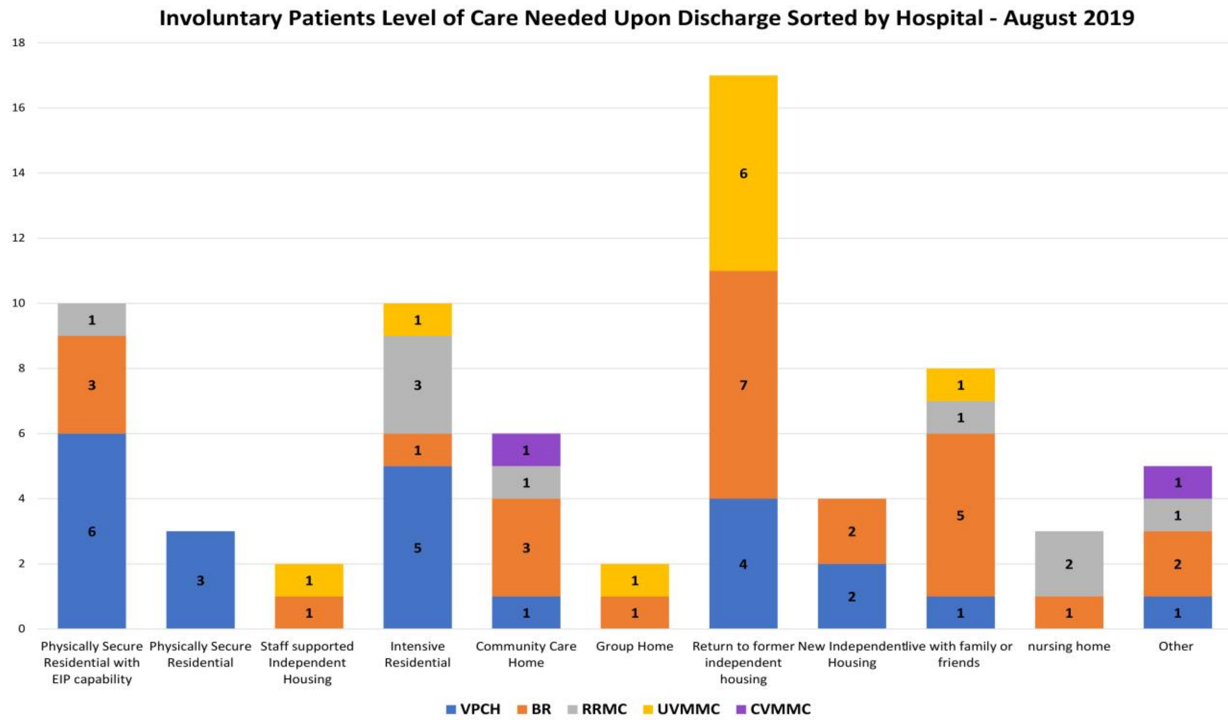


Figure 13: Level of Care Needed Upon Discharge- September

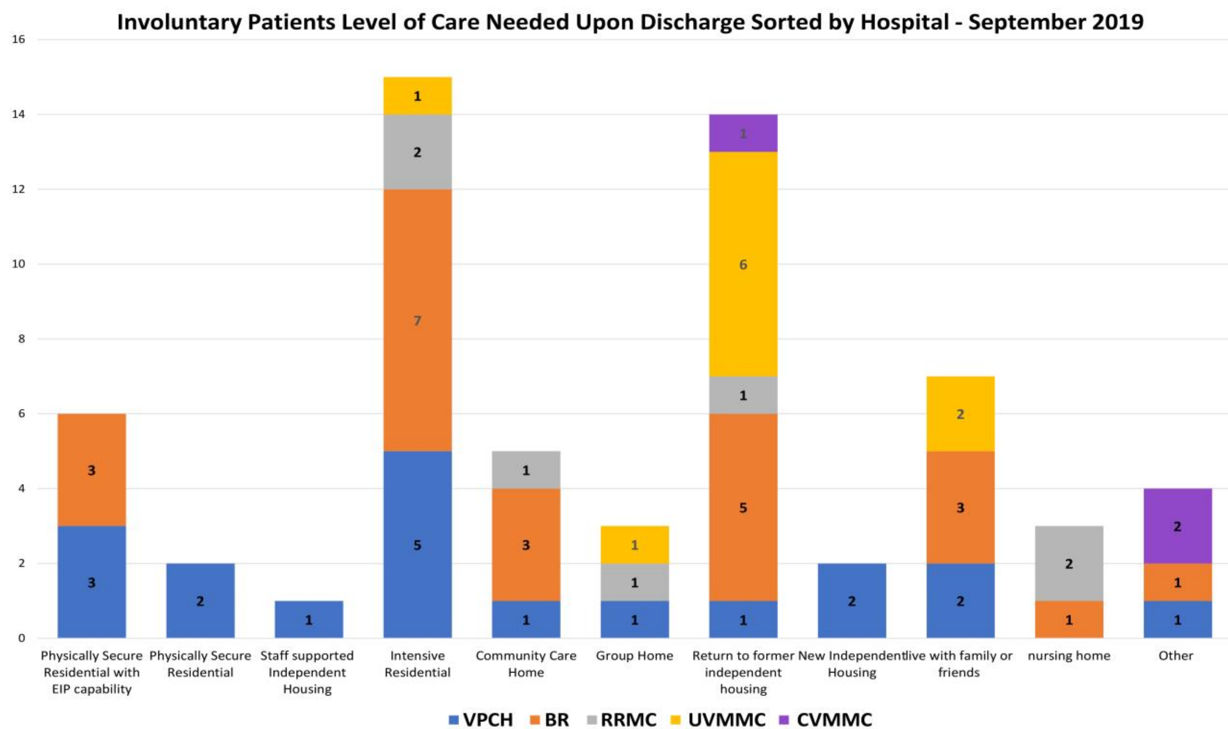


Figure 13: Level of Care Needed Upon Discharge- October

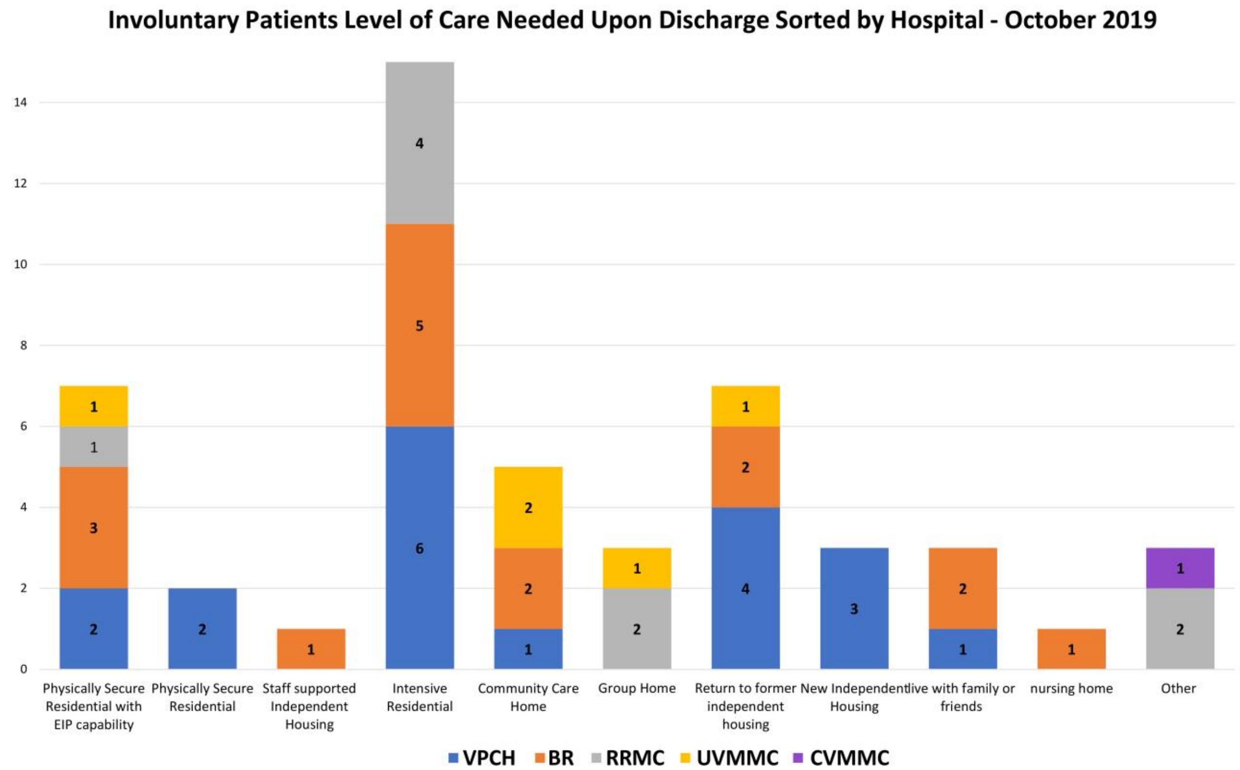


Figure 14: Level of Care Needed Upon Discharge- November

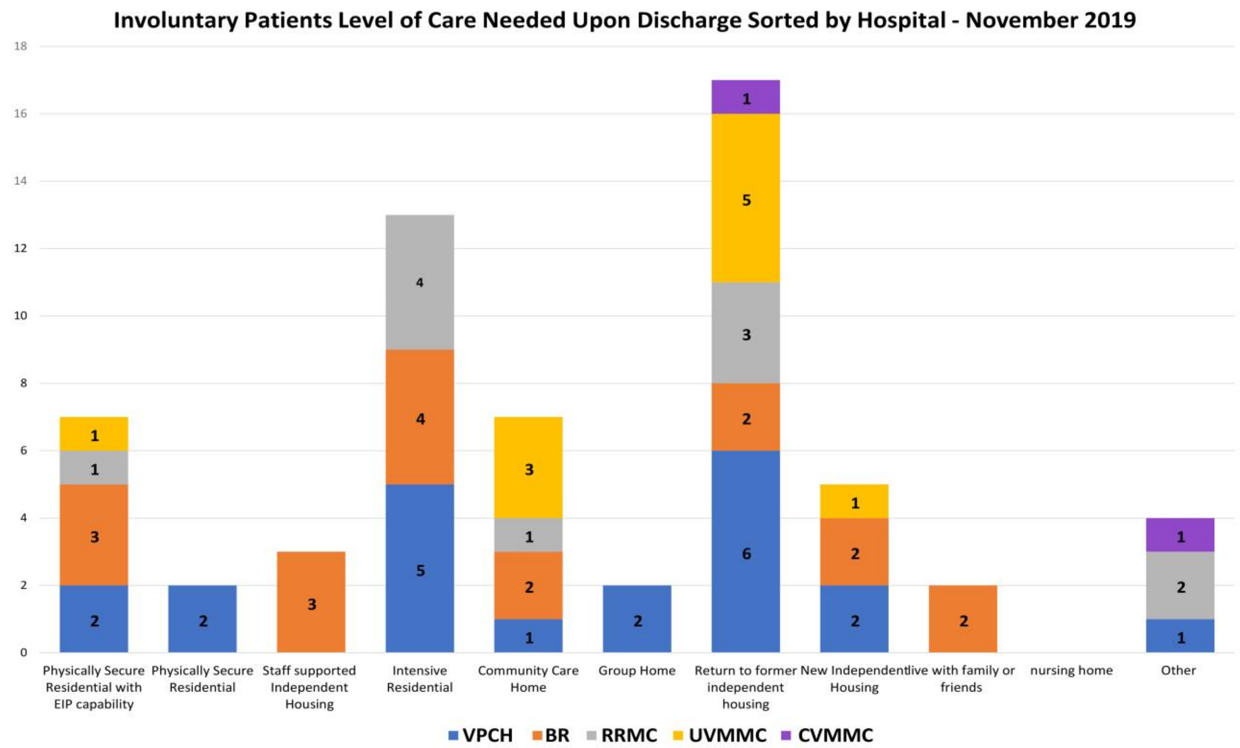
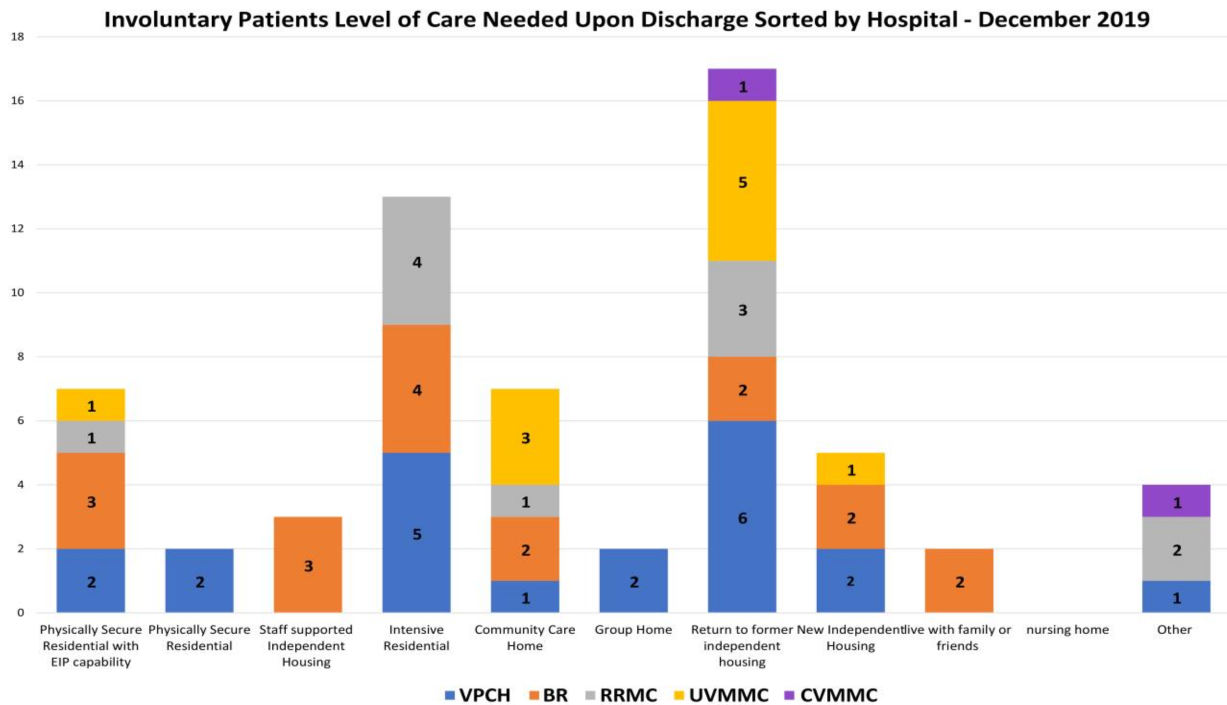


Figure 15: Level of Care Needed Upon Discharge- December



This is a point in time review of a 6-month period. As you will see, during the first month, "Group Home" was not identified as a discharge placement due to unavailability of the beds at the Designated Agency's group homes. During the second month, the inpatient treatment teams were asked, if there was a group home bed available, would that be a viable option for the individual?

Physically secure residential with EIP capabilities and Intensive Recovery Residence are consistently needed as a discharge option. If the IRRs were better able to transition people to more independent living situations, we would then see a decrease in their average lengths of stays and an increase in their ability to admit more individuals who could benefit from that level of care.

Return to former independent housing also stands out as consistently being one of the most common discharge dispositions. In other words, the treatment team is recommending that the individual return to their current independent living situation. With less than 7% of the state wide CRT population living in either a Group Home (5.4%) or an Intensive Recovery Residence (1.6%), it is not surprising that a significant cohort of involuntarily hospitalized people return to their prior living arrangement.

BARRIERS TO DISCHARGE: INTENSIVE RECOVERY RESIDENTIAL AND SECURE RESIDENTIAL

For individuals to have access to the appropriate level of care, barriers to discharge need to be explored. DMH needs to understand the barriers to discharge to continue to grow our community-based system of care. Through interviews with individuals residing in an IRR, IRR providers, as well as community providers, DMH received many repeated answers to this question, which are highlighted below.

Barriers to discharging from an Intensive Recovery Residential include:

- No Group Home/Community Care Home availability
- Lack of Nursing Home access
- First floor apartments in the community to accommodate mobility needs
- Client's choice is to remain in IRR, so difficult to do discharge planning as they feel safe and secure residing in an IRR.
- Concern from Designated Agency to provide appropriate level of care in the community. "Such a drop off from IRR living to community living".
- "We need something for the aging community. It's hard to discharge residents who need more nursing support. We need a program that is a combination IRR + nursing supports".
- Hiring staff is a challenge which can limit how many residents can live at an IRR.
- "The issue is a lack of community placement. We have enough IRRs when they are utilized correctly, but we need to educate the system of care that the first step should not be an IRR. Has the person used every option in the community before this referral is explored? Some DAs don't even have a group home, which is a disservice to the statewide system as people must move farther from home to get this service. People often feel abandoned by their DA teams when they are far from home and their support teams visit them irregularly."

These reported barriers are consistent with the data from Figures 9 and 10, which show a slow decline in admission rates to IRR over the past three years while occupancy rates remain relatively high.

Section 5: An Assessment of Barriers to Access for Individuals Requiring Residential Services

DMH Adult Care Management Team met with individuals living at Intensive Recovery Residences as well as providers at each of the homes. The meetings included consultation regarding the need of residential programs. The DMH Care Management Team visited 6 Intensive Recovery Residences. Out of the 42 individuals living at the Intensive Recovery Residentials, 24 agreed to meet to share their thoughts. Below are the results of the in-person meetings.

DMH assumed that individuals would prefer to live closer to their home community, however, when the residents of the 7 IRRs were asked about this, approximately 40% of the respondents to the survey indicated that they would have preferred an IRR closer to their home community and only 17% expressed a concern that they were not in their home community

Question	Responded	Yes	No	N/A	Notes/Quotes
Do you feel that you are in the right level of care now? If no, please explain.	24	62%	12%	26%	One resident expressed frustration with not being able to locate an available Community Care Home.
Were you concerned that the Intensive Recovery Residence that you are in may not be near where you had been living?	23	17%	78%	5%	
Were or are you concerned that you may be far from your family/friends/treatment team?	21	29%	37%	34%	One resident explained that his family lives in the Swanton area, and has to drive 2 ½ hours each way to visit him at inpatient or IRR setting, where he has mostly been over past several years. This resident noted the accumulated time, cost, and wear and tear on family vehicle in order for mother/family to maintain visits. This resident strongly advocated for similar programming closer to his family.
If an Intensive Recovery Residence was closer to your hometown, would	15	40%	47%	13%	

Question	Responded	Yes	No	N/A	Notes/Quotes
you have preferred that location?					
Do you feel that you are getting the time/skills you need to go to the next step from here?	20	95%	5%	*0*	
If a group home bed was available at your mental health agency, would you have preferred to have gone there instead of this Intensive Residential?	16	12%	69%	19%	
Where were you before here (hospital bed, another IRR, community, etc.)?	24	Inpatient Hospital 92%	Another IRR 4%	0	Community 4%
How long did you wait before moving here?	20				0-1 months: 6 (30%) 2 months: 5 (25%) 3-4 months: 2 (10%) >4 months: 1 (5%) Not sure / could not remember: 6 (30%)

Analysis

After review of data compiled for this analysis, there are a few counties that stand out from others in the state.

Chittenden County

Over the past 3+ years, 25% of involuntary admissions come from Chittenden County, approximately 20% of the beds at IRRs are filled with individuals from Chittenden County (this also represents about 1.4% of the Howard Center's entire CRT population) and over 30% of group homes beds are filled by Chittenden County residents.(This represents over 9% of the Howard Center's entire CRT population).

Rutland County

During the same time period, 15% of involuntary admissions came from Rutland County, 6% of IRR beds are filled with individuals from Rutland County (1% of Rutland Mental Health's entire CRT population), and 0% (Zero) group home beds are filled with Rutland County residents.

Looking at these regions, one can see that as a percentage of their CRT population the use of IRR beds is consistent, however the Howard Center's use of Group Homes is much higher than in Rutland (9% vs 0%). Further evaluation is indicated to determine if this is a result of purely a lack of a resource (no Group Homes in Rutland) or a different philosophy related to group home usage.

Windham/Winsor Counties

In the Windham/Windsor area (Health Care and Rehabilitative Services- HCRS) over 30% of the IRR beds are filled with individuals from this area (this represents over 4% of their entire CRT population) while just over 12% of group home beds are filled by individuals from HCRS (just over 4% of their entire CRT population). Further research will be required to determine if their high use of IRR (highest percentage of IRR bed use and highest percentage of CRT population in IRRs) beds is due to the fact that over 25% of the state's IRRs are in this area, or if it is due to a different philosophy related to IRR usage.

FINDINGS AND RECOMMENDATIONS

In order to allow individuals to live in the least restrictive environment, our analysis shows that our system needs a physically secure residential facility with the capacity for emergency involuntary procedures (EIP), some growth in IRRs and likely more expansion of group home capacity

Through a review of various residential settings within the mental health system, this report highlights opportunities to better understand where the current needs are. Through this report, there are various data points that show the occupancy rate for group homes are extremely high and unfortunately, are frequently not an option for individuals as a step down from the hospital.

The data consistently shows that over the last 6 months within inpatient psychiatric hospitals, there are between 7-10 individuals that need a physically secure residential setting with EIP capability. Active discharge planning is continuously explored for this cohort of individuals.

Residential treatment programs (IRRs and group homes) can be effective for people diagnosed with mental illness and allow them to reside in their community. While varying in style, residential psychiatric facilities share some core characteristics: individualized therapeutic treatment goals, supportive structures and routines, personal responsibility, contribution to the

community, peer support, and higher quality of life. These are settings that are critical for, as well as a need of, our system of care.

Even though further areas of research have been identified in this report, it is clear that the creation of a physically secure residence with EIP capability is indicated, as is some expansion of to the IRRs. It also is becoming clear that further investment in group homes and other independent living situations are indicated.