Department of Mental Health

Mental Health System of Care: Reforming Vermont's Mental Health System

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VERMONT

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Reference Legislation

18 V.S.A. § 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 Health Care 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) the number of petitions for involuntary medication filed by the State pursuant to § 7624 of this title and the outcome in each case;
(8) barriers to discharge from mental health inpatient and secure residential levels of care, including recommendations on how to address those barriers;
(9) performance measures that demonstrate results and other data on individuals for whom petitions for involuntary medication are filed; and
(10) 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.

Executive Summary

The Department of Mental Health (DMH) submits this report to the Senate Committee on Health and Welfare and the House Committee on Health Care in compliance with 18 V.S.A. § 7256. This report describes how mental health treatment is provided to Vermonters in the appropriate, least restrictive settings across the continuum of care.

The mission of the Vermont Agency of Human Services (AHS) is to promote and improve the health of Vermonters. DMH resides under the Agency of Human Services and has the same critical mission: to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves. DMH, in collaboration with community partners, oversees and provides a comprehensive continuum of mental health services, spanning community-based treatment, crisis stabilization, residential programs, and inpatient psychiatric treatment.

Community-based services continue to serve Vermonters across a range of acuity levels, with outpatient and case management utilization remaining stable and emergency services utilization stabilizing after increases that began during the COVID-19 pandemic. Vermont's Crisis System of Care has expanded access to community-based crisis stabilization, with Mobile Crisis maintaining statewide 24/7 response capacity and expansion within existing Alternative to the Emergency Department sites. Residential programs are supporting timely transitions from inpatient care, though barriers to discharge from both residential and inpatient care still impact some transition timelines. Inpatient psychiatric unit occupancy is increasing toward pre-pandemic levels. Vermont continues to rank among the highest in the country for access to mental health services and maintains a strong commitment to person-centered and recovery-oriented care. Together, these trends demonstrate a system balancing access, acuity, and level of care to support treatment in settings appropriate to individual need.

DMH monitors recovery outcomes across the system using performance measures that assess improvement upon discharge, rates of readmission, and stability in community settings. DMH also maintains oversight of involuntary treatment to ensure that patient rights, autonomy, and self-determination remain central. All Emergency Involuntary Procedures (EIPs) are reviewed by DMH, petitions for court-ordered medication are tracked and reported, and the EIP Review Committee provides continuous quality review and cross-provider learning.

Finally, DMH continues to strengthen recovery-oriented alternatives. The integration of peer support services across mental health services, the implementation of Alternatives to the Emergency Department, and the expansion of the Certified Community-Based Integrated Health Center (CCBHC) model, which requires person-centered treatment planning, support safe, person-led decision-making regarding the use of psychiatric medication.

Overview of the Results Based Accountability (RBA) Framework and DMH Data Reporting

AHS uses the Results Based Accountability (RBA) framework to evaluate the performance of programs and initiatives, as well as make data-driven decisions. RBA is a key component of achieving value-based care in an integrated system.

The DMH website provides RBA scorecards containing longitudinal data and performance measures related to programs and the broader system of care. The scorecards are a valuable resource for conducting evaluations and tracking progress toward clearly defined targets that align with national quality standards and compliance measures.

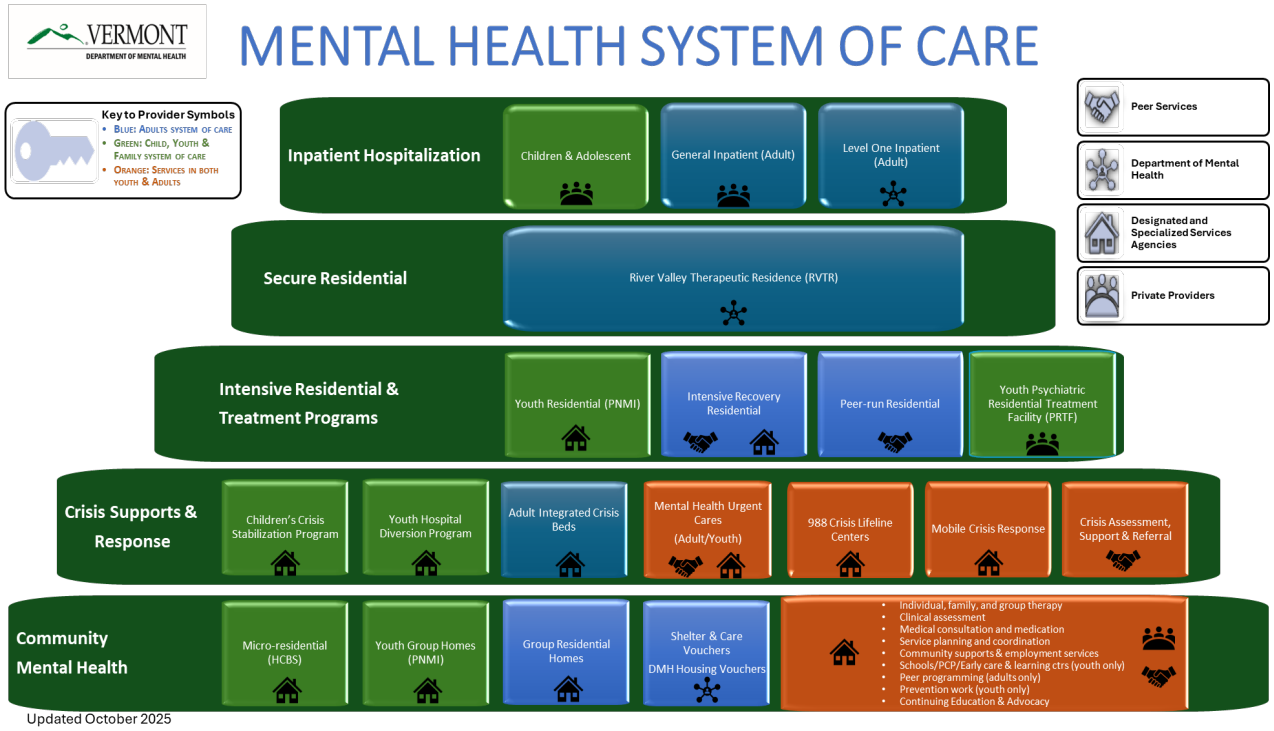
Regularly updated reporting by DMH includes:

- The Department of Mental Health (DMH) Scorecard
- DMH System Snapshot
- Reducing Seclusion and Restraint in Vermont's Psychiatric Hospitals
- Vermont Psychiatric Care Hospital (VPCH) Outcomes
- DMH Continued Reporting
- Power BI Dashboards and Reports
- DMH's Annual Statistical Report

Elements of this ongoing reporting are used below to address the reporting requirements of 18 V.S.A. § 7256. Point-in-time data from relevant scorecards are included in Appendix B.

The Mental Health System of Care

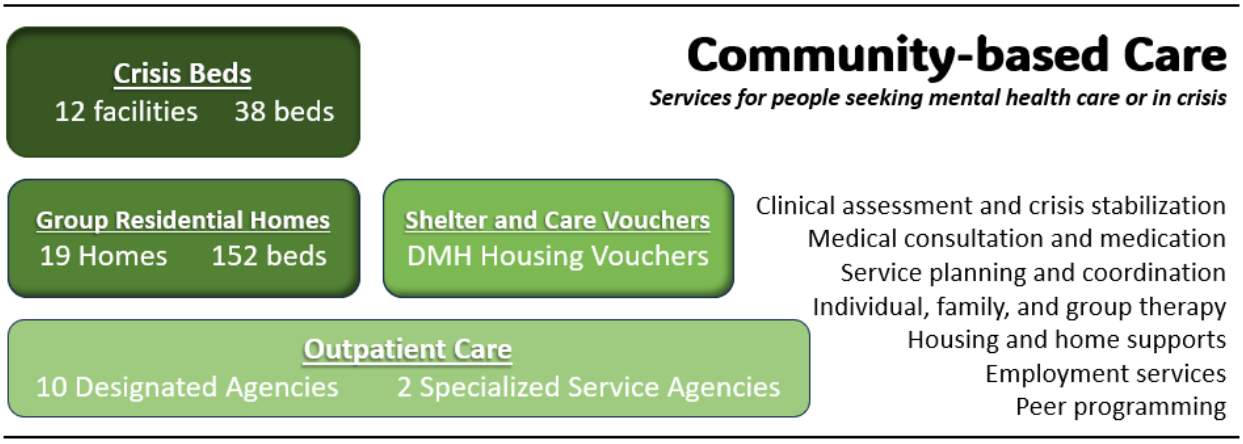
1. Use of Services and Adequacy of Capacity Across the Continuum of Mental Health Services



Vermont providers offer a broad spectrum of mental health services delivered by practitioners in the least restrictive setting necessary to meet an individual's needs. Individuals can access services in the community, in short and longer term residential settings, and in hospital inpatient settings.

DMH tracks use of services across the continuum, and reports through its System Snapshot Dashboard, which includes over 30 performance measures covering outpatient care, crisis services, residential programs, and inpatient hospitalization. DMH additionally submits an Annual Statistical Report, containing further detail on use of services both in the community and at the state run Vermont Psychiatric Care Hospital (VPCH).

1.1 Community-Based Services



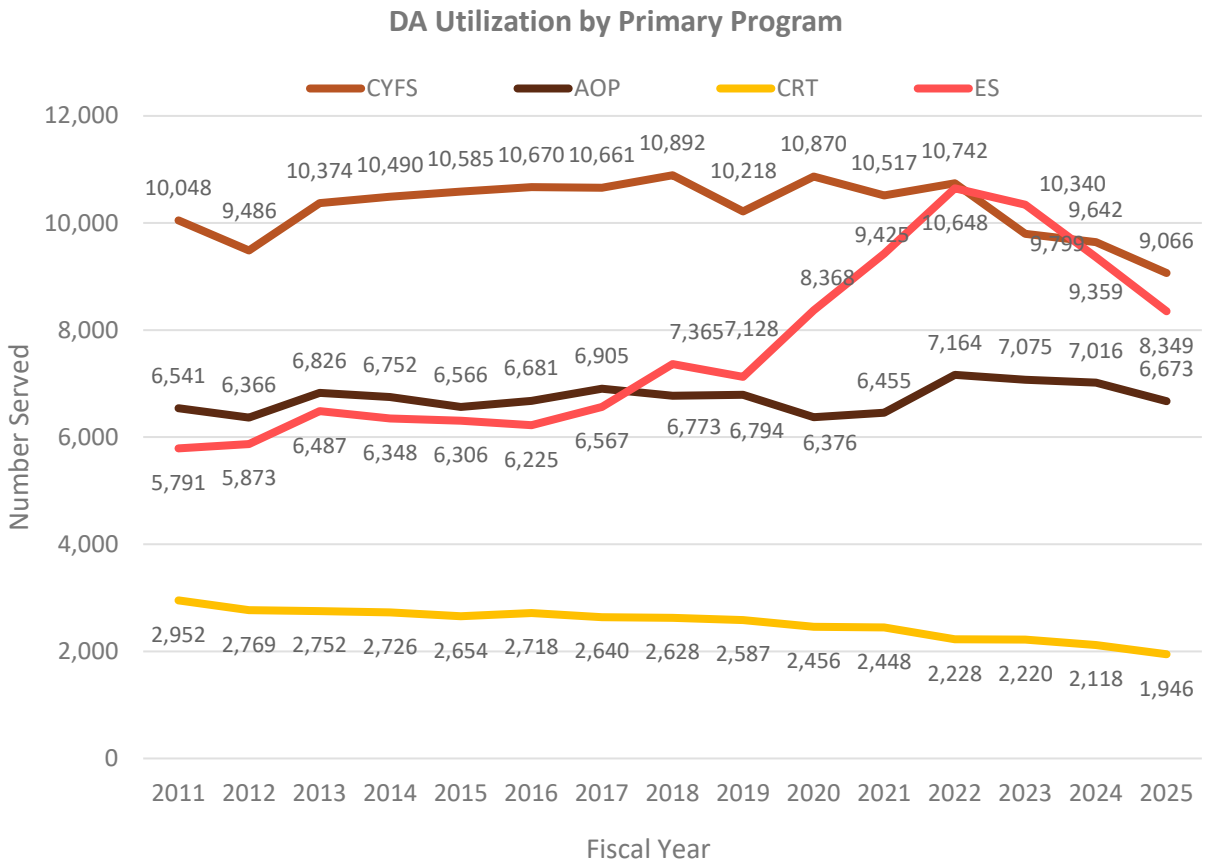
Community-based mental health care in Vermont is delivered by Designated Agencies (DAs) and Specialized Service Agencies (SSAs) operating under contract with DMH. DMH provides funding for mental health programs and services, establishes performance expectations, and maintains oversight to ensure that programs meet state and federal standards for quality, accessibility, and accountability. Community-based care provides a continuum of services including outpatient therapy, case management, crisis response, and treatment for adults with serious mental illness and children with emotional or behavioral challenges, designed to meet individuals' needs in the least restrictive settings possible.

Utilization and Capacity

DMH collects data from Designated and Specialized Service Agencies (DA/SSAs) to understand how many individuals access which services across a variety of community-based settings.

The chart below displays utilization of community-based services provided by DAs, by primary program. Primary programs include Children, Youth, and Family Services (CYFS), Adult Outpatient (AOP), Community Rehabilitation & Treatment (CRT)[1], and Emergency Services (ES).

[1] FY25 is the final year of the Community Rehabilitation and Treatment (CRT) program. On July 1 2025, DMH transitioned from the stand-alone CRT program to a unified adult mental health service model at the DAs and the Adult Specialized Service Agency (Pathways Vermont). This integrated approach means that all adults with mental health needs—regardless of diagnosis—will receive services through a single, coordinated adult mental health program in FY26 and future years.



Key Trends:

- **Children, Youth, and Family Services (CYFS)** utilization remained relatively stable through FY2020, followed by a gradual decline, decreasing from a peak of approximately 10,742 individuals in FY2021 to 9,066 in FY25.
- **Adult Outpatient (AOP)** utilization has remained comparatively steady over time, fluctuating within a narrower range.
- **Community Rehabilitation and Treatment (CRT)** has experienced a steady, long-term decrease in the number of individuals served, declining gradually from 2,952 in FY2011 to 1,946 in FY25.
- **Emergency Services (ES)** While still higher than before the COVID-19 pandemic, ES utilization appears to be stabilizing toward pre-pandemic levels. This reflects both strong community awareness of crisis supports, and capacity of non-emergency, community-based services to provide intervention prior to escalation in acuity.

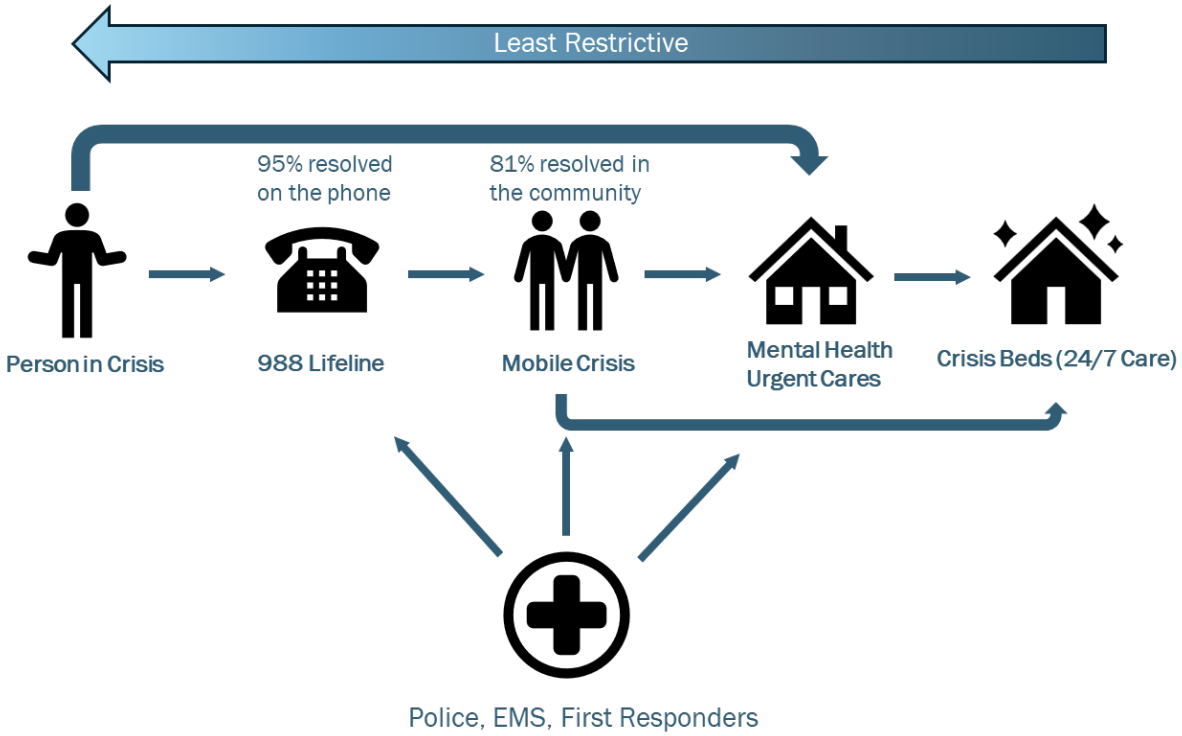
Utilization trends in community-based mental health settings suggest that community-based services are continuing to meet needs across a range of acuity levels, with

programs treating individuals in the least restrictive and most appropriate setting for their care.

Additional data related to utilization of community-based services is reported by DMH using these performance metrics:

(1) Number Served in Adult Outpatient Community Services
(2) Number of Adults Served in CRT Programs
(3) Number of Case Management Services by Adult Outpatient Programs
(4) Number of Children and Youth Served by Children, Youth and Family Services
(5) Percentage of Children and Youth Receiving Respite Services in their Homes

1.2 Crisis Services



Integrated Crisis Services in Vermont

This is the crisis continuum of care within the context of the entire mental health and substance use system of care. In Vermont, someone experiencing a mental health or substance use crisis can seek treatment at any point of access.

A mental health crisis or substance use crisis is an acute situation in which an individual's thoughts, emotions, or behaviors put themselves or others at risk of harm or impair their ability to care for themselves and function safely in the community, during which an individual may need immediate intervention and time-limited intensive supports.

Vermont's mental health Crisis System of Care ensures that individuals experiencing a mental health or substance use crisis have someone to call, someone to respond, and a safe place to go. The system includes the 988 Suicide and Crisis Lifeline (988), which provides 24/7 access to trained responders by call, text, or chat; Enhanced Mobile Crisis Response (Mobile Crisis), where local two-person teams deliver in-person support anywhere in the community; and Alternatives to Emergency Departments, which offer trauma-informed, short-term stabilization and recovery-oriented care.

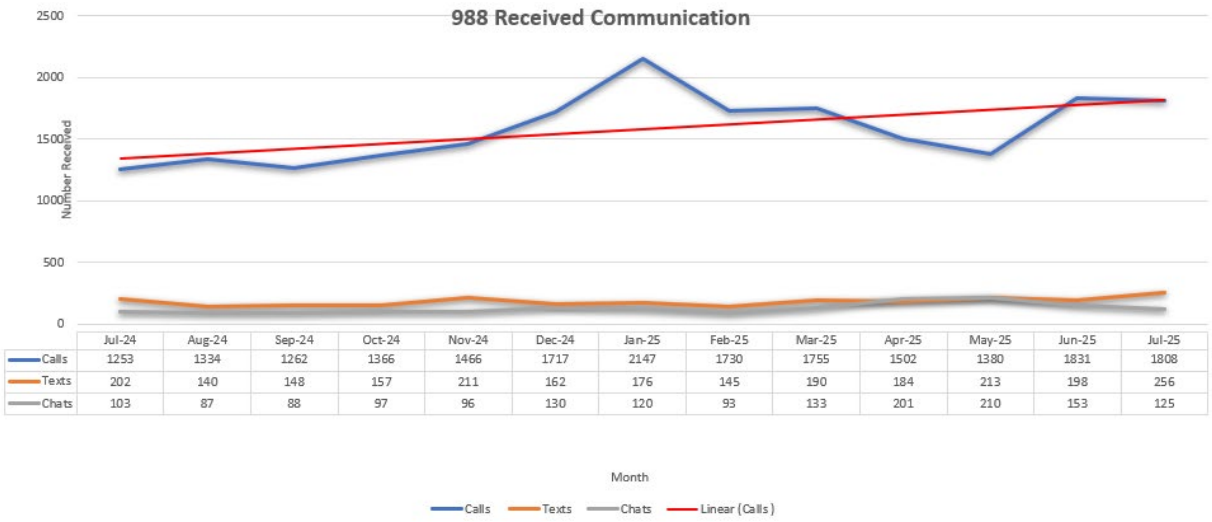
Together, these coordinated services reduce reliance on emergency departments and law enforcement while connecting Vermonters to the most appropriate care as quickly as possible. These elements are designed to work together so individuals can access the right help, at the right time, in the right setting, and to prevent unnecessary escalation to emergency services.

988 Suicide and Crisis Lifeline

The 988 Suicide and Crisis Lifeline offer free and confidential support 24/7. In Vermont, there are two 988 call centers, Northeast Kingdom Human Services (NKHS) and Northwestern Counseling and Support Services (NCSS), that provide continuous coverage for calls, chats, and texts. 988 also includes connections to specialized lines for Spanish speakers and veterans.

Utilization and Capacity

The chart below displays calls, texts, and chats received by 988 in FY25, showing a steady increase in utilization, with expected seasonal fluctuations.



	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Calls	1253	1334	1262	1366	1466	1717	2147	1730	1755	1502	1380	1831	1808
Texts	202	140	148	157	211	162	176	145	190	184	213	198	256
Chats	103	87	88	97	96	130	120	93	133	201	210	153	125

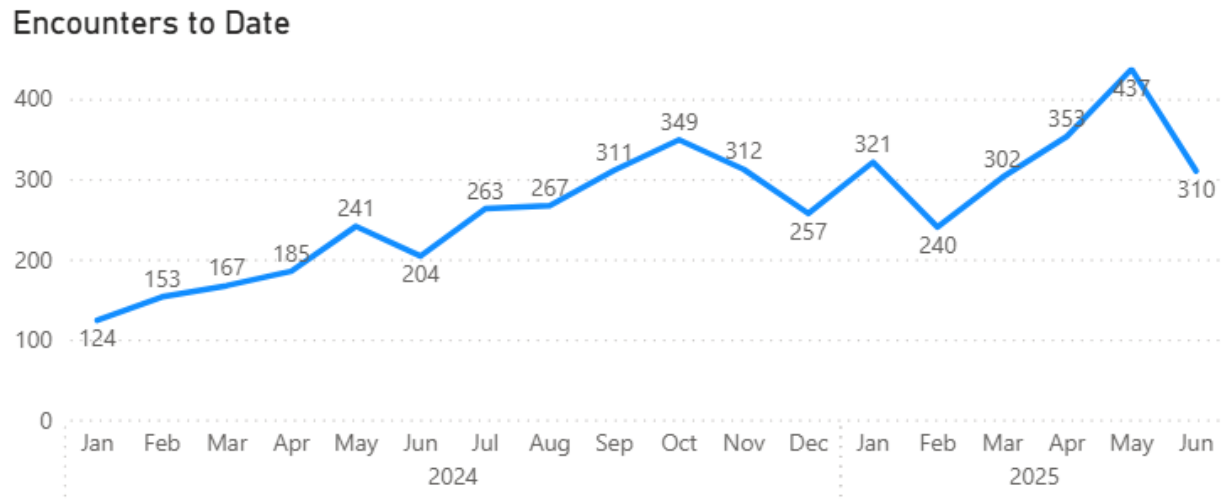
All conversations with 988, whether by phone, text, or chat, are answered by a real person. To ensure ongoing capacity for immediate, 24/7 responses, calls roll over to a national backup center when Vermont call centers are at capacity.

Enhanced Mobile Crisis Response

Available 24/7, enhanced community-based mobile crisis service is designed to assist individuals experiencing mental health, substance use, or co-occurring crises. A two-person team responds to these crises in the community—whether at home, school, or other settings—regardless of the individual's insurance status or age. The mobile crisis team provides rapid response, screening and assessment, de-escalation, and safety planning services.

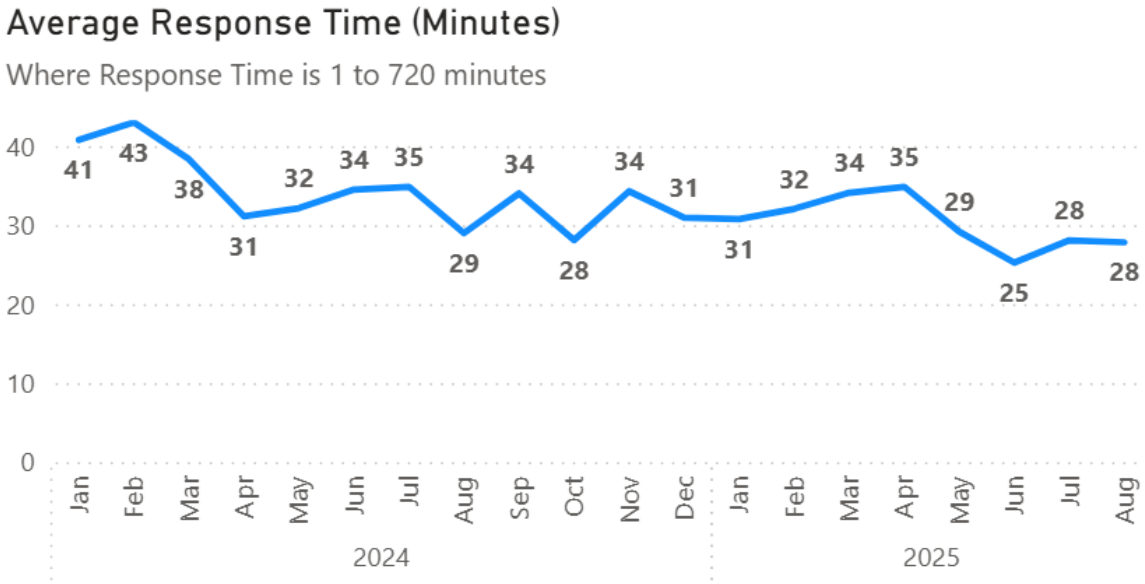
Utilization and Capacity

The chart below displays all Mobile Crisis encounters since the inception of the program on January 1, 2024, showing an increase in utilization throughout FY25, with expected seasonal fluctuations.



Mobile Crisis response is available 24/7, statewide. To maintain capacity for a 24/7 response, Designated Agencies can provide Mobile Crisis response outside of their typical service area when the local agency has reached capacity to respond.

To help assess capacity, DMH collects and reports response time for Mobile Crisis, with the goal of keeping all response times under one hour. The chart below provides average response time for all agencies, indicating strong capacity to respond to current demonstrated need.



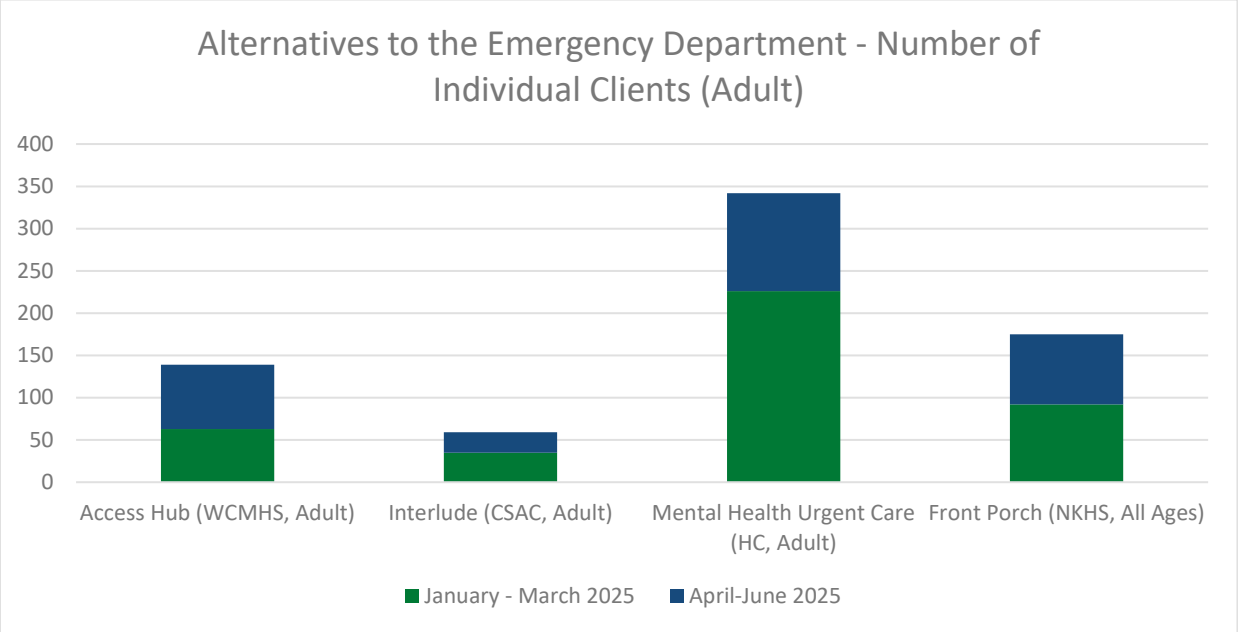
Alternatives to the Emergency Department

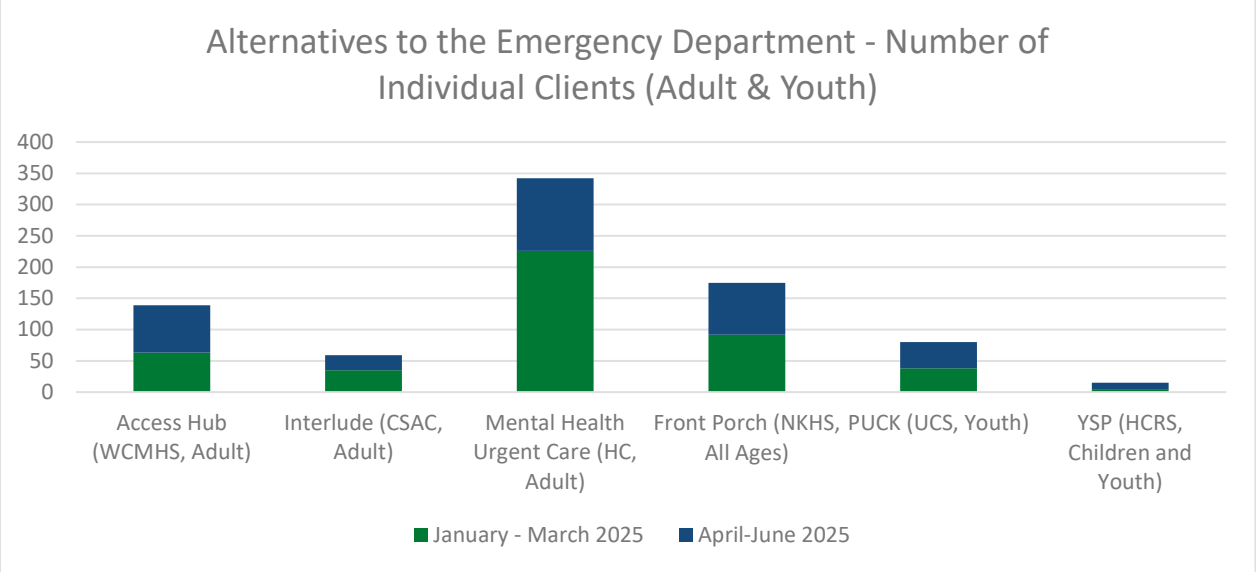
Alternatives to the Emergency Department sites provide mental health services and offer trauma-informed, person-centered, culturally responsive treatment for adults experiencing acute mental health crises. These services are intended for those with serious mental illness who are experiencing a crisis, as well as other adults who may not yet have an official diagnosis and require crisis support services. These programs include Northeast Kingdom Human Services' (NKHS) Front Porch, Counseling Services of Addison County's (CSAC) Interlude, Howard Center's (HC) Mental Health Urgent Care (MHUC), Washington County Mental Health's (WCMHS) Access Hub, Lamoille County Mental Health's (LCMH) Emergent Psychiatric Intervention for Children (EPIC), and United Counseling Services' (UCS) Psychiatric Urgent Care for Kids (PUCK).

Utilization and Capacity

In Calendar Year 2024, the data submitted to DMH by Alternatives to the Emergency Department varied significantly across sites, which resulted in data that could not be consistently compared across programs or used to reliably assess statewide utilization. To address this, DMH incorporated standardized data and reporting requirements into the new contracts that took effect at the beginning of Calendar Year 2025. This standardized approach ensures that all sites report comparable information when possible, supporting a clearer understanding of how these services are being used across the state and strengthening DMH's ability to evaluate access, utilization, and outcomes moving forward. However, this change effecting midway through FY25 creates difficulty in providing full reporting for FY25, as data reported in the first half of the fiscal year differs from the ongoing standardized reporting requirements currently in

effect. To ensure that data provided can be assessed across sites and accurately reflects the utilization and performance of Alternatives to the Emergency Department within the broader system of care, the data provided below reflects January-July of 2025, rather than the full 2025 fiscal year.





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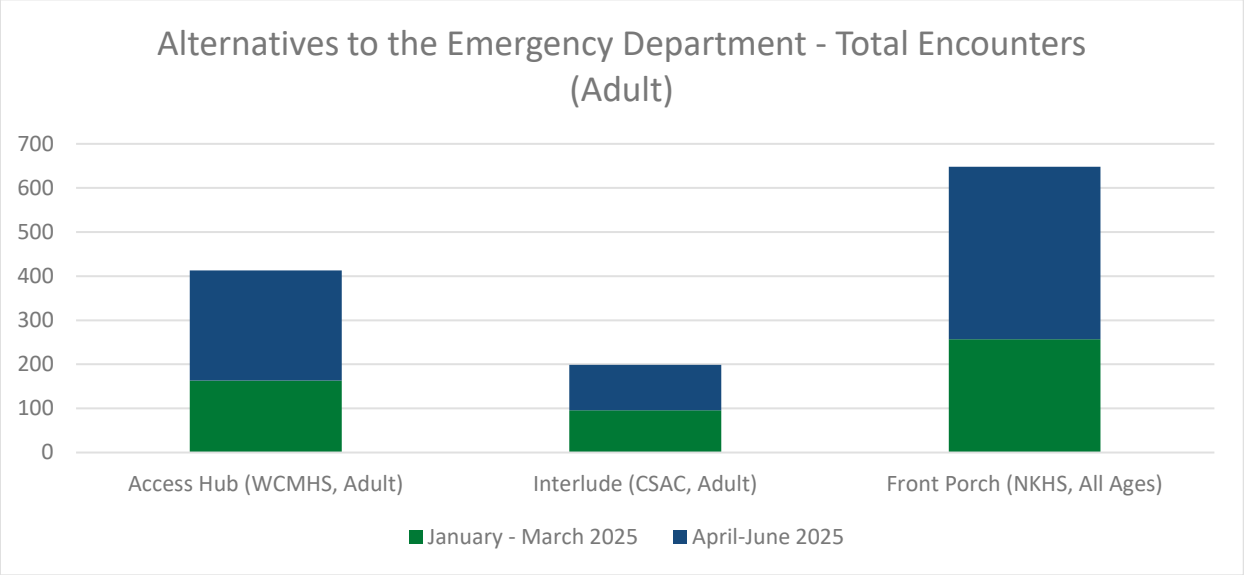
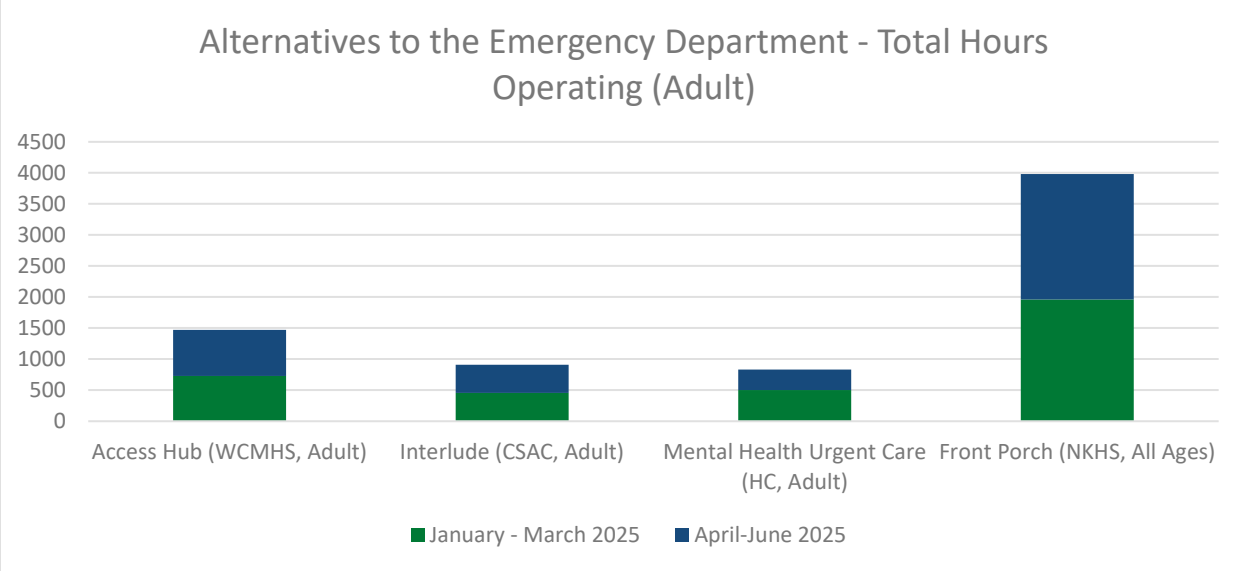
[2] Due to lack of utilization, data from LCMHS' EPIC program is not included in the charts above.

[3] HCRS' Youth Stabilization Program (YSP) is not a walk-in program and lower individual utilization numbers (with a high intensity of services) are expected.



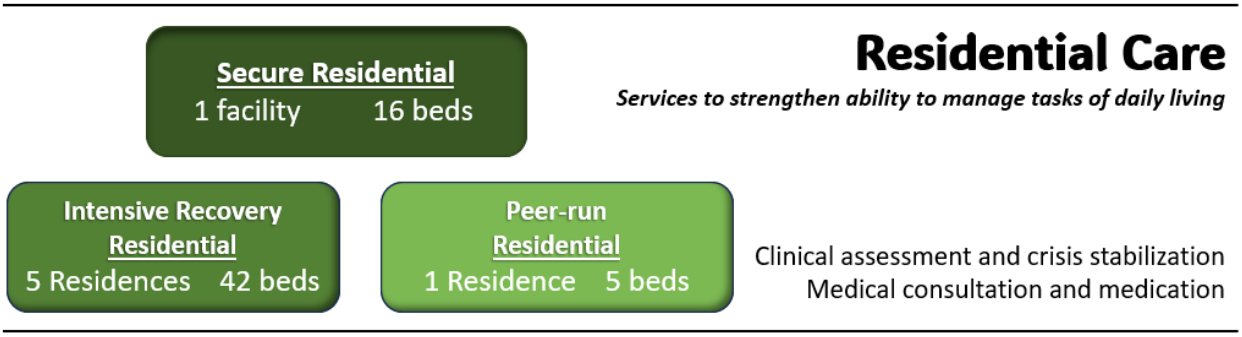


After careful review, LCMHS's Emergent Psychiatric Intervention for Children (EPIC) program was determined to be operationally unsustainable due to low utilization. The LCMHS executive team and board of directors decided that closure, effective December 1 2025, was the most appropriate course of action.

Despite this site closure, DMH is working to sustainably expand access and capacity for Alternatives to the Emergency Department across the state. As part of this effort, DMH is collaborating with community partners to examine opportunities to expand service provision at existing sites, including expanding operational hours and/or ages served. NKHS' 24/7 Front Porch site recently expanded capacity by constructing additional crisis beds. Additionally, the Howard Center's Mental Health Urgent Care site has been engaged in early-stage conversations with DMH to expand the age range of clients,

from adults only, to include individuals age 13 and older. By expanding current programs, and examining opportunities to create new, sustainable programs providing alternatives to the emergency department, DMH aims to ensure that this level of care is accessible to all who need it.

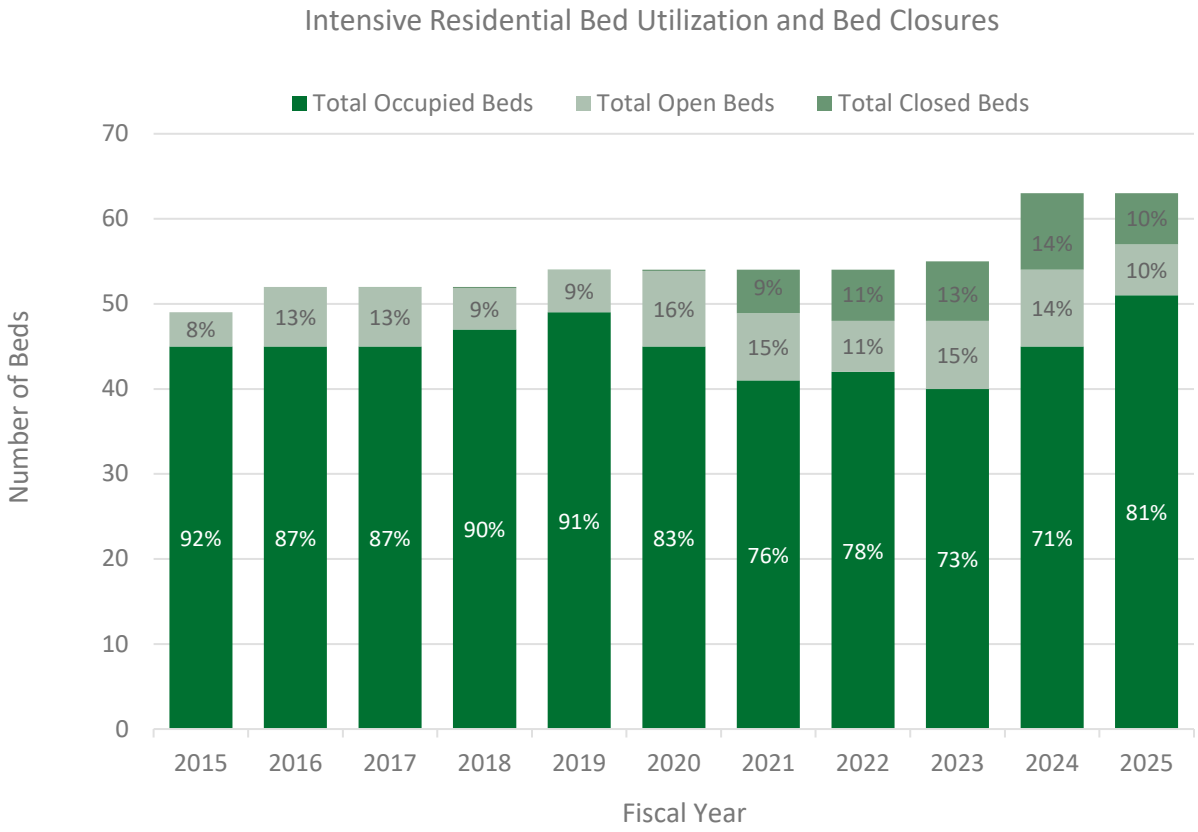
1.3 Residential Services



Community residential settings provide both transitional and longer-term treatment, meeting an essential need for many individuals, ready to leave higher levels of care, who require intensive support before independent living. Residential program lengths of stay average within a 12-to-18-month time frame for residents.

Residential treatment needs are provided in a variety of residential settings, as appropriate to individual needs, including secure residential (River Valley Therapeutic Residence), peer-run residential (Pathways Vermont Soteria House) and intensive recovery residences (Hilltop, Maplewood, Meadowview, Second Spring North and South).

Utilization and Capacity



The chart above illustrates the utilization of beds, and number of open beds, in community residential programs, based on the daily entries into the Electronic Bed Board System[4] by facility staff. Closed beds are beds not currently in service due to operational reasons such as staffing, unit safety needs, or patient acuity. These are common and expected fluctuations in hospital and residential environments.

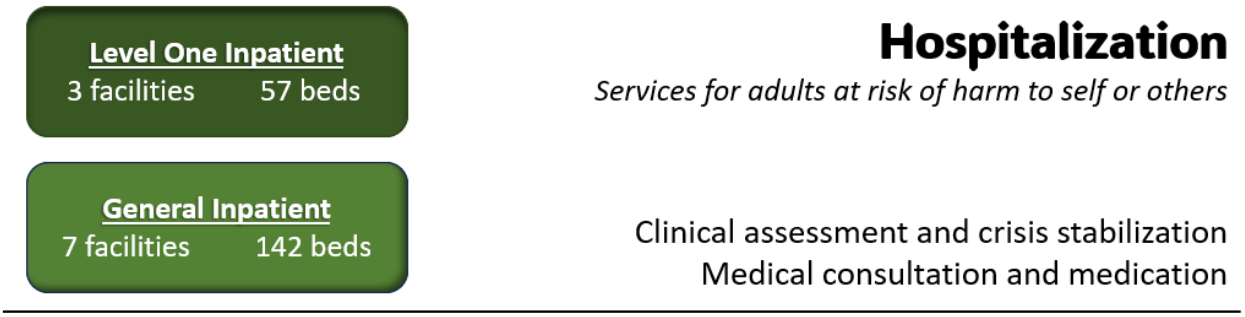
It is important to note that open beds are operational and ready for use, but may not be appropriate for every individual, depending on clinical or staffing factors – an open bed does not automatically equate to an available placement when considering an individual's specific treatment and medical needs, and wait times for placement may occur for some individuals regardless of nominally available capacity.

Residential programs function best when they are mostly but not completely full, which supports stable staffing patterns, therapeutic programming, and predictable use of beds. Occupancy that is too low may signal that referral pathways or admission processes are not functioning effectively, and the program's fixed operating costs (staffing, facilities, clinical supports) are spread across fewer individuals, increasing the cost per person

[4] Reported percentages serve as a point in time snapshot of a dynamic system and are influenced by various factors including reporting to DMH's Electronic Bed Board System regularly, unit staffing levels, and milieu acuity, which may contribute to fluctuations in data precision.

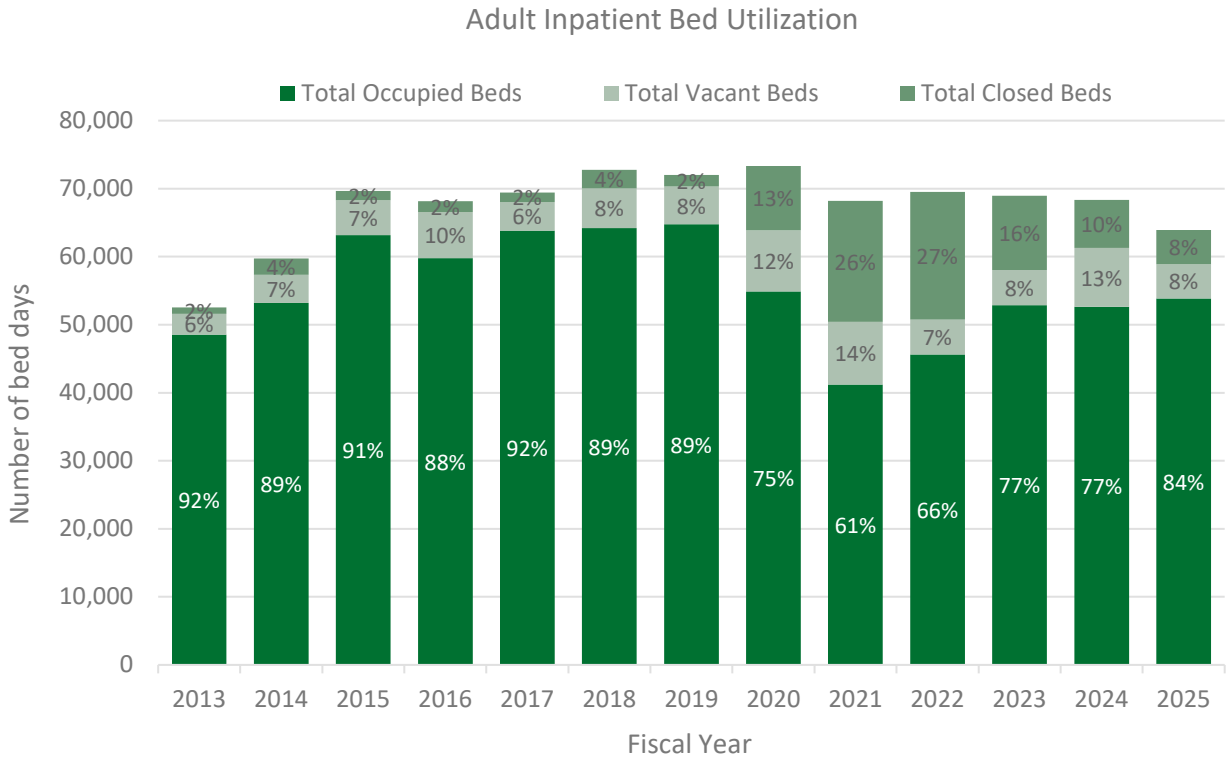
served. Conversely, if occupancy is consistently at or close to full capacity, the system has limited flexibility to admit individuals in crisis or transition those stepping down from inpatient treatment, which can contribute to longer emergency department stays, delayed discharges from hospitals, or extended waiting periods for community providers and families. Maintaining an occupancy level that is high but not full supports flow across the continuum, ensures that individuals can move into residential treatment when clinically appropriate, and reduces the potential for bottlenecks in inpatient and crisis services. As seen in the chart above, since COVID 19, residential treatment capacity has expanded, and occupancy rates are increasing toward optimal occupancy.

1.4 Hospital Inpatient Services



Vermonters in need of psychiatric hospitalization are provided treatment at either the state-run inpatient facility, Vermont Psychiatric Care Hospital (VPCH), or one of six Designated Hospitals (DHs) throughout the state. Level One care serves individuals who require the most intensive level of clinical support and services within the system. General inpatient units serve individuals facing significant mental health challenges and struggling to manage the symptoms to a degree that requires consistent, intensive clinical treatment and support to ensure their safety and well-being in daily living.

Utilization and Capacity



The chart above is based on data reported to DMH by DHs using the Electronic Bed Board System. It presents total bed use and number of open beds across the DH system by the number of bed days[5].

The capacity of inpatient psychiatric services is founded upon the balance between hospital admissions and discharges for people with acute mental health conditions. When more admissions than discharges occur, hospitalization capacity is reduced.

Maintaining inpatient occupancy at around 85% supports both efficient operation and timely access to inpatient treatment[6]. As shown in the chart above, from FY2013 through FY2019, Vermont's adult inpatient units operated slightly above optimal occupancy levels, meaning beds were consistently in use but still allowed limited flexibility for urgent admissions. During the COVID-19 period, staffing shortages and infection control constraints led to a substantial increase in closed beds and a reduction in occupied bed days, with occupancy dropping as low as 61–66%, which reflects underutilization not due to reduced demand, but reduced available capacity. This period demonstrates that when capacity falls too low, the system can struggle to meet clinical need, emergency departments may back up, and community programs may face extended waits. Operating too close to full occupancy leaves little room for individuals in

[5] "Bed days" is defined as the total number of beds across all hospitals, multiplied by 365 days.

[6] Bagust, A., Place, M., & Posnett, J. W. (1999). *Dynamics of bed use in accommodating emergency admissions: Stochastic simulation model*. *BMJ*, 319(7203), 155–158. https://doi.org/10.1136/bmj.319.7203.155

crisis and can delay admissions. In recent years, occupancy has begun to stabilize upward towards optimal occupancy, reflecting system efforts to restore staffing and operational capacity.

To help assess and report adequacy of capacity at the inpatient level, DMH collects and reports data on inpatient occupancy and wait-times for placement. Wait-times alone do not sufficiently represent overall capacity, as numerous factors impact individual wait-times, including an individual's unique medical needs or acuity of symptoms. Additional data related to capacity of inpatient services is reported by DMH using these performance metrics:

(6) Percent occupancy of adult inpatient hospital units
(7) Average Number of Adults Awaiting Involuntary Inpatient Placement, including in Emergency Departments
(8) Average Wait Time in Hours for Adults Awaiting Involuntary Inpatient Placement, including in Emergency Departments

2. Individual Experience of Care and Satisfaction

DMH has implemented an updated, electronic survey in Calendar Year 2024 to capture more comprehensive and user-friendly feedback. The transition to the new electronic survey will support more direct, consistent, and comparable reporting across programs. Results of the 2024 survey will be included in a re-issue of this report when available. DMH aims to synchronize the timelines of the survey with this report in future years, to ensure completed annual reporting of individual experience and satisfaction.

Additionally, and while this survey was developed, DMH relies on:

- **Quality Reviews by DAs**: Annual reviews include qualitative feedback on client experiences.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey**: Medicaid member responses indicate generally positive satisfaction with access to mental health services.

Sources: DMH Annual Statistical Report 2024, CAHPS Medicaid Adult Survey 2024.

3. Individual Recovery in Terms of Clinical, Social, and Legal Results

DMH reports outcome data for community-based treatment and involuntary hospitalization using the following performance metrics. These indicators are used to

assess trends regarding whether individuals receiving treatment are experiencing symptom improvement and are able to remain healthy in community settings with reductions in readmission to higher levels of care.

(9) Percentage of Adults Improved Upon Discharge from Adult Outpatient Programs
(10) Percentage of discharges readmitted involuntarily within 30 days of discharge
(11) 30-Day Readmission Rates for Discharged Involuntary Inpatient Clients

Additional Agency of Human Services (AHS) scorecards address population health measures related to mental health:

- Healthy Vermonters
- Suicide Surveillance Dashboard
- Agency of Human Services Performance Scorecards
    - Programmatic Performance Measure Budget Scorecard
    - State of Vermont Outcomes Report Scorecard

Finally, DMH's annual action plan for improving health outcomes is reflected in the State Health Assessment and Improvement Plan, which was informed by a robust assessment of health and social conditions for Vermonters.

4. Performance of the State's mental health system of care as compared to nationally recognized standards of excellence

Vermont's national Mental Health America ranking continues to improve: in 2025, Vermont was ranked 4th in the country, compared to 7th in 2024 and 12th in 2023. This overall ranking takes into account the prevalence of mental illness/substance use disorder (SUD), as well as access to treatment. This ranking is particularly notable, as Vermont ranks 45th (or 6th highest) in a combined measure of prevalence of mental illness and SUD.

Vermont has consistently led the nation in access to treatment, ranking first among all states for the sixth consecutive year. This ranking reflects the state's relatively higher percentage of insured residents, robust access to treatment, and strong support for students with emotional disturbance.

Nationally, there continues to be a projected increase in demand for mental health services, and the supply of mental health providers continues to decline. These ongoing trends highlight challenges of accessing and utilizing mental health treatment and challenges faced by the state's mental health system of care. DMH continues to evolve the continuum of care to ensure its ability to meet the mental health needs of Vermonters.

DMH has taken significant steps over the past five years to enhance the system of care and improve access to mental health services, including the development of a robust Crisis System of Care including the 988 Suicide and Crisis Hotline, statewide Enhanced Mobile Crisis Response, and Alternative to Emergency Department sites across the state; the launch of the Certified Community-based integrated Health Center (CCBHC) model, which is responsive to demonstrated community needs and offers same-day access to treatment; and ongoing investments in the mental health workforce.

Vermont is dedicated to maintaining and expanding a high-quality system of care, in the face of significant demand, and continues to set a benchmark of access for other states to follow.

5. Ways In Which Patient Autonomy and Self-Determination Are Maximized Within the Context of Involuntary Treatment and Medication

To ensure that patient rights are protected within the context of involuntary treatment, all Designated Hospitals (DHs) are required to submit detailed reports on every Emergency Involuntary Procedure (EIP) that occurs for any involuntary patient. 100% of these EIPs are reviewed by multiple content experts at DMH.

If problematic trends are identified through this review process, DMH works with the facility to address barriers to reducing seclusion and restraint rates and ensuring greater compliance with the regulations outlined in the EIP Administrative Rule, with the ability to impose corrective action when needed. If corrective action were given to a hospital and not resolved, or if the concern was severe enough, the designation status of that facility (and their ability to serve individuals involuntarily) could be revoked.

Additionally, all DHs are required to be members of the Emergency Involuntary Procedure (EIP) Review Committee, which is a public committee that meets quarterly. Each DH's involuntary EIP data for the quarter in review is presented as part of state-wide aggregate rates and as compared to other DHs in the system. Problematic trends identified are addressed in several ways by the EIP Review Committee, which serves as an opportunity for DHs to discuss trends in EIP data, appeal to peers and DMH resources for solutions, and provide valuable information on quality improvements that have positively impacted EIP rates in their facilities.

The Reducing Seclusion and Restraint in Vermont's Psychiatric Hospitals Scorecard is updated quarterly and displays the following performance measures:

(12)Number of hours of restraint per 1,000 patient hours
(13)Number of hours of seclusion per 1,000 patient hours
(14)Number of hours of seclusion and restraint per 1,000 patient hours

(15) Number of emergency involuntary procedures for involuntary patients
(16) Number of hours of emergency involuntary procedures for involuntary patients
(17) Average number of minutes for each emergency involuntary procedures for involuntary patients

DMH additionally submits an independent annual report, as required in Act 192 (2013), which addresses the administration of non-emergency involuntary medication and provides recommendations to DMH as to how to improve the process and individual experience of involuntary medication administration.

6. The Number of Petitions for Involuntary Medication Filed by The State Pursuant to § 7624 of This Title and the Outcome in Each Case

In SFY 2025, DMH filed 81 petitions for 68 unique patients for involuntary medication under 18 V.S.A § 7624, and 63 orders were granted. 55 unique patients had one Act 114 petition filed, and 13 unique patients had two Act 114 petitions filed.

DMH reports quarterly data on petitions and outcomes in the Court Ordered Involuntary Medications Scorecard using the metrics below:

(18) Number of applications for court-ordered involuntary medications
(19) Number of granted orders for court-ordered involuntary medications
(20) Average time from filing date to decision date in days

7. Barriers to Discharge from Mental Health Inpatient and Secure Residential Levels of Care, Including Recommendations on How to Address Those Barriers

DMH continues to closely monitor barriers to discharge for individuals discharging from involuntary inpatient psychiatric hospitalization as well as from the secure residential. Individuals generally discharged to lower levels of treatment when they were clinically ready to do so. However, access to housing or adequate residential treatment to meet the individual's needs remained the primary barriers for those whose discharge was delayed.

DMH has also continued to work closely with the Department of Aging and Independent Living to identify skilled nursing facility placements for individuals who are involuntarily hospitalized due to serious mental illness and meet skilled nursing facility level of treatment. This small subset of individuals tends to experience prolonged inpatient admissions when they decline all available placements or placements have identified

not being able to meet their needs, generally due to challenging behaviors related to their mental illness.

On July 1, 2025, DMH started a new process of completing Prior Authorizations for both residential treatment programs and Intensive Residential Recovery programs prior to an individual's admission. This process change formalizes alignment with Medicaid requirements and standardizes eligibility criteria statewide for each level of treatment. This change is expected to contribute to movement through the system of care for individuals who are clinically ready for discharge to less intensive settings.

8. Performance Measures That Demonstrate Results and Other Data on Individuals for Whom Petitions for Involuntary Medication Are Filed

Studies and reports submitted by DMH on Act 114 (1998) non-emergency involuntary psychiatric medication provide comprehensive detail on involuntary medication and are available here.

The Continued Reporting and System Snapshot scorecards track different outcome measures for adults served by inpatient psychiatric hospital units, those who are on involuntary status and adults served by Level One inpatient services.

Data related to involuntary hospitalization results is reported by DMH using these performance metrics. These measures support understanding of the duration and recurrence of involuntary hospitalization.

(21) Average time from filing date to decision date in days
(22) 30-Day Readmission Rates for Discharged Involuntary Inpatient Clients
(23) Length of Stay for Discharged Clients from Involuntary Inpatient Units

9. 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

Recovery Services and Crisis Training Manager

The Department of Mental Health has established a new Recovery Services and Crisis Training Manager position, to strengthen Vermont's recovery-oriented system of care. The position provides leadership for the development and coordination of recovery services across the continuum of care, with a particular focus on advancing peer-based

approaches. This position now oversees the statewide peer support specialist certification initiative**,** including coordination of credentialing provided by the Copeland Center, and collaboration with Pathways Vermont on training peers for certification.

As part of the collaborative development of a peer support specialist training curriculum, this position reviewed and adjusted the initial curriculum provided by Pathways to ensure it meets the needs of Vermonters pursuing peer support specialist certification, including integrating elements of the Medication Empowerment training course, which teaches mental health providers to identify common challenges related to using psychiatric medications and tools to effectively support individuals facing these challenges.

The Recovery Services and Crisis Training Manager has additionally collaborated with Pathways Vermont to provide a “Harm Reduction Approach to Psychiatric Drugs Training” webinar on appropriate use of psychiatric medication, in December of 2025. Attendance at this webinar was not restricted to clinicians or peers, to allow community partners, stakeholders, or any other Vermonter to attend.

Through these efforts, the Recovery Services and Crisis Training Manager advances Vermont’s commitment to expanding alternative treatment options and providing opportunities to avoid, reduce, or improve the experience of taking psychiatric medication. In addition, the Recovery Services and Crisis Training Manager role provides consultation and training support to crisis programs to ensure recovery-oriented and trauma-informed practices, including peer supports, are embedded throughout the crisis system.

Crisis System of Care

Peer providers within the Mental Health Crisis System of Care, including Mobile Crisis Response and Alternatives to the Emergency Department sites, work to deescalate and prevent mental health crises from escalating to the point where medication could be involuntarily administered.

Alternatives to the Emergency Department sites provide a non-medical model to access crisis services in a safe and supportive environment, rather than a hospital emergency department. No medication is administered at Alternatives to the Emergency Department sites, although individuals can be referred from the site to other providers to receive medication if desired. All Alternatives to the Emergency Department sites have peer provider staff, and individuals accessing these services may choose to interact only with peers, rather than clinical staff. To ensure that peer providers are supported in these settings, the peer may request support from clinical staff and may recommend to the individual that they receive a voluntary clinical assessment.

Individuals seeking care at Alternatives to the Emergency Department locations are

never required to interact with clinical staff, or to take or be on medication, in order to receive stabilizing treatment in that setting.

Certified Community-Based Integrated Health Centers (CCBHC)

CCBHCs are a federal model for community-based agencies, designed to deliver integrated mental health and substance use disorder services. As of July 1, 2025, two Designated Agencies (DAs), Clara Martin Center (CMC) and Rutland Mental Health Services (RMHS), officially transitioned to the federal CCBHC Medicaid Demonstration. An additional five DAs are currently undergoing certification review to implement the CCBHC model, with the goal of seven CCBHCs operating across Vermont on July 1, 2026.

The CCBHC model requires person-centered treatment planning, ensuring that individual choice, autonomy, and self-determination guide decision-making. Individuals seeking treatment determine their own goals and develop plans for their treatment in partnership with their provider. Providers recommend medication when it is clinically indicated and share information on the potential benefits and risks of medication and other treatments, but there is no requirement that medication be included in any treatment plan, nor is medication or adherence to medication a condition for receiving services. If an individual does not wish to begin, continue, or wishes to withdraw from psychiatric medication, person-centered treatment planning processes support the development of a safe, clinically informed strategy to do so.

CCBHCs are required to provide a range of at least ten evidence-based practices (EBPs), including Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), and Attachment, Regulation, and Competency (ARC). Most EBPs (excluding medications for opioid use disorder, medications for alcohol use disorder, and nicotine replacement therapy) can be delivered without the use of medication. For individuals living with SUD, there are excellent peer recovery centers that the DAs and CCBHCs can refer to and collaborate with. In addition, DAs and CCBHCs can refer individuals to other peer-run programs such as Soteria House and Alyssum, for support in a non-clinical, non-medical setting, including support during medication withdrawal.

This structure ensures that, if an individual's goal is to avoid or reduce reliance on medication, their autonomy and goals are respected and supported by providers, and they have access to safe, supported, and evidence-based alternatives across the continuum of care.

Conclusion

Vermont's mental health system of care continues to evolve to ensure that individuals receive treatment in the most integrated and least restrictive settings appropriate to their needs. The continuum of services, from community-based treatment and crisis response to residential treatment and inpatient hospitalization, is designed to promote recovery, stability, and connection to community.

DMH works with community providers and system partners to identify areas where access can be strengthened and to address barriers that contribute to delayed transitions across levels of care. Recent system enhancements, including the development of a statewide Crisis System of Care and the expansion of person-centered, recovery-oriented practice models through the Certified Community-Based Integrated Health Center (CCBHC) model, further support timely access to treatment and alignment with individual choice.

Involuntary treatment, including involuntary hospitalization and court-ordered medication, is used only when an individual's symptoms present significant risk and when less restrictive alternatives are not sufficient to support safety and recovery. DMH maintains oversight of involuntary treatment through multiple mechanisms to ensure that patient autonomy and self-determination remain central, and publicly reports outcomes to ensure accountability and transparency. These processes support DMH's responsibility to safeguard individual rights while ensuring that necessary treatment is available when it is essential for safety and stabilization.

DMH remains committed to supporting Vermonters in achieving and maintaining their mental health and well-being and to ensuring that appropriate treatment is available across the lifespan, across levels of need, and across the state. DMH will continue to evaluate, refine, and enhance the system of care to respond to emerging needs, strengthen capacity, and advance recovery and autonomy for all Vermonters.

Appendix A: Acronyms

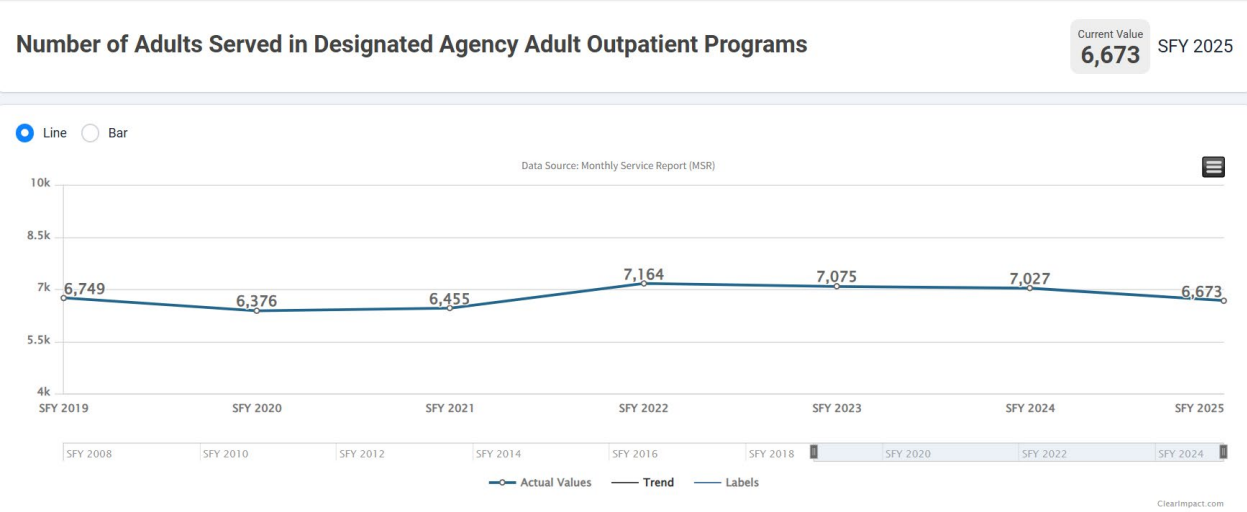
Acronym	Meaning as used in this Report
AHS	Agency of Human Services
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCBHC	Certified Community-Based Integrated Health Clinic
CRT	Community Rehabilitation and Treatment Program
CSAC	Counseling Service of Addison County

CYFS	Children, Youth and Family Services
DA	Designated Agency
DA/SSAs	Designated and Specialized Service Agencies
DH	Designated Hospital
DMH	Department of Mental Health
ED	Emergency Department
EPIC	Emergent Psychiatric Intervention for Children
HC	Howard Center
LCMH	Lamoille County Mental Health Services
MHUC	Mental Health Urgent Care
NCSS	Northwestern Counseling and Support Services
NKHS	Northeast Kingdom Human Services
PUCK	Psychiatric Urgent Care for Kids
RBA	Results Based Accountability
FY	State Fiscal Year
FY25	State Fiscal Year 2025 (July 1, 2024 - June 30, 2025)
SSA	Specialized Service Agency
SUD	Substance Use Disorder
UCS	United Counseling Services
VPCH	Vermont Psychiatric Care Hospital
WCMHS	Washington County Mental Health Services
988	The 988 Suicide and Crisis Lifeline

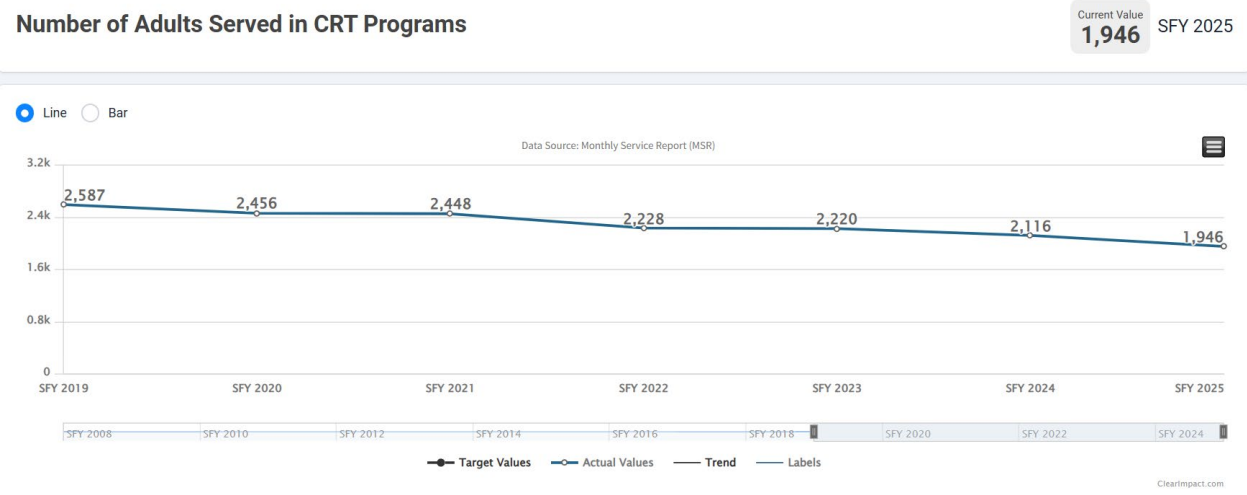
Appendix B: Performance Metric Data

Point-in-time data for the scorecards referenced in this report is found below. Hyperlinks in this appendix direct to the live scorecards.

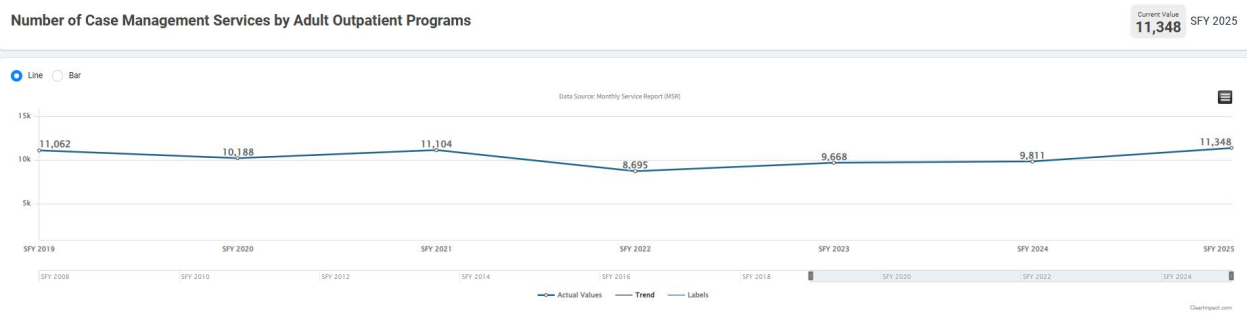
(1) Number Served in Adult Outpatient Community Services



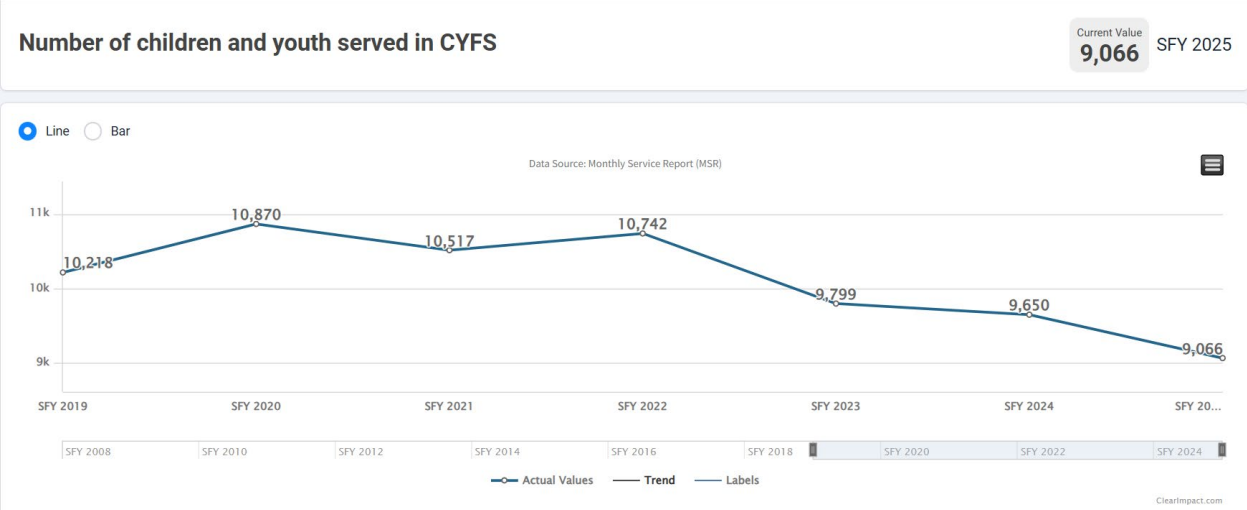
(2) Number of Adults Served in CRT Programs



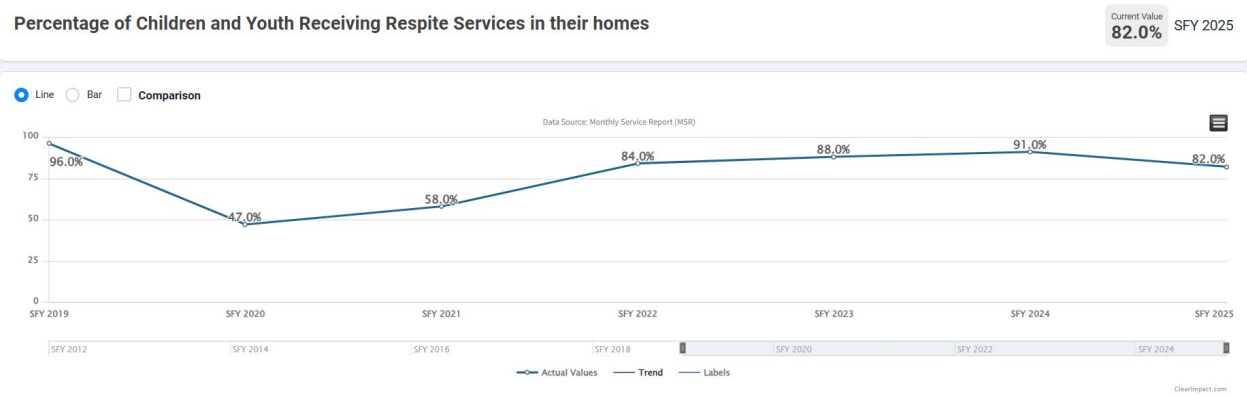
(3) Number of Case Management Services by Adult Outpatient Programs



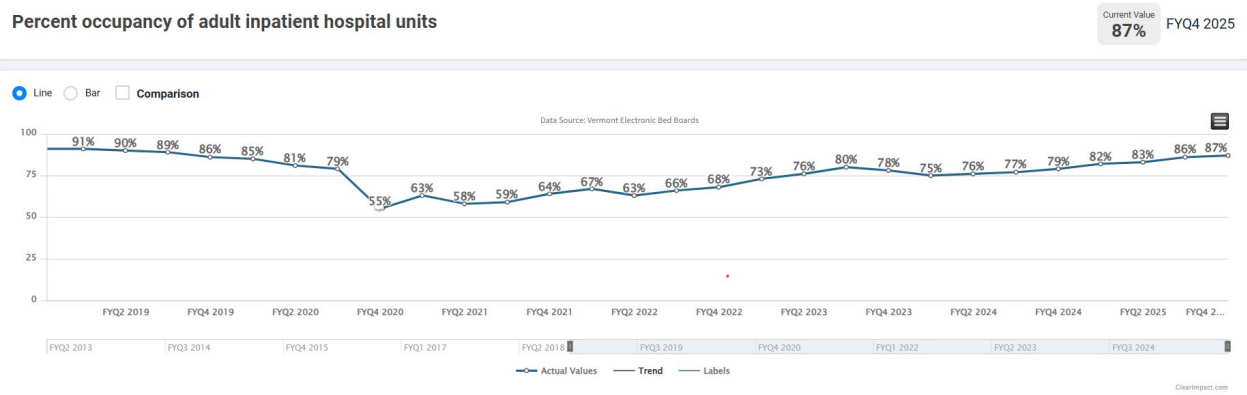
(4) Number of Children and Youth Served by Children, Youth and Family Services



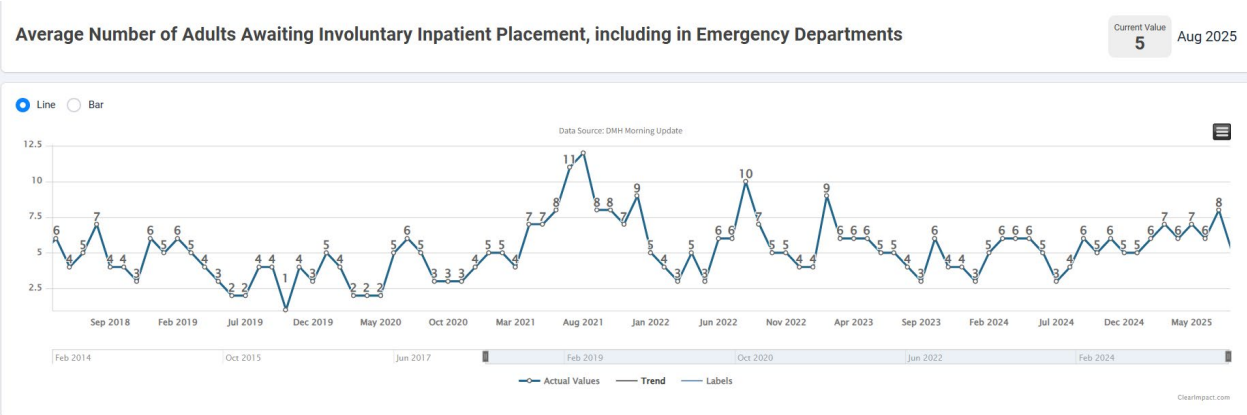
(5) Percentage of Children and Youth Receiving Respite Services in their homes



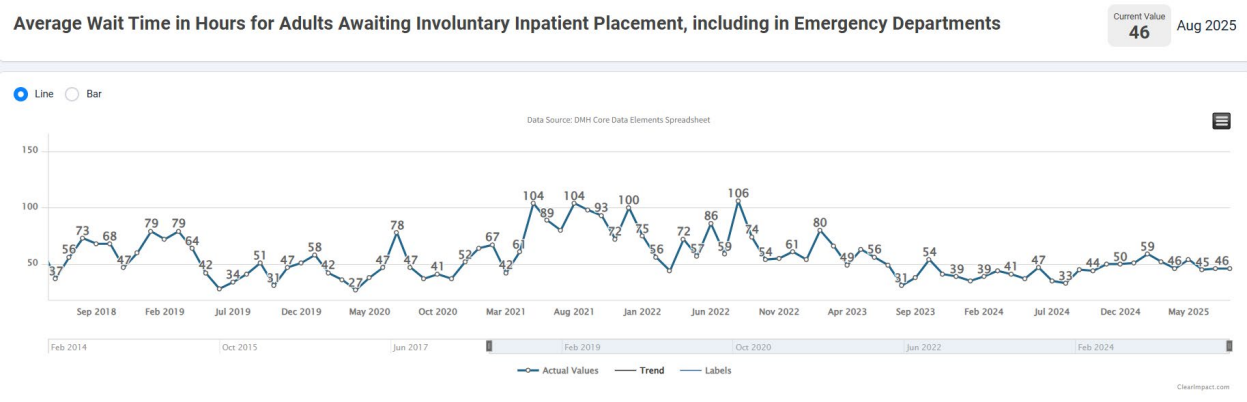
(6) Percent occupancy of adult inpatient hospital units



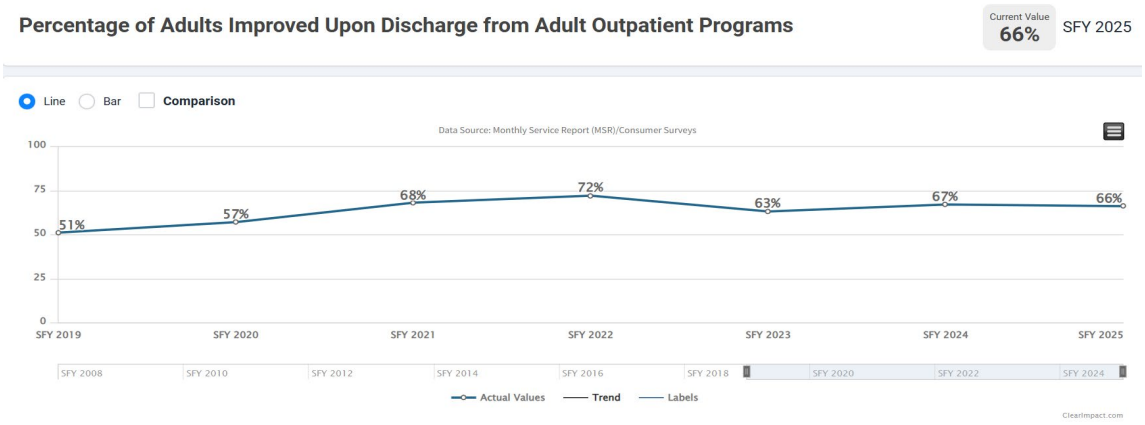
(7) Average Number of Adults Awaiting Involuntary Inpatient Placement, including in Emergency Departments



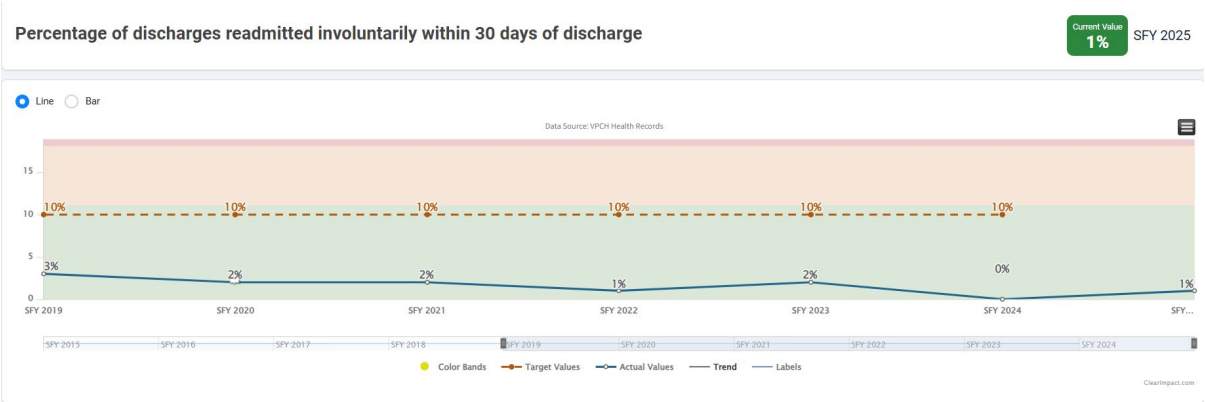
(8) Average Wait Time in Hours for Adults Awaiting Involuntary Inpatient Placement, including in Emergency Departments



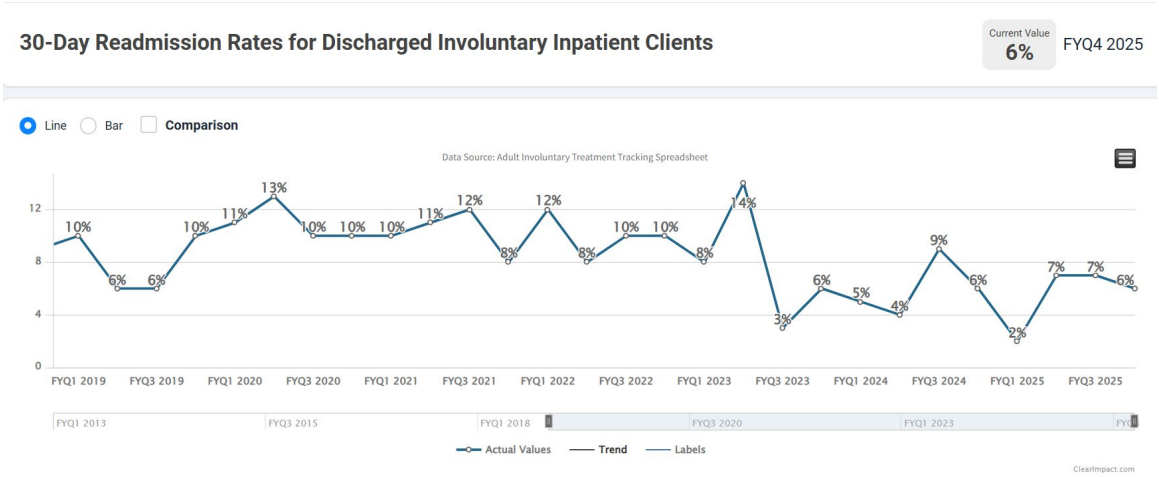
(9) Percentage of Adults Improved Upon Discharge from Adult Outpatient Programs



(10) Percentage of discharges readmitted involuntarily within 30 days of discharge

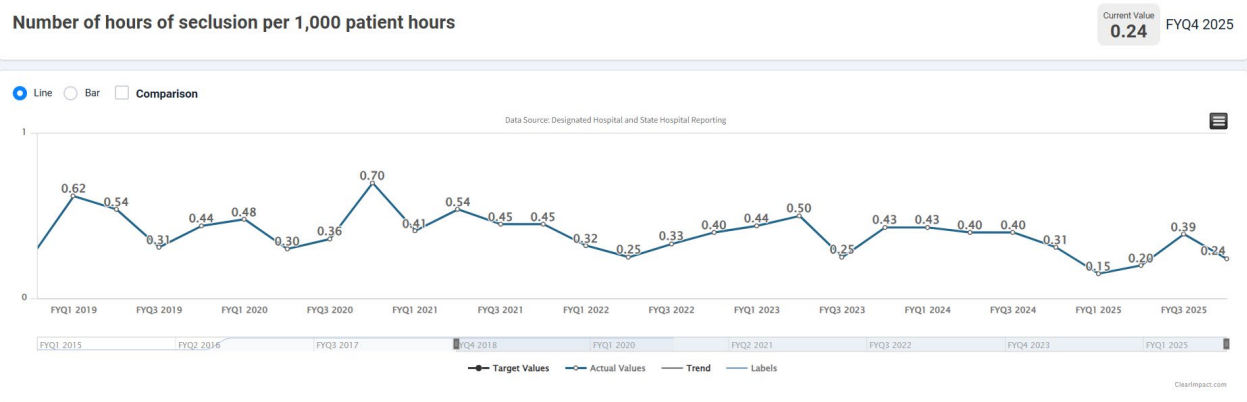


(11) 30-Day Readmission Rates for Discharged Involuntary Inpatient Clients

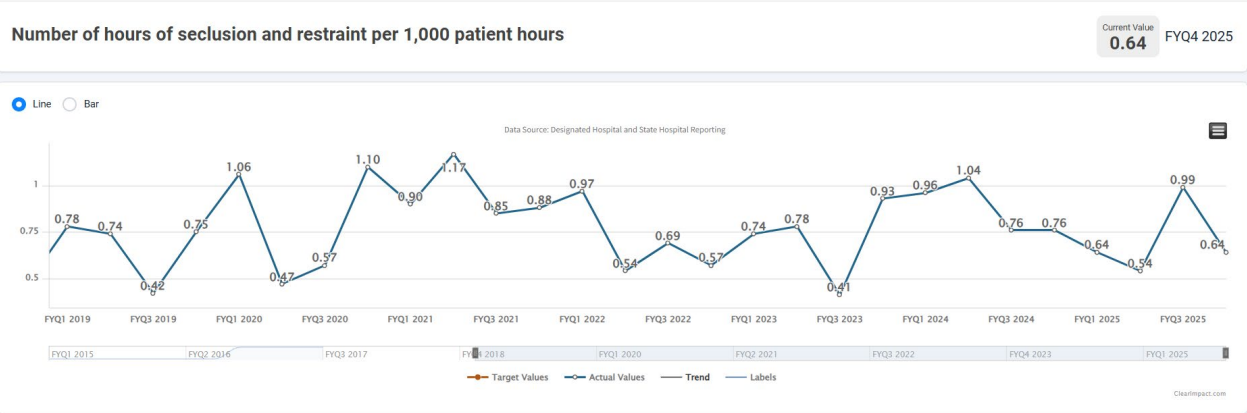


(12) Number of hours of restraint per 1,000 patient hours

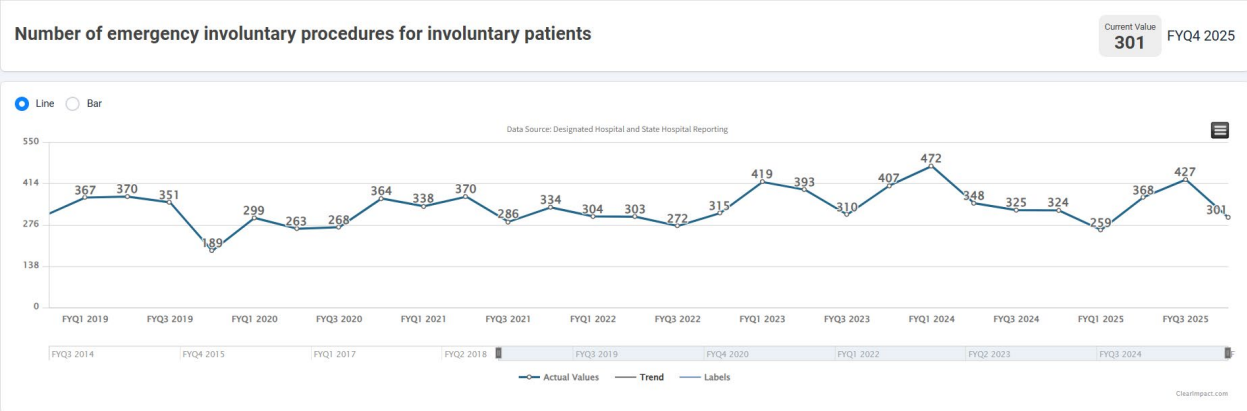
(13) Number of hours of seclusion per 1,000 patient hours



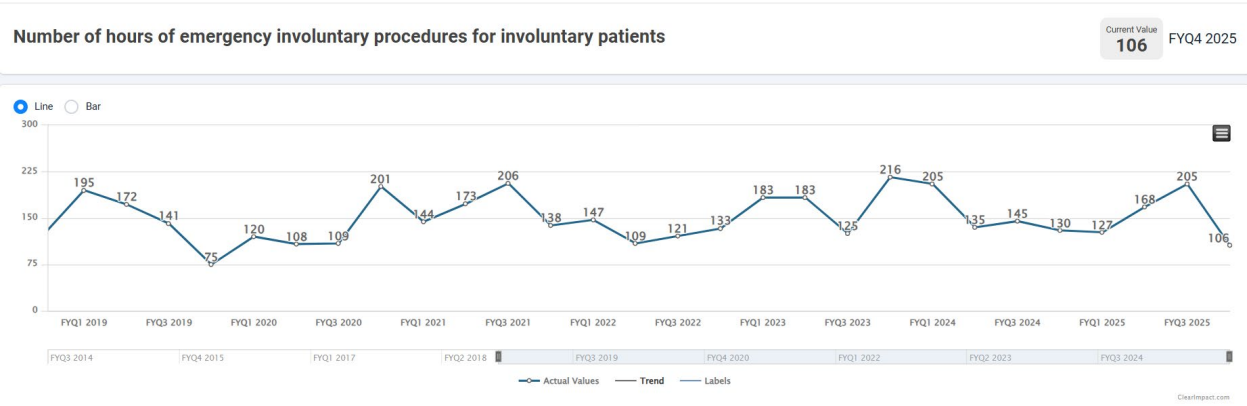
(14) Number of hours of seclusion and restraint per 1,000 patient hours



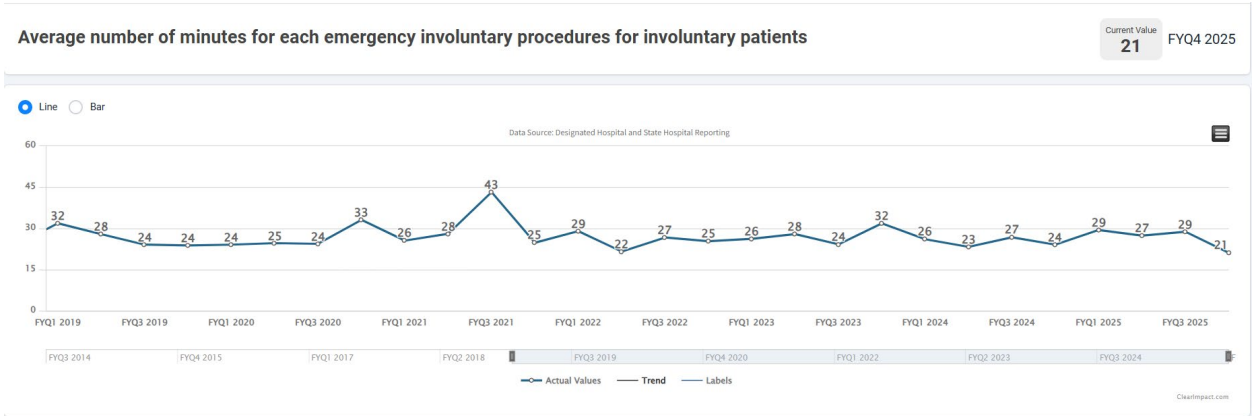
(15) Number of emergency involuntary procedures for involuntary patients



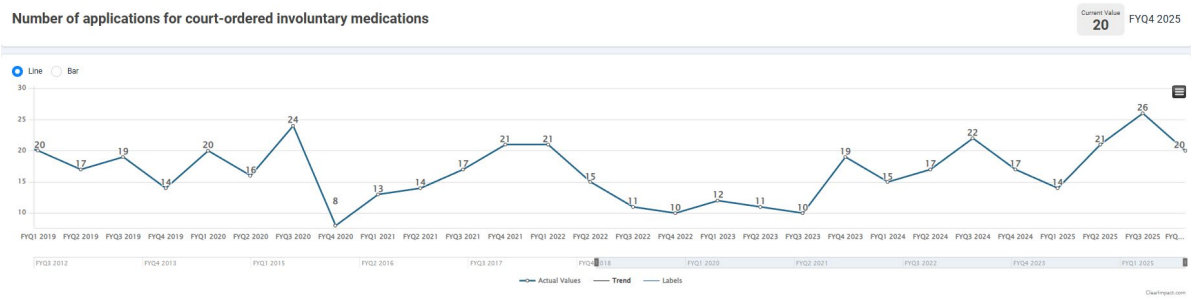
(16) Number of hours of emergency involuntary procedures for involuntary patients



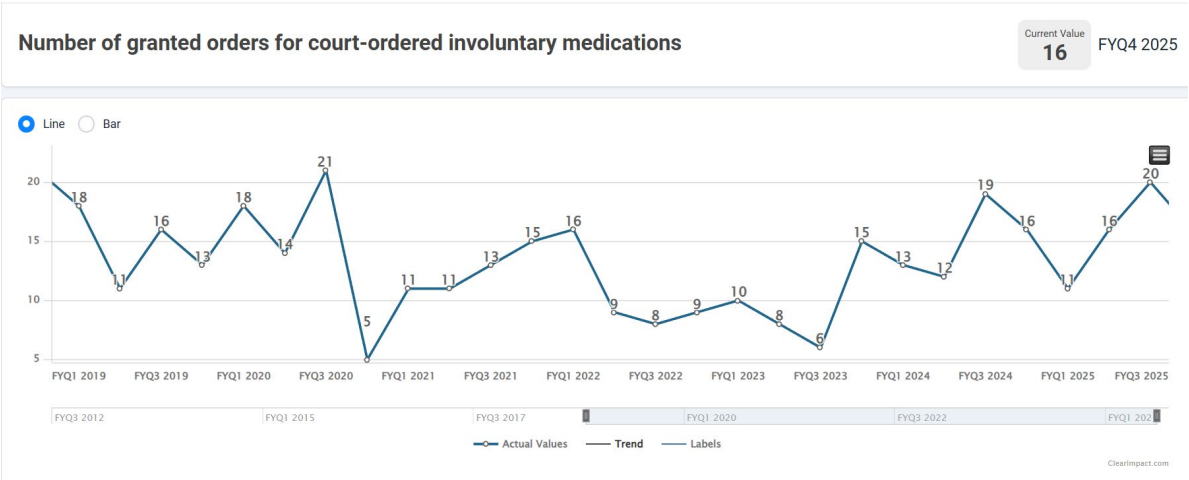
(17) Average number of minutes for each emergency involuntary procedures for involuntary patients



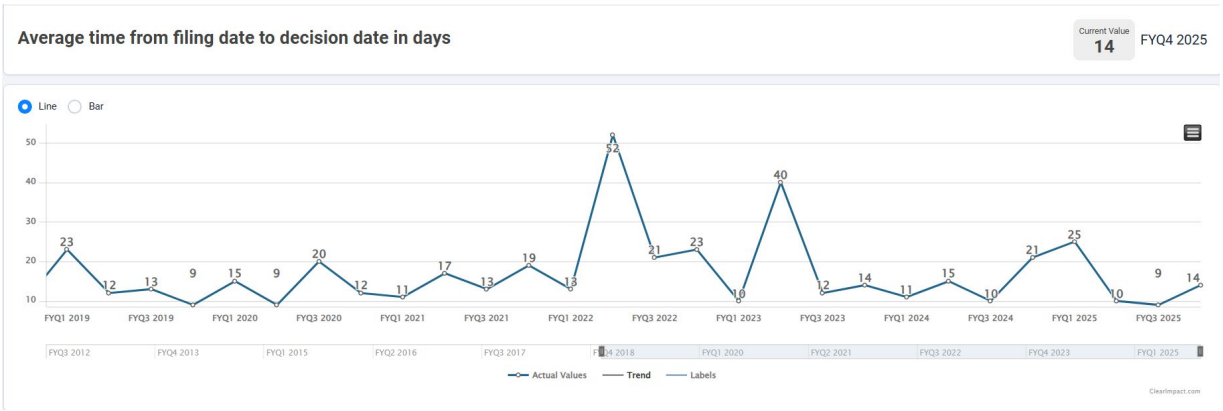
(18) [Number of applications for court-ordered involuntary medications]



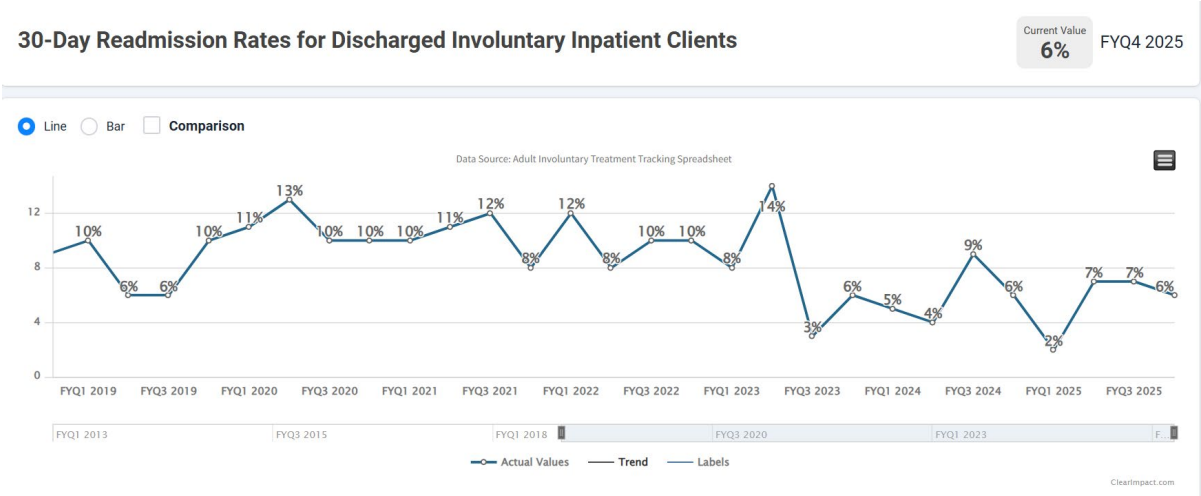
(19) [Number of granted orders for court-ordered involuntary medications]



(20) [Average time from filing date to decision date in days]



(21) 30-Day Readmission Rates for Discharged Involuntary Inpatient Clients



(22) Length of Stay for Discharged Clients from Involuntary Inpatient Units