VERMONT2021

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 79

January 15, 2021

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 year 2020 introduced additional and novel challenges for advancing the mental health system of care.

With the onset of the Coronavirus (COVID-19) Pandemic in early 2020 Vermont's health care system has adapted to shifts in finances, service delivery guidelines and workforce capacity fluctuation as it became necessary to ensure a public health informed response for all Vermonters that included staying at home when possible and closure of non-essential businesses following the Governor's executive orders put in place March 2020.

DMH and mental health care providers worked tirelessly to deliver mental health services under rapidly changing state and federal guidance and evolving guidelines as all Vermonters learned more about the coronavirus. Providers across Vermont navigated new processes on uncertain financial footing to redesign service delivery and acquire essential resources like personal protective equipment to continue to provide services. Providers also managed staffing shortages as the workforce struggled to care for children unexpectedly home from school and shifting domestic and financial stressors while adapting to new workplace environments or transitions to remote work requirements. The inpatient and outpatient mental health provider systems adapted and continue to adapt to new physical distancing, interactions through necessary environmental modifications and the fundamental shifts in finance, service delivery and workforce challenges.

The COVID-19 pandemic has had a sustained impact on our health care system, and we may have yet to see the full impact in mental health care. In July of 2020, more than half of American adults reported that their mental health has been negatively impacted due to worry and stress over the coronavirus.[1] They also reported increased consumption of alcohol or substance misuse and worsening chronic conditions from the worry and stress related to coronavirus.

Under the guidance of cross-sectoral leaders who worked diligently with Vermont's public health experts, the state has had the lowest number of cases, infection rates and fatalities from coronavirus. We are aware mental health supports will be greatly needed due to the the impacts this pandemic has had on Vermonters mental health. We are well-poised to support these needs in our

[1] https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/ . accessed Sept 29, 2020

system of care due to diligent planning and additional grants that were obtained by DMH during this time. Vermont ranks first in the nation for access to mental health services, according to the annual State of Mental Health in America report, and we feel fortunate to continuing work to sustain our system of care.

CURRENT/ONGOING DEVELOPMENTS

SYSTEM STABILIZATION

With coronavirus financial relief packages enacted at the federal level, there was an influx of grant opportunities and other financial resources for expanding services and supports.

Federal funding made available to AHS was distributed in two phases, by an application process to Designated Agencies. Phase 1 financial relief strategies executed in March 2020 focused on stabilizing programming, services and supports within existing payment methods and funding available. This included:

- Maximizing the flexibility of the current Mental Health Case Rate model of which DA/SSA providers are paid monthly for case rate services on a prospective basis using an annual budget and adjusting the reconciliation process to reflect changes in practice and utilization due to COVID-19
- Private Non-Medical Institutions were provided an opportunity to submit a request for extraordinary financial relief (EFR) if their daily rate did not cover their costs. The state is providing flexibility to approve a request that considers the cost of underutilization due to extraordinary circumstances.
- Expedited payments for Electronic Health Record (EHR) implementation at Designated Agencies
- Adjusted minimum thresholds for Success Beyond Six services

Phase 2 included fiscal relief for:

- Lost revenue from Medicaid
- DA/SSA Hazard Pay– Face to Face Contact with Clients during COVID-19 Crisis
- Increased Funding for Shared Living Providers
- Overtime pay for transitioning to 12-hour shifts to preserve and stabilize our workforce with limited impact to safety or care delivery, at both VPCH and MTCR.
- Covering the increased cost of travel nurses
- Lodging healthcare workers who were working face to face with clients at VPCH
- Managing Inpatient Psychiatric Hospital Capacity for COVID-19 positive patients (Renovations and operating costs for 10 Beds at Windham Center)

GRANTS

The DMH and the Alcohol, Drug Abuse, and Prevention (ADAP) Division within the Vermont Department of Health (VDH) jointly applied for and were awarded a $2 million Substance Abuse and Mental Health Services Administration (SAMHSA) grant that will allow VT to address statewide mental health and substance use COVID-19 associated needs through implementation and expansion of services and supports, bolstering emergency services and mobile response. It will also increase access to care for healthcare workers with mental health support and treatment needs. This SAMHSA grant ends in December 2021.

Additionally, through the Governor's Emergency Declaration, Vermont also became eligible to apply for a FEMA Crisis Counseling Assistance and Training Program (CCP) grant in response to the COVID-19 pandemic. The Department of Mental Health through Vermont Emergency Management applied for and was awarded a first phase response FEMA grant called an Immediate Services Grant (ISP) principally focused on advancing both public health and mental health information and messaging to support populations immediately impacted by COVID-19. COVIDSupportVT was established in partnership with Vermont Care Partners to undertake this work. A second phase response FEMA grant called a Regular Services Grant (RSP) was subsequently applied for by DMH and awarded so work could continue until mid-March 2021. The second phase work also undertaken by COVIDSupportVT bought on three resource counselors who are working within Vermont 2-1-1 to respond to ongoing community education and individual support and referrals to callers impacted by COVID-19. Outreach to communities and populations (e.g., elderly, homeless, children and families, limited English proficient and migrant farm worker communities, healthcare and first responders) who may need informational and support materials, connections with mental health and substance use providers, or housing and food insecurity resource options continue under these combined grant awards of approximately $770,000.

Two Federal Grant initiatives reported in last year's Act 79 Report have continued through 2020 and focus on early childhood development and school age youth. One of the grants is 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). In partnership with the VDH

Maternal Child Health Division, effective screening, intervention and treatment of maternal depression and related behavioral disorders has been the focus of the 5-year, $627,525 federal cooperative agreement.

A second grant 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 (Advancing Wellness and Resiliency in Education) Vermont undertaken in partnership between AOE and DMH. The Child, Adolescent, and Family Unit of DMH is 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 continues through September 2023.

SERVICE CAPACITY

- Inpatient facilities were set up to safely accommodate COVID-19 positive people needing mental health care.
- Facilities redesigned intake protocols to align with federal guidance, including testing, physical distancing, and capacity restrictions
- Adapted to reduced census due to people staying home
- Success Beyond Six staff accompanied school staff on lunch deliveries to check in with students and parents
- People experiencing homelessness were offered temporary housing in motels, where mental health needs could be assessed and/or delivered
- Telehealth flexibilities allowed:
    - Expansion of services
    - Expansion of services that may be delivered via audio-only communication
    - Expansion of allowable patient locations for telehealth (e.g., allowing telehealth to be delivered in the patient's home)
    - Expansion of types of professionals who may conduct telehealth visits
    - Removal of regulatory barriers for remote prescribing of controlled substances
    - Flexibility in licensure requirements for the practice of telemedicine across state lines
    - Relaxation of federal privacy and confidentiality standards
    - Funding for purchase of telehealth equipment
- Workforce and Staffing

- Shift durations increased to reduce risk of exposure to staff, and maximize use of limited staff available
- Travel nurses were hired from out of state, and psychiatrists as well as other clinicians rotated to meet needs across the system

The community mental health system and its response continues to be bolstered to assist people living and receiving treatment in their communities, especially now with the ongoing impacts of COVID-19. Increasing capacity to deliver essential services and flexibility in how services may be delivered has been a priority in 2020. With DA workforce challenges this year, there have also been opportunities for peer programs to develop and expand their essential role in our system of care. Along with Emergency Services program response, peer community outreach, support, education, and advocacy have continued to be part of the overall system of capacity in meeting individual needs in 2020. The array of peer support programs conceptualized in Act 79 continues to develop and expand their essential role in our system of care.

10-YEAR VISION

In January 2020, DMH delivered to the Vermont State Legislature "Vision 2030: A 10-Year Plan for An Integrated and Holistic System of Care". This 10-Year Plan was the result of a public input process the Department of Mental Health (DMH) undertook in 2019. The Department began the work in June of that year, traveling to Rutland, Burlington, St. Johnsbury, Randolph, and Brattleboro for a total of 10 listening sessions. More than 300 people attended those sessions, where DMH staff facilitated small group discussions to get detailed input on what Vermont's future mental health system of care should be – what it should look like, how it should function, what the priorities should be and more. All of the notes from those listening sessions are organized by region can be found on the DMH website.

DMH followed the listening tour with a "Think Tank" comprised of people with lived experience, peer support specialists, providers, legislators, and others interested in the mental health system of care. To ensure the Think Tank would be representative of the broad range of stakeholders and yet be small enough to be able to work, DMH selected members via an application process. The application was emailed to contact lists the department had for Designated Agencies, hospitals, advocacy groups, standing committees and more. DMH also posted the application on its website, which was announced at each listening session. The Think Tank met five times over the fall and early winter of 2019 and drafted the 10-year plan for mental health. The plan includes

short term, mid-term, and long-term strategies for the system of care that support goals identified by Vermonters during the Listening Tour.

Following the plan submission to the legislature in January 2020, DMH was anticipating convening a Mental Health Integration Council in the fall of 2020, to begin the work of implementation. The demands of the COVID-19 pandemic on Vermont's health systems, however, has delayed that work. Work that was called for in the plan, however, has in many instances been advanced in direct response to the pandemic. Telehealth options, for example, are now available for anyone seeking mental health care, and are fully reimbursable. Much work has been undertaken to ensure children's mental health services are available even if children are not in a physical school building. DMH is creating an inventory of work that is moving ahead and continues its support in that work within the department staff capacity available. DMH has continued planning for the Council and looks forward to convening this work as soon as circumstances allow.

BEST PRACTICES

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 has been under Northern Vermont University's umbrella for a year and has experienced a smooth and successful transition. During this year, VCPI has quickly pivoted its approach to training, practice implementation, and technical assistance in the wake of COVID-19 by redesigning activities to be entirely remote. Some key VCPI activities that directly impacted the workforce and mental health communities are summarized below:

- Canvas LMS E-learning Platform launched in late FY19 has become a critical resource in response to the COVID-19 pandemic as practitioners and Designated Agency (DA) providers required remote working situations. The platform offers a digital space to share eLearning curriculum, on-demand training opportunities, learning community discussions, and collaborative work among participating DA practitioners and hospital sites. A public-facing COVID-19 resource library became available in the spring of 2020. Additionally, practitioner-only technical resources and specialized practice trainings for Vermont providers are available on a self-service basis and continue growing in number as they are produced and shared on the platform.

- Six Core Strategies © – VCPI managed the 6CS project for the sixth year to create a collaborative implementation process between participating hospitals and DMH with the shared goal of reducing emergency involuntary procedures (EIP) statewide. The in-person trainings and consultations were quickly transformed into online versions with three well-attended 2-day trainings for the Vermont designated hospitals, teleconference site visits for progress check-ins, and written plans for continued progress. The webinar videos and associated materials were recorded and are available to the participating hospital staff as an on-demand asynchronous learning opportunity on VCPI's Canvas LMS.
- Emergency Involuntary Procedures Committee (EIP) VCPI facilitated meetings for the legislatively mandated committee charged with reviewing all EIPs at designated hospitals and drafted the annual EIP report provided to the Commissioner.
- Children's Health Integration, Linkage, and Detection (CHILD) Grant – Programs and Practices For the third year, VCPI managed the training and workforce development efforts related to the adoption of evidence-based and promising practices for the integration of health and mental health services for children with or at risk of serious emotional disturbances and youth who are transitioning out of children's mental health services. This is a 5-year SAMHSA grant currently in its 3rd year with several practices being implemented simultaneously.
- DBT Virtual regional one-day trainings on Dialectical Behavior Therapy (DBT) were provided during the summer of 2020 with DA provider participants. This has been a highly successful collaborative effort to implement the DBT practice across the state for both adults and adolescent populations. Several strategies to support sustainability have been successfully implemented. Advanced training for DBT practitioners was held virtually by a DBT expert and trainer, Dr. Charles Swenson. In addition, VCPI collaborated with a Vermont DBT trainer, Sue Swindell, to curate virtual training materials and role-play videos into an online course for practitioners. The materials have been published to the VCPI LMS system and will be shared with practitioners during the early part of 2021.
- CT-R e-Learning Training Modules VCPI collaborated with DMH and experts from the Beck Institute for Cognitive Behavior Therapy to develop and launch a series of digital, eLearning modules which provide broad access to an overview of Recovery-Oriented Cognitive Therapy (CT-R) and its core components. The modules are very interactive, and the series includes an assessment of learning to assist practitioners in evaluating their newfound knowledge on CT-R best practices.

In addition to the above efforts, VCPI is also developing and supporting training in the following clinical areas:

- Core Orientation and Clinical Skills for Direct Care Staff;
- 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);
- Trauma Informed Care;
- Act 264 Overview;
- Children's Health Integration Linkage and Detection (CHILD) Grant;
- Antiracism Workgroup;
- Telehealth technology assistance;
- Collaborative documentation practice;
- Tobacco cessation efforts

PHYSICALLY SECURE RESIDENTIAL PROGRAM

Pursuant to Act 42 (2019) a total of $4,500,000 was allocated for exploration and planning activities with intent to replace the temporary secure facility in Middlesex. In FY 20, $3,000,000 was allocated for replacement, land acquisition, design, permitting, and associated construction documents. In FY 21, an additional $1,500,000 is allocated for ongoing costs associated with replacement planning. Working in conjunction with Buildings and General Services, replacement planning continues and reports as required have been provided to the legislature. Unavoidable delays in finalizing site selection and the onset of the COVID-19 pandemic slowed progress early in 2020. In May, design and planning work resumed on a new 16-bed physically secure residential program with mental health advocates joining with architects and DMH in further planning discussions. A first conceptual design emerged, and feedback sought from the advocate community and VPCH/MTCR, and Second Spring, which operates a 16-bed Intensive Recovery Residence. In July 2020, DMH held a public review of the Physically Secure Recovery Residence schematic drawing that was informed by current residents and staff of the secure residential program and external stakeholders including members from Vermont Psychiatric Survivors, National Alliance of the Mentally Ill, Legal Aid, members of the Adult State Program Standing Committee, and other providers and peer groups.

Ongoing development and feedback regarding facility features have continued into the fall of 2020. The former Woodside program site was identified as the primary site for new build construction. In September, the House Institutions Committee amended the FY21 Capital Bill, removing the land acquisition from existing language, and added site preparation and construction so that the allocated funding supported demolition of the Woodside building. The committee also separated the programmatic aspects of

treatment so those can be developed separately from site-specific (state ownership of land) elements of the project. Potential demolition of the Woodside facility may be possible sometime in early winter. Chairs of the Institutions committees would be notified of the intent to demolish of the Woodside site for authorization of the plan before moving forward.

BRATTLEBORO RETREAT INPATIENT BED EXPANSION

Act 190 (2018) initially 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. Renovation of space at the Brattleboro Retreat, formerly the Linden Lodge building, began in 2019 with intent to address ongoing wait times in local emergency departments for individuals in need of higher acuity inpatient psychiatric care. In 2020, COVID-19 significantly threatened the Retreat's ability to provide mental health care to Vermonters, and the Retreat's financial situation is tenuous due to low client census and strained staffing capacity, AHS is working collaboratively with the Retreat on a long-term plan to stabilize the Retreat as a more adaptable component in the evolving integrated system of care in Vermont.

The Brattleboro Retreat's Action Plan for Sustainability was presented to the Legislature in June of 2020 and recognized the need for nimble planning, adaptable work force and operations. The Action Plan outlined key areas of current and future service delivery reconfigured for the Retreat including expansion of residential programming for adults and youth as well community-based service expansion opportunities. The infusion of additional state resources, bringing project appropriation to $7.0 million, have assured continuation of construction of the 12 level-1 beds project at Brattleboro Retreat that is nearing completion and occupancy in early 2021 and ongoing facility to key populations served at the facility.

In July 2020 Act 140 (An act relating to miscellaneous health care provisions) was enacted and included provisions pertinent to the Brattleboro Retreat and expectations relevant to receiving additional state funds during the COVID-19 pandemic in Section 5 of the Act:

Act 140, 2020 - Sec. 5. BRATTLEBORO RETREAT; CONDITIONS OF STATE FUNDING

(a) Findings. In recognition of the significant need within Vermont's health care system for inpatient psychiatric capacity, the General Assembly has made significant investments in capital funds and in rate adjustments to assist the Brattleboro Retreat in its financial sustainability. The General Assembly has a significant interest in the quality of care provided at the Brattleboro Retreat, which provides 100 percent of the State's inpatient psychiatric care for children and youth, and more than half of the adult

inpatient care, of which approximately 50 percent is paid for with State funding.

(b) Conditions. As a condition of further State funding, the General Assembly requires that the following quality oversight measures be implemented by the Brattleboro Retreat under the oversight of the Department of Mental Health:

(1) allow the existing mental health patient representative under contract with the Department pursuant to 18 V.S.A. §7253(1)(J) to have full access to inpatient units to ensure that the mental health patient representative is available to individuals who are not in the custody of the Commissioner;

(2) in addition to existing policies regarding the provision of certificates of need for emergency involuntary procedures, provide to the Department deidentified certificates of need for emergency involuntary procedures used on individuals who are not in the custody of the Commissioner; and

(3) ensure that the mental health patient representative be a regular presenter at the Brattleboro Retreat's employee orientation programming.

(c)(1) Patient experience and quality of care. To support proactive, continuous quality and practice improvement and to ensure timely access to high-quality patient care, the Department and the Brattleboro Retreat shall:

(A) to the extent feasible by the Department, meet jointly each month with the mental health patient representative contracted pursuant to 18 V.S.A. § 7253(1)(J) and the mental health care ombudsman established pursuant to 18 V.S.A. § 7259 to review patient experiences of care; and

(B) identify clinical teams within the Department and the Brattleboro Retreat to meet monthly for discussions on quality issues, including service delivery, clinical practices, practice improvement and training, case review, admission and discharge coordination, and other patient care and safety topics.

On or before February 1, 2021, the Department will report to the House Committee on Health Care and to the Senate Committee on Health and Welfare regarding patient experiences and quality of care at the Brattleboro Retreat. As part of the reporting requirements of the Sustainability Report between the Agency of Human Services and the Brattleboro Retreat, AHS and the Brattleboro Retreat shall submit a final report to the Senate Committee on Health and Welfare and to the House Committee on Health Care describing the steps that the Brattleboro Retreat is taking to improve communication and relations with its employees, the Brattleboro Retreat's assessment of the effectiveness of those efforts, and how the Brattleboro Retreat plans to manage future communications and relations with its employees.

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 142 beds are used for **Non-Level 1 Involuntary** and **Voluntary** inpatient stays. As of this report, approximately 76% of these bed days were used for **Voluntary** stays.

Hospital	Location	Total Adult Inpatient Beds
Brattleboro Retreat	Brattleboro, VT	75
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[1]	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.*

Windham Center

In late March 2020, the Department of Mental Health (DMH) convened hospital leadership across the state who manage inpatient psychiatric hospitals and units to assess current risks and to make recommendations to ensure the health and safety of patients. This included the University of Vermont Medical Center, Rutland Regional Medical Center, Central Vermont Medical Center, the Vermont Psychiatric Care Hospital, the Brattleboro Retreat, the VA Hospital, and the Vermont Association of Hospitals and Health Systems.

What became clear in the meeting was the need for an alternative inpatient psychiatric facility that had the capacity to care for individuals with significant psychiatric needs who test positive for COVID-19 but have only mild symptoms. The facility could provide care for individuals who are already receiving treatment in inpatient settings and become COVID-19 positive or who may be seeking care/treatment and waiting in the emergency department while COVID-19 positive.

DMH fully supported the creation of an alternative unit and has worked since that initial meeting to create that capacity. DMH felt an alternative unit would serve three primary goals:

1. Create the capacity to provide treatment and care to COVID-19 positive patients who have mild COVID-19 symptoms but significant psychiatric needs. This includes those currently receiving inpatient care or those who may present in an emergency department.
2. Mitigate the spread of COVID-19 in psychiatric inpatient facilities to ensure the health and safety of patients receiving treatment as well as to preserve inpatient capacity.
3. Ensure individuals who require inpatient treatment that are under the care and custody of the Commissioner of Mental Health have access to timely and appropriate mental health care and treatment.

While early trend lines looked much better than they did at the initial meeting in late March, DMH determined it was critical that a plan to ensure that capacity to contain COVID-19 and the capacity to treat individuals with COVID-19 remain a priority.

It was recognized that general hospitals, for a variety of reasons, might not be able to safely absorb these patient's care needs. Also, VPCH and the Brattleboro Retreat had very limited medical capacity and could not easily contain an outbreak at one of their facilities. It was also understood that there could be individuals presenting in emergency departments who were COVID-19 positive and needed timely access to an appropriate inpatient psychiatric setting.

An initial plan to consider Woodside for this alternative unit presented many challenges and concerns, so DMH continued to explore other opportunities. One such opportunity was Springfield Hospital, who agreed to prepare their 10-bed psychiatric unit at the Windham Center to be used as this alternative unit for individuals who require inpatient psychiatric treatment and who are COVID-19 positive with mild symptoms. The unit at the Windham Center offered much needed capacity for the inpatient mental health system of care. The facility capacity would prioritize individuals who are on an involuntary status but also has the capacity to accept voluntary patients if needed.

In late Spring 2020, the Springfield Hospital entered into an agreement with DMH that would allow disaster relief funding to be used to renovate existing bed space, upgrade treatment service space, and add additional medical equipment at the Windham Center for the hospitalization and treatment of Covid-19 positive psychiatric inpatients identified within the state who could not be readily maintained elsewhere. Additionally, Springfield Hospital agreed to have up to two beds in its Emergency Department utilized for persons waiting for a Covid-19 test result or had a positive test result until disposition could be determined and/or the Windham Center was operational. While renovations were underway and prior to accepting new involuntary care patients, DMH worked closely with Windham Center Staff to re-train in areas of Advance Directive Search Protocol, Involuntary treatment and court-ordered medication requirements and documentation standards, and Emergency Involuntary Procedures Rules to assure staff preparedness for designation. Windham Center was temporarily redesignated by the DMH Commissioner as a Designated Hospital in to accept psychiatric patients for the duration of this needed capacity. The updated inpatient bed capacity came back on-line in mid-September 2020 to serve adults testing positive for the novel Coronavirus and requiring psychiatric inpatient level of care.

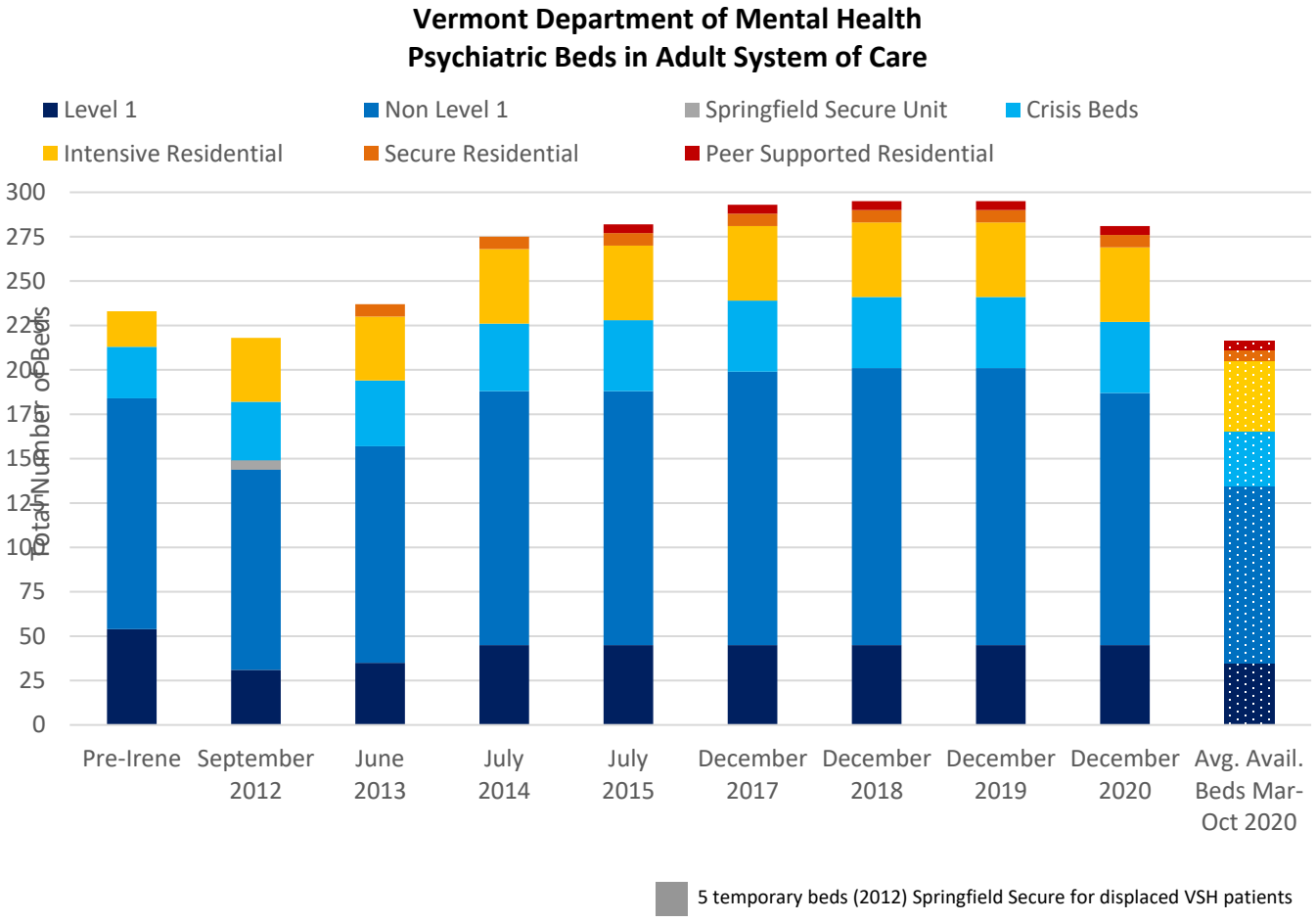
Central Vermont Medical Center

As well in April 2020, the development planning for additional psychiatric inpatient bed capacity on the CVMC campus was paused due to the impact of the COVID-19 pandemic. Given the number of COVID-19 positive cases rising in Vermont during this period, all available CVMC and UVM Health Network focus and attention shifted resources to the deployment of a COVID-19 response to the care and management of patients and vulnerable population groups that would be most susceptible to the COVID-19 virus.

Electronic Bed Board

The electronic bed board that is updated daily to track capacity and facilitate placement of patients needing hospitalization or other crisis services in the system continued to serve as a key tool in monitoring bed inpatient and outpatient bed capacity. Departmental leadership, care management staff, and community service providers have access the bedboard to determine potential bed capacity at the local level and resolve issues as quickly as possible for individuals who are waiting for an open bed. As inpatient and community bed capacity was impacted by COVID-19 bed closures, quarantine or isolation requirements, and lower than expected workforce staffing levels timely information to support movement in the system of care remained available through this information resource tool.

1: Psychiatric Beds in the System of Care



Although Vermont increased its inpatient bed capacity between August 2011 – March 2020, planned renovations underway for 12 new Level I inpatient beds at the Brattleboro Retreat in early 2020 were coupled with unforeseen impacts of the COVID-19 pandemic that occurred

beginning in March 2020 and extending through CY 2020. This confluence of factors resulted in a temporary loss of 14 adult beds in response to public health and environmental safety guidance for both inpatients and staff until renovations are completed and effects of the COVID-19 pandemic mitigated. This temporary bed loss is identified in Graph 1: Psychiatric Beds in the System of Care, December 2020 bar diagram.

In addition to this temporary loss of adult beds, the COVID-19 pandemic had a ripple effect across the adult inpatient system of care during this same period. An additional graphic display in Graph 1: Psychiatric Beds in the System of Care is provided displaying Average Available Beds March – October 2020. This bar graph reflects a system-wide impact across inpatient and community-based crisis beds and residential programs. In a report to the House Committee on Health Care, September 3, 2020, the DMH presented information on the current overall inpatient and crisis bed capacity in the mental health system of care, as well as facility-by-facility bed availability.

Current Overall Capacity in the System

Type of Bed	Total Beds	Occupied	Closed due to COVID	Open	Avg % Open	Notes
Adult Inpatient	187	108	52	27	14%	This total includes all adult inpatient at BR, VPCH, CVMC, RRMC, VA
Youth Inpatient	30	14	7	9	30%	All inpatient beds for youth are at the Brattleboro Retreat
Adult Crisis Beds	38	25	7	6	16%	
Youth Crisis Beds	18	8	8	2	11%	

Note: These numbers do not include the Windham Center (Level One COVID Positive Facility)

Current Adult Inpatient Capacity by Facility

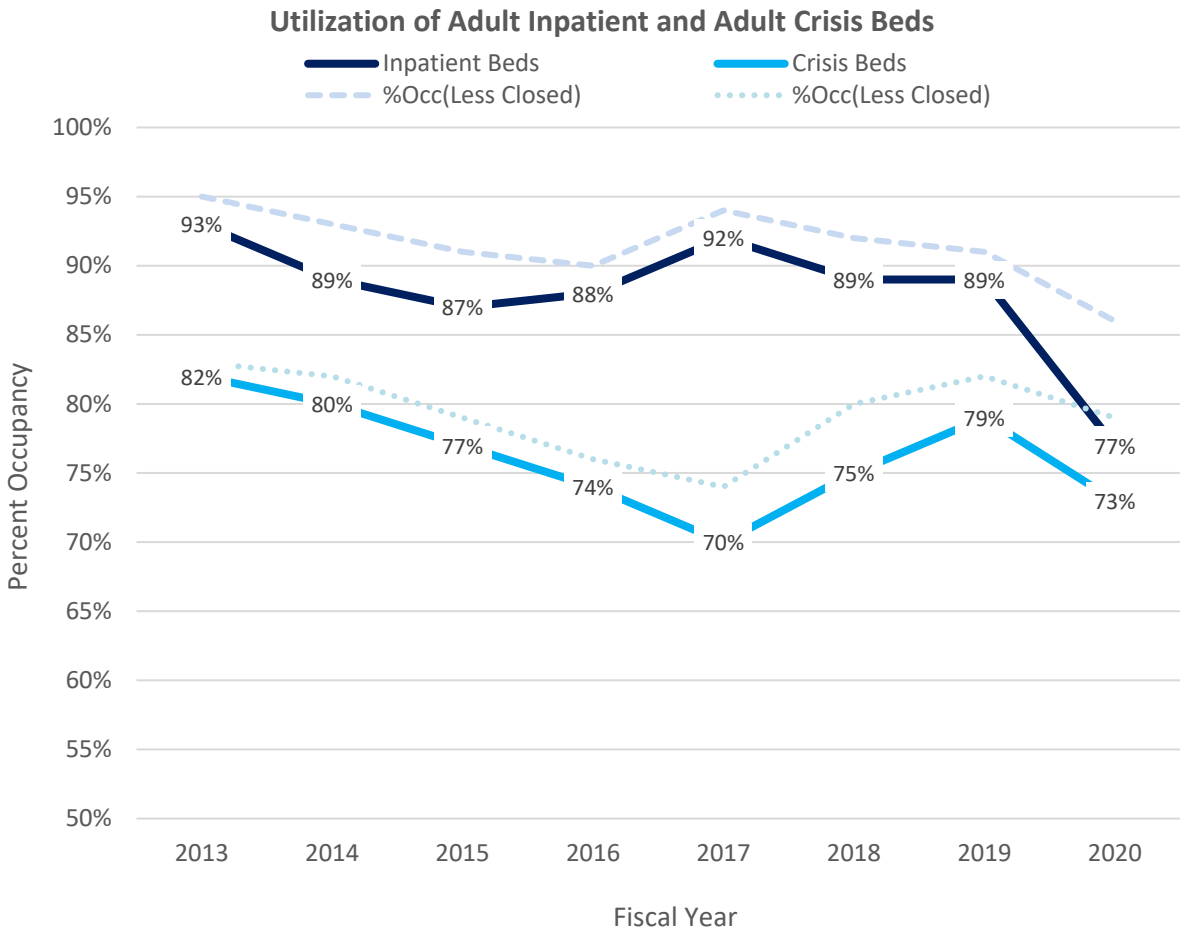
Facility	Total Beds	Occupied	Closed due to COVID	Open	Avg % Open	Notes
Brattleboro Retreat	75	41	22	10	13%	
Rutland Regional Medical Center	23	19	2	2	.08%	

VPCH	25	10	11 (MTCR) 4 due to acuity/staffing	0	0%	
CVMC	14	7	4	3	21%	
Veterans Administration	12	7	4	1	.08%	
UVM Medical Center	28	24	0	4	14%	

Of note during this period, is also the closed bed impacts. Windham Center's 10-bed temporary loss for renovations to a COVID-19 unit extended until mid-September 2020. The temporary relocation of MTCR residents to the Vermont Psychiatric Care Hospital became necessary to address staffing challenges during the early period of the Covid-19 pandemic in Vermont. Both VPCH and MTCR consolidated personnel at VPCH to maintain minimum staffing rations and address environmental and safety needs of patients, residents, and staff. Subsequently, the need to temporarily utilize the vacant MTCR facility to accommodate juveniles who had been housed at the Woodside facility, contributed to a 60% reduction in capacity for inpatient treatment from the end of March 2020 through mid-October 2020. Both the Brattleboro Retreat and the Central Vermont Medical Center bed closures represented a 29% temporary inpatient bed loss for both facilities during this time as well.

Adult and Youth crisis beds also saw an impact from the COVID-19 pandemic in their capacity to avoid unnecessary hospitalization or to receive individuals who may have been ready to step-down from higher levels of care, having only 16% and 11% respectively open bed capacity due to quarantine or isolation protocols at the time of referrals for transfer consideration. The Act 79 annual report for 2020 reveals additional likely data anomalies scattered throughout this calendar year.

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.

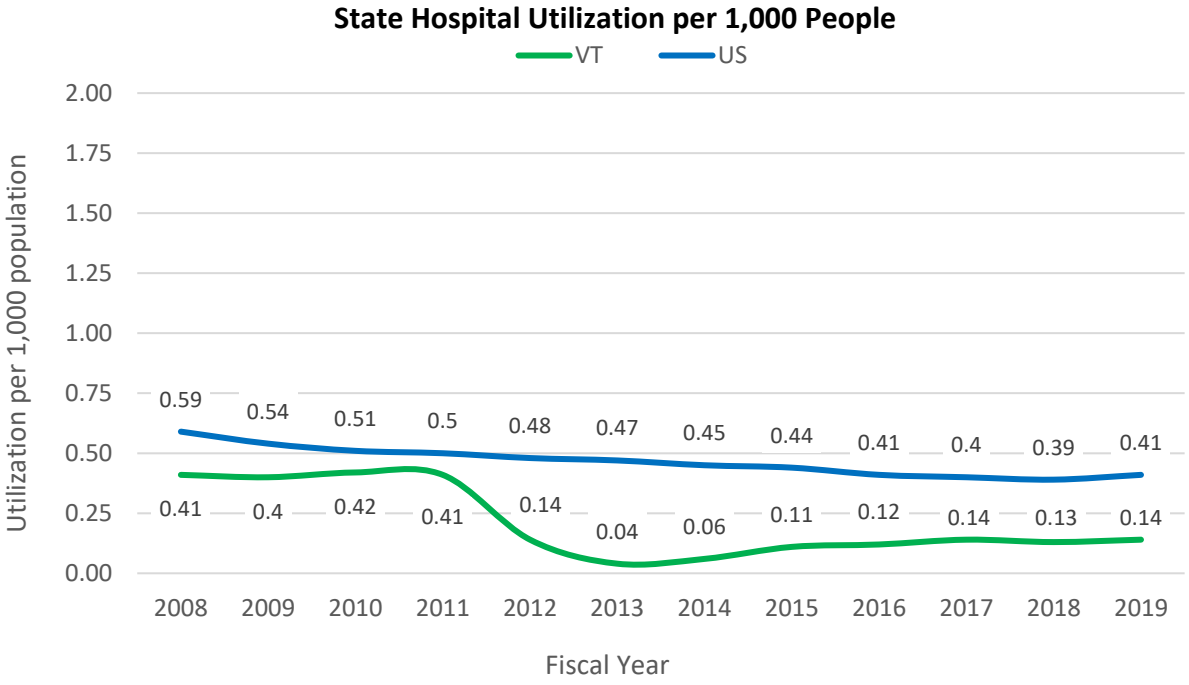
Occupancy of adult crisis beds has declined consistently since FY 2013 and utilization was further impacted by hospital and community provider risk management concerns in the wake of the Kuligoski Supreme Court decision (2016). A slow upward trend in crisis bed utilization was noted in both 2018 and 2019 and a somewhat flattened trend in inpatient bed utilization over the same period can be seen as well. While no correlation is implied, less utilization of

higher level of care options and increasing utilization in lower level of care settings, when clinically appropriate, is preferred. However, in CY 2020 both adult inpatient and crisis bed utilization precipitously dropped. Adult inpatient utilization declined by 12% while crisis bed utilization also decreased by 6%. As referenced earlier, the impacts of COVID-19 bed closures and a more public health informed admission process for referrals to these treatment settings do appear to have a stronger correlation to process changes that became the norm in 2020.

During FY 2020, mean days of involuntary inpatient lengths of stays returned to averages seen throughout FY 17 and 18. 30-day readmission rates crept up three percentage points (11%) closer to national averages (13%) in 2020. The 30-day readmission rates for in adult involuntary psychiatric stays in Vermont have been relatively stable between 8-10% in the preceding seven 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 2019 is the most recent data available.

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

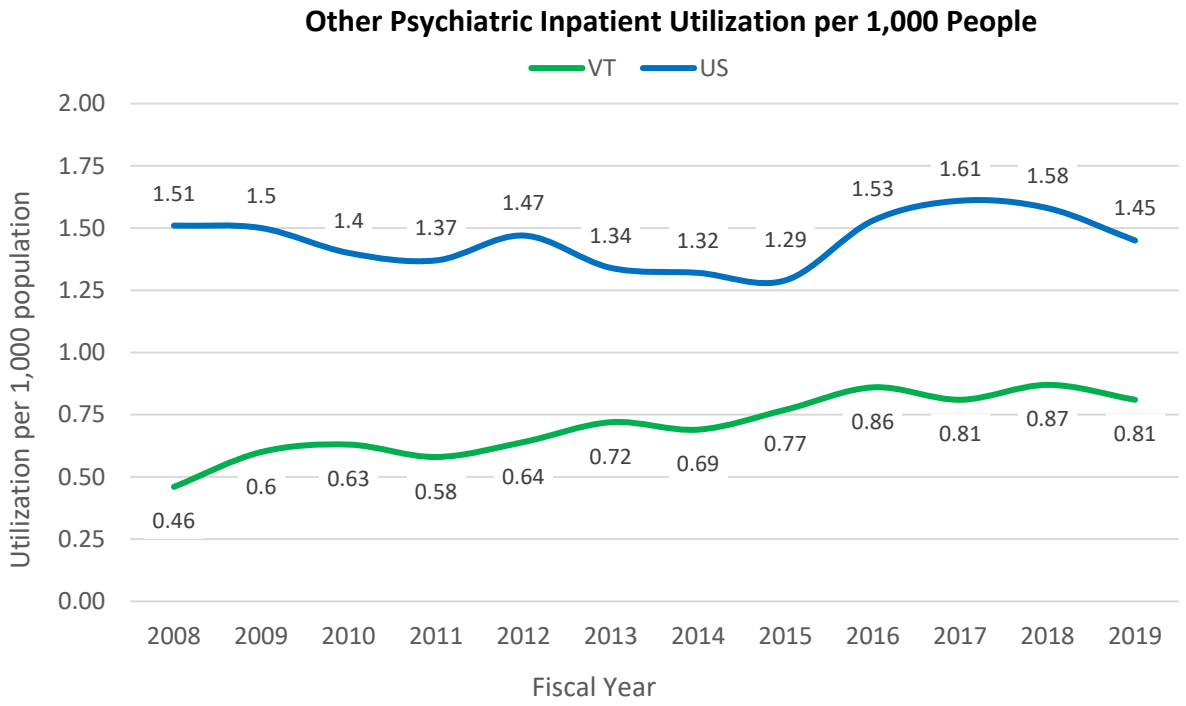


Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2019.

The national rate of state hospital utilization continues to remain below the national average each year. The sharp decline from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. Capacity development

continued through 2014. Vermont Psychiatric Care Hospital opened in FY 2015 adding 25 beds for inpatient care to the de-centralized inpatient treatment capacity post closer of the former VSH. The Vermont hospital utilization data remains relatively flat since 2015. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds has seen a slow declining trend since 2008.

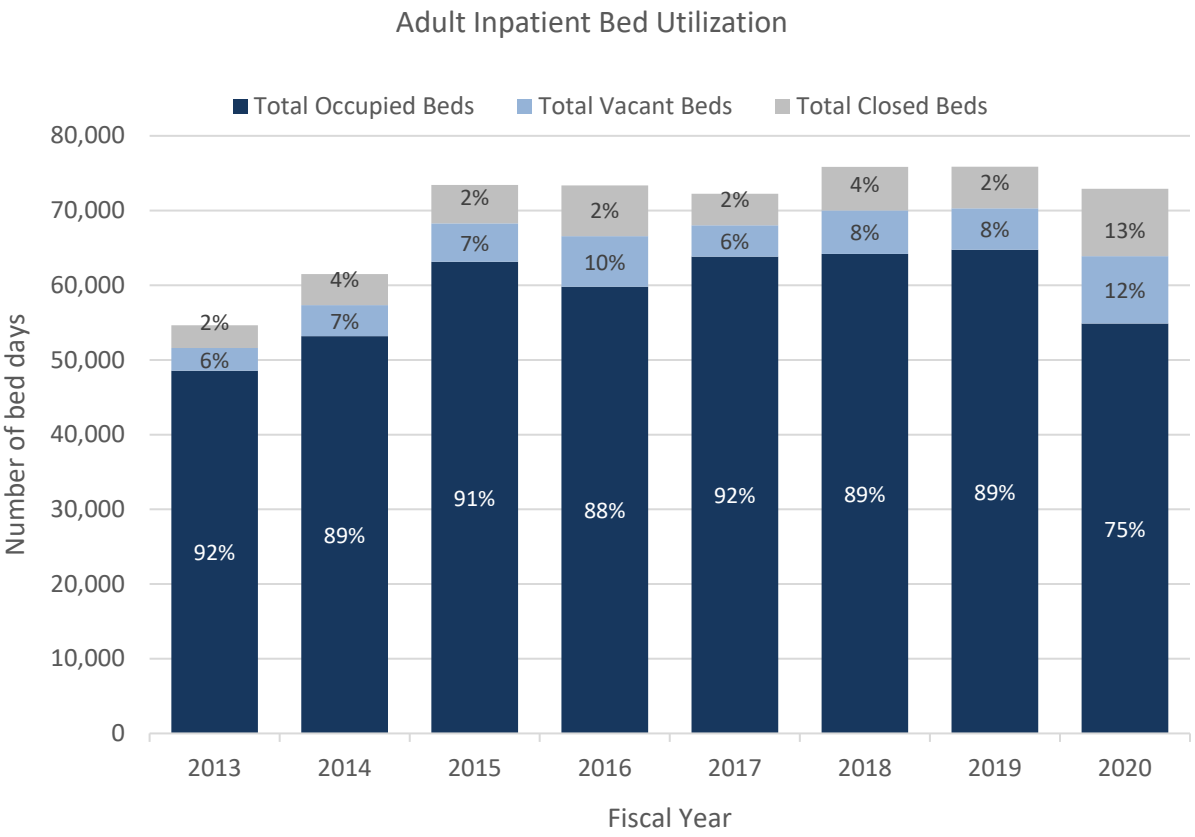
Chart 4: Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



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

Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in the chart above. Since 2008, the national rate of psychiatric hospital utilization had generally declined year-over year through 2015. Between 2016 and 2017, a bubble of increased utilization nationally began to occur that appear to correct course in 2018 and 2019 bringing utilization downward once again. Vermont has continued a slow upward trend that has been well below the national average and remains so as of this reporting period.

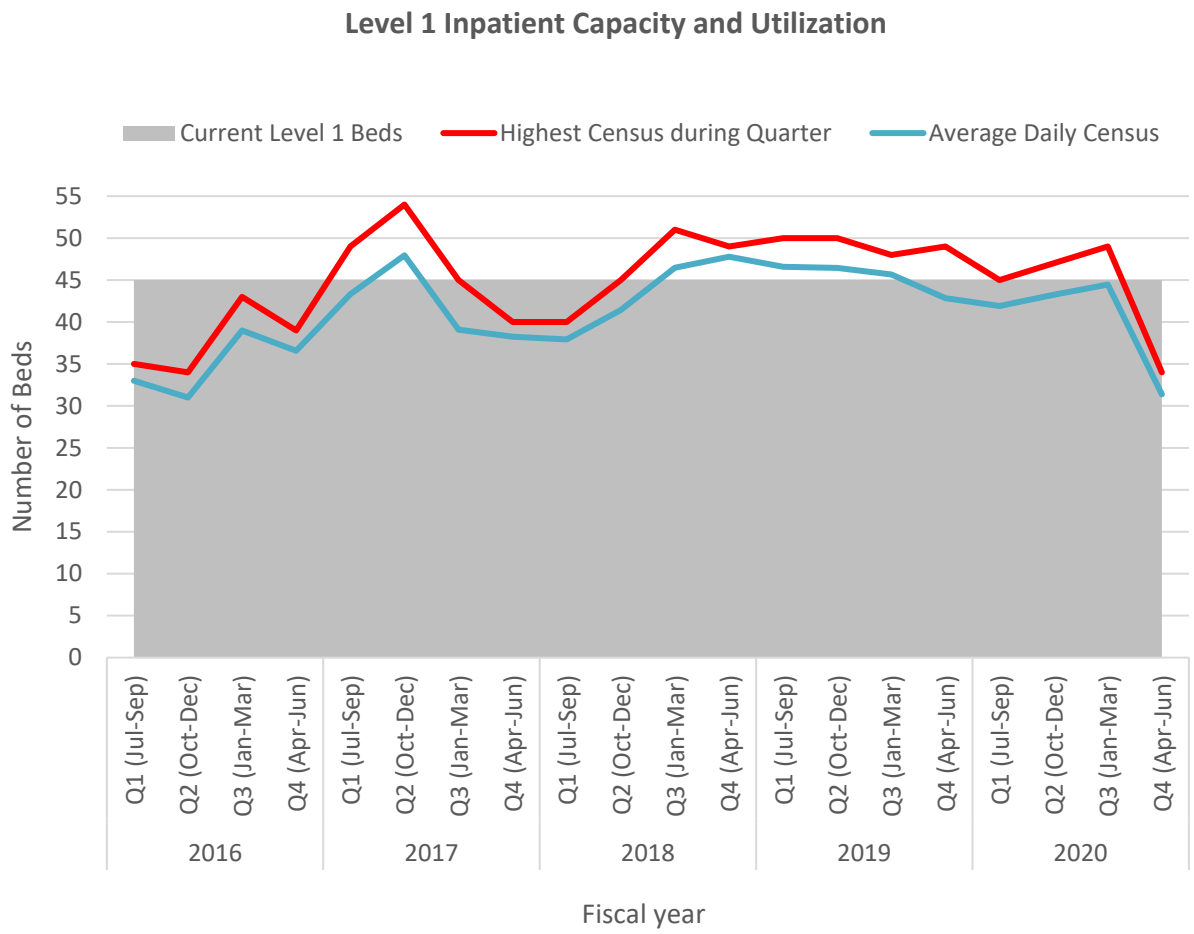
Chart 5: Adult Inpatient Utilization and Bed Closures



This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2019. The total bed day availability across the system has remained relatively constant in 2018 and 2019 with bed day utilization decreasing 14% in 2020. The impact of the COVID-19 pandemic has contributed to the 4% increase in bed vacancies and the 11% increase in beds closed for much of 2020. Over this eight-year period, 2020 has seen the lowest level of adult inpatient bed utilization.

LEVEL 1 AND NON-LEVEL 1 INVOLUNTARY INPATIENT CARE

Chart 6: Level 1 Inpatient Capacity and Utilization



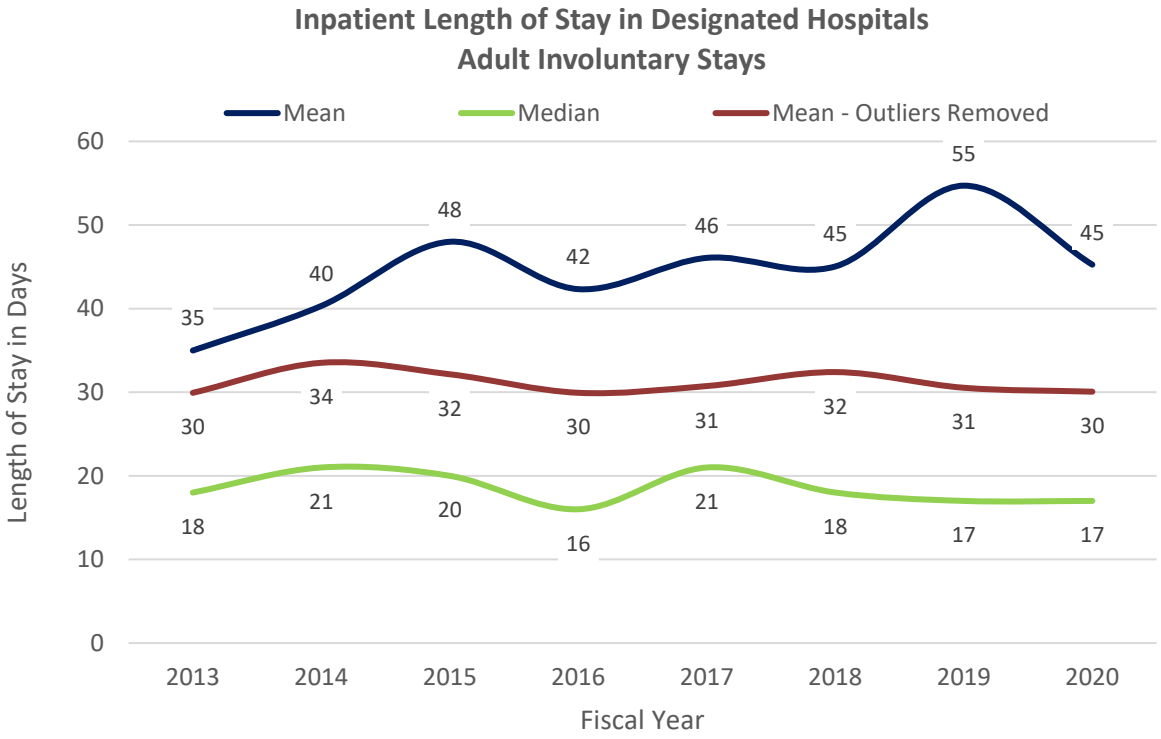
Level 1 patients require the highest level of care and services within the inpatient system. The chart above represents the average number of Level 1 patients receiving acute inpatient care in any hospital setting and the single combined one-day highest number each quarter. As a reminder, Level 1 involuntary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

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. While initially on track for continuation of a more stabilizing trend, the 3rd quarter of FY 2020 as seen in earlier graphs show a precipitous drop in Level 1 inpatient capacity and utilization. Again, the efforts to add additional bed capacity took some inpatient beds temporarily off-line for renovations as the same time that the COVID-19 pandemic began impacting Vermont.

Chart 7: Inpatient Length of Stay in Designated Hospitals

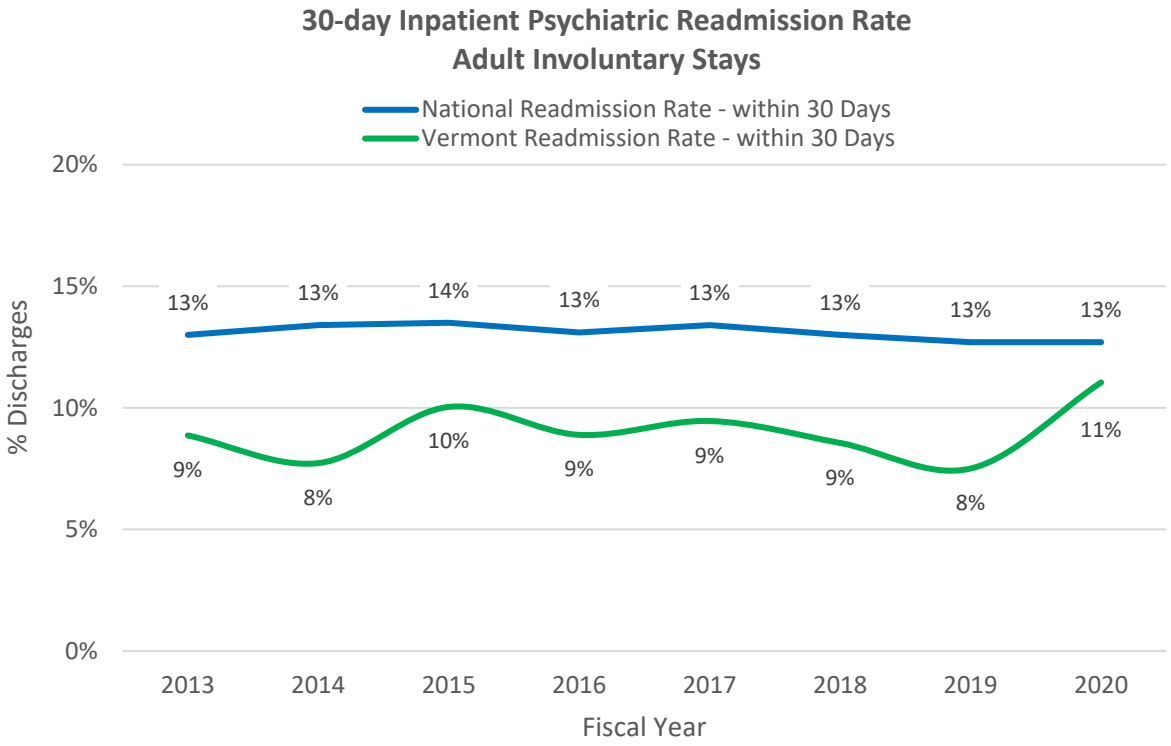


This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients from FY 2013 through FY 2020. A mean length of stay of 45 days in 2020 from a high of 55 days in 2019 is likely an artifact of the COVID-19 pandemic and a less reliable indicator of system trend in 2020 overall.

The 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 identical to 2019 and appears generally stable with caveat that COVID-19 impacts to bed capacity are a factor in this outcome. The same can be assumed in the median length of stay that is also identical to 2019. Maximizing effective use of inpatient hospitalization, availability of aftercare

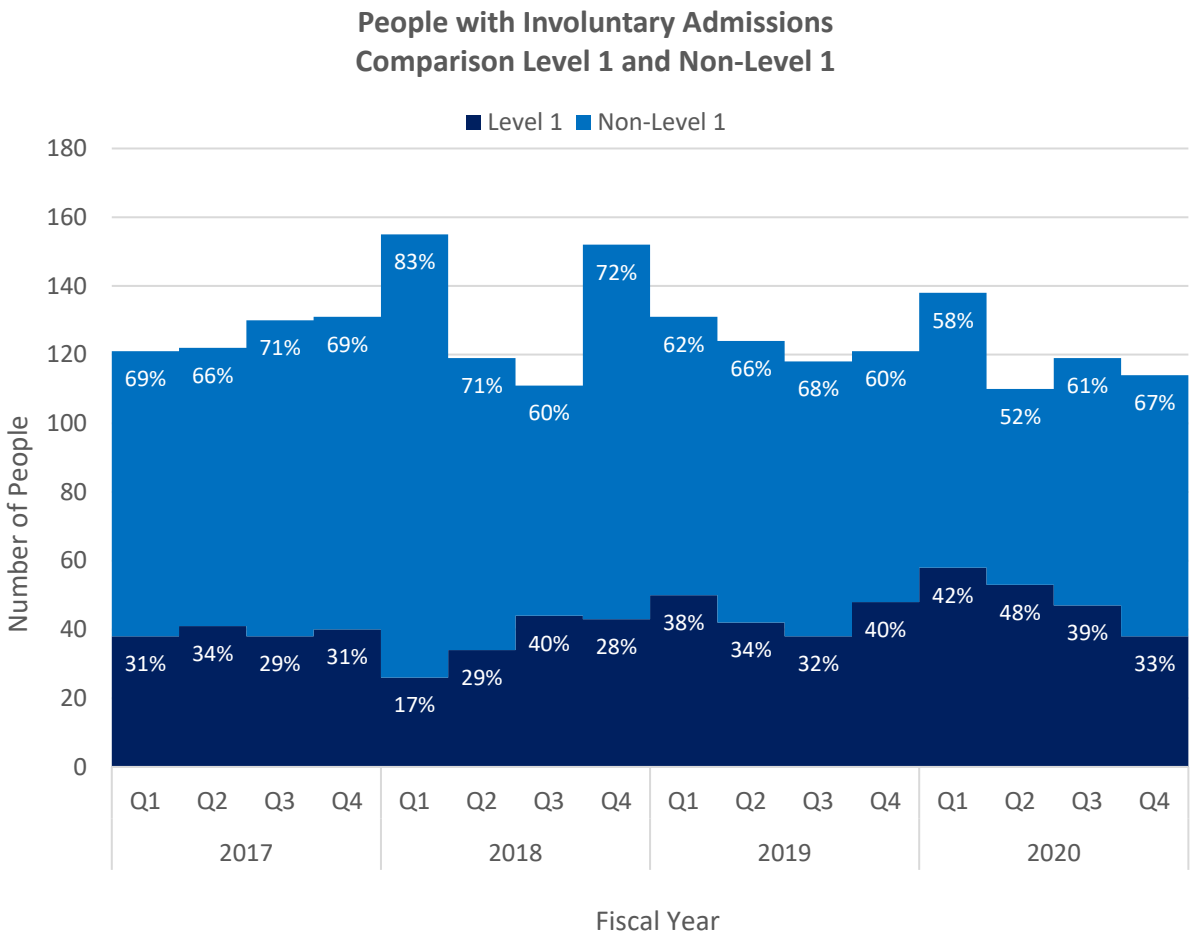
supports and treatment services, and community connection and resources post-discharge remain central to reducing length of stay.

Chart 8: Inpatient Readmissions in Designated Hospitals



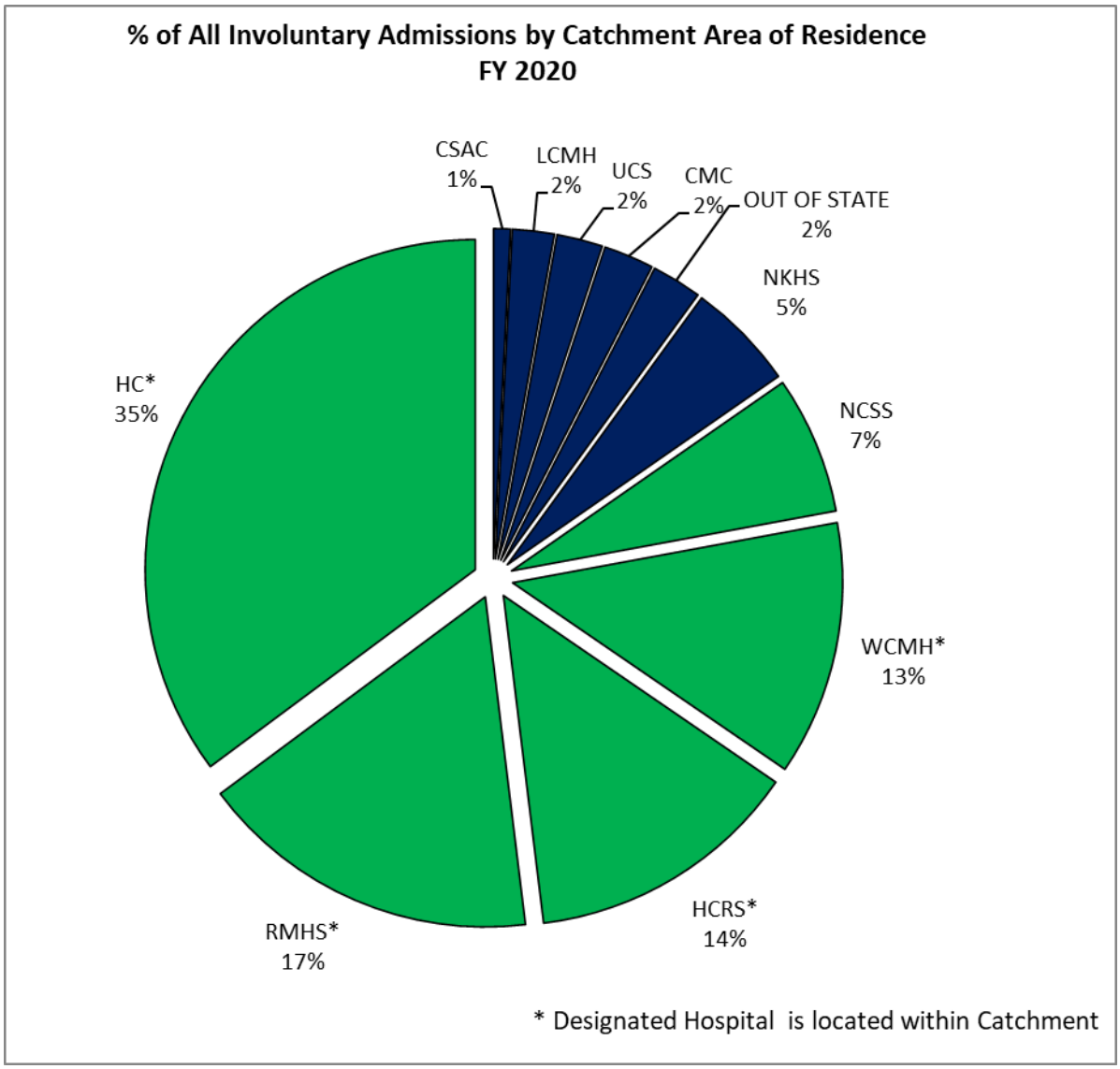
Readmission rates within 30 days of discharge were calculated and compared to national benchmarks. Most notable in 2020 is the readmission rate increase for Vermont. While only 3% increase, it brings Vermont closer to the national re-admission rate that remains level at 13% based on the 2018 National Outcome Measures (NOMS). The anomalies in Vermont's 2020 experience likely parallels other states experiences. The next update to the NOMS will shed better light on the actual COVID-19 pandemic impacts for the nation as a whole.

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



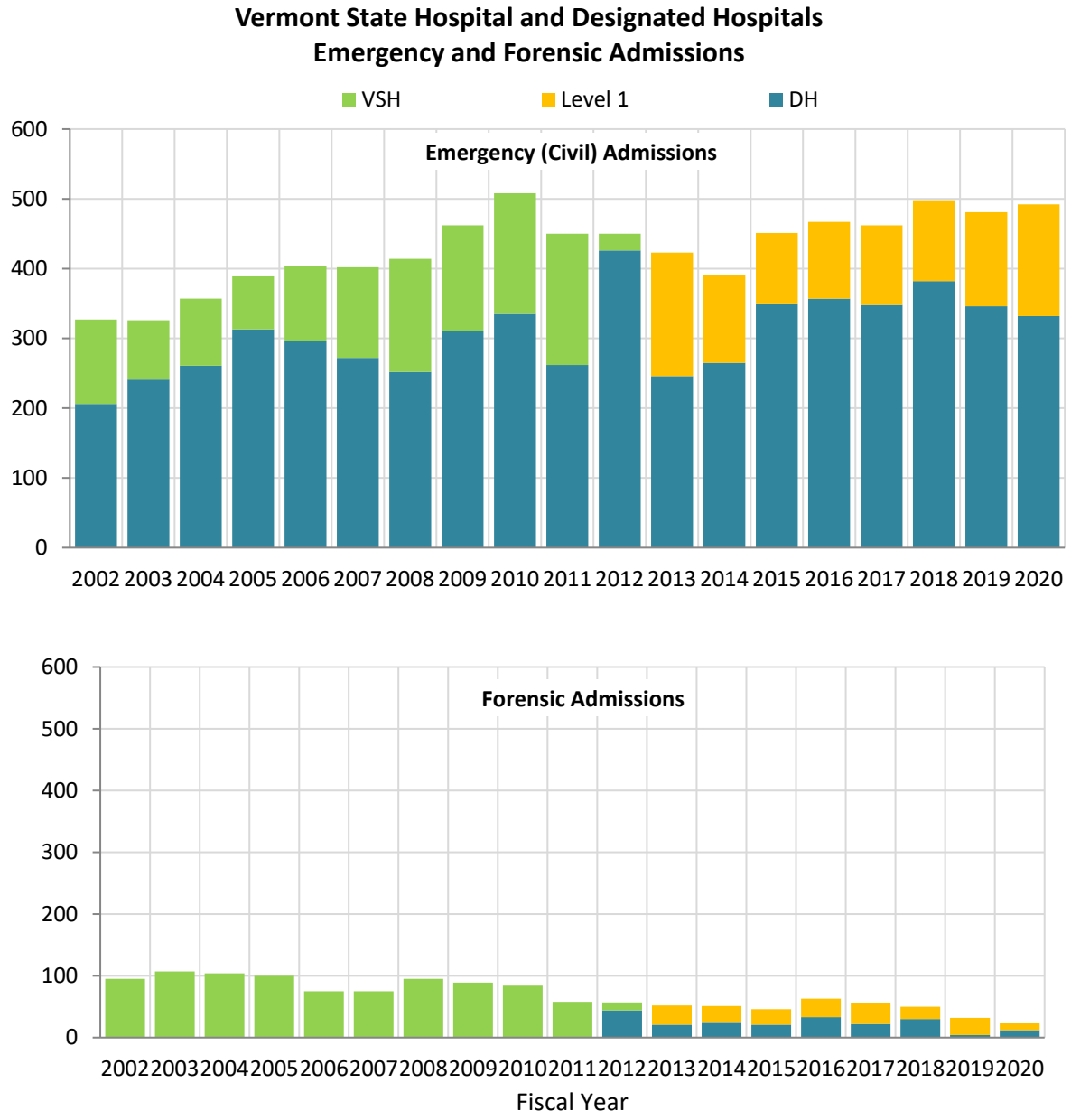
Over the past four fiscal years, the number of people involuntarily admitted to Level I (higher acuity) inpatient care has averaged 65% of the overall admissions, with non-Level I (less acuity) averaging 35% on balance. While 2020 is notably an unusual year, the proportional distribution of Level I and non-level I admissions remained somewhat consistent overall at 60% Level I and 40% non-Level I admissions. System capacity limitations and decreased numbers of involuntary patients hospitalized, despite the pandemic, does not appear to significantly impact the distribution of higher and lower acuity involuntary admissions in FY2020.

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. In examining 2020 for anomalies from FY 2019, catchment areas that were lower utilizers involuntary psychiatric care in 2019 remained so in 2020. Three DA areas with designated hospitals, WCMH, HCRS, and RMHS saw decreases of 2-4% in their catchment areas. The HCHS and UVM-MC experienced a 7% increase in their service area.

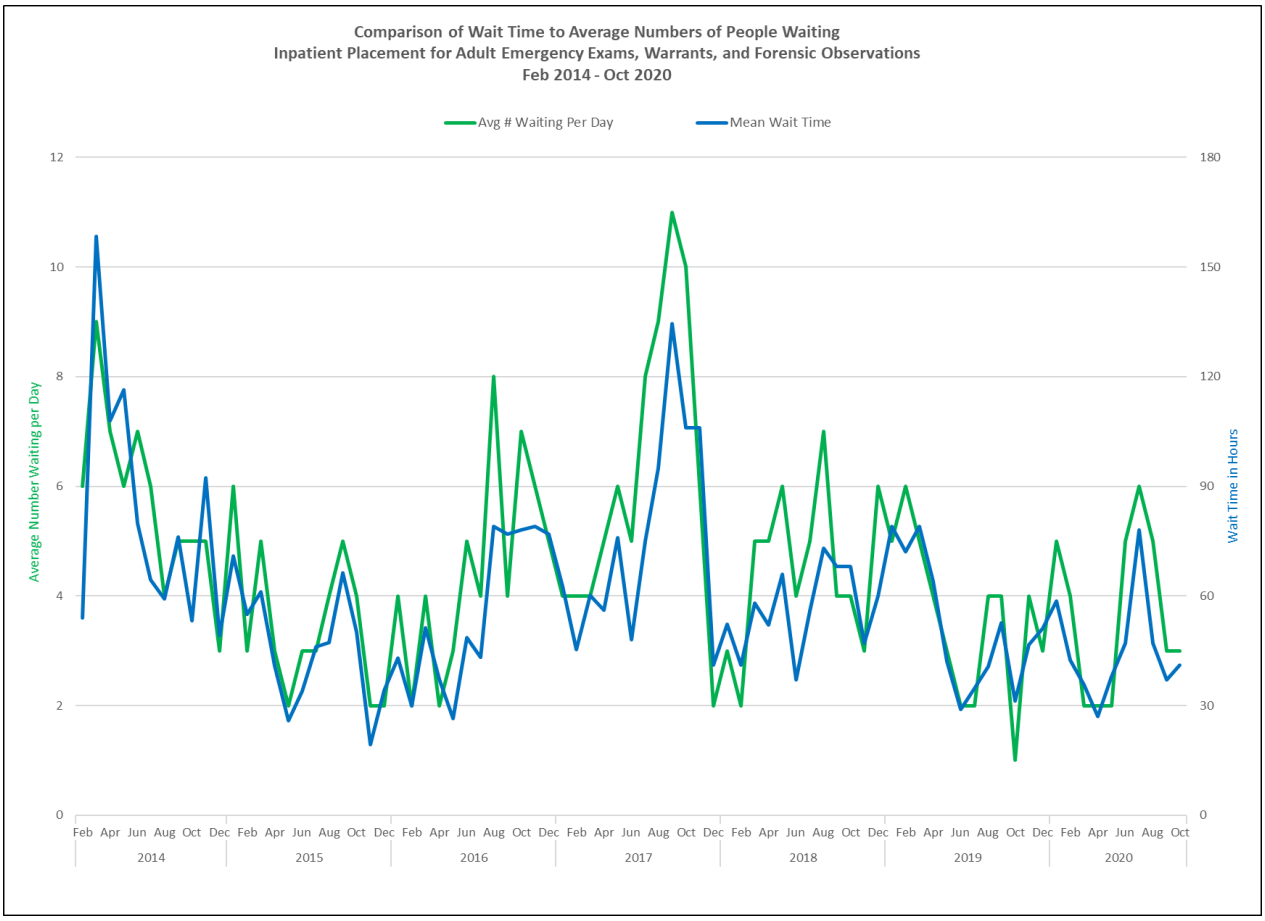
Chart 11: Emergency and Forensic Admissions



The total number of emergency (civil) and forensic admissions increased by less than 3% in FY 2020, recognizing that the COVID-19 pandemic likely played some role in this decrease, which still places 2018-2020 as the three highest years for admissions since 2010. The low numbers of forensic admissions in 2020 is likely an artifact of court closure during 2020 as well. Designated hospital emergency admissions decreased by nearly 6% but were offset by a

notable increase in Level I emergency admissions of 16% in 2020. 2019 also reflected a 14% increase in Level I emergency admissions at Level I hospitals. Level I emergency admissions (160) in 2020 were the highest since 2013 at 177 in the first year of tracking Level I emergency admissions since closure of the former Vermont State Hospital.

Chart 12: Average Number of People Waiting Inpatient Placement

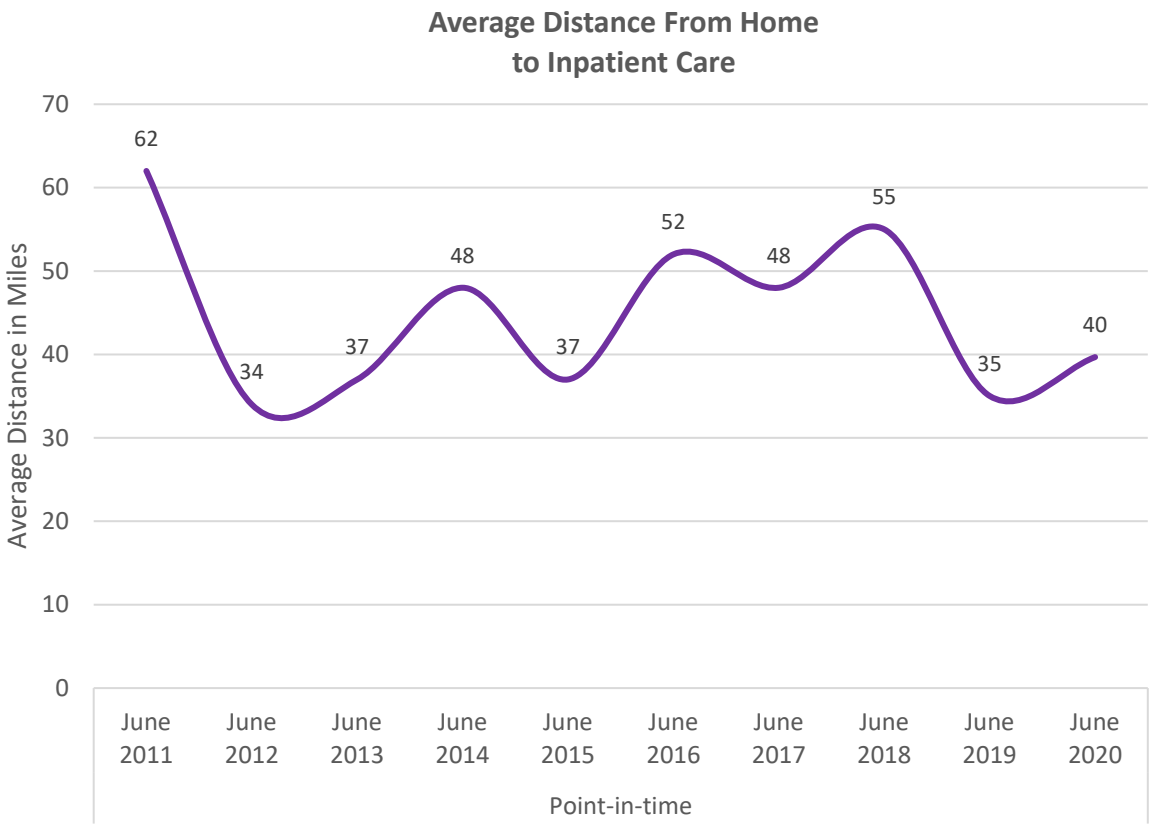


This chart reports the mean wait time and the average number of adults waiting per day from February 2014 to October 2020. Timely transition of people to inpatient care requires active management daily for individuals of all statuses in need of hospital care. The department's goal is to continue to place individuals in appropriate beds as soon as they are available. The data represented in this graph demonstrates the volatility and reactive nature of demand spikes and wait time variables for bed capacity subject to each hospital's inpatient acuity. Between March 2019 - March 2020, generally between 1-6 persons per month were waiting for involuntary inpatient bed placement in the year prior to the arrival of the Coronavirus in Vermont. At the onset of the pandemic, an average of two people were waiting per day for involuntary care in the system which again quickly rose to an average of 6 per day waiting through July 2020. As of

this report, that number has been decreasing through October 2020 as hospital providers have responded with necessary adjustment to ensure safest treatment environments for both patients and staff. Wait times that generally track somewhat closely with bed capacity also experienced an increase of up to three days in wait for transfer to an involuntary inpatient bed before showing wait time decreases for the same period.

The Department of Mental Health adult care management team who work with each of the Designated Hospitals, the Designated Agencies emergency services teams, and the hospital emergency departments statewide has continued to operate remotely since mid-March 2020 and maintain active understanding and involvement with hospitals and their workforce who were also adjusting and rapidly responding to public health guidance. 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. All levels of care, and especially congregate care facilities that include residential, intensive residential care facilities, and crisis bed programs that are frequently transfer destinations for individuals stepping down from inpatient care were equally impacted during this time. The care management team 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. During this time, the decentralized placement considerations became more complex and contingent on all service providers closely coordinating the different levels of care with evolving public health guidance and environmental safety recommendations for patients, residents, and essential workforce staff.

Chart 14: Distance to Service for Involuntary Inpatient Admission



A de-centralized inpatient system of care has increased reliance of beds in Designated Hospitals around the state for involuntary psychiatric hospitalizations. The distance required to travel to an inpatient bed, as demonstrated in the graph above, reflects the use of beds at Designated Hospitals. While more regionalized care is available, the highest acuity hospital capacity is 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 inpatient bed. Available bed capacity shifts in 2020, continue to reflect the average number of miles experienced by individuals and may be traveled by their support systems through inpatient care that may or may not occur close to the area of their primary supports. The DMH care management team does work 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. 2020 has presented unique challenges given admission and transfer considerations in moving patients that must comport with responsible public health measures during the pandemic.

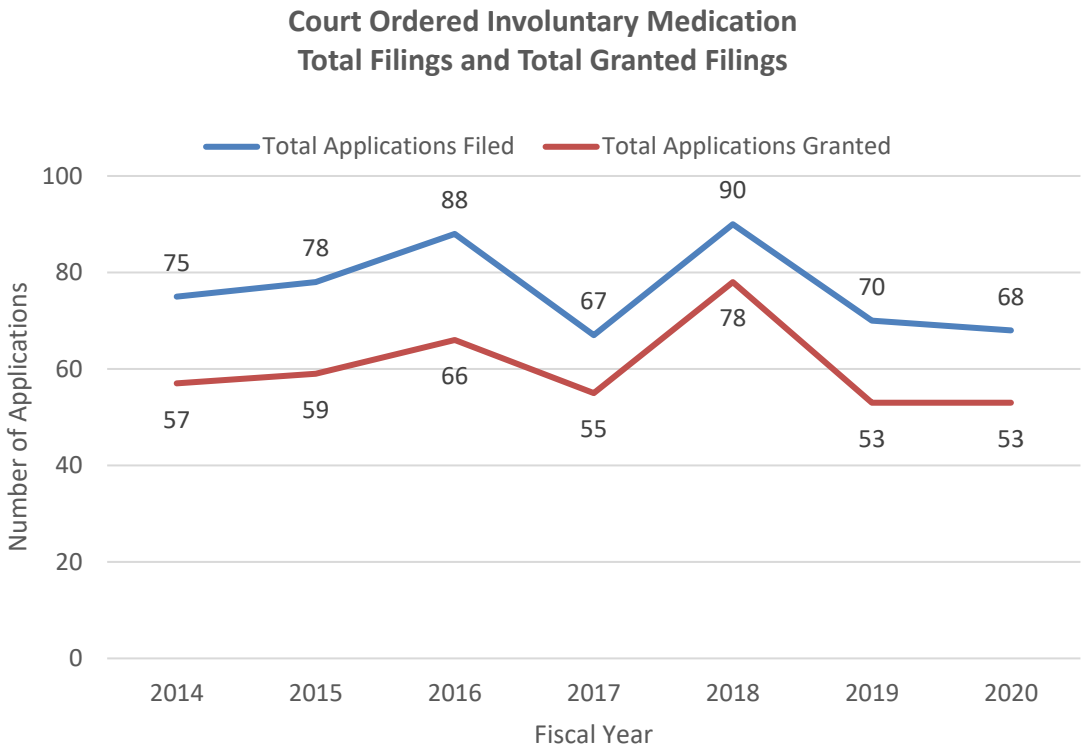
INVOLUNTARY MEDICATIONS

The ability to care for those most acutely ill individuals may require a Designated Hospital to seek a court order to administer medication recommended by a psychiatrist and that a patient is unwilling to consent to during hospitalization. This is an issue that has ongoing state-wide interest by multiple stakeholder groups, the DMH, 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 medication.

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.

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**	**2019**	**2020**
Number of people	57	60	73	61	79	65	54
Total Applications Filed	75	78	88	67	90	70	68
Total Applications Granted	57	59	66	55	78	53	53
% Granted	76%	76%	75%	82%	87%	76%	78%

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 number of persons with fillings annually for court-order medication in comparison to all persons admitted through civil or forensic legal proceedings in the most recent seven years varied between a low of 10.48% (2020) and a high of 14.41% (2018). Over the same seven-year period, the percent of filings granted has generally ranged between 75 -78% annually with only 2017 and 2018 having slightly higher numbers granted at 82% and 87% respectively. During 2020, the total number of court-ordered medication applications and applications granted were roughly the same as those in 2019.

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	FY 2019	FY 2020
Total Discharges	Overall	55	56	56	76	64	52
	Inp. Stays with One Filing	44	52	53	70	60	47
	Inp. Stays with Multiple Filings	11	4	3	6	4	5
Mean LOS (days)	Overall	191	103	161	136	155	122
	Inp. Stays with One Filing	155	98	150	130	147	107
	Inp. Stays with Multiple Filings	334	165	355	204	306	262

Over the most recent five-year period, patients having one filing for the administration of court-ordered medication represented 90% of the discharges in this patient cohort. Consequently, roughly 10% of this patient cohort required multiple filings prior to being able to be discharged. Multiple filings can occur in 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.

In 2020, average LOS for all involuntary patients averaged 45 days (*Chart 7*). In 2020, patients who required one filing of court ordered medication experienced average length of stay over two times greater (107 days) and patients who required multiple filings had an average length of stay that was five times greater (262 days).

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

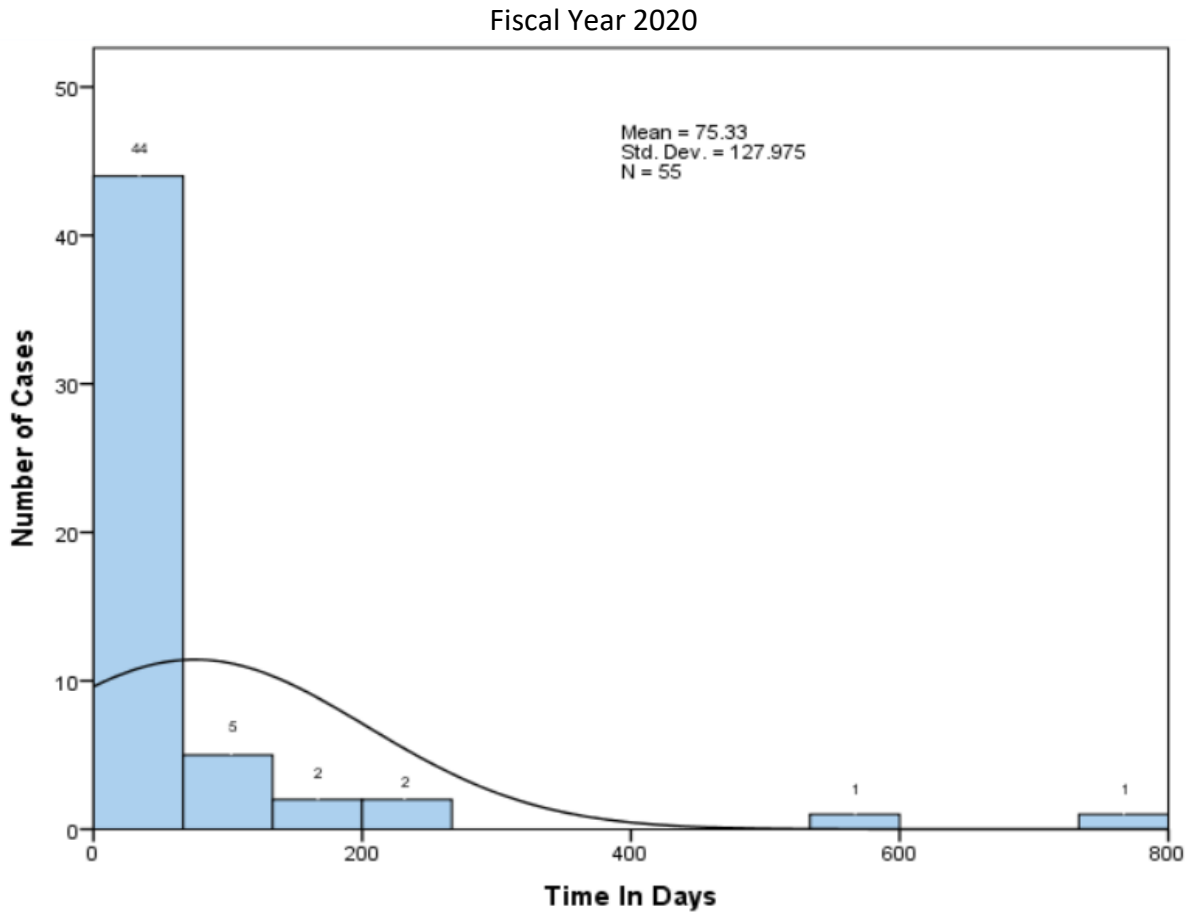
Court Ordered Involuntary Medication 30 Day Readmission Rate for Discharged Patients							
		FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Total Discharges	Overall	55	56	56	76	64	52
	Inp. Stays with One Filing	44	52	53	70	60	47
	Inp. Stays with Multiple Filings	11	4	3	6	4	5

30 Day Readmission Rate	Overall	5%	5%	11%	1%	1%	1%
	Inp. Stays with One Filing	7%	6%	11%	0%	1%	0%
	Inp. Stays with Multiple Filings	0%	0%	0%	1%	0%	0%

Vermont 30-day readmission rates for all adult involuntary care (*Chart 8*) were 11%. Patients who have received one or multiple filings for court-ordered medication was between 0-1% for the most recent three-year period.

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

Court Ordered Involuntary Medication
Time from Inpatient Admission to Involuntary Medication Decision



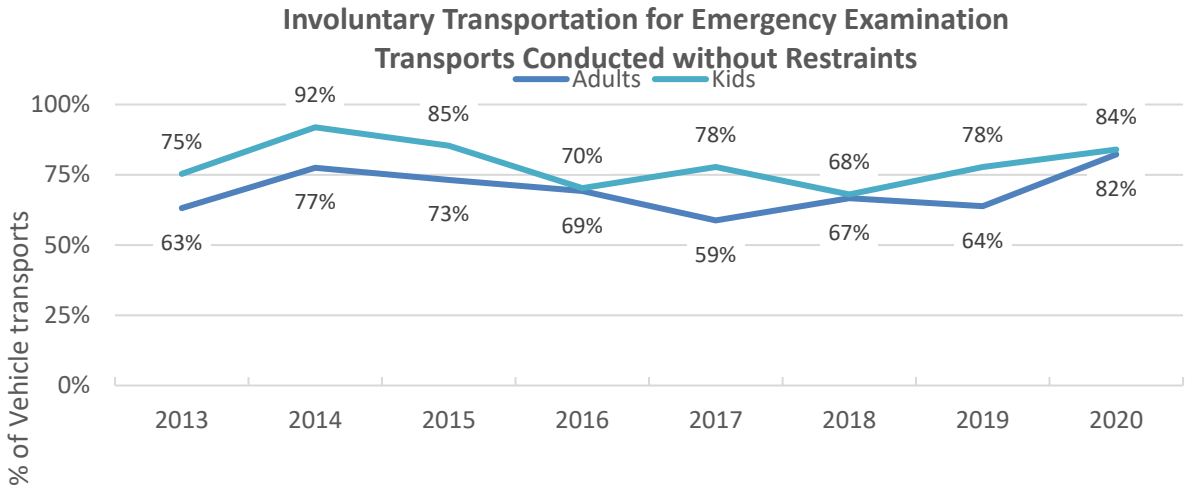
This graph illustrates all initial cases (55) filed for involuntary medication in FY 2020. The average (mean) length of time between an admission to the hospital and to the medication decision is approximately 75 days, with only a very small number of outliers on the longer end of the curve. The mean of 75 days in FY 20 represent 24 fewer days on average than FY 19. In FY 20, over 92% of cases resolved in under 200 days.

TRANSPORTATION

Since April 2012, the Department has implemented a 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.

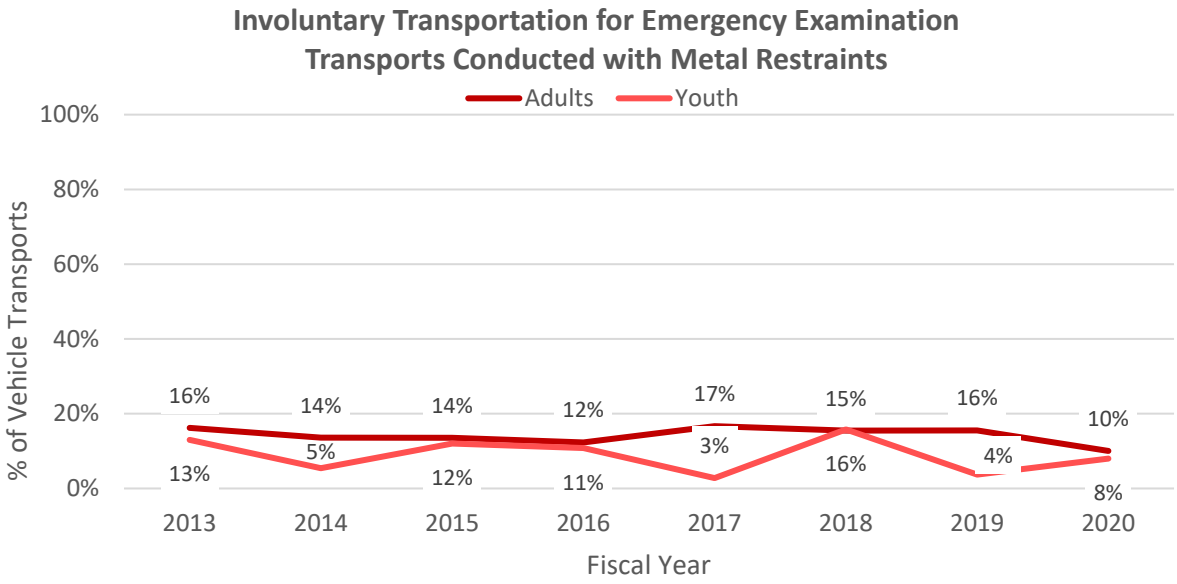
Grants to support pilot programs with sheriffs in Lamoille and Windham Counties using a least-restrictive approach by deputies in plain clothes with an unmarked van have continued throughout this period. Subsequently the passage of Act 85 (2017), Section E. 314 required that any new or renewed contracts 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.

Chart 19: Involuntary Transports Conducted without Restraint



Based on the Involuntary Transportation data maintained by the Vermont Department of Mental Health for people transported

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 Chart 19 data provided for transportation shows that the majority of transports are conducted without restraint and continues an upward trend for both adults and youth in 2020. Transport for adults without restraint increased from 64% to 82% and transports for youth without restraint increased from 74% to 84% for the same period. This change is the highest level in a positive direction for adults going back to 2013. While also a positive change for youth, it remains just below levels previously attained in 2014-2015.

The Department continues to monitor transport data for involuntary adult and child transports and closely monitor for predominant use of soft or no restraints during transport by 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. As a specification of the AHS sheriff transport contracts, the Department has been collaborating with sheriffs in the delivery of training to sheriff departments who are called upon less frequently for transports for involuntary inpatient hospitalization and have higher reliance on metal restraints. The Department remains committed to creating a consistent law enforcement response and adherence with least restrictive transportation expectations outlined in its involuntary transportation manual.

Chart 20 data reflects a 6% reduction from 2019 and the lowest use of metal restraints (10%) for adult transports going back to 2013. Youth transports using metal restraints was 8% in 2020. While this represents a doubling from 2019 data, it represents two youth being

transported in 2020 rather than only one youth in 2019. This serves as an example of where an increase may appear significant given the very small numbers it represents. Detailed reporting follows in Charts 21 and 22 on youth and adult transports.

Chart 21: One-Year Overview of Adult Involuntary Transport

Vermont Department of Mental Health
Youth Involuntary Transportation for Emergency Examinations
Fiscal Year 2020

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	2	0	0	0	0	1	0	0	1	0	0	0	**4**
Non-Restrained	1	0	1	1	2	3	5	3	1	2	0	2	**21**
Missing													
Restraints Used in Transport													
None	1	0	1	1	2	3	5	3	1	2	0	2	**21**
Metal	1	0	0	0	0	0	0	0	1	0	0	0	**2**
Soft	1	0	0	0	0	1	0	0	0	0	0	0	**2**
Missing													
% All vehicle transports that use Metal	33%	0%	0%	0%	0%	0%	0%	0%	50%	0%	0%	0%	**8%**
Vehicle Used in Transport													
Ambulance	0	0	1	1	0	0	1	1	0	1	0	0	**5**
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	3	0	0	0	2	3	3	2	0	0	0	1	**14**
Sheriff Cruiser	0	0	0	0	0	1	1	0	2	1	0	1	**6**
Other													
Not Applicable ("Walk Up")													
No Data													
%Vehicle Transports that use Ambulance			100%	100%			20%	33%		50%			**20%**
%Vehicle Transports that use MH Van Alternative													
%Vehicle Transports that use Sheriff's Alternative	100%				100%	75%	60%	67%				50%	**56%**
%Vehicle Transports that use Sheriff's Cruiser						25%	20%		100%	50%		50%	**24%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	3	0	0	0	2	4	4	2	2	1	0	2	**20**
TOTAL EE Transports	3	0	1	1	2	4	5	3	2	2	0	2	**25**

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: 10/30/2020

Chart 22: One-Year Overview of Youth Involuntary Transport

Vermont Department of Mental Health
Adult Involuntary Transportation for Emergency Examinations
Fiscal Year 2020

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	2	5	5	4	4	3	0	5	1	5	7	3	**44**
Non-Restrained	25	25	20	12	26	17	22	16	9	10	12	19	**213**
Missing	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Restraints Used in Transport													
None	25	25	20	12	26	17	22	16	9	10	12	19	**213**
Metal	0	5	3	2	2	2	0	5	0	2	4	0	**25**
Soft	2	0	2	2	2	1	0	0	1	3	3	3	**19**
Missing	0	0	0	0	1	0	0	0	0	0	0	0	**1**
% All vehicle transports that use Metal	0%	17%	12%	13%	6%	10%	0%	24%	0%	13%	21%	0%	**10%**
Vehicle Used in Transport													
Ambulance	1	1	4	0	2	1	0	2	1	0	0	0	**12**
MH Van Alternative													
Private Transport													
Sheriff Alternative	15	13	7	7	7	10	17	20	13	10	18	11	**148**
Sheriff Cruiser	7	6	2	8	12	12	9	9	8	6	11	8	**98**
Other													
Not Applicable ("Walk Up")													
No Data													
%Vehicle Transports that use Ambulance	4%	5%	31%		10%	4%		6%	5%			0%	**5%**
%Vehicle Transports that use MH Van Alternative													
%Vehicle Transports that use Sheriff's Alternative	65%	65%	54%	47%	33%	43%	65%	65%	59%	63%	62%	58%	**57%**
%Vehicle Transports that use Sheriff's Cruiser	30%	30%	15%	53%	57%	52%	35%	29%	36%	38%	38%	42%	**38%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	22	19	9	15	19	22	26	29	21	16	29	19	**246**
TOTAL EE Transports	27	30	25	16	31	20	22	21	10	15	19	22	**258**

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: 10/30/2020

ADULT OUTPATIENT CARE AND UTILIZATION

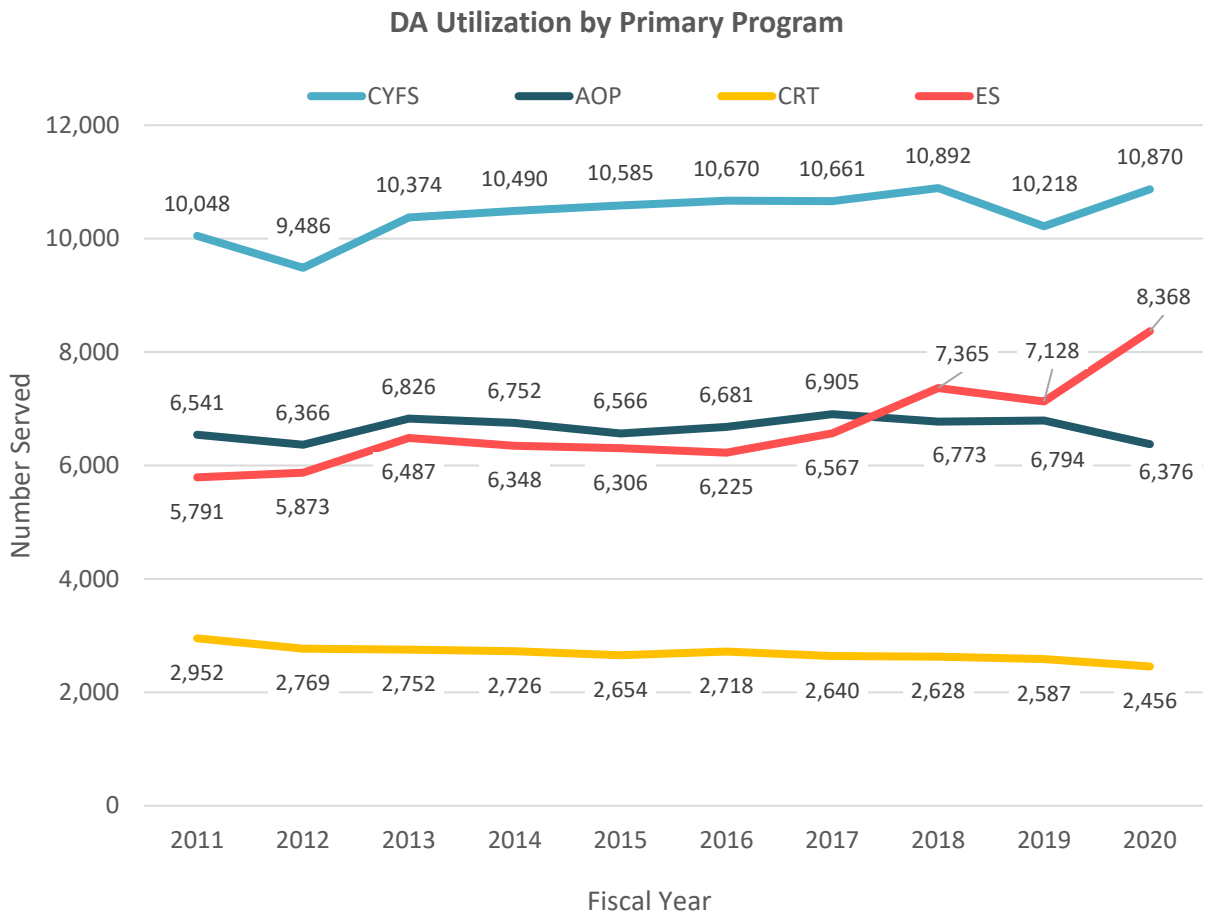
Outpatient services are provided through a system of care that includes the Designated Agencies, a Specialized Service Agency (Pathways Vermont), private practitioners, and other state and local social services agencies. The Designated Agencies provide comprehensive services to individuals through the Community Rehabilitation and Treatment programs; they also support and manage crisis beds and alternative services to hospitalization, intensive residential recovery beds, residential services, supportive housing, supported employment services, 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. Time to contact after discharge 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.

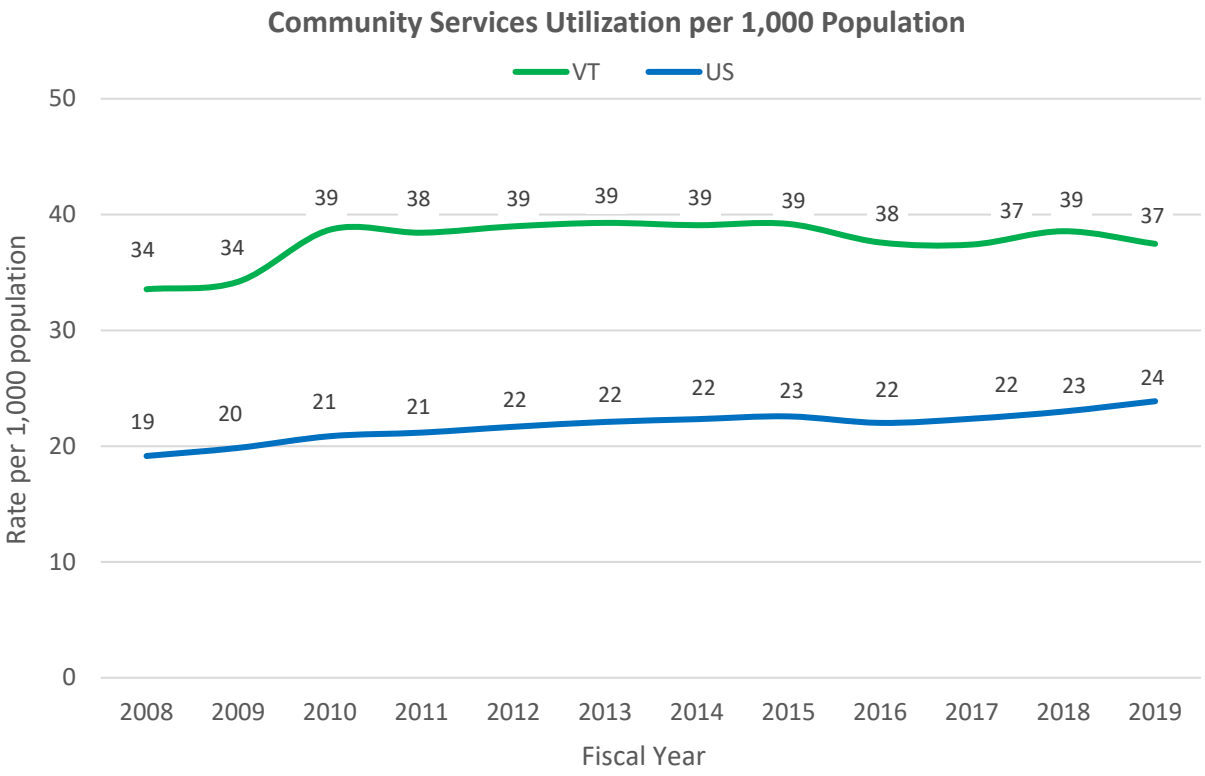
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle. The payment reform initiative beginning January 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. This payment reform methodology, more flexible service delivery, and value-based incentive payment framework focuses 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 programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. The 6% decrease noted in 2019 appears to have self-corrected and closely approximates utilization in 2018. Similarly, the Emergency Services programs also had an upward trend overall in 2020 which may reflect the increased support needs associated with the impacts of Covid-19. The Adult Outpatient programs saw a 6% decline in utilization while the Community Rehabilitation and Treatment (CRT) programs saw 4% decline. Both of these adult programs have seen flat or slow trend changes over the nine-year period reflected. As FY 2020 all programs utilization essentially reflects only one quarter of potential impact from the COVID-19 pandemic, FY 2021 will be more reflective of the virus' impact to system services and capacities to meet the needs of individuals served in Calendar Year 2020.

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 - 2019.

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national utilization rate. The most recent national data available through 2018 shows that Vermont has a strong and fairly consistent record of service delivery in community-based programs. 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 case rate payment reforms provide the ongoing flexibility to meet the needs of the individuals and provide the necessary services.

The ***State of Mental Health in America 2021***, the nation's leading community-based nonprofit, using national survey data supplied by the Substance Abuse and Mental Health Services Administration (SAMHSA), The Centers for Disease Control and Prevention (CDC), and the Department of Education (DoE) identified Vermont as Number 1 in its overall ranking of states.

Previously (2020) Vermont held the Number 3 spot nationally.

Adults

Ranking considered Adults with Any Mental Illness (AMI); Adults with Substance Use Disorder in the Past Year; Adults with Serious Thoughts of Suicide; Adults with AMI who Did Not Receive Treatment'; Adults with AMI Reporting Unmet Need; Adults with AMI who are Uninsured; and Adults with Cognitive Disability who Could Not See a Doctor Due to Costs – Vermont ranked 10th in state ratings.

Youth

Likewise, youth rankings considered Youth with Substance Use Disorder in the Past Year; Youth with Severe MDE; Youth with At Least One Major Depressive Episode (MDE) in the Past Year; Youth with MDE who Did Not Receive Mental Health Services; Youth with Severe MDE who Received Some Consistent Treatment; Children with Private Insurance that Did Not Cover Mental or Emotional Problems; and Students Identified with Emotional Disturbance for an Individualized Education Program – Vermont ranked 1st in state ratings.

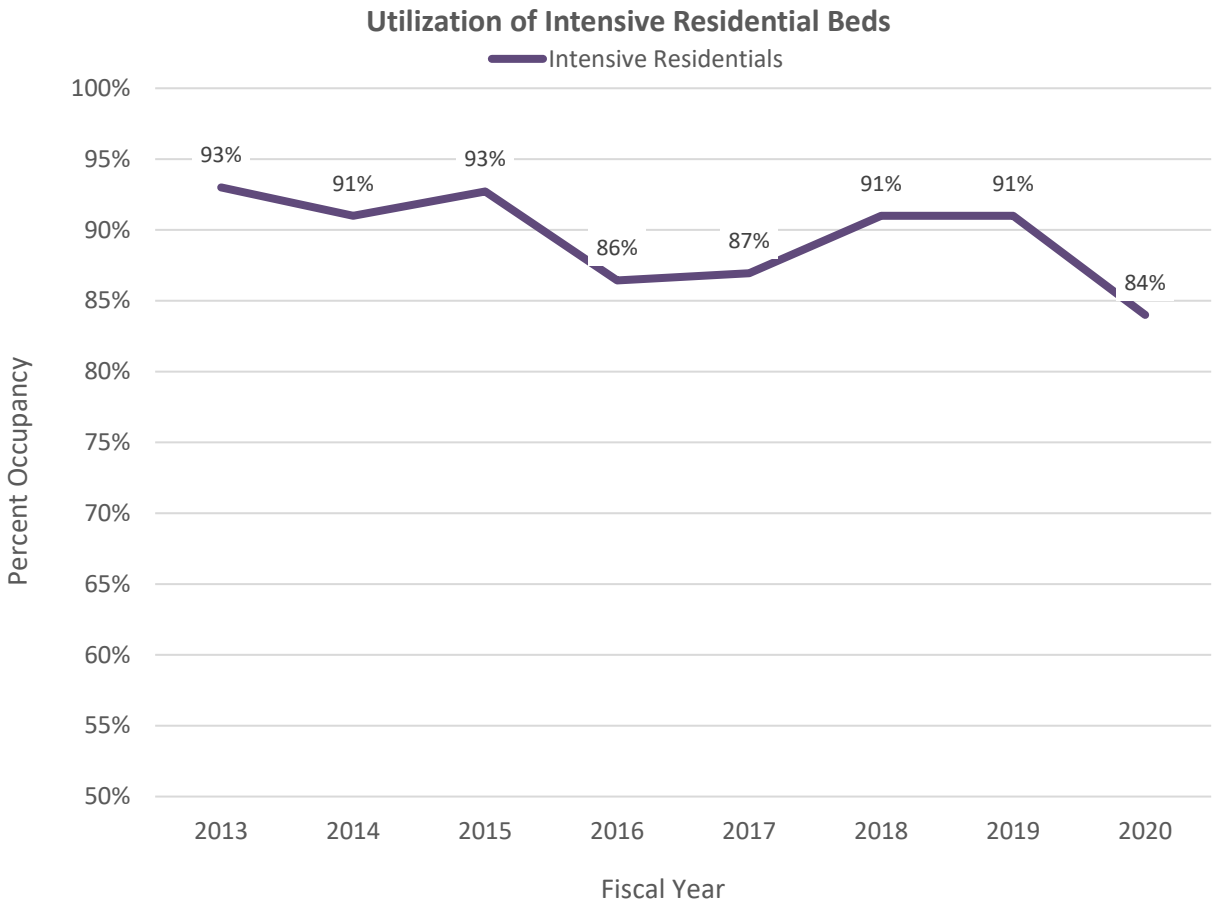
Access to Care

Ranking considered Adults with AMI who Did Not Receive Treatment; Adults with AMI Reporting Unmet Need; Adults with AMI who are Uninsured; Adults with Cognitive Disability who Could Not See a Doctor Due to Costs; Youth with MDE who Did Not Receive Mental Health Services; Youth with Severe MDE who Received Some Consistent Treatment; Children with Private Insurance that Did Not Cover Mental or Emotional Problems; Students Identified with Emotional Disturbance for an Individualized Education Program; Mental Health Workforce Availability – Vermont ranked 1st in state rankings.

Prevalence of Mental Illness

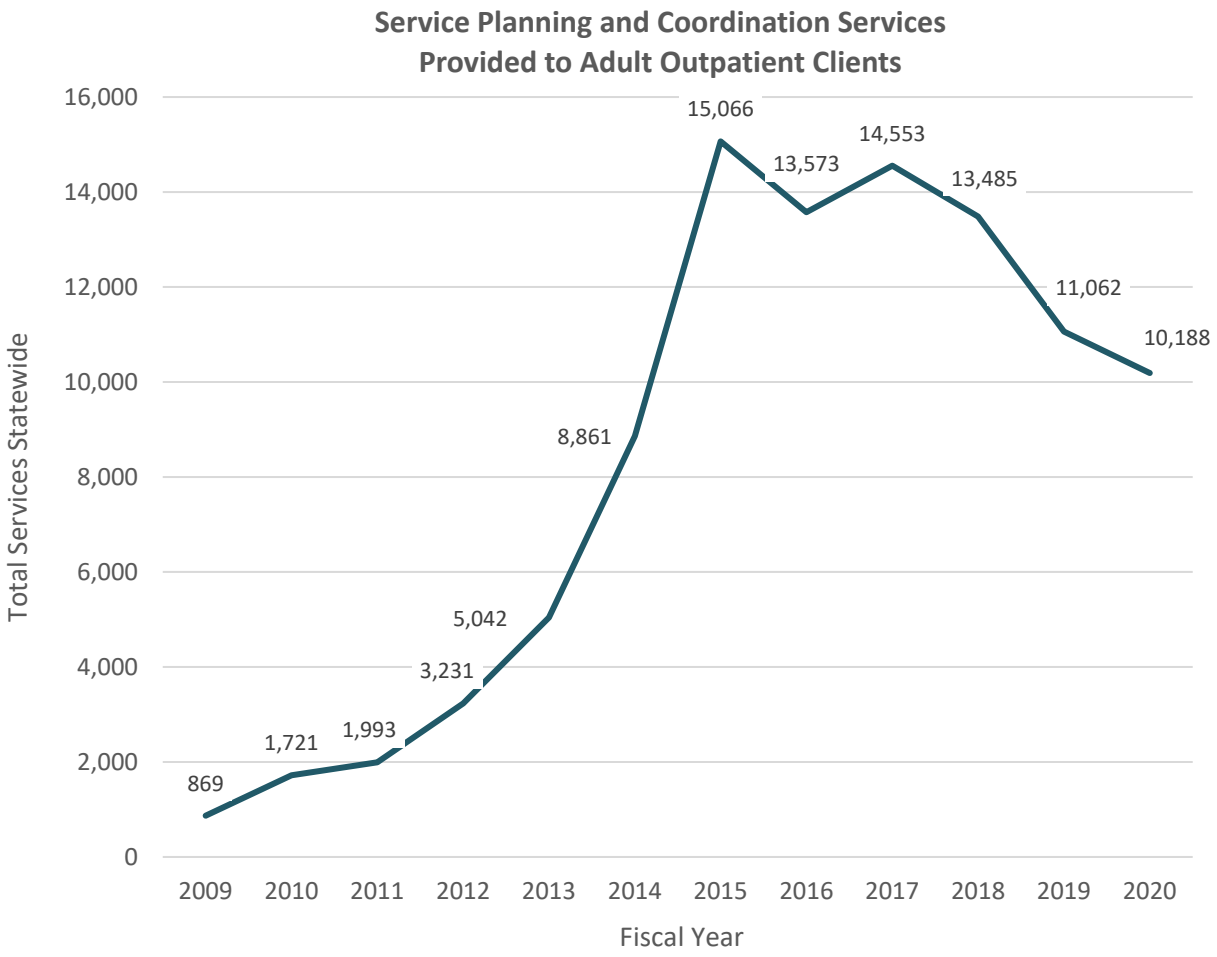
Finally, regarding the identification of Prevalence of Mental Illness (a higher ranking in state rankings reflects better identification of mental health and substance use issues) – Vermont ranked 50th in state ratings.

Chart 25: Intensive Residential Bed Utilization



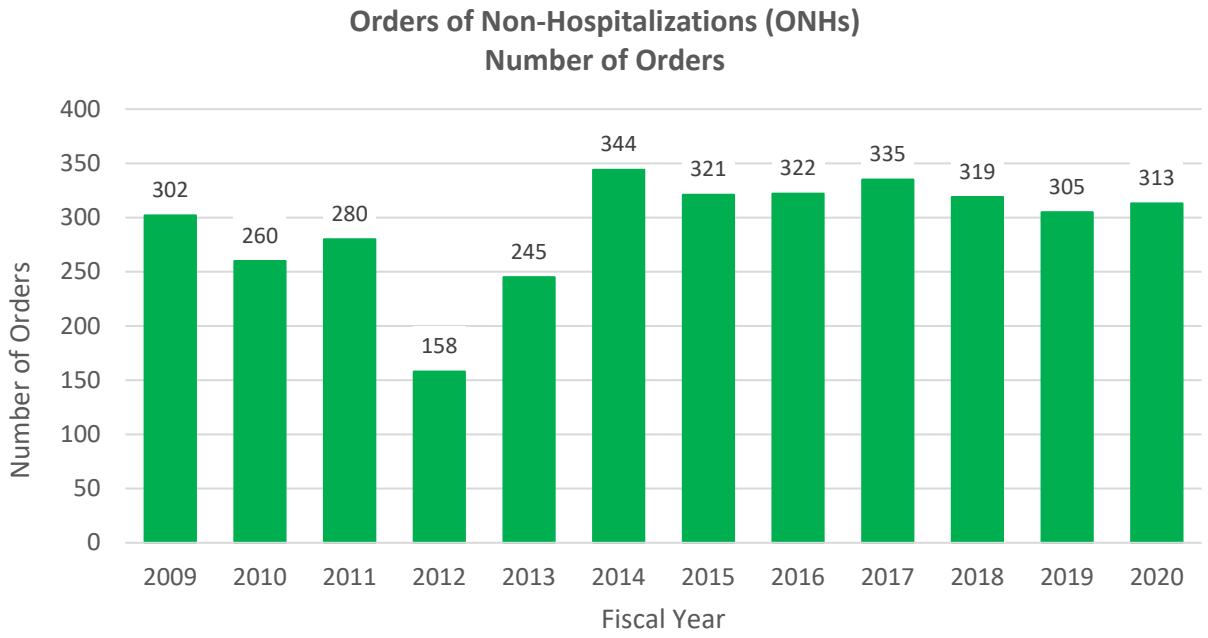
The Intensive Residential Recovery Programs (IRRs) provide both transitional and longer term supports, averaging residential program lengths of stay within a 12-18-month time frame for residents. The (IRRs) have met a key need for a significant number of individuals who are ready to leave higher levels 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. Despite higher utilization rates in 2013 and 2015 and dips in utilization in 2016 – 2017, the utilization appeared to plateau at 91% in 2018 – 2019. 2020 saw the greatest decrease in utilization over the eight-year period to 84%. The influence of the pandemic through much of 2020 and the changing capacities of programs to safely transfer and introduce new residents into programs likely contributed to this drop. Effects of the virus on 2020 data appears evident throughout this reporting period.

Chart 26: Non-Categorical Case Management



The support of non-categorical case management 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 through FY 2015. Levels remain elevated for this population FY 2016 through FY 2018, but the data shows a decline in recent years. It is still worth noting that the expansion of services provided for service planning and coordination has met a population need for this level of case management services for adults. The Department's payment reform launched in January 2019 continues to support flexible service delivery including case management services when needed.

Chart 27: Orders for Non-Hospitalizations



Between 2014-2020, the average number of Department of Mental Health Orders of Non-Hospitalization (ONHs) has averaged 284 annually, with a high of 344 (2014) and recent low of 305 (2019). ONH's are legal tools that may be utilized by DMH and treatment providers that request a court to identify conditions for participation in community-based outpatient mental health treatment plan. Such conditions may be ordered for individuals who have been involuntarily hospitalized and discharged back to their communities for a set period of time. Renewal of an ONH may be requested if such orders can be justified to assure ongoing treatment participation. Revocation of an ONH may also be sought if an individual is unable to adhere to the ONH conditions and subsequently decompensates in the community and warrants rehospitalization.

Departmental legal staff members work closely with clinical staff and Designated Agency (DA) clinicians to monitor treatment participation 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 following treatment 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 were utilized at Designated Agencies in various ways and fell into several major categories:

- 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.

The ongoing reporting of initiatives and evolving service delivery and practice innovations continue to be reported annually to DMH under its comprehensive grant agreement with Designated Agencies, by Vermont Care Partners on behalf of the Designated Agencies.

ACT 79 ENHANCED FUNDING:

HCHS	We were excited to announce the launch of a new initiative aimed at streamlining access to mental health therapy for children and families in Chittenden County. Partners for Access is a single point of contact resource for youth and families seeking outpatient mental health therapy in Chittenden County. Partners for Access can assist families in finding available providers and can also be a resource for providers who may refer families seeking care to a reliable resource. TeleCare Connection provides 24-hour remote monitoring with in-person support when need. The program is delivered through a partnership between Howard Center and UVM Health Network Home Health and Hospice to provide participants with help when needed, prevent crises, and reduce hospital readmission and healthcare costs.
CSAC	Community Bridges - is a peer led group started in conjunction with community members. The goal of Community Bridges is to "Foster opportunities for people who feel isolated to form new connections, and to engage in meaningful activity within the community". During the pandemic, our efforts have shifted from in person activities to "zoom" based opportunities for engagement. A book club

	weekly hang out sessions, and a Friday night pajama party featuring a local musician are examples of current Community Bridges opportunities offered exclusively on zoom. The events are peer led, attended by clients of CSAC's CRT program, and open to all community members. Open dialogue and related practices and paradigm changes continues, as well as, OK! resiliency campaign
WCMH	Housing Projects: Tiny Homes with peer staff, new SRO single room occupancy building with peer staff. New Positions with partners: new MSW position working with police; new position working closely with CVMC ED unit, to provide emergency care as part of ED follow-up. Partnering and collaborating on new UEMR as part of CORE 4 [electronic medical record with three other agencies, this improves the opportunities for coordinated care and data driven care]. Continued implementation of zero suicide throughout agency.
UCS	Psychiatric Urgent Care for Kids (PUCK) Same Day Access (SDA) Unified Electronic Medical Record (UEMR VT)
NKHS	Warm lines for families with children and for those with SA issues that need support. During the early phases of the COVID pandemic, these warmlines were staffed 24-hours. Implemented an Emergency Preparedness Team with full representation across the agency to determine the best courses of action to keep staff and consumers safe. This group met daily in the early stages of COVID and is still meeting weekly. Prior to COVID the agency was very slow to move towards telehealth options, but we are now all therapists are fully equipped to provide telehealth services--we also have in-house telehealth rooms for consumers who have connectivity issues at home but would rather do telehealth then in-person.
CMC	Older Adults programming focused on treatment for those age 65+ that have a substance use disorder; services can be provided in the office or at the client's home -LGBTQ+ service delivery - development of specific programming for transgender youth in addition to enhanced clinical education to staff and modifications to EHR to better reflect EDI efforts – [EDI = equity diversity and inclusion] Housing - expanded on current housing offerings by developing and launching permanent supportive housing units in renovated CMC building adjacent to CRT services and Safe Haven 24/7 staffed living shelter.
NFI	1. Providing outstanding IOP services for both adults and adolescents (Crossroads) 2. Evolving our Diversity and Inclusion training into Equity and Inclusion programming, training, responsiveness for Racism/Antiracism learning/unlearning opportunities 3. Introducing different technologies to provide additional client service provision and for increased efficiency with administrative needs
RMHS	Collaborations within the Agency Crisis case management and Crisis Peer Support Services
HCRS	Implemented Same Day Access program, an initiative developed to improve access to care.
	No reporting received for NCSS or LCMH

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 and their families 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 something that has a long-standing presence with 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]

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 and employment services, 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.

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

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

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

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 peer programming supported by the Department of Mental Health through Act 79 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 offers peer support services including 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.
Pathways Vermont Support Line	Statewide telephone peer support to prevent crisis and provide wellness coaching.
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 (patient representatives).

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.
Peer Workforce Development Initiative including Peer Core Competency curriculum development	Provides infrastructure and workforce development for individuals and organizations that provide peer supports. Activities include: • Coordinating peer support trainings (e.g., Intentional Peer Support, WRAP, Peer Core Competency trainings) • Mentoring and co-supervision/reflection for peer support workers • Tracking of peer services and peer workers in Vermont • Communication and networking among peer organizations, including support for peer workforce development (i.e., recruitment, retention, career development) • Systems advocacy including consideration of peer credentialing
Vermont Federation of Families for Children's Mental Health (VFFCMH)	The Vermont Federation of Families for Children's Mental Health exists to support families and children where a child or youth, age 0-22, is experiencing or at risk to experience emotional, behavioral, or mental health challenges. The Federation collaborates with schools, communities, governmental, and private agencies, and other advocacy organizations to achieve these ends.

SPOTLIGHT: PATHWAYS VERMONT COMMUNITY CENTER

Pathways Vermont uses funding from Act 79 to operate a peer-based community drop-in center in the Old North End of Burlington. The Community Center provides outreach, early intervention, and support services for adults in Chittenden County with or at risk of serious mental illness, with a focus on young adults who have experienced trauma, mental health or addiction challenges and desire support outside the traditional mental health and addictions service system.

Services are provided with the overall goal of improving recovery from mental health challenges and encompass wellness promotion, self-management of mental health-related issues, social connectedness, housing and community stability, improved employment and education, and basic health needs. The space is designed to make people feel welcome to engage in connection and community building through collective learning, creative expression, and peer support. Peer-based supportive employment services are available to individuals who have struggled to access or maintain employment independently. Individuals are informed and helped to access other services and supports in the community (e.g., psychiatric treatment, supported housing, economic services, case management). Other services at the Community Center include exercise classes, community meals, and access to a shower.

The coronavirus pandemic brought significant changes to the Community Center program. The physical space was closed in late March to meet federal and state safety recommendations. The Community Center initially provided to-go meals to community members. This ended and no community meals were served in April through June of 2020. During closure of the space, the staff focused on networking and advertising through social media outlets to promote the Community Center's newly available video-chat versions of peer support groups and community events. Some of the groups that continued to draw interest include the Writing Circle, Open Ears / Open Minds support group, the Hearing Voices support group, and a psychiatric medication support group. The employment team modified their services, reaching out to all individuals enrolled in the supported employment program to continue peer support. The employment staff increased their work with residents at Soteria House, assisting with job searches and other skills to support independent living. Employment staff also served on the Support Line, aiding in its transition to 24/7 availability.

The Community Center staff offered a total of 1235 individual and group peer supports in FY 2020, with 69 supports offered via video-conferencing in the 4th quarter. The peer support groups included a Writing Circle, a Hearing Voices group, Alternatives to Suicide group, an Employment Seekers support group, and a group for Conversations about Coming Off Psychiatric Medication. The Supported Employment team worked with an average of 95 individuals during each of the first 3 quarters of FY 2020 and 30 during the 4th quarter, providing assistance with resume and cover letter writing, mock interviews, job development (outreach to potential employers), job matching services, and peer employment supports. 54% of individuals had a job start within the first 60 days of enrollment in employment services during the first 9 months of FY 2020. An average of 66% of individuals receiving peer employment supports maintained stable employment for at least 6 months during FY 2020. 1086 meals were served between in the first 3 quarters of FY2020.

SPOTLIGHT: ANOTHER WAY

Another Way is a community drop-in center in Montpelier operated for and by individuals with the lived experience of mental health challenges, mental illness, or psychiatric disability. It provides a safe and friendly place for individuals struggling with mental health challenges to share community, to network, and to learn from each other.

The culture of Another Way is based on the principles of Intentional Peer Support, which promotes mutually accountable relationships. Staff include a peer support specialist, a peer employment specialist and programming coordinator, a house manager, and a workshop/maintenance manager.

The services provided by Another Way include peer support services and outreach, peer crisis

interventions, wellness promotion and self-management of health issues, employment supports, education based on Wellness Recovery Action Plan (WRAP) to help create natural supports, and collaboration with other local service providers.

In the first 3 quarters of fiscal year 2020, Another Way served 363 unique individuals, with a total of 6,306 visits at the center. Over ½ of the individuals participated in groups. Group activities included Accu-Wellness, art, community meetings, fitness room, Friday night dinners, gardening, karaoke, music, outings, Wednesday breakfast, WRAP and Share (psychiatric survivors' support), woodshop, yoga, reiki and writing group. 91% of individuals reported that they "are better off due to participation". Over 89% of individuals reported positive staff interactions. 66 employment seekers were supported during fiscal year 2020, with a total of 32 job starts.

Another Way collaborated with the Good Samaritan Haven Overflow Shelter at the Bethany Church in Montpelier during the cold winter season. The partnership included Another Way remaining open 9am – 8pm every day from November 10 – March 24th, when the doors to the Another Way community center closed due to Governor Scott's executive asking all non-essential businesses to close their doors.

The community center remained closed throughout the 4th quarter. Another Way worked closely with other local service providers to respond to the COVID-19 pandemic and were part of the Homelessness Task Force. During the remainder of FY 2020, the peer support specialist, the employment specialist, and the house manager provided peer support remotely to 60 unique individuals through 486 contacts. Another Way staff also collaborated with other peer support organizations to increase the capacity of Pathway's Support Line to 24/7. 4 staff members from Another Way were trained to work on the Support Line.

EMPLOYMENT

Successful employment is the most powerful catalyst for recovery and change, especially for individuals living with a mental illness.[5] National data have shown that employment decreases hospitalizations, substance use, and involvement with corrections while increasing community integration, economic independence, and overall wellness. Working helps further recovery more than any other single intervention – more than therapy, case management or medication alone. Research also demonstrates that unemployment is extremely bad for one's overall health.[6] However, returning to work after unemployment improves health by as much as unemployment damages it.[7] Employment also has the potential to create significant savings to the system of care over time. Extensive and rigorous research (27 randomized controlled trials) demonstrates that the Individual Placement and Support (IPS) practice is the most effective approach for helping people with mental illness obtain competitive employment of their choice.[8]

During COVID-19, employment has been a critical component of maintaining peoples' hope and health in addition to food, housing, and crisis supports. Employment program staff worked remotely to support individuals employed in essential jobs and supported those who were temporarily displaced. Providers reached out to individuals to ensure they had the needed technology to receive telehealth supports and to pursue educational courses online and/or to find online employment. Social Security benefits counseling was also an essential service to help people maintain eligibility for healthcare and financial supports which the increase in unemployment and bonus checks unintentionally threatened to eliminate. Employment staff continue to offer creative methods for connecting with employers and job seekers while protecting the health of themselves and their community members.

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[5] IPS Employment Center: Evidence for IPS (2020). Retrieved on 11/16/2020 from https://ipsworks.org/index.php/evidence-for-ips/

[6] Mathers, C. and Schofield, D. (1998). The health consequences of unemployment: The evidence. *Medical Journal of Australia*, 168 (4) 178–82.
Libby, A. M., V. Ghushchyan, et al. (2010). Economic Grand Rounds: Psychological Distress and Depression Associated with Job Loss and Gain; the Social Costs of Job Instability. *Psychiatric Services* 61(12): 1178-1180.
Dance, A. (2011). The unemployment crisis. *American Psychological Association Monitor*, 42(3). Warr, P. (1987). *Work, unemployment, and mental health*. Oxford: Oxford University Press.

[7] Schuring, M., Mackenback, J., Voorham, T., Burdorf, A. (2011). The effect of re-employment on perceived health. *Journal of Epidemiology and Community Health*, 65(7), 639-644.
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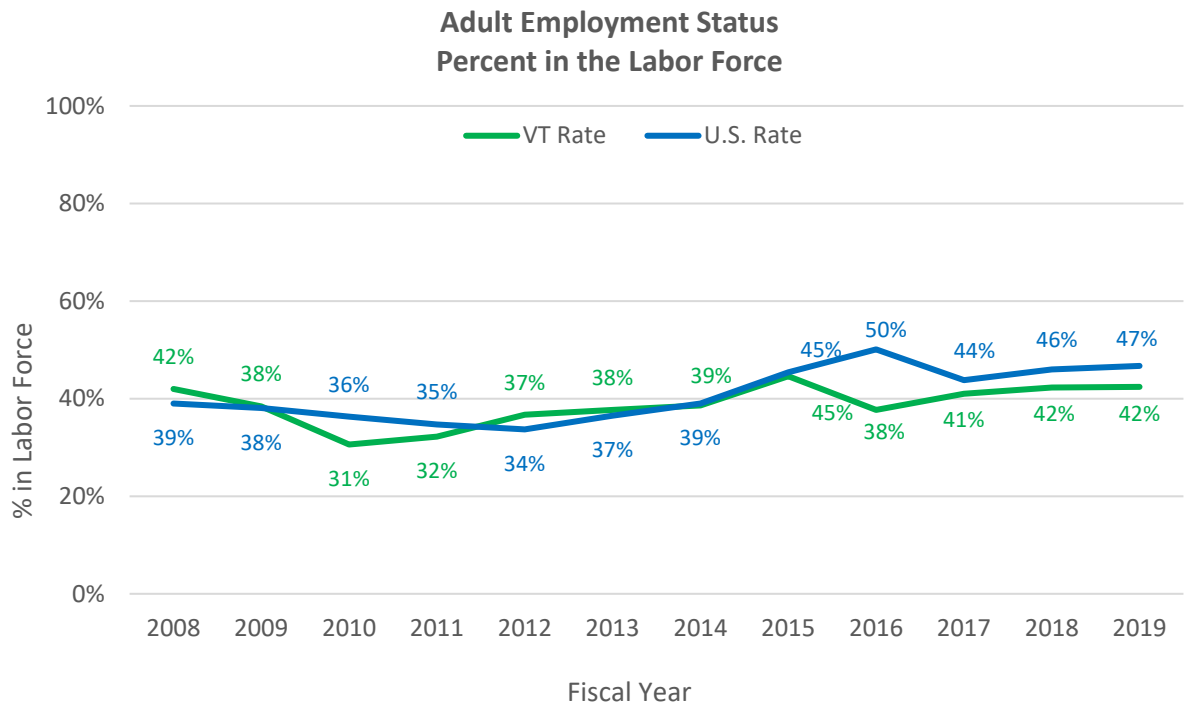
[8] Marshall, T., Goldberg, R.W., Braude, L., Dougherty, R.H., Daniels, A.S., Ghose, S.S., et al. (2014). Supported employment: Assessing the evidence. *Psychiatric Services*, 65, 16-23.

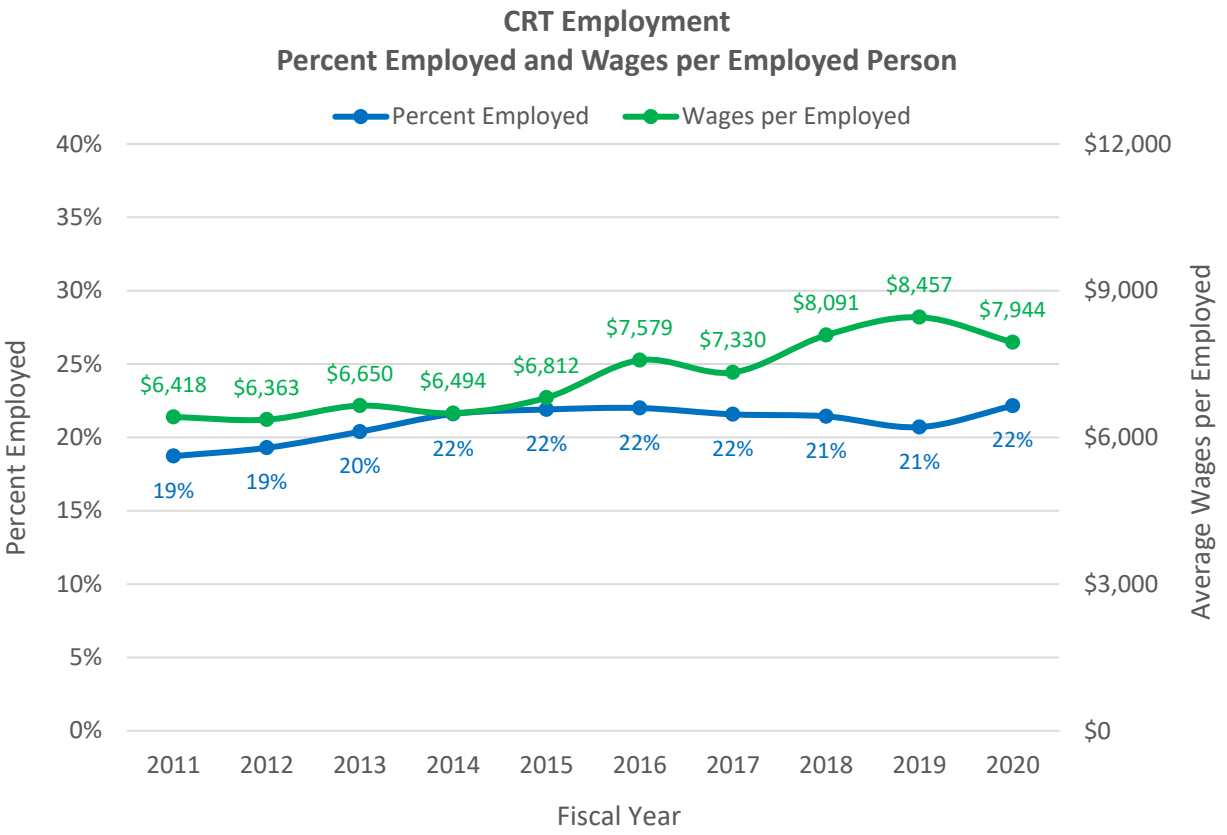
Chart 29: Percentage of All Adults with Mental Illness Employed in U.S. and VT



Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2019. 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 - 2019. 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—reflects a slow upward trend from 38% to 42% from 2016. This number has been ticking back up from a previous high of 45% in 2015 and dip to 38% in 2016. Nationally, data on the rate of employment for adults with mental illness declined from 2016 – 2017, but both Vermont and U.S. rates appear to be remaining parallel over the most recent two years of employment data with U.S. rate slightly higher than Vermont.

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 somewhat level Vermont trend of employment of between 21-22% rate of employment in Community Rehabilitation and Treatment employment outcomes between FY 2014 - FY 2020. Community Rehabilitation and Treatment programs continue to support individuals with employment goals despite competing challenges with other mental health services and supports in the system of care. Flexibility in the case rate payment reform continues to support such a wide range of service needs for those served. Individuals, on average, earned $7,944 per year in FY 20 which is down from $8457 per year in 2019. While lower overall, a small increase in numbers served allowed wages for individuals to remain comparable at $1751 (2019) and $1760 (2020).

HOUSING SUPPORTS

Chart 33: Housing Subsidy and Care

Self-Sufficiency Outcomes Matrix (SSOM) Domain Areas

In Calendar Year 2020 a total of 156 individuals were served with existing funds. Average length of stay was 1,593 and median 1,401 days. There were 7 exits from subsidy with only 2 negative destinations (e.g., eviction or other undesirable tenancy outcome).

Program Averages

	Domain	Initial	Recent	Change	%
1	Shelter/Housing	2.162	3.706	1.543	71.4%
2	Employment	1.107	1.223	0.117	10.6%
12	Community Involvement	2.726	2.954	0.228	8.4%
14	Legal	4.178	4.289	0.112	2.7%
15	Mental Health	2.274	2.929	0.655	28.8%
16	Substance Abuse	3.954	4.117	0.162	4.1%
90	Vulnerability Index	2.015	2.665	0.65	32.2%
	Average:	**2.631**	**3.126**	**0.495**	**18.8%**

Program Averages of initial SSOM and most recent SSOM scores for person enrolled in HS&C program. All domains reflect improvements over initial scores since being housed. A total of 271 individuals have been served since the subsidy was put in place in Dec. 2011.

- The lengths of stay in housing since the program began range from 0 days (for those just recently enrolled) to 3,231 days for those who have had long term stability.
- The average length of stay in housing since the program began is 1331 days with the median stay being 1,053.
- Slightly more males were served, 151 vs 112 female (8 gender not specified – e.g., refused to answer/not answered)
- Of the 271 served:
    - 87% (235/271) were literally or temporarily housed, meaning on the streets, in emergency shelter, or staying in temporary housing such as hospitals/jails.
    - 40% (106/271) were chronically homeless in places not meant for habitation or emergency shelter prior to entering the Housing Subsidy & Care.
    - Less than 24 % (62/271) came from psychiatric hospitalizations.
    - Over 46% (126/271) housed have exited since December 2011.
        - 29% (37/126) had positive destinations and 14% (18/271) are deceased.

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 ensure ongoing availability of housing to individuals who are homeless, severely, and persistently mentally ill, and in acute care settings. DMH continues the focus of efforts with Community Mental Health Centers and Pathways Vermont collaborations with local not-for-profit housing developers. The Self Sufficiency Outcome Matrix is required as part of a subsidy allocation.

All ten Designated Agencies and the Department's adult Specialized Service Agency (Pathways Vermont) 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.

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.

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.

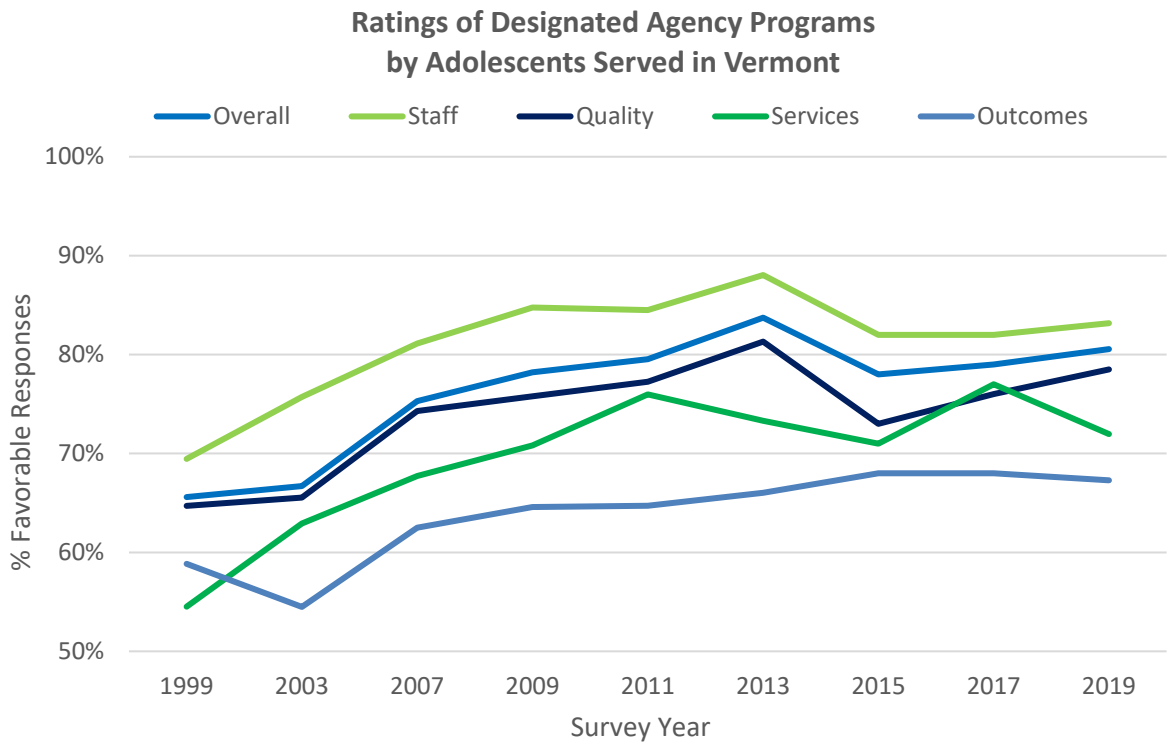
The federal Mental Health Block Grant (MHBG) budget calls for 10% of the funds to be allocated to evidence-based practices for early interventions for Early Serious Mental Illness (ESMI). Current research indicates that early intervention and treatment of individuals who are

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 collaborated with Howard Center and the Counseling Center of Addison County 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.

PERCEPTION OF CARE SURVEYS

Chart 31: Perception of Care Surveys Adolescents Served in Vermont

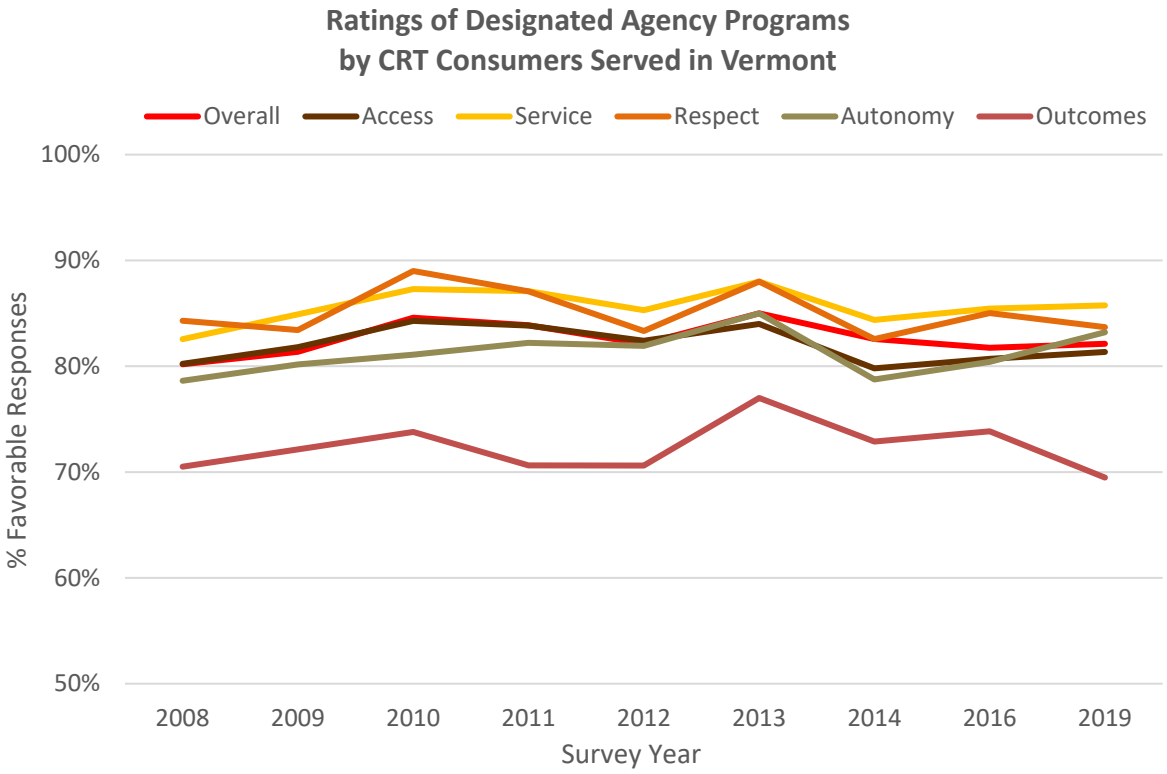


Analysis is based on responses to surveys of children served by Vermont's Department of Mental Health regional community-based child and adolescent mental health programs. Responses of "agree" or "strongly agree" are considered positive, compared to "no opinion", "disagree", and "strongly disagree".

In general, the ten-year period in ratings for adolescent served has seen an upward trend overall in the four key areas of measure: Staff, Quality, Services, and Outcomes. Scoring in

2019 saw satisfaction with Staff (83%) and Quality of experience at (79%) rated the highest for Designated Agencies. Services follow at (72%) while outcomes comes in at (67%). Overall, trend has increased consistently between 1999 – 2013 by (18%), experiencing only small declines of (5-6%) between 2014-2018.

Chart 32: Perception of Care Surveys Adult Community Rehabilitation and Treatment Served in Vermont



Analysis is based on responses to surveys of adults 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".

Similarly, the CRT Program providing services to adults with serious mental illness has had a reasonably stable overall satisfaction trend of 80% or above over the ten-year period. Key areas of measure for this adult population include Access, Service, Respect, Autonomy, and Outcomes. In 2019, Services satisfaction received the highest rating (86%) since a previous high of (88%) in 2013. In 2019 Access received a rating of (81%), Respect (84%), Autonomy (83%), and Outcomes (69%). Outcome ratings for this population served have seen a decline of (8%) between 2014 – 2018.

PLANNING FOR THE FUTURE

VISION 2030: 10-YEAR PLAN

The Vision 2030 Plan aims to provide Vermonters timely access to whole health, person-led care that achieves the Quadruple Aim of healthcare: 1) increasing the quality of care and patient experience; 2) improving population health, wellness, and equity; 3) lowering per capita costs; and 4) creating a better environment for Vermont's care teams. By fully embracing an integrated system that works collectively to address population health, wellness and equity, Vermonters will have improved access to care, will be healthier and happier, and the state will realize significant economic benefits as a whole.[9]

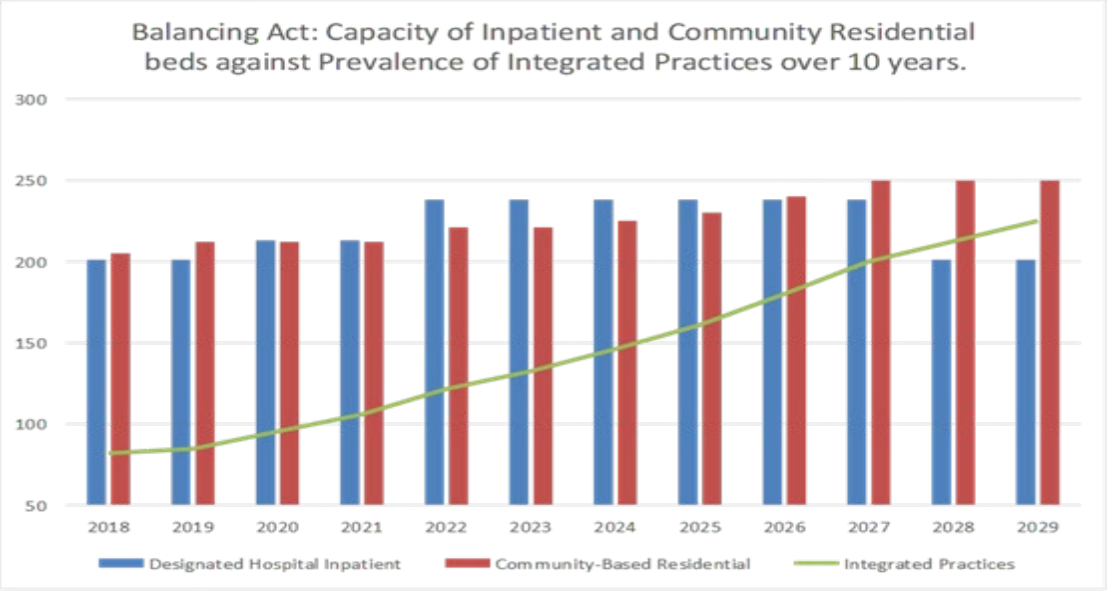
This plan identifies eight specific Action Areas to guide mental health stakeholders toward the Quadruple Aim, with short, mid, and long-term strategies recommended for each action. These recommendations reflect the expertise and input gathered during statewide listening sessions and numerous planning activities with Think Tank members and advisory committees (including persons with lived experience, legislators, care providers, state agency representatives and community members).

[9] http://www.jabfm.org/content/30/1/25.full?sid=f635119b-7243-4bfe-bbd2-3241c11377f4; https://www.ncbi.nlm.nih.gov/pubmed/28379819; http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/affordable-care-act/integrating-primary-care-and-mental-health-key-im?page=full

Vision 2030 leverages our system's current strengths to shape an integrated system of whole health—with holistic mental health promotion, prevention, recovery, and care in all areas of healthcare—across every Vermont community. This requires improved coordination across sectors, between providers, community organizations and agencies. Our workforce must use the best technologies, evidence-based tools, and practices for making data-informed decisions, supporting systems-learning and producing measurable outcomes.

Links to materials generated throughout this process are posted at this link: https://mentalhealth.vermont.gov/about-us/department-initiatives/10-year-planning-process-mental-health-think-tank

The Department of Mental Health is progressing toward an integrated system that will be guided by the newly enacted Mental Health Integration Council (which is now being convened in January 2021), and will continue building a system that fully meets Vermont's standards for affordable, accessible, quality health care. As DMH implements the Vision 2030 action plan with the Council, we will include the Retreat as a component of the analysis of current and future priorities-and a resource for meeting a broader range of mental health needs. Work will include a Strategic Plan for the long-term reuse of the renovated Brattleboro Retreat.



A team from DMH and leadership of the Retreat have been meeting to develop a strategic plan for long term reuse of the renovated facility (12 new Level 1 beds), anticipating over the long term an integrated system with increased community-based services and decreased need for psychiatric inpatient. This work will be informed by Vision 2030 as well as the Analysis of Residential Beds

Needs Report completed by DMH in 2020. Initial planning has highlighted opportunities for the Retreat in the following areas:

- Adult Rapid/Crisis Stabilization Unit that could provide rapid stabilization, assessment, psychiatric evaluation, brief treatment, and social service supports for adults experiencing acute mental health concerns
- Youth/Adolescent Hospital Diversion Program
- Youth/Adolescent Partial Hospitalization
- Additional secure residential capacity

It should be noted that the impact of COVID-19 has resulted in significant fluctuation in the demand for mental health inpatient beds across state. It is unknown at this time what the long-term impact on need/demand for inpatient beds will be. However, it does remain that demand and occupancy for Level 1 Beds remains consistent. The ongoing need and demand for inpatient capacity across the state should be considered as part of the long-term planning for the strategic reuse of the new Level 1 beds at the Retreat.

The AHS and Brattleboro Retreat teams will continue to explore the re-use opportunities, which will be inclusive of stakeholder feedback and responsiveness to system of care needs. Further engagement will require inclusion of legal and licensing experts as well as consideration of impact on business and revenue operations, and achievement of organizational efficiency for the Retreat.

DMH, encouraged by the 10-Year vision work and degree of stakeholder interest, will continue to also explore opportunities like:

- More robust Mobile Response and Support Services (MRSS) capacity in Vermont. Contributors to the visioning and report development for long-range planning recommended that one of the strategies for enhancing crisis intervention and discharge planning services could be achieved in the short-term through The Crisis Intervention Team (CIT) program that has become a globally recognized model to safely and effectively assist people with mental and substance use disorders who experience crises in the community. The CIT Model promotes strong community partnerships among law enforcement, mental health and substance use treatment providers, people with mental and substance use disorders, along with their families and others. While law enforcement agencies have a central role in program development and ongoing operations, a continuum of crisis services available to citizens prior to police involvement is part of the model. These other community services (e.g., mobile crisis teams, crisis phone lines) are essential for avoiding criminal justice system involvement for those with mental health challenges.

- Innovative programs, Like the Parachute Project (NYC) that uses the evidence-based practice of Open Dialogue to provide need-adapted treatment. It has various levels of support including mobiles crisis, outreach, and respites programs to help support people with serious mental health concerns to learn how to live with acute stress. Teams of people including social workers, psychiatrists, peers, and family members work together in a non-hierarchical manner to encourage people living with mental health issues to develop their own route to recovery. This model is consistent and complimentary with Open Dialogue practices already being prioritized by a portion of the state's Mental Health Block Grant funds.

- Examine the most recent data coming out of the National Research Institute's 2020 State Profiles: Impact of COVID-19 on State Mental Health Services (Oct 2020) for implications for additional areas of need and focus for mental health services in Vermont at the following link: http://nri-inc.org/media/1677/nri-2020-profiles-report-the-impact-of-covid-on-state-mental-health-systems.pdf

- Explore opportunities to advance training and/or certification and recognition of a Peer Workforce and compensation as other state plan services

- Explore more robust "Six Core Strategies for Reducing Seclusion and Restraint" funding strategies and training initiatives for all the designated hospital workforces

APPENDICES

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.

https://mentalhealth.vermont.gov/reports-forms-and-manuals/reports/results-based-accountability

DMH System Snapshot

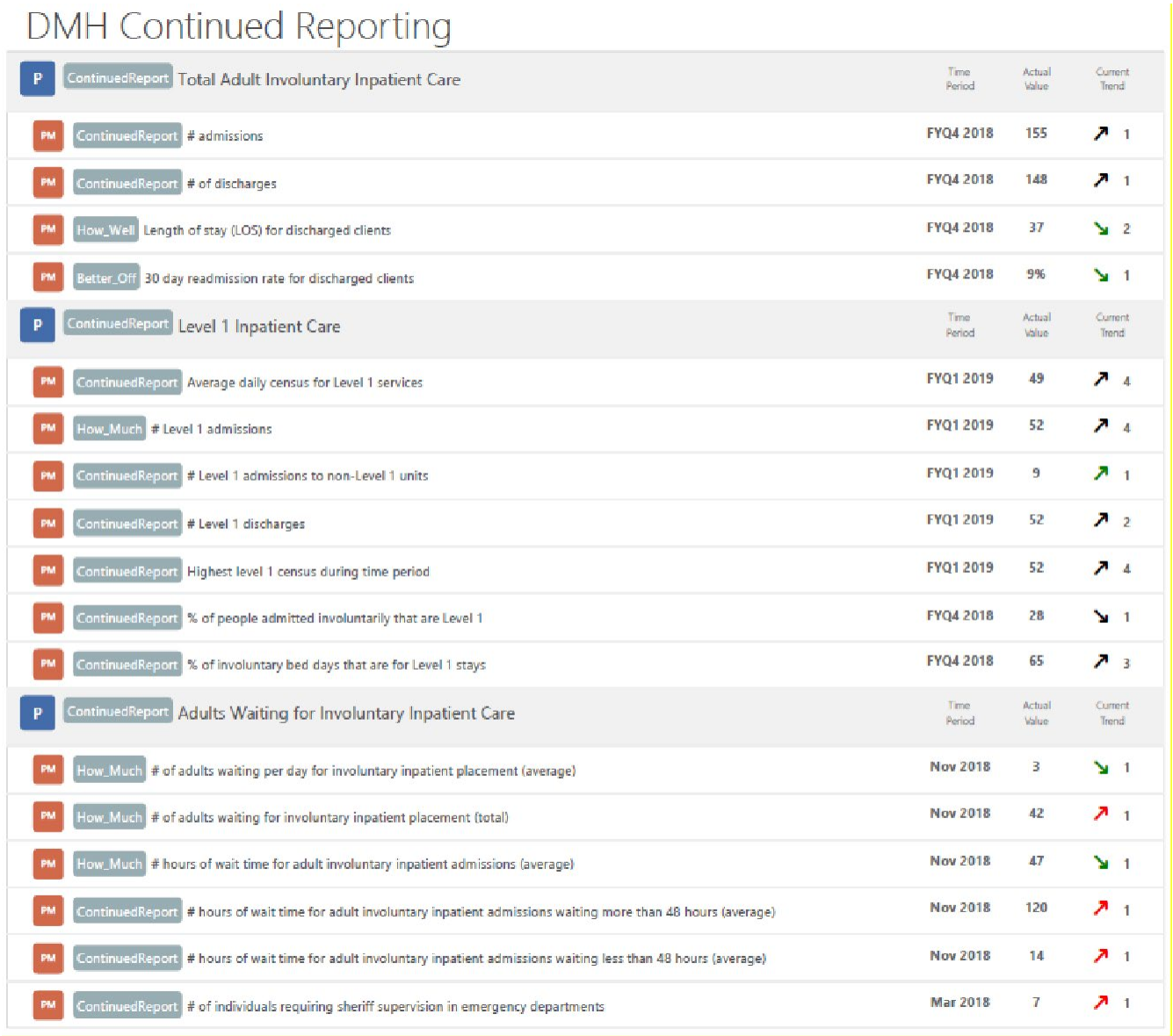
		Time Period	Actual Value	Current Trend
P	Snapshot Adult Inpatient Hospitalization			
PM	How_Much % occupancy of adult inpatient hospital units	FYQ1 2019	91%	→ 1
PM	Snapshot # of closed adult inpatient beds per day (average)	FYQ1 2019	8	↗ 1
PM	Snapshot % of all adult inpatient bed days used for involuntary 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 B: 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.

https://mentalhealth.vermont.gov/reports-forms-and-manuals/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 2018 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	7,808,416	38.69	23.69	58
Community Utilization per 1,000 population	7,577,095	38.56	22.99	58
State Hospital Utilization per 1,000 population	129,300	0.13	0.39	52
Other Psychiatric Inpatient Utilization per 1,000 population	447,545	0.87	1.58	41

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	758,207	42.3%	46.0%	57
Employed (percent with Employment Data)**	758,207	28.5%	22.2%	57

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	-	80.4%	50

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	-	72.3%	46

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	5,658	1.2%	7.2%	46
State Hospital Readmissions: 180 Days	13,392	11.1%	17.1%	50
State Hospital Readmissions: 30 Days: Adults	5,104	1.2%	7.3%	45
State Hospital Readmissions: 180 Days: Adults	11,997	11.1%	17.1%	49
State Hospital Readmissions: 30 Days: Children	545	0.0%	6.5%	17
State Hospital Readmissions: 180 Days: Children	1,386	0.0%	16.5%	19

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,154,672	85.6%	83.5%	56
Homeless/Shelter	222,312	3.8%	4.5%	53
Jail/Correctional Facility	111,902	0.1%	2.2%	50

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	91,920	-	2.9%	35
Supported Employment	70,310	26.2%	2.0%	45
Assertive Community Treatment	76,802	-	2.1%	45
Family Psychoeducation	39,412	-	2.8%	15
Dual Diagnosis Treatment	250,051	-	11.6%	28
Illness Self Management	336,335	-	20.0%	21
Medications Management	524,689	84.4%	32.1%	19

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	7,762	-	1.1%	22
Multisystemic Therapy	25,203	-	3.8%	20
Functional Family Therapy	24,841	-	4.9%	16

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	-	76.6%	48
Child/Family Improved Social Connectedness	-	86.3%	45

*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 - 2018 State Mental Health Measures

Vermont

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	24,104	38.69	7,808,416	23.69	58
Community Utilization per 1,000 population	24,025	38.56	7,577,095	22.99	58
State Hospital Utilization per 1,000 population	79	0.13	129,300	0.39	52
Medicaid Funding Status	15,552	68%	5,310,831	71%	56
Employment Status (percent employed)	2,626	29%	758,207	22%	57
State Hospital Adult Admissions	60	0.76	96,700	0.80	52
Community Adult Admissions	6,654	0.48	10,921,488	2.26	52
Percent Adults with SMI and Children with SED	2,570	11%	5,519,497	71%	58

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	83 Days	90 Days	49
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	65 Days	85 Days	49
Percent of Client who meet Federal SMI definition	18%	70%	56
Adults with Co-occurring MH/SA Disorders	24%	27%	56
Children with Co-occurring MH/SA Disorders	-	5%	48

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	-	88.6%	50
Quality/Appropriateness of Services	-	89.5%	50
Outcome from Services	-	80.4%	50
Participation in Treatment Planning	-	86.2%	50
General Satisfaction with Care	-	90.1%	50

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	-	85.2%	46
General Satisfaction with Care	-	86.9%	47
Outcome from Services	-	72.3%	46
Participation in Treatment Planning	-	87.1%	47
Cultural Sensitivity of Providers	-	92.9%	45

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	17,346	85.6%	4,154,672	83.5%	56
Jail/Correctional Facility	21	0.1%	111,902	2.2%	50
Homeless or Shelter	764	3.8%	222,312	4.5%	53

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	1	1.2%	5,658	7.2%	46
State Hospital Readmissions: 180 Days	9	11.1%	13,392	17.1%	50
Readmission to any psychiatric hospital: 30 Days	-	-	28,791	13.0%	20

State Mental Health Finance (2018)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community Mental Health*	$212,924,990	88.8%	$29,108,504,837	68.5%	58
State Expenditures from State Sources	$2,271,952	0.9%	$21,077,218,310	49.6%	55
Total SMHA Expenditures	$239,890,344	-	$42,463,280,813	-	58

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	76,802	2.1%	45
Supported Housing	-	-	91,920	2.9%	35
Supported Employment	651	26.2%	70,310	2.0%	45
Family Psychoeducation	-	-	39,412	2.8%	15
Integrated Dual Diagnosis Treatment	-	-	250,051	11.6%	28
Illness Self-Management and Recovery	-	-	336,335	20.0%	21
Medications Management	2,101	84.4%	524,689	32.1%	19

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	7,762	1.1%	22
Multisystemic Therapy	-	-	25,203	3.8%	20
Functional Family Therapy	-	-	24,841	4.9%	16

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	-	-	33,739	4.0%	33
Juvenile Justice Contacts	284	3.1%	5,869	2.9%	33
School Attendance (Improved)	-	-	8,959	30.4%	23

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