VERMONT2017

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 79

January 15, 2017

Department of Mental Health
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Executive Summary: The Mental Health System of Care

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

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

The array of peer support programs conceptualized in Act 79 continues to develop and expand their essential role in our system of care. These services include community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. Peers are also working within some Designated Agencies to provide supports to individuals awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services. Enhancement of these programs over the past year have included core training and mentoring for staff using the Intentional Peer Support Curriculum, which is used nationwide for peer support providers, and expansion of service outcomes reporting using the Results-Based Accountability framework.

Emergency services provided by the Designated Agencies are the initial point of access for crisis beds and, to some extent, hospital beds for psychiatric care throughout the state. Working closely with law enforcement is essential to this process. A statewide inter-disciplinary training program between law enforcement personnel and mobile crisis responders, known as “Team Two,” has grown and expanded to include further training opportunities this coming year for dispatchers and 911 call center staff. This continues to be an area of need for further collaboration across many jurisdictions that are served by multiple law enforcement agencies. The Department has welcomed the support of the Department of Public Safety in achieving the goal of integration of these services in the interest of quality mental health care and public safety.

The departmental care management system facilitates the coordination of admissions and aftercare services across the involuntary inpatient system at all Designated Hospitals and the Vermont Psychiatric Care Hospital. Care managers assist crisis services teams and providers triage individuals into programs for admission, as well as facilitating the referral process for individuals to step-down programs, transitional housing programs, and supportive housing units when they are ready to return to the community. To accomplish this task, the team works closely with hospitals by holding weekly clinical

team meetings regarding inpatient status, supporting discharge and aftercare planning, creating a bridge to community programming, and providing technical assistance when necessary. Acting as a managed care organization in partnership with the Department of Vermont Health Access (DVHA), a segment of the team performs utilization review for Community Rehabilitation and Treatment (CRT) clients and Designated Agency Adult Outpatient (AOP) clients receiving Medicaid benefits who are hospitalized. The utilization review care managers also review all Medicaid involuntary and Level 1 admissions, regardless of whether they are enrolled in any DA programs.

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 is entering its third year of facilitating a statewide initiative to reduce seclusion and restraint in Designated Hospitals, using the "Six Core Strategies to Reduce the Use of Seclusion and Restraint ©"and is also developing and supporting training in the following clinical areas:

- Integrated Dual Disorder Treatment (IDDT) for Co-Occurring Mental Health and Substance Use Disorders;
- Core Orientation and Clinical Skills for Direct Care Staff;
- Dialectical Behavior Therapy;
- Open Dialogue;
- Treatment of Early Episode Psychosis;
- Integrated Mental Health, Health and Wellness Interventions;
- Mental Health First Aid; and
- Collaborative Mental Health and Law Enforcement Crisis Response (Team Two).

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

Through its expanding focus on suicide prevention, the Department of Mental Health has partnered with the Center for Health and Learning and other AHS departments to begin implementation of the

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

nationally-recognized Zero Suicide model, which has included training for clinicians in Chittenden and Franklin/Grand Isle counties on *Collaborative Assessment and Management of Suicidality* (CAMS). This process will make access to services for people better and provide training for clinicians to deliver state-of-the-art care to those seeking help.

The Department, in collaboration with the Vermont Suicide Prevention Coalition, is also working with the Vermont Federation of Sportsman's Clubs and the Gun Owners of Vermont to develop and disseminate public education and suicide awareness materials and contact information for crisis lines throughout Vermont for Gun Shop owners.

The Department continues to plan for the replacement capacity of the current Secure Residential Recovery (SRR) program and the 7-bed temporary facility in Middlesex. Recent activity has included a *Request for Proposals* posting to assess interest among community stakeholders to participate in the development and/or operation of permanent secure recovery program options, and planning across multiple AHS departments to assess how the mental health needs of populations being served by other departments might be addressed by future permanent programs.

The "Planning for the Future" section of this document outlines the path to move forward. The Department realizes that many of the new programs put into place over require continual monitoring as to the outcomes we are aiming to achieve. The Department of Mental Health looks to the legislature, stakeholders, and their colleagues in the Designated Hospitals and Designated Agencies to continue to work together towards improving care and the quality of life for persons with complex mental health needs.

2016 Accomplishments

The Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of Human Services (AHS) Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of Community Rehabilitation and Treatment (CRT) services for adults with severe and persistent mental illness; Adult Outpatient for adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions; Emergency Services for anyone, regardless of age, in a mental-health crisis; and child and adolescent mental health services, including children who have a serious emotional disturbance and their families. The Department also contracts with several peer and family-run organizations to provide additional support and education for peers and family members who are seeking supplemental or alternative supports outside of the Designated Agencies in their catchment area. Peer and family-run organizations also help educate individuals and families to advocate for their needs within the Designated Agencies and across multiple service provider organizations.

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

The new Vermont Psychiatric Care Hospital, which opened in July 2014, has been in operation for over two years and has attained Centers for Medicare and Medicaid Services (CMS) certification and The Joint Commission (TJC) accreditation. The Level 1 units at the Brattleboro Retreat and the Rutland Regional Medical Center are fully operational and have remained at capacity throughout the year.

Local hospital emergency departments in collaboration with the Designated Agencies throughout the state provide screening, stabilization, and limited treatment until admission to a psychiatric inpatient bed can be facilitated. As part of "decentralizing high intensity inpatient mental health care,"[2] the Department is also working to preserve the quality of treatment services afforded to patients who experience involuntary hospitalization in Vermont.

Under Act 79, the Department continues its collaborative work to strengthen Vermont's existing mental health care system. This work has included the development of enhanced community services, including emergency/crisis responses, residential services and support, housing, and inpatient treatment capacity. Specific enhancements by category include:

- Hospital Services
  - Operating a new 25 bed psychiatric hospital (July, 2014) that is both CMS certified and TJC accredited
  - Ongoing operational capacity for Level 1 inpatient care at both Rutland Regional Medical Center and Brattleboro Retreat

[2] http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACT079/ACT079%20As%20Enacted.pdf

- 45 Level 1 beds with a total of 188 adult psychiatric inpatient beds across the system of care
- Emergency Involuntary Procedure Rule-making process completed with Legislative Committee on Administrative Rules (LCAR)
- Designation of the Veterans Administration Medical Center at White River Junction to provide involuntary inpatient care (December 2016)

- Community Services
  - Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
  - Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs
  - Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
  - Increased and additional training for Team Two collaboration between law enforcement and mental health responders
  - Additional availability of soft-restraints for law enforcement transports for mental health hospitalizations
  - Resources to assist individuals in finding and keeping stable housing
- Residential and Transitional Services
  - Soteria, a five-bed, peer supported alternative residential program opened in Chittenden County
  - Maintaining full occupancy at the secure residential recovery program, the Middlesex Therapeutic Community Residence, serving 7 individuals.
  - Continued planning for permanent replacement capacity for the Secure Residential Program
- Performance and Reporting
    - Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts
    - Creation of a "VPCH Outcomes" scorecard to meet legislative reporting requirements
    - Creation of a "DMH Scorecard" using the RBA scorecard reporting tool
    - Migration of the "DMH Snapshot" and the "DMH continued reporting" report to the RBA scorecard reporting tool
- Regulation and Guidance
    - Revision of the Designated Hospital Manual and Standards to better reflect the scope of review and designation and creation of a designation protocol to efficiently manage the process
    - Creation of involuntary transportation manual to consolidate the expectations of the department into a single document

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

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

DMH has also taken a lead role in the Medicaid Pathways work and aligning necessary changes in the provider system with the All Payer Model. The goals of this work include an agreed upon model of care; reduction in required data reporting and outcome measures; expectations of integration with health care partners; payment reform to drive service delivery reform and improve outcomes. The planning phase is mostly complete and the next steps will be to move toward implementation. DMH is committed to reforming the system to better serve our population and continue to move towards full integration.

The remainder of this report will provide more in-depth information about utilization, capacity, and outcomes of these programs within the Mental Health System of Care with a focus on adult services. Measures with national rates are calculated from Substance Abuse and Mental Health Services Administration (SAMHSA) Uniform Reporting System Tables. A summary report is provided in the appendix.

Utilization of Services and Capacity

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

Inpatient Care

Vermont has a decentralized system of adult inpatient care, where people in need of hospitalization are provided treatment at either the state-run inpatient facility or one of five 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).

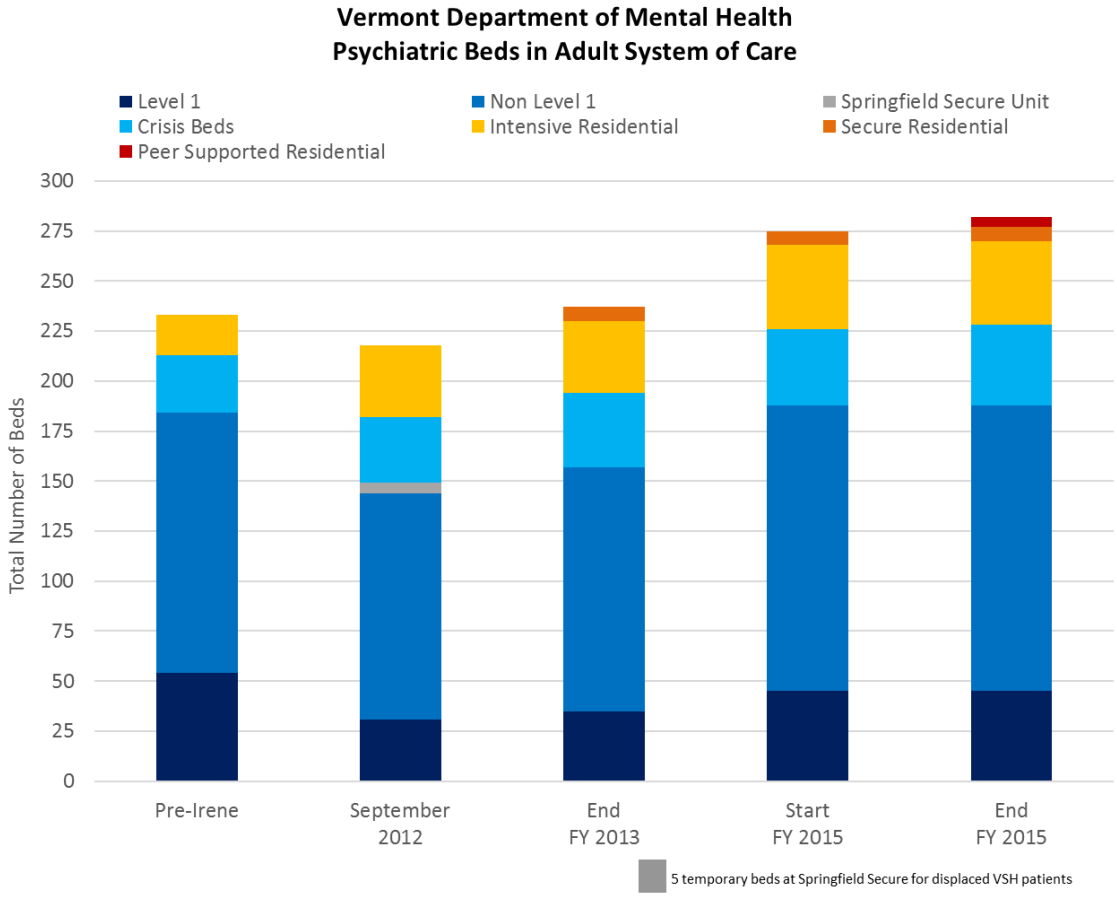
The remaining 143 beds are used for **Non-Level 1 Involuntary** and **Voluntary** inpatient stays. At our last estimation, approximately 80% of these beds days were used for **Voluntary** stays.

Hospital	Location	Total Adult Inpatient Beds
Brattleboro Retreat	Brattleboro, VT	89
Central Vermont Medical Center	Berlin, VT	14
University of Vermont Medical Center	Burlington, VT	27
Rutland Regional Medical Center	Rutland, VT	23
Windham Center at Springfield Hospital	Springfield, VT	10
Vermont Psychiatric Care Hospital	Berlin, VT	25

An electronic bed board is updated daily to track capacity and facilitate placement of patients needing hospitalization or other crisis services in the system. Departmental leadership and care management staff work to resolve issues as quickly as possible. Emergency departments across the state have had to hold individuals needing inpatient psychiatric care while waiting for an open bed. This is disruptive to the emergency care setting and not a standard that the department regards as adequate for individuals requiring inpatient care. With the additional services implemented in FY 2014, and with the opening of the Vermont Psychiatric Care Hospital in FY 2015, the numbers of patients waiting for admission and the

lengths of time they spend in Emergency Departments or the Department of Corrections has decreased throughout FY 2016. However, there have been substantial increases in the number of adults referred for inpatient treatment which has impacted the wait time in emergency departments (please see *Planning for the Future: Kuligoski Decision and System Pressures).*

Chart 1: Psychiatric Beds in the System of Care



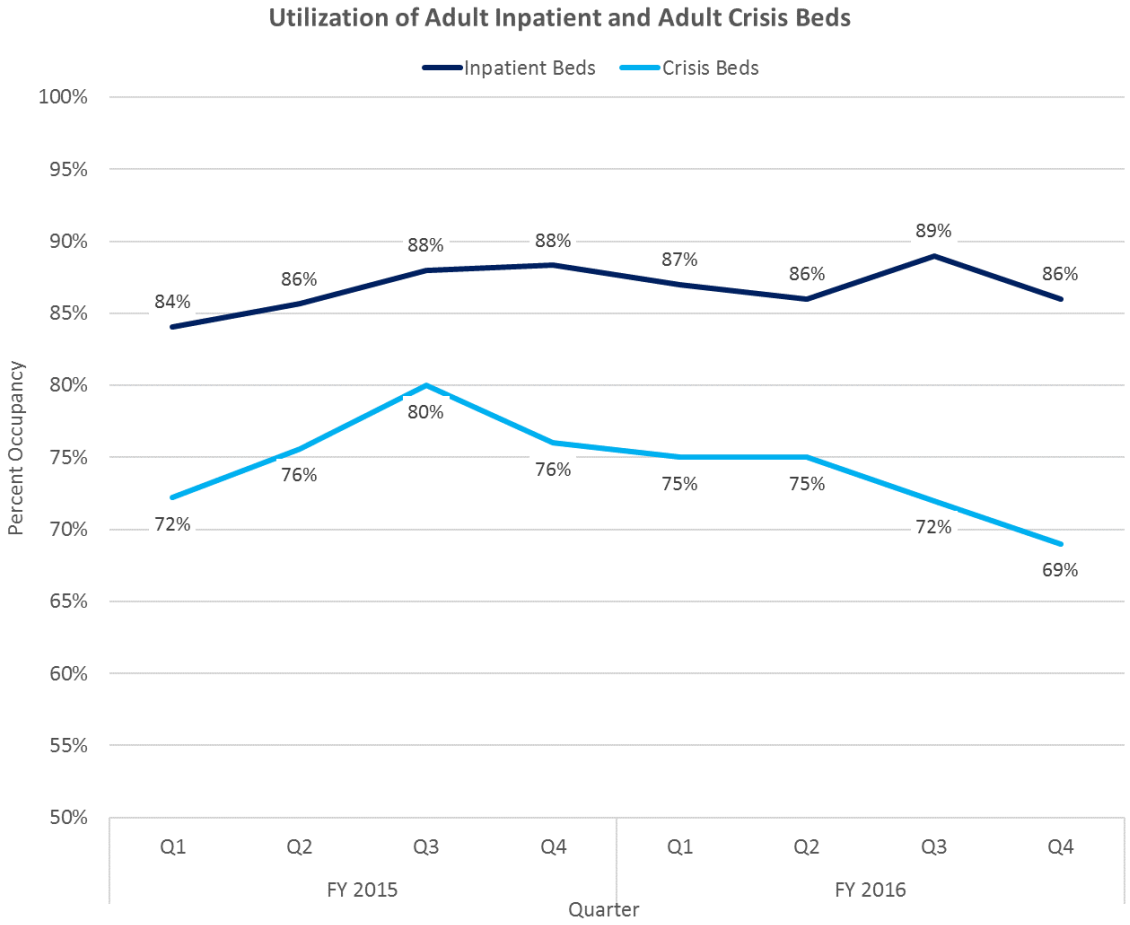
Vermont has increased its capacity for mental health care substantially since August 2011. Overall, the system capacity for psychiatric beds has increased by almost 50 beds since August 2011. Vermont's adult psychiatric inpatient system has a total of 188 beds, which is four (4) more than before tropical storm Irene closed the Vermont State Hospital.

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

The Department and other AHS agencies are working together to find and develop permanent replacement capacity for the Secure Residential Recovery Program. DMH has recently posted a *Request for Proposals (RFP)* seeking proposals from interested parties for the development and operation of staff-secure and facility-secure (locked) residential recovery (SRR) programming that would replace the temporary SRR psychiatric facility owned and operated by the State of Vermont in Middlesex, Vermont and may serve additional populations in need of a therapeutic, secure residential treatment setting.

The RFP allows for and supports further exploration of public-private partnership efficiencies and detailed cost projections in order to determine overall cost benefits for both quality and service delivery to the population served. As an example, collaborative program proposals from service provider organizations and property development organizations are being encouraged. AHS plans to have the FY 2018 budget include requests for identified resources that will be necessary to initiate Certificates of Need or Certificates of Approval requirements, as well as project development and management coordination necessary to oversee the establishment of a permanent replacement program for the current secure residential program. Awarding of any contract associated with this RFP will be dependent on future allocation of funding in the state budget passed by the Vermont Legislature.

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

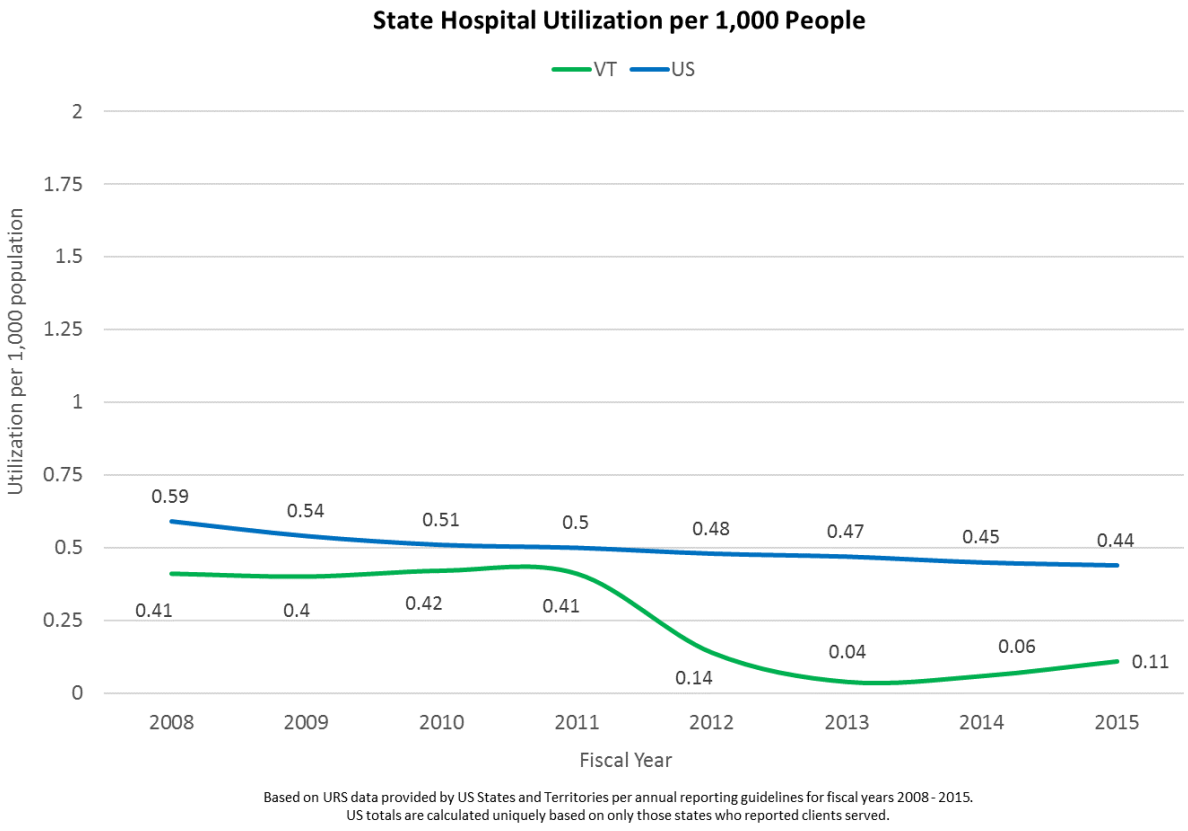


Occupancy of adult crisis beds has declined consistently since Q3 FY 2015. While the target has been set at 80%, there are many factors that influence this data, including the time to move people in and out of the facility, staffing, preparation for new admissions, and assuring clients' needs are met. This under-utilization trend has only been further exacerbated by community provider concerns in offering complex care to individuals through voluntary programs when risks, as spotlighted in the Kuligoski Supreme Court decision, may be present but involuntary treatment is not warranted. The department is meeting with stakeholders and providers to better understand this trend. We are exploring alternate uses of some of these beds to better meet the needs of Vermonters experiencing a mental health crisis.

Adult inpatient bed occupancy has remained stable throughout the time period, with bed occupancy ranging from 84-89%. As with last year's report, there were no new adult inpatient beds added during this time period, leaving the number of adult inpatient beds system-wide at 188.

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 2015 is the most recent data available.

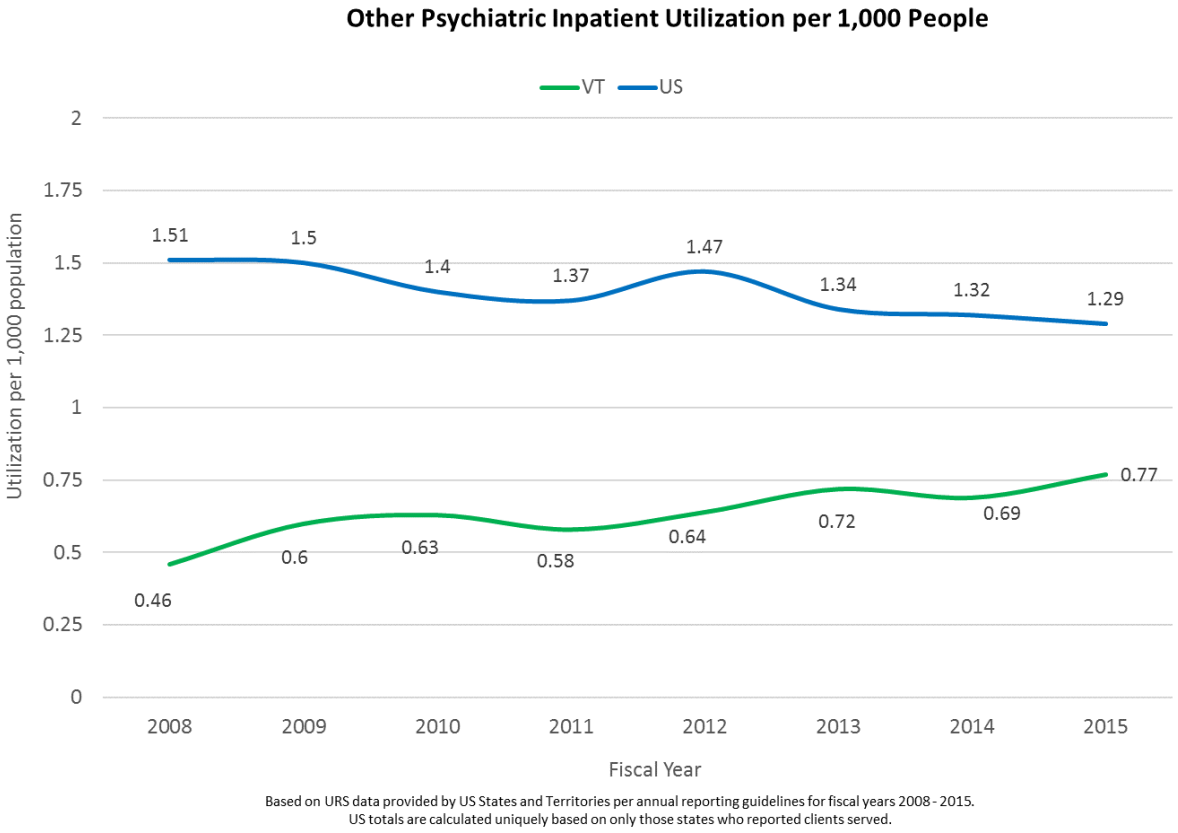
Chart 3: State Hospital Utilization per 1,000 people (in Vermont and the United States)



The national rate of state hospital utilization continues to decline year-over-year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be

lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011.

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



Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in chart above. The national rate of psychiatric hospital utilization continues to decline year-over year while Vermont's rate of utilization continues to increase. Utilization is still below the national averages while rates of community utilization continue to be markedly higher than national averages (*Chart 24: Community Utilization per 1,000 Populations*).

Chart 5: Adult Inpatient Utilization and Bed Closures

Adult Inpatient Utilization and Bed Closures
FY 2016

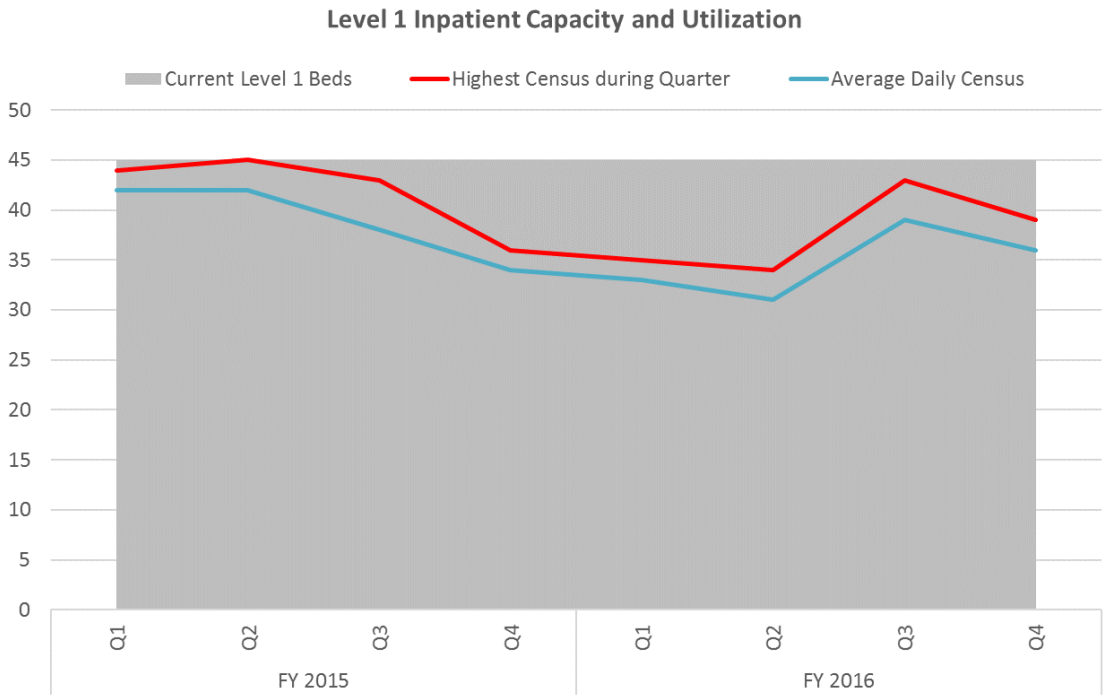
	Q1	Q2	Q3	Q4
ADULT INPATIENT UNITS				
Total Beds	188	188	188	188
Average Daily Census	164	161	167	161
Percent Occupancy	87%	86%	89%	86%
# Days at Occupancy	0	0	0	0
# Days with Closed Beds	92	82	80	76
Average # of Closed Beds	6	3	6	4

Based on data reported to the Vermont Department of Mental Health (DMH) by designated hospitals (DH) for adult inpatient care using the electronic bed boards system. Beds at inpatient settings can be closed based on the clinical decision of the director of each inpatient unit.

This chart depicts the total census capacity and average daily census across the Vermont Designated Hospital system for FY 2016. The range of average numbers of closed beds for this time period is 3, with a minimum of three and a maximum of six, which is markedly less than the range reported last year (7) and the year previously (15). Bed closures throughout the system may be due to renovation, staffing, patient safety and care, or other causes. The Department, in concert with the Designated Hospitals, works to maintain the maximum compliment of beds and utilization of these beds through the bed board system.

Level 1 and Non-Level 1 Involuntary Inpatient Care

Chart 6: Level 1 Inpatient Capacity and Utilization

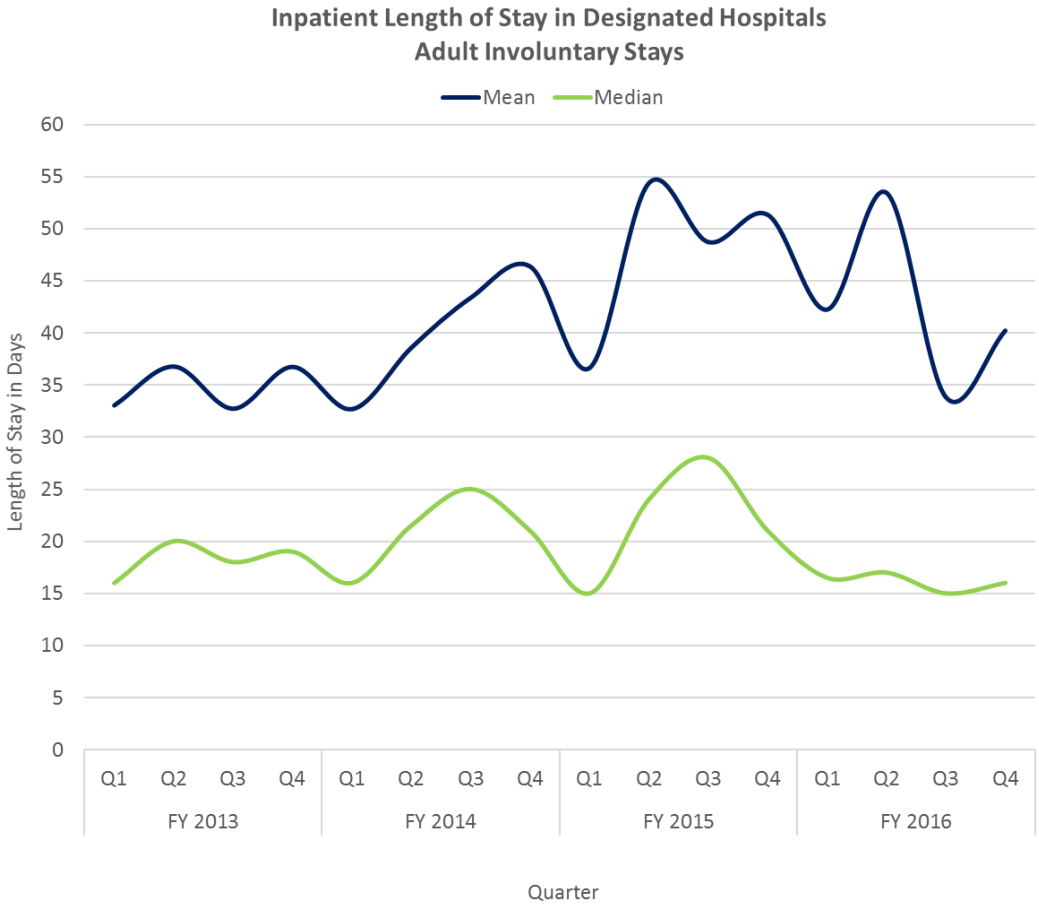


Level 1 patients require the highest level of care and services within the inpatient system. The chart above represents the average number of Level 1 patients receiving acute inpatient care in any hospital setting and the single combined one-day highest number each quarter. As a reminder, Level 1 involuntary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

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

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

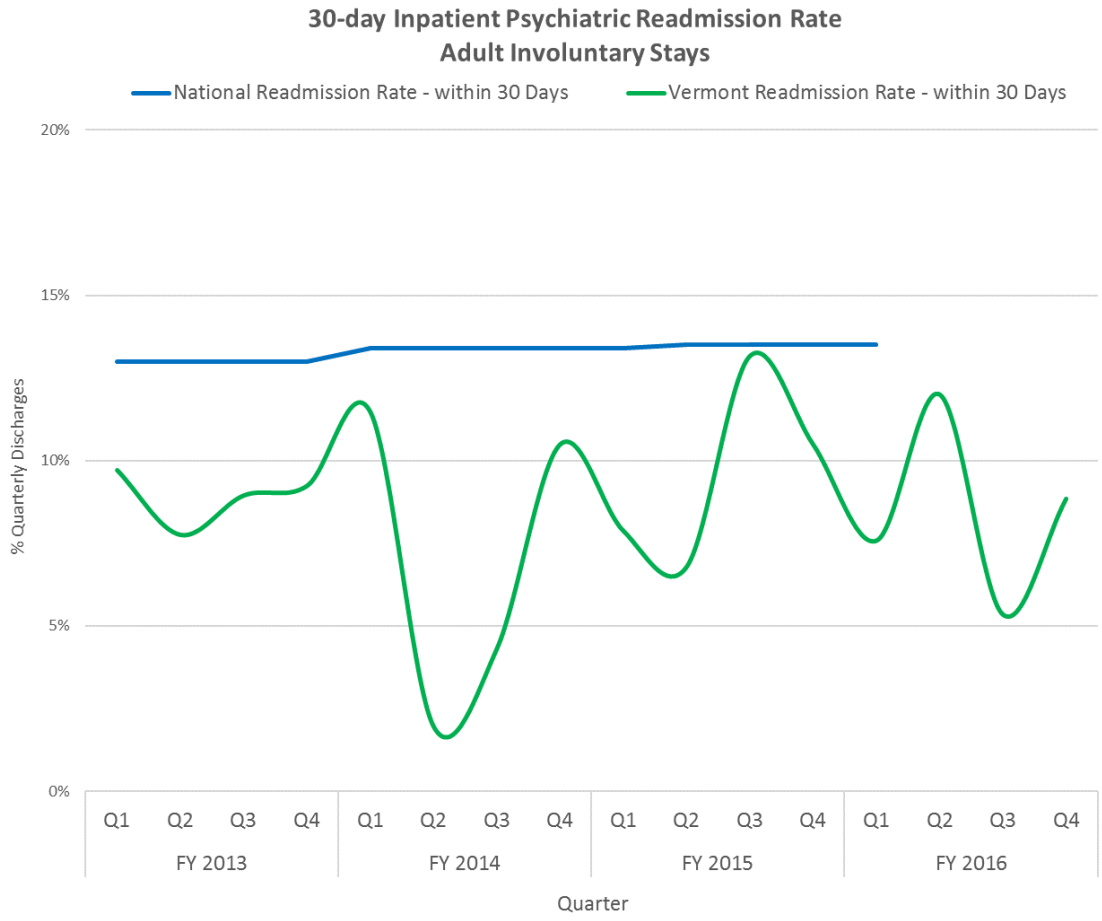
Chart 7: Inpatient Length of Stay in Designated Hospitals



This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients from FY 2013 through FY 2016. The trend indicates an increase in length of stay in hospital settings, from an average of 33 days to 40 days overall. Addressing factors such as patient acuity, participation in treatment, and the availability of resources post-discharge are central to reducing length of stay.

Additionally, this time period also encompasses the introduction of the Level 1 system of care, which started in Designated Hospitals in Q1 FY 2013. From this initial start date, the system has seen an increase from 25 Level 1 patients per day (on average) to 45 Level 1 clients per day. Level 1 patients also have longer lengths of stay than non-Level 1 patients, which can also be a contributing factor to the overall increase in lengths of stay over the time period.

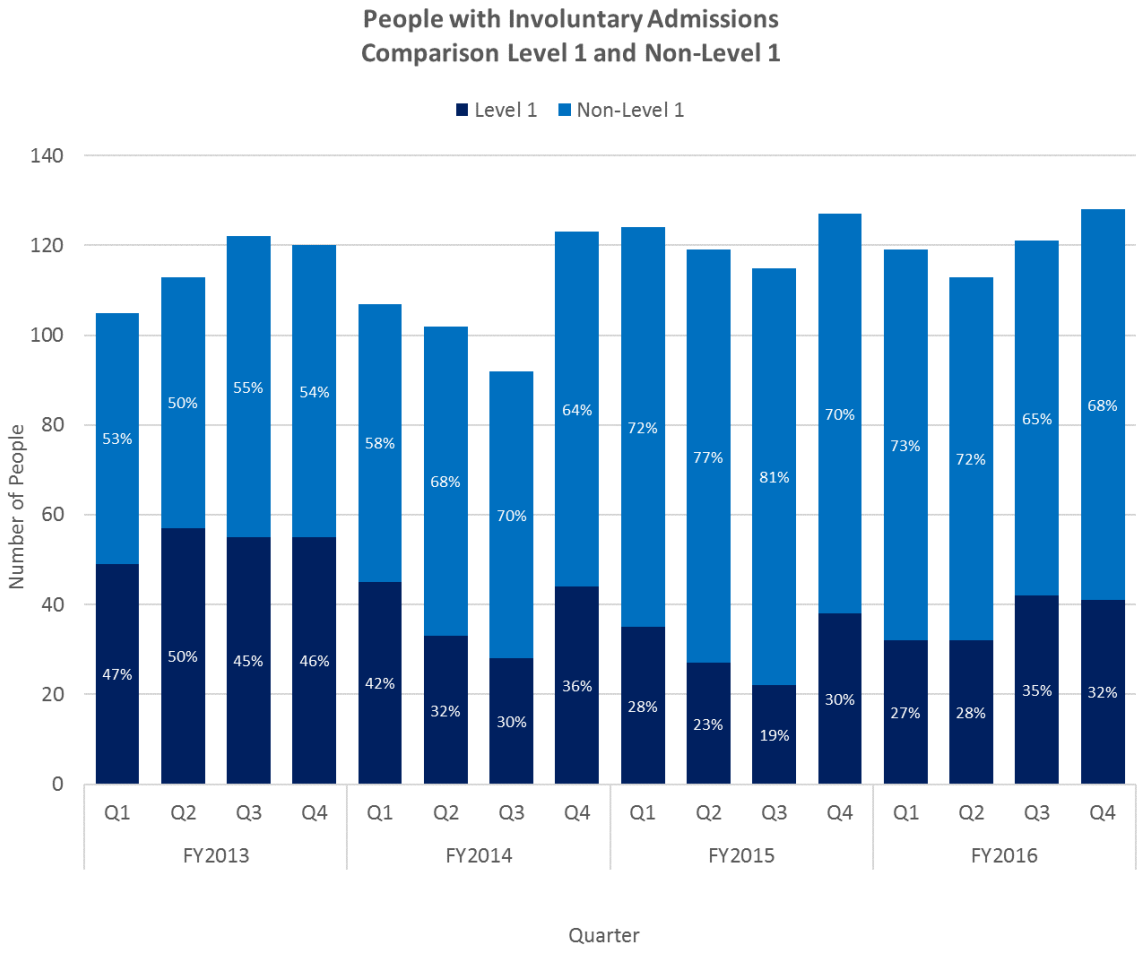
Chart 8: Inpatient Readmissions in Designated Hospitals



Readmission rates within 30 days of discharge were calculated and compared to national benchmarks. While less stable than prior time periods, this data continues to show that Vermont's rates at their highest were still lower than the average national rate—presented in the National Outcome Measures (NOMS)—and as much as ten percent lower at the lowest rate. Future reporting on Length of Stay and Readmission rates will be reported using annual numbers instead of quarterly, in order to present a better comparison to national data and to provide a better historical context. Quarterly figures will still

be available in the DMH snapshot and DMH continued reporting RBA scorecards, available on the DMH website.

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



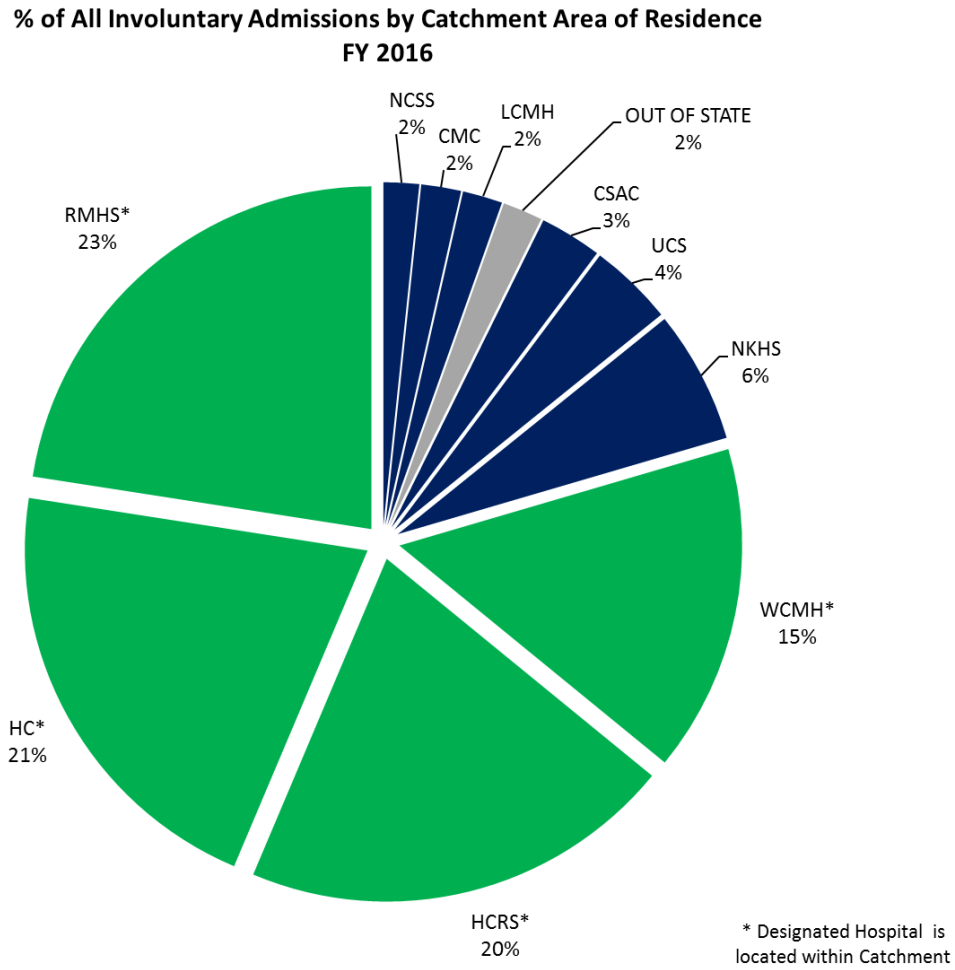
The number of people involuntarily admitted to inpatient care was at its highest during Q4 FY 2015 (127) and Q4 FY 2016 (128); 30-32% of all people admitted were for Level 1 stays. Given the reduction in capacity of inpatient psychiatric beds and their geographic placements in different parts of the state, the system of care continues to manage the challenge of access for those in need of inpatient psychiatric care.

As can be seen on this graph, the overall percent of patients admitted to psychiatric care with a Level 1 designation has decreased from FY 2013 with the addition of the Level 1 beds. The actual numbers of people admitted has held stable through FY 2015 and FY 2016.

As noted previously, Q1 FY 2013 represents the starting period of the Level 1 system and admission numbers for the time period through FY 2013 represent the gradual increase of Level 1 patients in the system of care. It is an expected result to see fewer people with the Level 1 designation since lengths of stay are longer than the non-Level 1 cohort. In other words, the capacity of the Level 1 system is limited

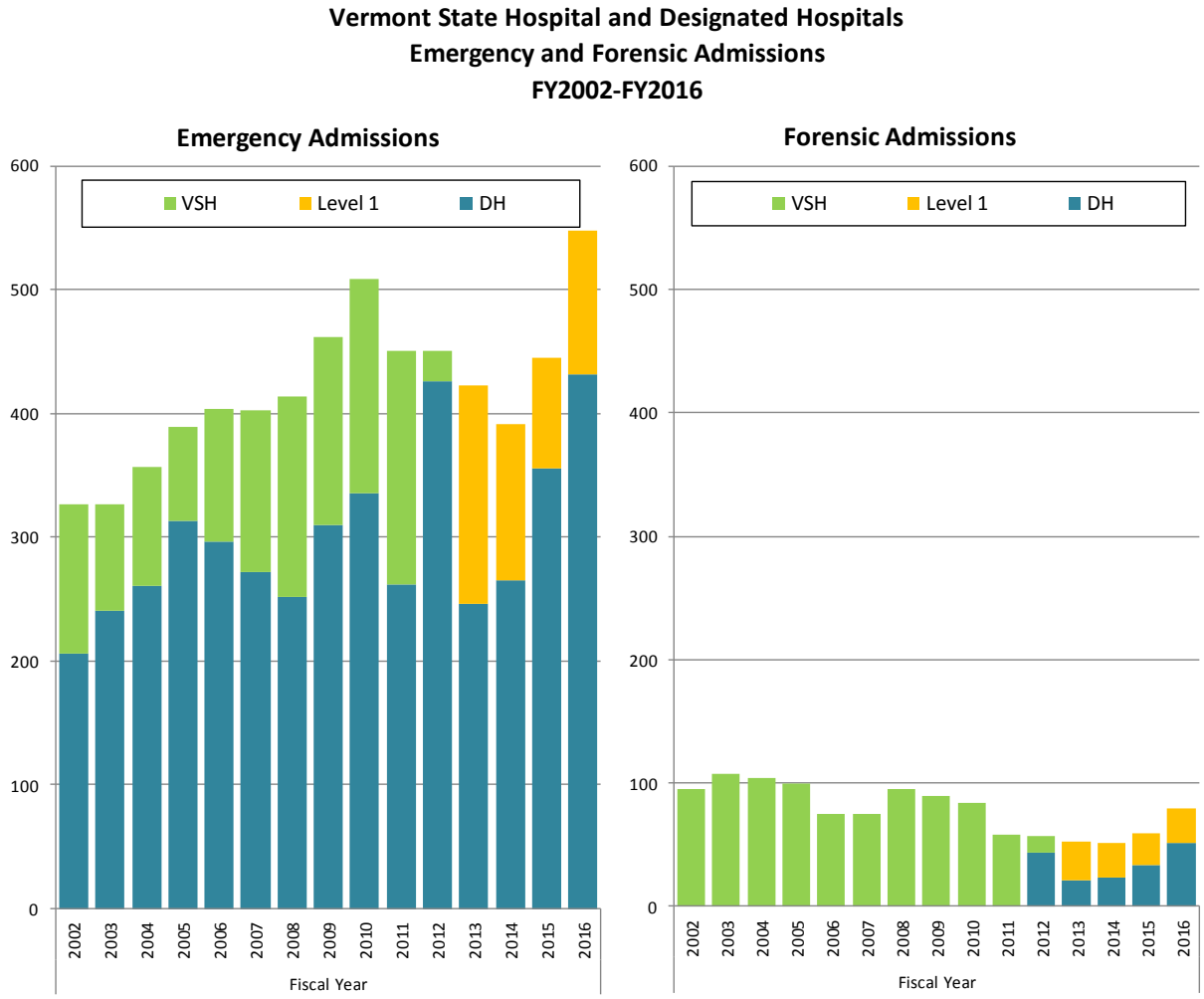
by longer lengths of stay for the population, while the non-Level 1 system experiences more people moving through the system with shorter lengths of stay.

Chart 10: Involuntary Admissions by Catchment Area of Residence



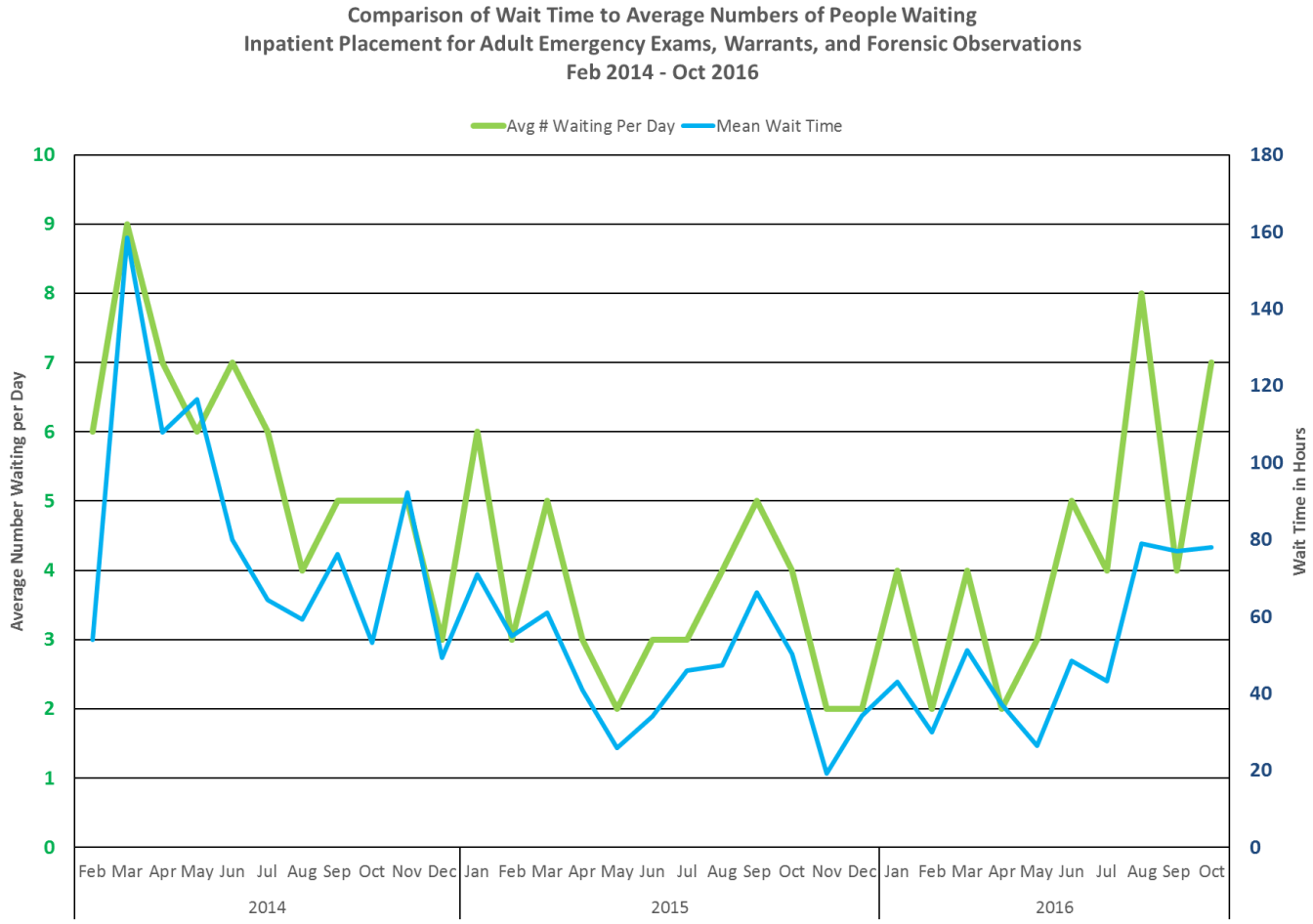
This chart provides information on the location of individuals who are admitted to an inpatient setting. As expected, larger agencies have a greater number of admissions as they are serving more individuals. This chart also suggests that the placement of hospitals in the decentralized system of care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

Chart 11: Emergency and Forensic Admissions



The number of emergency (civil) and forensic admissions increased in FY 2016 overall and for each category. While not all Level 1 patients are admitted for forensic reasons—and not all forensic patients are Level 1— Level 1 admissions do represent a greater percentage of total forensic admissions than total emergency exam admissions. See *Planning for the Future: Kuligoski Decision and System Pressures* for more discussion.

Chart 12: Average Number of People Waiting Inpatient Placement



The average number of individuals per day waiting for admission to a psychiatric treatment bed continues to fluctuate over the time period. Timely transition of people to inpatient care requires active management on a daily basis for individuals of all statuses in need of hospital care.

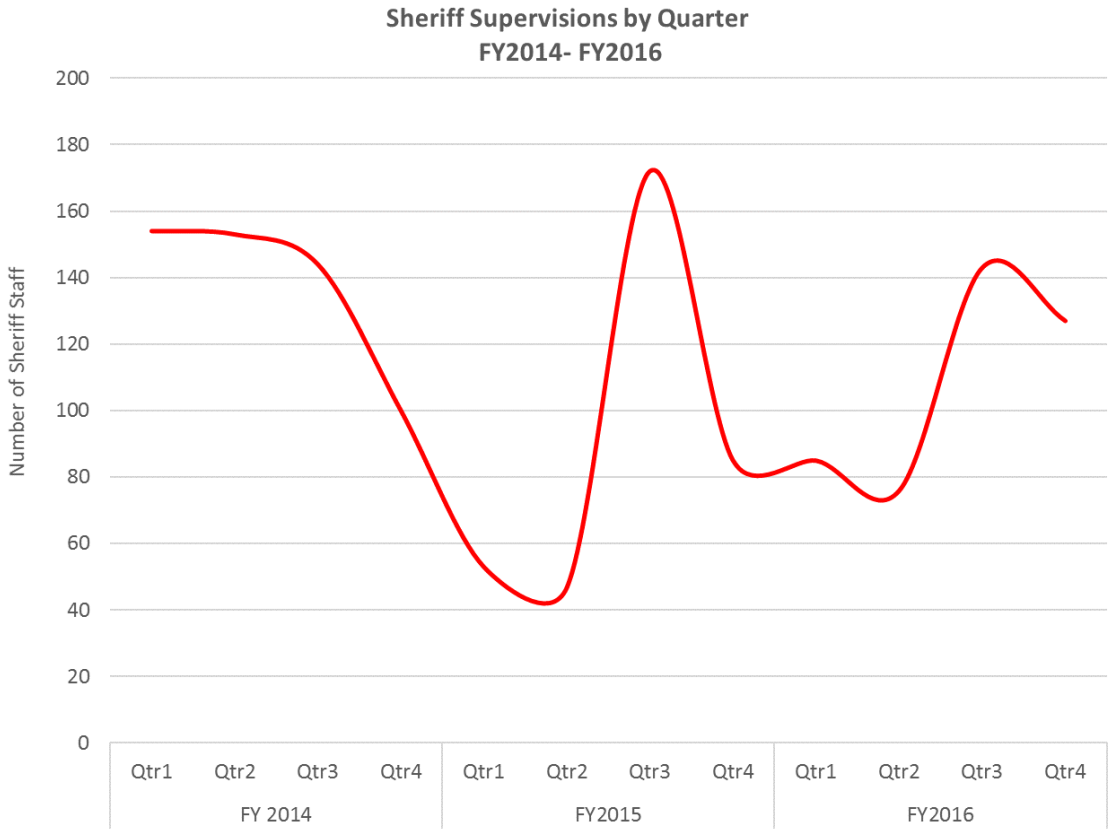
This chart contains information across a three-year time period, between February 2014 to October 2016, presenting the mean wait time and the average number of adults waiting per days. The department's goal is to continue to place individuals in appropriate beds as soon as they are available. There has been a substantial decrease in the number of people waiting per day and the average hours waited through May 2016.

The average wait time and numbers waiting per day are highly correlated with the numbers of adults referred to inpatient care. For example, the sharp decrease from October to December 2015 coincides with a sharp decrease of adults held (15% decrease) for inpatient care via emergency exam or warrant. In July-September 2016, the Department had almost 165 adults held via emergency exam or warrant, a 22% increase from the previous quarter and almost 20 more adults than any other quarter since March 2013. Please see *Planning for the Future: Kuligoski Decision and System Pressures* for more discussion.

The Department of Mental Health has a cadre of experienced care managers (care management team) who work with each of the Designated Hospitals, the Designated Agencies emergency services teams, and the hospital emergency departments statewide. Their function is to work with individual cases and the relevant systems to move people needing care through the system. The system is comprised of several points along a continuum which represent appropriate levels of care. Since our acute mental health treatment system became decentralized, placement considerations have become more complex. The care management team also works on longer term planning for these individuals, monitoring availability of placements in various levels of community care across the state.

When patients are awaiting placement for treatment in a psychiatric hospital setting, supervision assistance by sheriff departments is sometimes required. This is a service funded through the department and the chart below illustrates utilization of sheriff supervision.

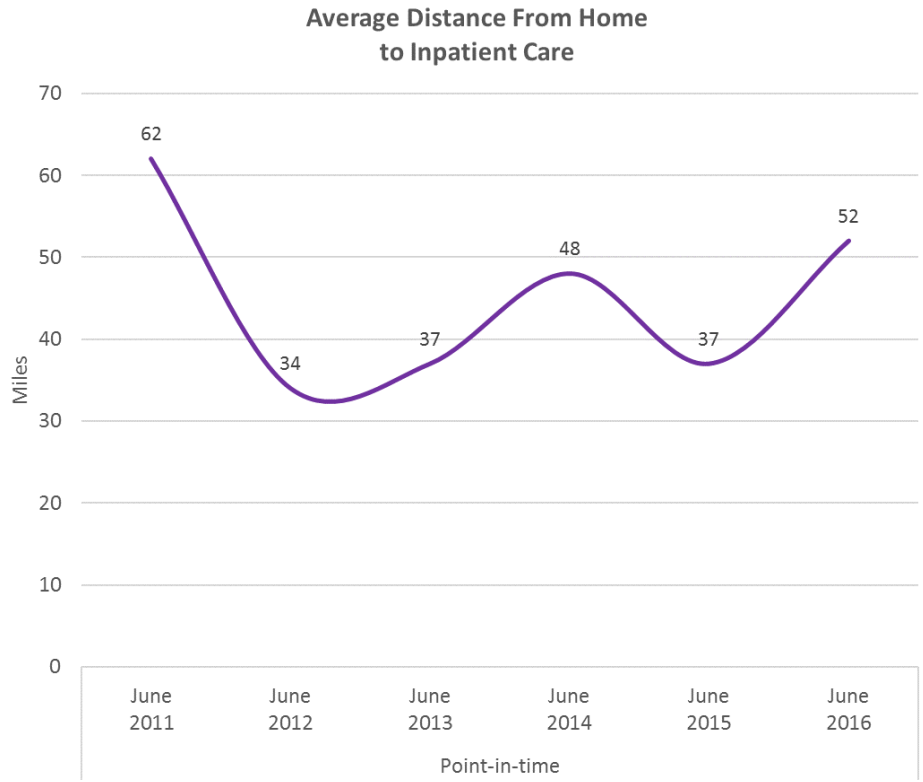
Chart 13: Sheriff Supervision in Emergency Departments



A hospital's ability to manage the dysregulated behavior of a patient who is waiting for an inpatient psychiatric bed varies from hospital to hospital. This may be due to the need to maintain a safe surrounding, availability of support resources, or security services at the hospital. There continues to be significant variation from quarter to quarter in the usage of sheriffs. As hospitals continue to build psychiatric-specific supports in their emergency departments, DMH would expect the usage of sheriffs in emergency rooms to decrease. There has been a spike in the use of sheriffs recently as the number of initial applications for emergency examination has increased, possibly in response to the recent

Kuligoski decision. Provider efforts may be directed toward mitigating an organization's potential risk exposure in instances where individuals remain in crisis and are refusing voluntary care options. The department is continually working with sheriffs, screeners and emergency department staff to use sheriffs only when clinically indicated.

Chart 14: Distance to Service for Involuntary Inpatient Admission



The closing of the Vermont State Hospital resulted in an increased use of beds in Designated Hospitals for involuntary psychiatric hospitalizations. The decreased distance required to travel to an inpatient bed post-Irene, as demonstrated in the graph above, reflects the greater use of beds at nearby Designated Hospitals. This is also reflected in *Chart 10: Involuntary Admissions by Catchment Area of Residence*.

The department considers timely treatment and treatment within one's community to be important factors in successful recovery, however, these two factors are sometimes incongruous. Sometimes being placed in a hospital farther away from home is a better clinical alternative to remaining in an emergency department waiting for a closer bed. The care management team also works on transferring patients between hospitals, if clinically appropriate, so that people can continue or finish their inpatient treatment nearer to their home community.

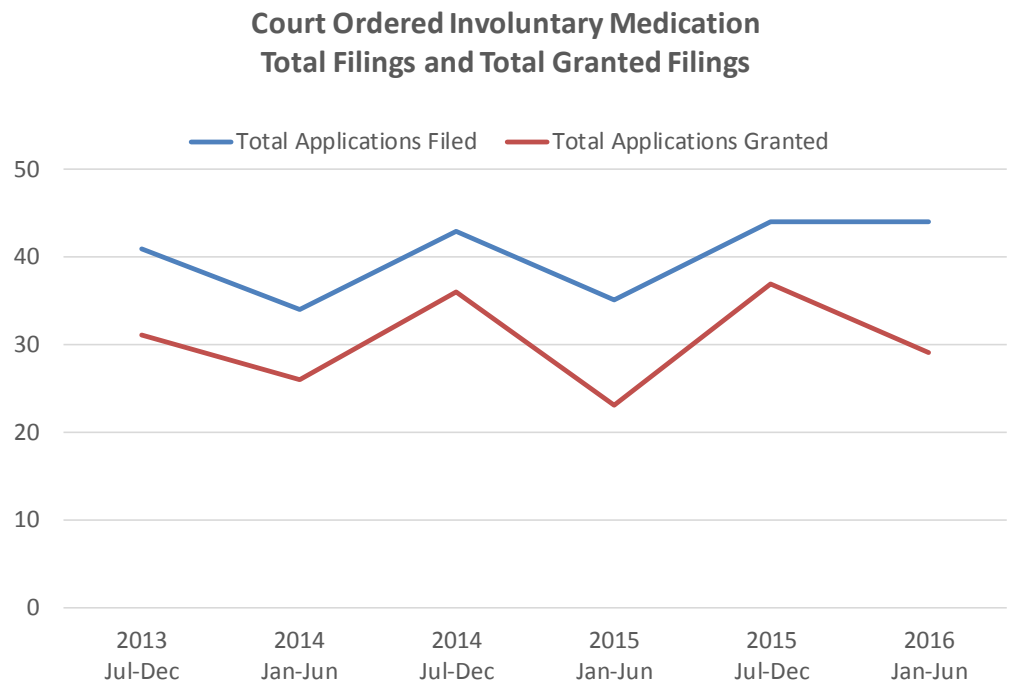
Involuntary Medications

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

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

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

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



Total People, Total Filings, and Total Granted Filings

Court-Ordered Medication	Jul-Dec 2013	Jan-Jun 2014	Jul-Dec 2014	Jan-Jun 2015	Jul-Dec 2015	Jan-Jun 2016
Number of people	**36**	**28**	**41**	**29**	44	42
Total Applications Filed	41	34	43	35	44	44
Total Applications Granted	31	26	36	23	37	29
% Granted	76%	76%	84%	66%	84%	66%

This chart represents the total number of court ordered involuntary medication orders filed, the total granted, and the total number of people with filings. The percent of filings granted varies from 66%-84%.

Long term trends (not shown in this chart) do indicate that the number of filings have increased substantially since the closure of the Vermont State Hospital in 2011, with more Designated Hospitals seeking involuntary medication orders.

This trend is explained by the expectations that inpatient care is both time limited to the acute need and complimented by both best practice treatment approaches and active treatment interventions. In psychiatric hospitalization, duration of episode and intensity of treatment are influenced by services that can only be delivered in the inpatient setting. Acute interventions, stabilization, and medication management are generally the roles of hospitals with ongoing rehabilitation and recovery occurring in sub-acute and community-based treatment programs. Measurement of future time periods will indicate whether there is a trend regarding court ordered involuntary medication filings as a result of 2014 Act 192.

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

Court Ordered Involuntary Medication
Length of Stay for Discharged Patients

		FY 2015	FY 2016
Total Discharges	Overall	55	56
	Inp. Stays with One Filing	44	52
	Inp. Stays with Multiple Filings	11	4
Mean LOS (days)	Overall	191	103
	Inp. Stays with One Filing	155	98
	Inp. Stays with Multiple Filings	334	165

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
Total Discharges	Overall	55	56
	Inp. Stays with One Filing	44	52
	Inp. Stays with Multiple Filings	11	4
30 Day Readmission Rate	Overall	5%	5%
	Inp. Stays with One Filing	7%	6%
	Inp. Stays with Multiple Filings	0%	0

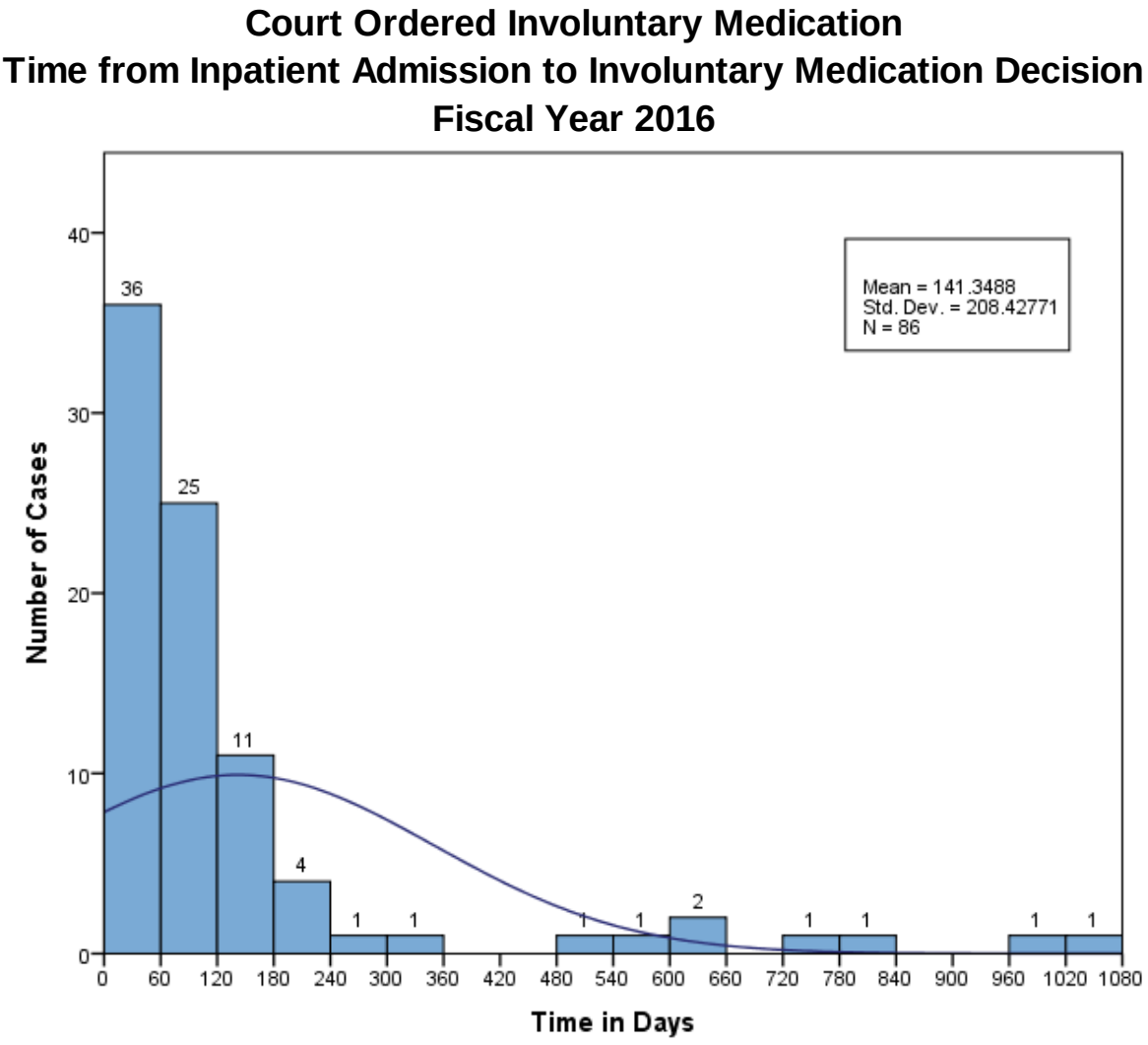
The Department has worked to provide lengths of stay and 30-day readmission rates for people that had a court-ordered involuntary medication filing at any time during their hospital stay and were discharged in during the fiscal year. The number of people who have met these criteria have been consistent each fiscal year. Of those, the number with multiple medication filings decreased from 11 (20%) to 4 (7%) between FY 2015 and FY2015.

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

medication ordered by the court is not effective and a new order has to be pursued for different medication.

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

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



This graph illustrates all cases (86) filed for involuntary medication in FY 2016. The average (mean) length of time between an admission to the hospital and to the medication decision is approximately 141 days, with a small number of outliers on the longer end of the curve. This illustrates the variability in

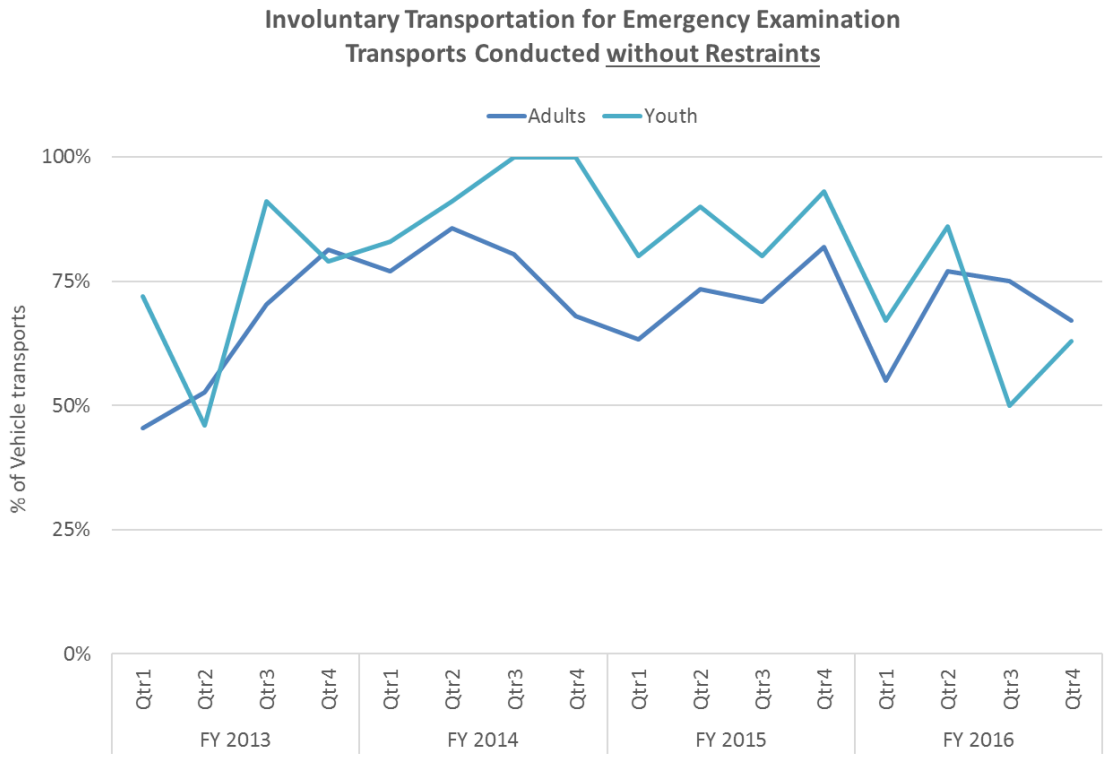
this measure across time and jurisdictions, with approximately 40% of cases resolved in less than 60 days and 71% of cases resolved in less than 120 days.

Transportation

Since April 2012, the Department has developed an aggressive implementation plan for changing the manner in which individuals are transported to inpatient hospitalization with the goal of reducing metal restraints and providing options for transport whenever possible. Act 180, Title 18 §7511, recognizes the need to take steps to reduce trauma for people who are found to need sheriff transport for involuntary psychiatric hospitalization. For many years, secure transport was defined as a transport by sheriffs. The current definition of secure transport is defined as the application of mechanical restraints, either soft or metal. This change in terms evolved out the success of the involuntary transportation workgroup.

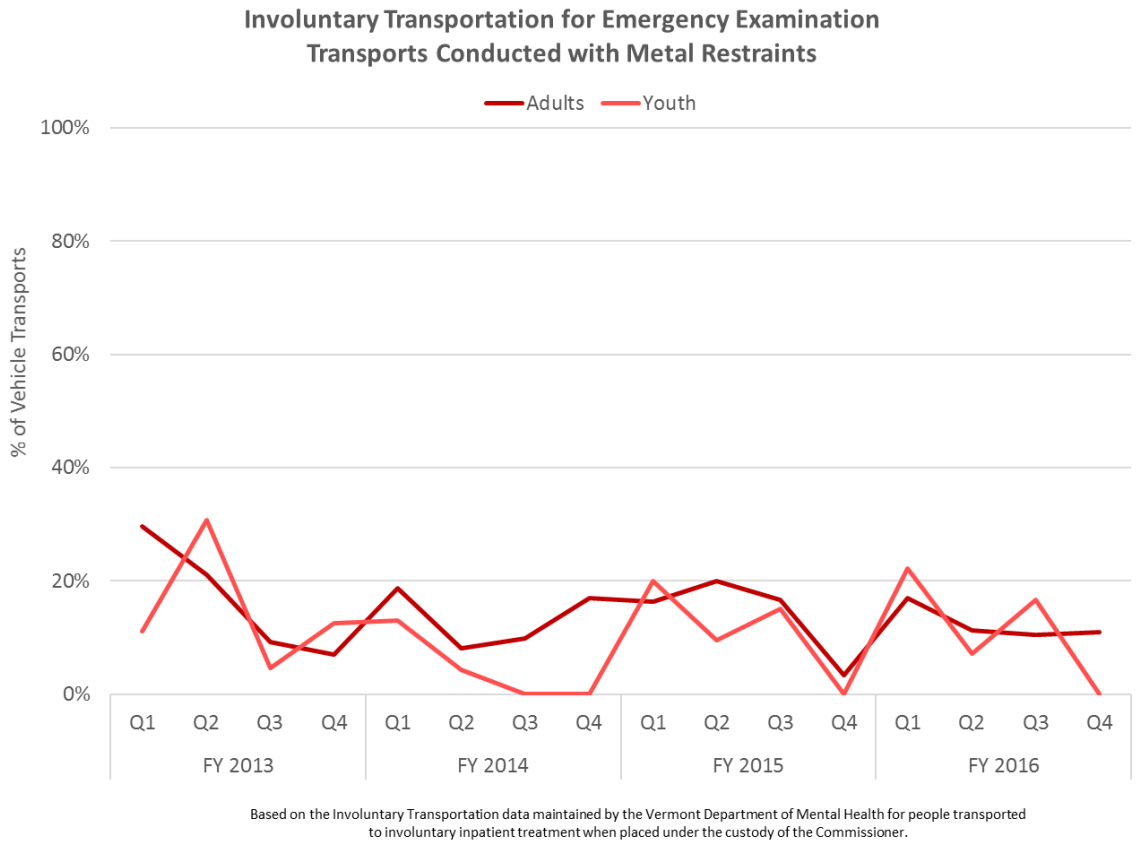
Grants to support a pilot program with sheriffs in Lamoille and Windham Counties using a least-restrictive approach by deputies in plain clothes with an unmarked van have been continued. Progression to some type of restraint is utilized only when a no-restraint approach fails.

Chart 19: Involuntary Transports Conducted without Restraint



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

Chart 20: Involuntary Transports Conducted with Metal Restraint



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

A review of the data provided shows that a majority of transports are conducted without restraint for both adults and youth. When examining the use of metal restraints by quarter, less than 20% of transports are conducted with metal restraint. The Department continues to work towards a goal of no metal restraint.

The Department is aware of differing practices that exist across law enforcement agencies; these differences are due in part to the need for more frequent training and monitoring of expectations from those who work in law enforcement. The Department continues to have specific contracts for use of soft or no restraints during transport but other law enforcement agencies may not utilize the same policy and procedures that make these contracted agencies successful. The Department is continually working to create a consistent law enforcement response to the need for least restrictive transportation protocols and has released an involuntary transportation manual that emphasizes Departmental expectations around transports.

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

Chart 21: One-Year overview of Adult Involuntary Transport

Vermont Department of Mental Health
Adult Involuntary Transportation for Emergency Examinations
Fiscal Year 2016

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	8	6	13	4	7	3	6	3	4	6	7	11	**78**
Non-Restrained	8	20	5	17	15	16	13	14	16	15	17	19	**175**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport													
None	8	20	5	17	15	16	13	14	16	15	17	19	**175**
Metal	2	3	5	3	3	1	2	2	2	3	3	2	**31**
Soft	6	3	8	1	4	2	4	1	2	3	4	9	**47**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	13%	12%	28%	14%	14%	5%	11%	12%	10%	14%	13%	7%	**12%**
Vehicle Used in Transport													
Ambulance	0	3	1	3	8	4	6	3	5	7	5	5	**50**
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	4	6	5	6	6	5	3	6	9	5	7	5	**67**
Sheriff Cruiser	12	17	12	12	8	10	10	8	6	9	12	20	**136**
Other	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not Applicable ("Walk Up")	0	0	0	0	0	0	0	0	0	0	0	0	**0**
No Data	0	0	0	0	0	0	0	0	0	0	0	0	**0**
%Vehicle Transports that use Ambulance		12%	6%	14%	36%	21%	32%	18%	25%	33%	21%	17%	**20%**
%Vehicle Transports that use MH Van Alternative												0%	**0%**
%Vehicle Transports that use Sheriff's Alternative	25%	23%	28%	29%	27%	26%	16%	35%	45%	24%	29%	17%	**26%**
%Vehicle Transports that use Sheriff's Cruiser	75%	65%	67%	57%	36%	53%	53%	47%	30%	43%	50%	67%	**54%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	16	23	17	18	14	15	13	14	15	14	19	25	**203**
TOTAL EE Transports	16	26	18	21	22	19	19	17	20	21	24	30	**253**

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

Date of Report: 11/09/2016

Chart 22: One-Year overview of Youth Involuntary Transport

Vermont Department of Mental Health
Youth Involuntary Transportation for Emergency Examinations
Fiscal Year 2016

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	2	0	1	1	1	0	0	1	2	2	1	0	**11**
Non-Restrained	0	1	5	4	7	1	1	0	2	1	2	2	**26**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport													
None	0	1	5	4	7	1	1	0	2	1	2	2	**26**
Metal	2	0	0	1	0	0	0	1	0	0	0	0	**4**
Soft	0	0	1	0	1	0	0	0	2	2	1	0	**7**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	100%	0%	0%	20%	0%	0%	0%	100%	0%	0%	0%	0%	**11%**
Vehicle Used in Transport													
Ambulance	0	1	0	4	7	0	1	0	3	1	1	1	**19**
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	0	0	1	0	0	0	0	0	1	0	1	0	**3**
Sheriff Cruiser	2	0	5	1	1	1	0	1	0	2	1	1	**15**
Other	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not Applicable ("Walk Up")	0	0	0	0	0	0	0	0	0	0	0	0	**0**
No Data	0	0	0	0	0	0	0	0	0	0	0	0	**0**
%Vehicle Transports that use Ambulance		100%		80%	88%		100%		75%	33%	33%	50%	**51%**
%Vehicle Transports that use MH Van Alternative												0%	**0%**
%Vehicle Transports that use Sheriff's Alternative			17%						25%		33%	0%	**8%**
%Vehicle Transports that use Sheriff's Cruiser	100%		83%	20%	13%	100%		100%		67%	33%	50%	**41%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	2	0	6	1	1	1	0	1	1	2	2	1	**18**
TOTAL EE Transports	2	1	6	5	8	1	1	1	4	3	3	2	**37**

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

Date of Report: 11/09/2016

Adult Outpatient Care and Utilization

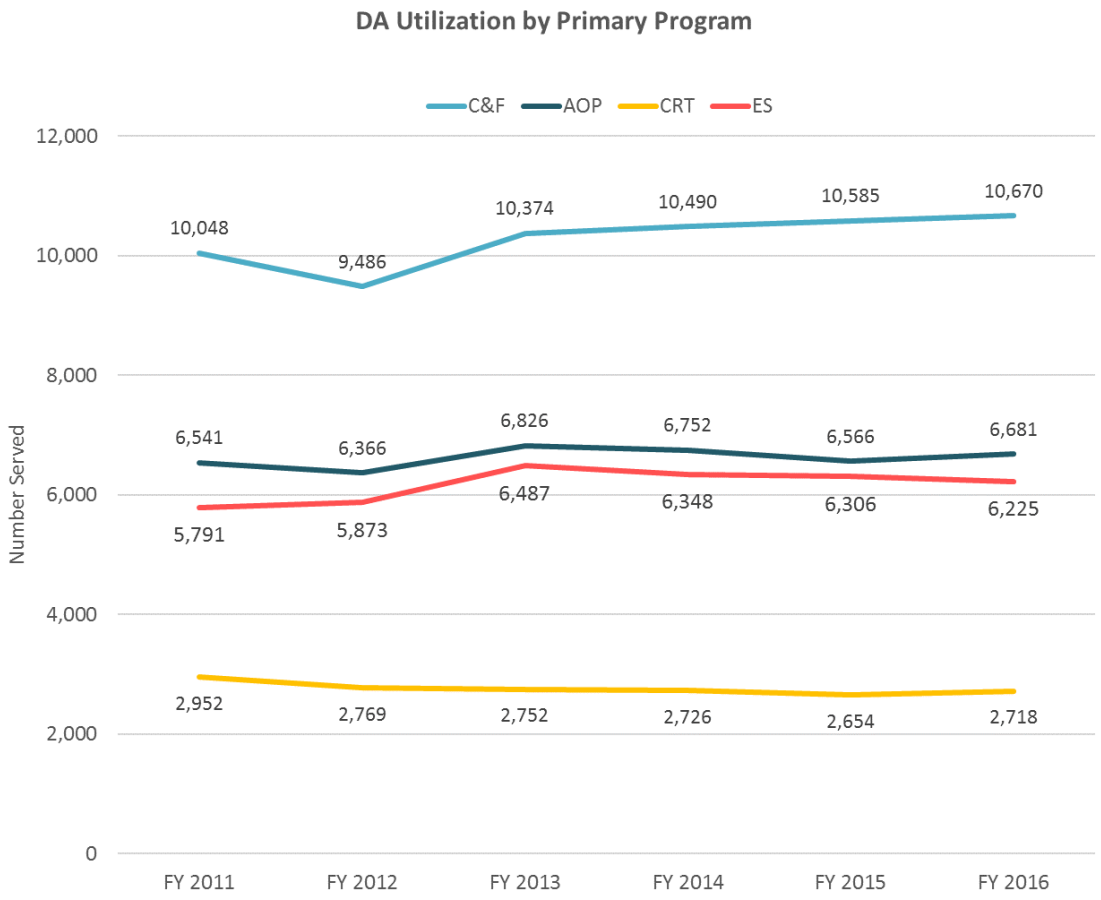
Outpatient services are provided through a system of care that includes the Designated Agencies, private practitioners, and other state and local social services agencies. The Designated Agencies provide comprehensive services to individuals through the Community Rehabilitation and Treatment programs,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

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

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

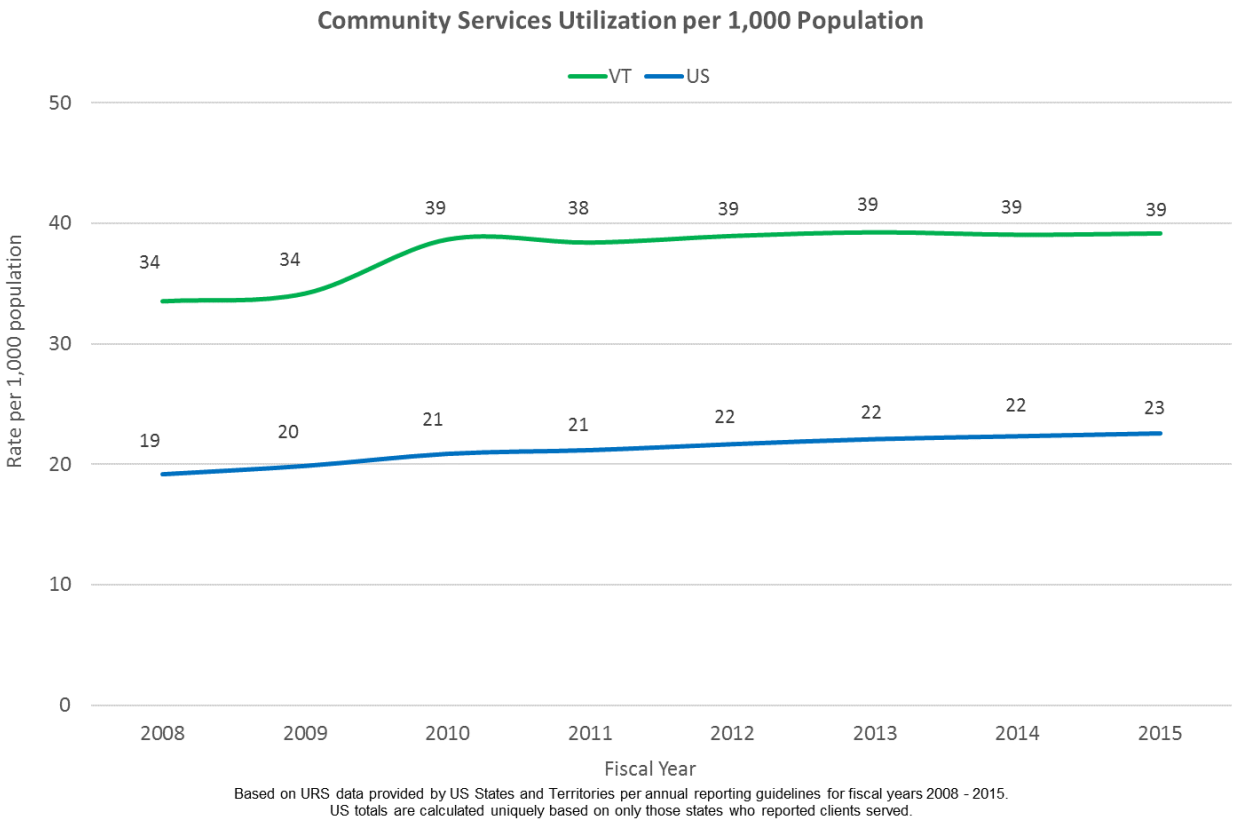
Although the Department provided enhanced community services funding through increased appropriations to key mental health programs in the community in FY 2013 and FY 2014, staff recruitment necessary to expand these service levels has continued to be a struggle. Information provided by the Designated Agencies in the Local System of Care Plans continues to identify staffing, both recruitment and retention, as a major barrier to increasing services. Consistent with this report, the numbers served in community programs through FY 2016 remained relatively stable and do not reflect any upward trend in persons served.

Chart 23: Designated Agency Volume by Program



The highest number of persons served by a program offered by the Designated Agencies (DAs) continues to be in services for children and families, while the lowest numbers of persons served by a Designated Agency program are those in the Community Rehabilitation and Treatment (CRT) programs. The volume of clients served in all of the program areas has been fairly stable over time. There is a significant increase in case management services to outpatient clients as discussed later in this report.

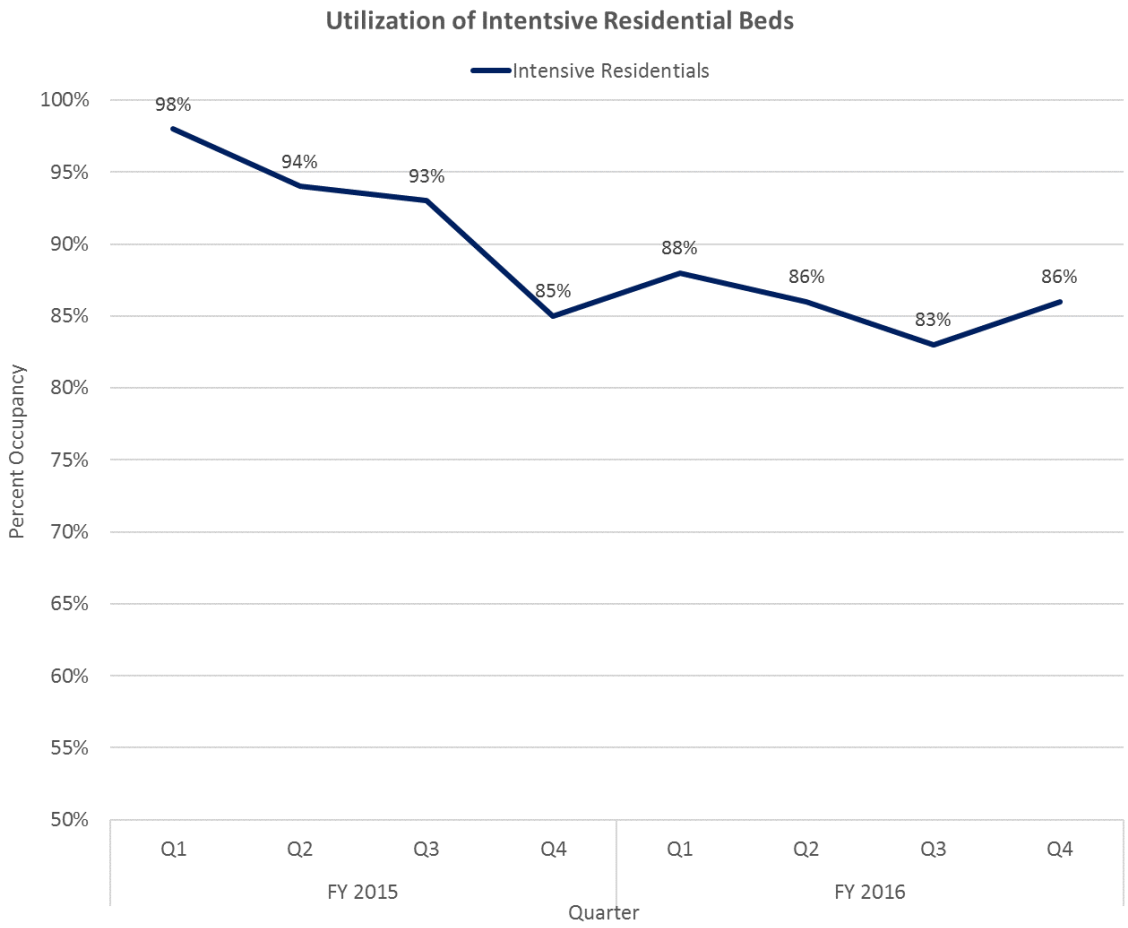
Chart 24: Community Utilization per 1,000 Populations



The Vermont community mental health system serves 39 out of every 1,000 Vermonters, which is substantially higher than the national figure. These data show that Vermont is achieving success in moving care from the highest levels of hospitalization to least restrictive settings in the community. While the progress appears to be static, other data shown in *Chart 26: Non-Categorical Case Management* indicate that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care.

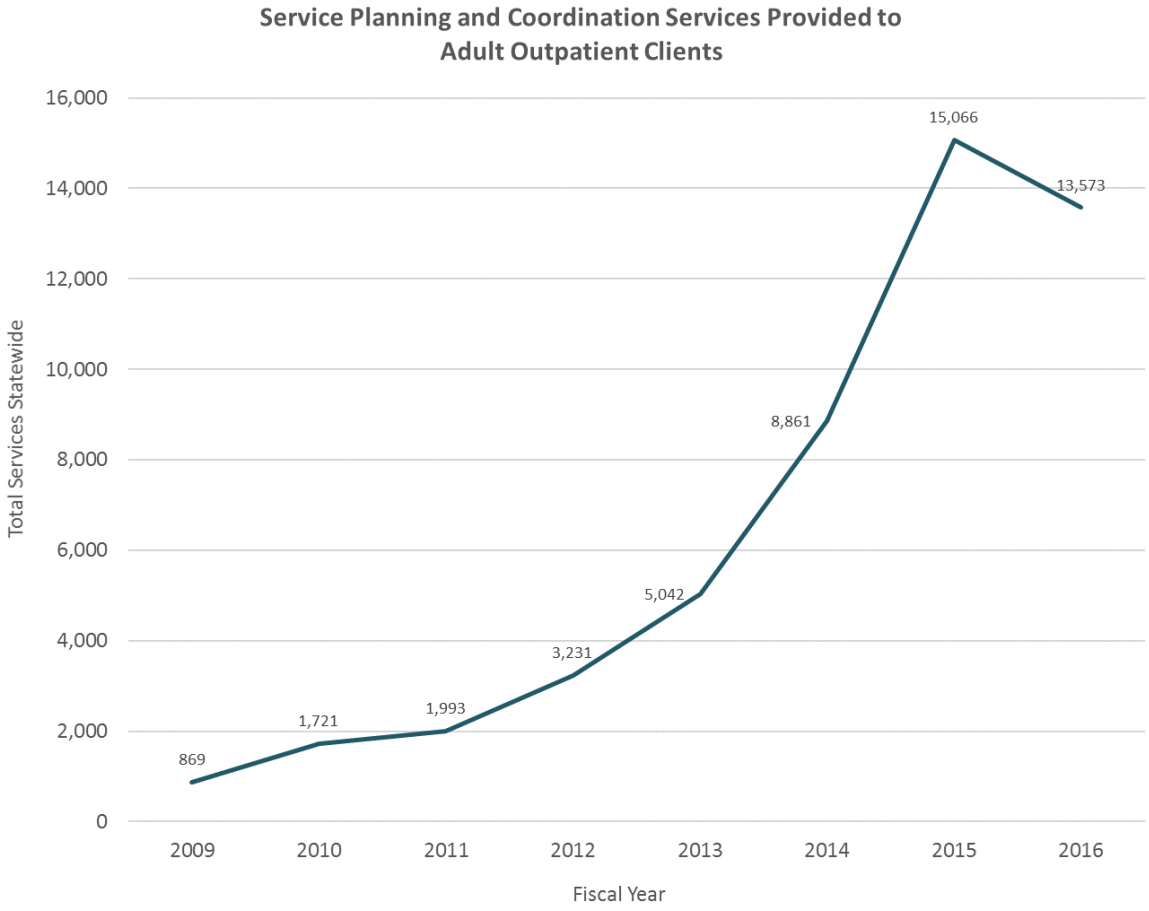
The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic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

Chart 25: Intensive Residential Bed Utilization



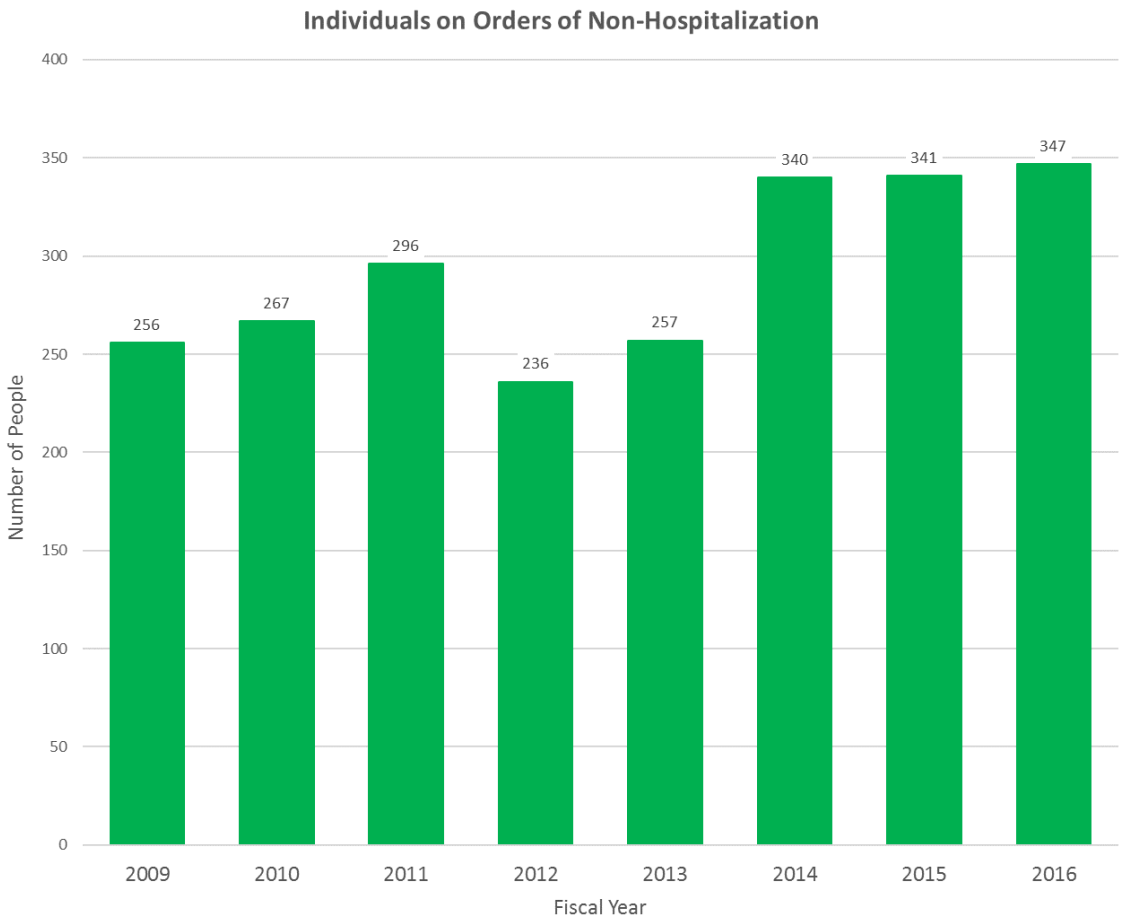
The Intensive Residential Recovery Programs (IRRs) are continuing to meet a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward independent living. The chart above illustrates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

Chart 26: Non-Categorical Case Management



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

Chart 27: Orders for Non-Hospitalizations



The number of people on Department of Mental Health Orders of Non-Hospitalization (ONHs) continues to be around 340, with 347 people during FY 2016. Departmental legal staff members work closely with clinical staff and Designated Agency clinicians to monitor treatment compliance and maintain communication with providers. The Care Management Team monitors community care through the Designated Agencies which provide direct services in the community. Through this process, community service providers are required to provide clinical justification of the ongoing need and their efforts to engage individuals in the treatment planning process and in understanding and complying with community conditions imposed by the Court. The Department plans to continue providing oversight through the care management team. The Department assigned a care manager in May 2015 to work solely with Designated Agencies to provide closer oversight and case consultation in regards to individuals being served who are on ONHs. Designated Agencies consult with this care manager prior to submitting a request to continue or discontinue Orders of Non-Hospitalization. The ONH Manual was finalized in November 2015 with significant input from the Designated Agencies.

DMH also recently participated in a free technical assistance site visit focused on Vermont's use of Orders of Non-Hospitalization. A representative from the Treatment Advocacy Center (TAC) visited Vermont in December 2016 to collect information on Vermont's use of ONHs for improving outcomes among individuals who struggle with adherence to psychiatric treatment and are frequently hospitalized

or arrested. During the site visit, TAC met with staff from the Department (including Vermont Psychiatric Care Hospital), mental health professionals, judges, policymakers, and advocates familiar with the Vermont's current use of ONHs. In the coming weeks, TAC will provide DMH with a written report on his observations, including recommendations on how Vermont's ONH-related laws, practices and procedures might be improved to achieve better results.

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 of the Designated Agencies participated in developing additional services and enhancing those services that were already in place, in order to provide more timely access to and response for those in crisis. The list of services covered by the changes was fairly broad, with common themes and best practices identified and implemented across all of the Designated Agencies.

Law Enforcement and Mobile Crisis

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

Each Designated Agency has developed mobile crisis teams to better respond to individuals experiencing psychiatric crisis and all programs have begun to perform crisis assessments and interventions in the community, as well as providing law-enforcement related crisis response. The capacity for this mobile outreach varies among the DAs due to ongoing recruitment and retention issues. In addition, the Designated Agencies are providing increased services to patients waiting in emergency rooms for admission to psychiatric hospital care.

To continue these efforts successfully, standards and training for law enforcement personnel and crisis teams have been established. Law enforcement staff from local and statewide jurisdictions have participated in the trainings which will continue into 2017. A statewide communications protocol for deployment and safety between mobile crisis teams and law enforcement has been established. An interdisciplinary training model has been developed by the Department and Public Safety and has been delivered regionally through a collaborative effort between Vermont Care Partners, the Department of Public Safety, and the Department of Mental health using a train-the-trainers model referred to as "Team Two" Training. "Team Two" teams have been established in the 5 regions of the State:

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

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

Peer Services

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

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

The Importance of Peer Support in Vermont

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

"Peer support for people with similar life experiences (e.g., people who've lost children, people with alcohol and substance abuse problems, etc.) has proven to be tremendously important towards helping many move through difficult situations (Reissman, 1989; Roberts & Rappaport, 1989). In general, peer support has been defined by the fact that people who have like experiences can better relate and can consequently offer more authentic empathy and validation. It is also not uncommon for people with similar lived experiences to offer each other practical advice and suggestions for strategies that professionals may not offer or even know about. Maintaining its non-professional vantage point is crucial in helping people rebuild their sense of community when they've had a disconnecting kind of experience."[3]

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

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

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.[4]

Peer support can take many different forms such as self-help and mutual support groups, peer crisis respite, warm lines, inpatient peer services, wellness planning and skill development, peer-driven housing supports, peer drop-in and community centers. This support has been shown to be effective in supporting recovery. As stated by the Substance Abuse and Mental Health Services Administration (SAMHSA), "evidence shows that consumer-operated services are supporting people in their wellness and recovery while also contributing to the entire mental health service system."[5] For these reasons, it is the goal of the Department of Mental Health to make a variety of peer supports available to anyone in the state struggling with mental health and other co-occurring issues. The implementation of the programs described below is helping the Department move closer to this goal.

Implementation of Peer Services

Over the past year, the Department has focused primarily on improving and refining Vermont's expanded array of peer services, many of which were developed or enhanced following the passage of Act 79. This expanded array of services includes community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. A full listing of peer programming supported by the Department of Mental Health is listed below.

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

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

Chart 28: Vermont Peer Services Organizations

Organization	Services Provided
Alyssum	Operates two-bed program providing crisis respite and hospital diversion and step-down.
Another Way	Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving individuals who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services.
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.
NAMI-VT	Statewide family and peer organization providing support groups, educational and advocacy groups for individuals with mental health conditions and their families.
Northeast Kingdom Human Services Peer Cadre	Provides respite and peer support for individuals waiting in hospital emergency departments for inpatient psychiatric care.
Pathways – 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.
Wellness Cooperative	Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving young adults who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services.
Wellness Workforce Coalition	Provides infrastructure and workforce development for organizations that provide peer support. Activities include: o Coordinating core training (e.g Intentional Peer Support) o Workforce development (e.g. recruitment, retention, career development) o Mentoring o Quality improvement o Coordination of peer services o Communication and networking o Systems advocacy.

During FY 2016, each program has worked closely with the Wellness Workforce Coalition (WWC) to participate in core training and mentoring for staff using the Intentional Peer Support Curriculum, which is used nation-wide for peer support providers. These peer organizations have also worked with the

WWC to improve their infrastructure (e.g. financial management, board development) and expand their capacity for collecting and reporting service outcomes using the Results-Based Accountability framework. In addition, the WWC has completed the development of peer support core competencies for all peer service providers. These core competencies will be used to support enhanced training and mentoring to improve the quality and consistency of peer services throughout the state.

Spotlight: Vermont Support Line

The Vermont Support Line (VSL) is one of the programs developed subsequent to the implementation of Act 79. This program provides statewide telephone peer support to prevent crisis and provide wellness coaching. VSL operates 365 days per year, seven days a week, and, with new funding from Vermont's Mental Health Block Grant, the line is now open an average of 10 hours per day. VSL is operated by full time and part time peer staff who have been trained using the *Intentional Peer Support* model, which uses a specialized curriculum developed expressly for support line workers. The Vermont Support Line took its first call on March 18, 2013 and has provided 22,638 individual instances of completed support through November of this year. FY16 surpassed FY15's completed call volume by 1,344 calls. Through November 2016, the Vermont Support Line has diverted 1,080 callers from emergency level services (crisis, emergency room, hospital, 911, etc.). In 2016, the support line has been able to increase the amount of incoming calls answered from 12.8% in 2015 to 20.6% (through November) of total incoming calls. So far in 2016, 82% of callers who answered the survey questions reported that the call was helpful.

Spotlight: Alyssum

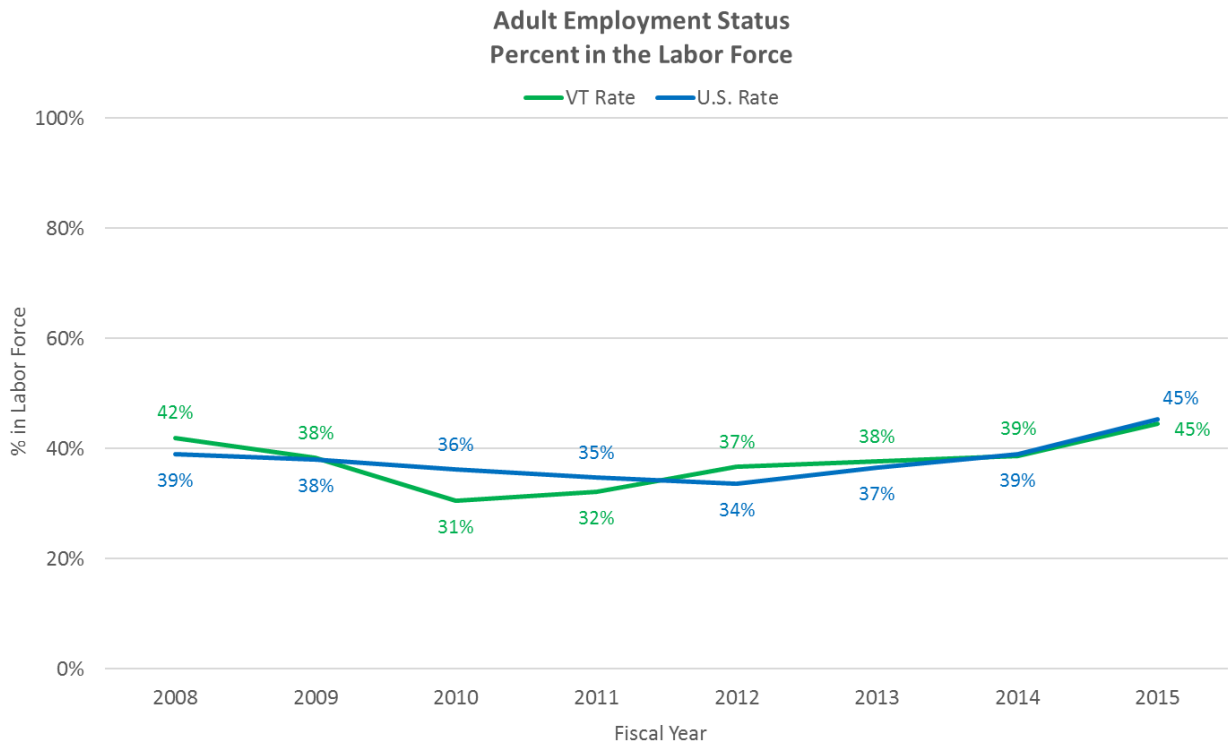
Alyssum opened its doors in November 2011 and expanded its capacity through additional Act 79 funding. The program offers a peer-developed approach to crisis support for individuals who are seeking an alternative to traditional DA crisis programs. As one resident stated, "*Alyssum is a safe haven for me. It works so much better for me than a traditional hospital setting. Being able to talk to peers who have been in my shoes and giving me first hand advice that works for them and try it myself is amazing."*

As of the end of November 2016, Alyssum has had a total of 375 admissions and served 252 individuals (unduplicated). Over this period, Alyssum has had an 86% occupancy rate and an average length of stay of 7 days. Demand for the program has been high—a total of 568 unique individuals have been denied a bed due to full occupancy. 80% of admissions have been for hospital diversion and 20% were for transition from a hospital (step-down). Out of a possible 100% satisfaction rate, guests report 90% satisfaction with the progress made on personal goals while at the program. Upon departure from Alyssum, 84% of guests self-report feeling better, 20% say they feel the same, while 6% say they feel worse. The staff turnover rate at Alyssum is less than 10% annually.

Employment

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

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

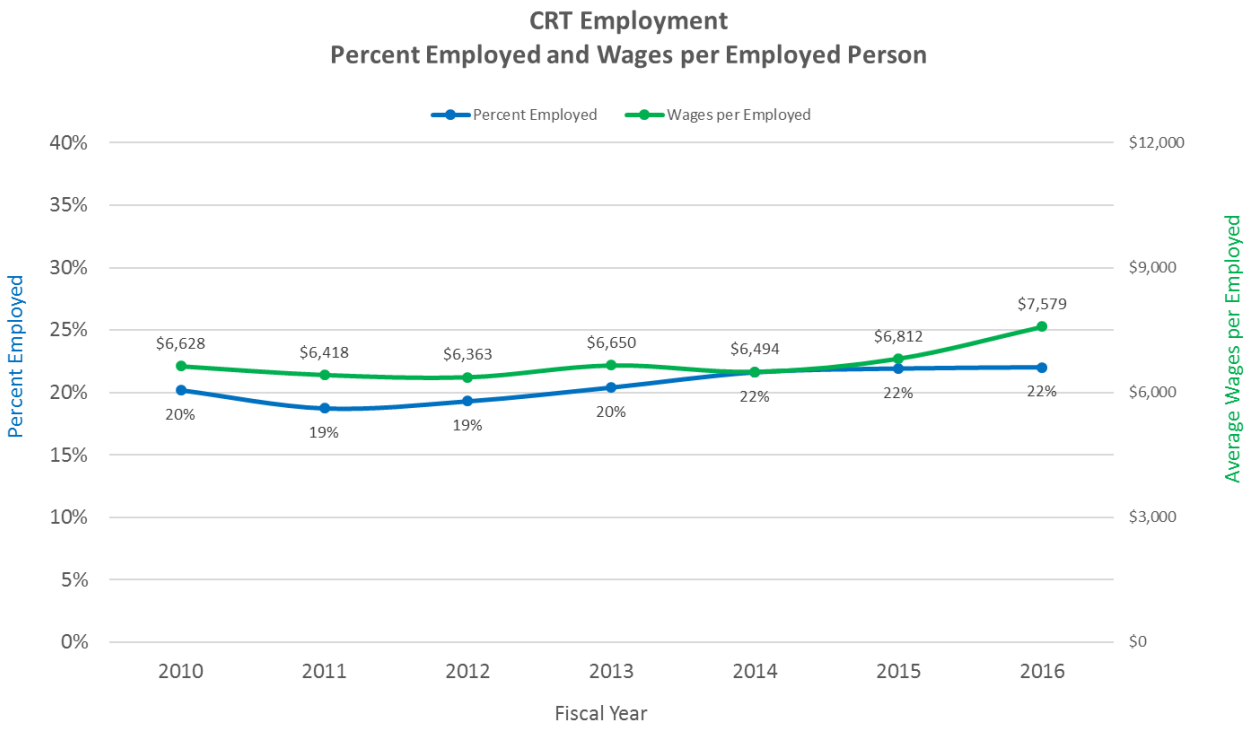


Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2015. Employment status for other mental health clients is based on case manager monthly service reports. Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2015. 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.

Chart 32 shows the employment rate for all adults with mental illness in Designated Agencies—Adult Outpatient and Community Rehabilitation and Treatment combined—increased by 6% and matches the national rate. Reasons for the continued increase may include:

- Sustained efforts of peer employment staff in two peer-run programs
- Increased focus on employment as key component of wellness and recovery at DAs
- Consistent evidence-based supported employment training and technical assistance at DAs
- Creative Workforce Solutions
- Collaborative efforts between Vocational Rehabilitation and the Department.

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.

Chart 33 indicates a 1% increase in Community Rehabilitation and Treatment employment outcomes between FY 2012 and FY 2013 and an additional 2% increase by end of FY 2014 that has held steady through FY 2016. Wages dipped slightly for the period but have increased substantially in FY 2016. Community Rehabilitation and Treatment programs continued to support individuals with their employment goals despite continued challenges within the system of care. Individuals, on average, earned $7,579 per year (*15 hours per week for full year at Vermont's current minimum wage of $9.60 per hour*).

Individual Experience and Recovery

A significant aspect of the intent of Act 79 was to improve the care and the experiences of those receiving mental health services in the State of Vermont. The Department routinely surveys consumers of mental health care and staff who provide the services as part of its Agency Review process. Additionally, the Department also surveys consumers and families annually using a nationally developed survey. These surveys are one measure of individual experience and recovery, and the results are summarized in the following charts.

Person centered care is focused upon the individual needs and movement towards stabilization and recovery. The individual needs of clients are the focal point at all of 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 a number of 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 a number of other non-medical interventions for the management of and recovery from distressing symptoms associated with mental illness. Interventions such as *Wellness Recovery Action Planning, Illness Management and Recovery, Cognitive Behavioral Therapy for Schizophrenia*, *Open Dialogue,* and the *Hearing Voices* curriculum module support individuals to develop non-medical methods for 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 a number of initiatives underway to expand the availability of several of these interventions.

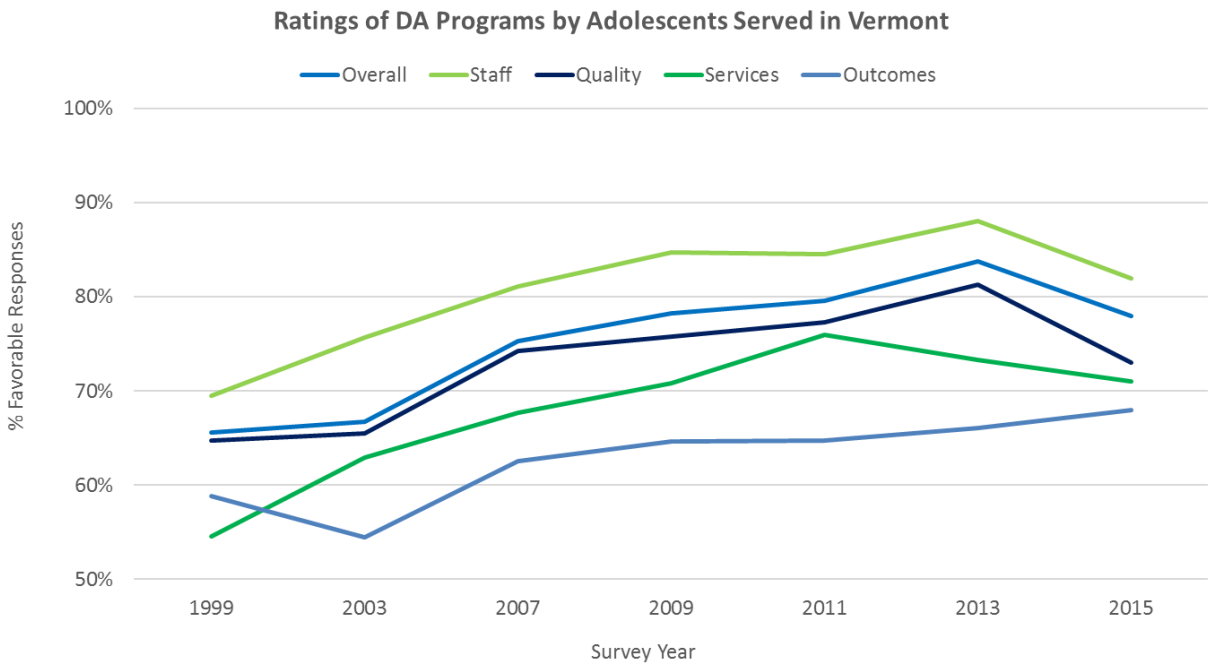
Over the past year, the Department has continued to support options for individuals seeking to avoid or reduce reliance on medications through funding of the residential program *Soteria – Vermont*, which provides specialized treatment and support for individuals experiencing first break psychosis who 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 using the *Soteria* model.

Lastly, Vermont was recently informed of an increase in their Federal Mental Health Block Grant to support the expansion of targeted services for individuals experiencing early episodes of psychosis. Current research indicates that early intervention and treatment of individuals who are first experiencing psychosis has the ability to prevent or reduce long-term disability, and, in some cases, reduce long-term reliance on psychotropic medication. In 2015, the Department began working with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) to identify and promulgate specific evidence-based practices for this population and is supporting an ethnographic study on the personal and familial experience of Vermonters who have experienced psychosis as a young adult. Results of this study should be available in 2017 and will inform system and programmatic improvements for this population.

Perception of Care Surveys

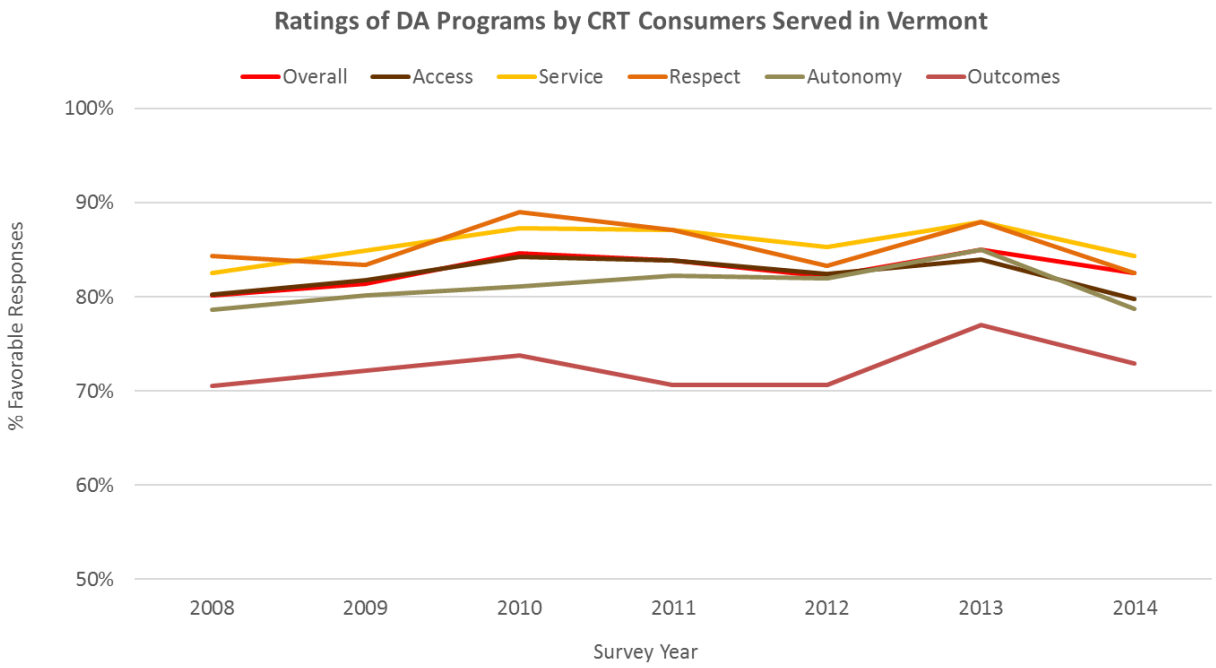
The Department conducts consumer surveys to evaluate Community Rehabilitation and Treatment Services and Children and Family Services provided by the ten designated agencies in Vermont. The survey for children and families includes parents of children and adolescents with a severe emotional disturbance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

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



Overall satisfaction in Child and Adolescent Mental Health Programs has increased over the years, along with satisfaction surrounding staff and quality of services. The next adolescent survey will be conducted in late 2017, with results available in 2018.

Chart 32: Ratings of CRT Programs by CRT Consumers



Satisfaction with Community Rehabilitation and Treatment programs has shown less improvement, but remains close to the eightieth percentile for all domains, with the exception of outcomes. Survey results vary widely by Designated Agency. Information from surveys is used in the designation process and when working with Designated Agencies to improve care. Due to staff turnover a CRT survey was not conducted for 2015 but will resume in 2016.

Housing

Since its creation in December 2011, a total of 183 persons who were homeless, mentally ill, and needing an acute care bed have been allocated a subsidy and have subsequently been housed with community supportive services by the Department's Housing Subsidy & Care Program. The Vermont State Housing Authority remains the Department's collaborating partner verifying income, setting rent payments, and working with landlords.

The performance indicator the department seeks to achieve is a one-year housing retention. The lengths of stay in housing since the program began range from 108 for those more recently enrolled to 1,480 days for long term stayers, greater than 79% having lengths of stay of more than one year. An equal number of male and female were also served. Of the 183 served, more than 80% were literally homeless, meaning on the streets, in a shelter, or in a hospital. Less than 18% of those assisted came from psychiatric hospitalization. Of the 183 housed since December 2011, 61 persons have exited. Thirty-five percent of those have positive outcomes.

In an effort to insure ongoing availability of housing to individuals who are homeless and mentally ill DMH is focusing new efforts on Community Mental Health Center and Pathways to Housing collaborations with local not-for-profit housing developers.

Department staff have been working with providers and peers to update the Self Sufficiency Outcome Matrix. The updated version will be tested before the end of this year.

All 9 self-sufficiency outcome measures recorded demonstrate improvement for the individuals participating in the Housing Subsidy & Care program. Most notable was the improvement in disability, income, housing, mental health, and community involvement.

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

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

Planning for the Future

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

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

Building and Maintaining Capacity

The Department of Mental Health's top priority for the past year has been improving access to the right level of care through a more reliable "system flow" as both inpatient bed and various community residential capacities have come on line. With the full complement of Level 1 available the state's psychiatric inpatient hospital units are better positioned to serve voluntary individuals with mental health needs as well. In combination with enhanced community-based treatment and support programs a fundamentally essential underpinning of our public mental health system of care is fully maturing as a continuum of care and better resourced for the complexity of needs present in our local communities. The Department's task ahead continues to be active monitoring and evaluation of the adequacy of the system that has been built.

Lastly, the array of system treatment capacities achieved to date will only be complete when there is both access across care and service settings and full integration of care delivery environments. Over the coming year, the Department will continue to prioritize mental health as an integral component of overall health. In order to realize this broader mission of integrated care for all Vermonters, DMH will be seeking opportunities to further embed and develop this expectation in current health reform efforts.

Kuligoski Decision and System Pressures

The Kuligoski decision (Kuligoski v. Brattleboro Retreat, 2016 VT 54A) significantly changed the obligations of mental health providers and others involved in the care of people with mental illness, as well as impacting the privacy rights of those with mental illnesses. Before this decision, providers had clear guidance about their obligations – the duty to warn was triggered when a mental health professional knew or should have known based on the standards of their profession that a patient posed a serious and imminent risk of danger to an identifiable victim. This warning was consistent with HIPAA privacy requirements.

The Kuligoski decision added additional duties – mental health providers now must give reasonable information to caregivers (identified in the patient's treatment plan) to warn them of a patient's risk of violence and provide them with "reasonable information to enable them to fulfill their role in keeping him safe." This decision is seen by many mental health care providers as unworkable for several reasons. First, the decision no longer requires the risk be serious or imminent. This puts providers in a position of either violating federal HIPAA law or this new case law. Second, there is no longer a requirement that the victim be "identifiable" and instead requires mental health professionals to essentially guess who may be a victim. As for caretakers, the decision potentially sets up a situation where they could be held liable for the actions of the person they are caring for which will likely make caretakers less willing to take on this role and thus leave patients without the supports they need.

Departmental data moving into FY 2017 regarding involuntary inpatient admissions and emergency room waits indicates that there has been an increase in use of involuntary inpatient care. While forensic admissions are lower than previous years, FY 2016 had the highest number of civil involuntary admissions since FY 2002 (*Chart 10: Involuntary Admissions by Catchment Area of Residence*).

Additionally, the number of adults waiting per day and the amount of time they wait has increased since the inpatient system is operating at high capacity (*Chart 12: Average Number of People Waiting Inpatient Placement*). In the last quarter of FY 2016, the number of adults held on civil orders (emergency exam or warrant), increased by additional 30 people as compared to the previous quarter. This was also the highest number of adults held since the Department has been tracking wait times for inpatient care. The number of adults whose civil holds expire and are released to other levels of care appears to be increasing. Departmental discussions with providers via the DMH care management team suggests that civil holds are expiring because the need for hospitalization is unnecessary.

The Department believes that the increase in the number of emergency exams and warrants is stemming from a national focus on unmet mental health treatment needs, interactions between mental health and law enforcement (in Vermont and Nationwide) culminating violence or more severe negative outcomes, and a more recent Vermont Supreme Court Decision (Kuligoski) which expands the scope of duty-to-warn and may place providers at-risk if their patients engage in harmful actions. Secondly, options for treatment only exist as involuntary or voluntary program services for individuals, allowing a gap to exist for the period of recovery that may be needed when individuals are neither acutely ill nor requiring hospitalization, but are unwilling to accept services needed to further recovery and prevent future hospitalization. The absence of sub-acute options for this phase of recovery leave providers with only containment at the highest level of care or release to fully voluntary programming in the community. A small cohort of individuals exist who have complex mental health needs and account for a significant number of Level 1 and involuntary inpatient bed days for the system as a whole. Until this gap in treatment service is addressed or tools developed to compel treatment participation that address the needs of this cohort, access to inpatient beds (from emergency departments and the community) and timely step down or diversion from inpatient beds will remain a continuing struggle.

Until a continuum of programming exists to meet the individualized needs of people on their journey of recovery, the judicial system, mental health screeners, and both inpatient and community-based mental health provider systems will likely need to exercise caution in their approach to individuals presenting in mental health crisis and seeking treatment. Each will continue to be less willing to explore alternatives to hospitalization or confinement when the perceived risk of harm to self, harm to others, or harm by others is too high.

Changes to Report Approach

As the Act 79 report is due annually to the legislature, DMH has been evaluating its current approach to the annual report process and will be implementing the following changes for the FY 2017 report:

- Restructure report to better reflect the report's legislative requirements
- Move data reporting to annual figures.

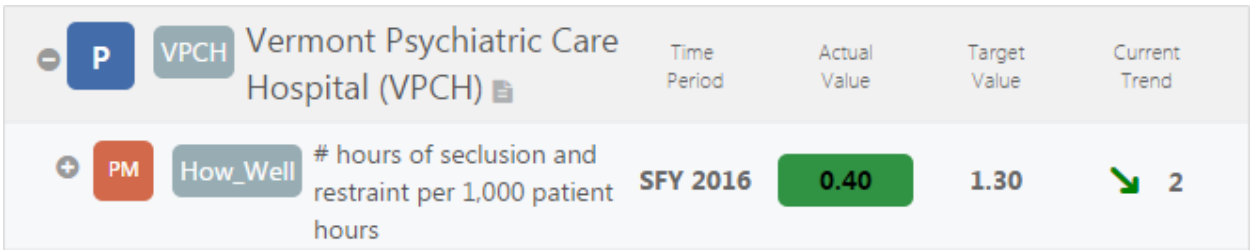
By restructuring the report to reflect the legislative report requirements, it is the hope that the report will become easier to read and clearer to understand. An interested reader will be able to refer to the report structure to find sections relevant to their interests.

By moving data to annual figures, it will be easier to see the impacts of Act 79 on the system of care. DMH will still be reporting quarterly and monthly figures in its RBA Clear Impact Scorecard, which is publically accessible via the DMH website and updated as soon as new figures are available (see Appendices). Since the Act 79 report is due annually to the legislature with no expiration on reporting expectation, reporting annually better matches the long term reporting structure and will allow DMH to report historical numbers in a clearer fashion.

RBA Scorecard

As part of the Agency of Human Services, the Department has been working to move its performance measures to the RBA Clear Impact Scorecard, which allows for stakeholders, legislators, and the general public access to DMH measurements as soon as they are updated. The scorecard is interactive, allowing users to expand and collapse measures. It is also coded with color and symbols that allow users to quickly see the performance of a measure.

A brief explanation is included below:



The color box around the ***Actual Value*** represents how close the measure scored as compared to the established targets. In this instance, the following ranges are used and in the scorecard, there would be an expandable graph that would contain this range information:

- **Red**: 2+ hours
- **Yellow**: between 1-2 hours
- **Green**: less than 1 hour

The current trend represents how long the data has been moving in the indicated direction. The color indicates whether that movement is good (**green**) or bad (**red**). For example: The rate has been decreasing (↘) over the past two time periods in the right direction (**green**).

In the scorecard, you can click on the +/- sign next to each **P** or **PM** to expand or collapse the information.

The Department will be working over the next year to evaluate each measure and assign a target and baseline as appropriate so that this functionality can be used. Additionally, the Department will be working to provide a "Story Behind the Curve" for each indicator and performance measure that is presented.

Appendices

Appendix A: DMH Snapshot

Appendix B: DMH Continued Reporting

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

APPENDIX A: DMH MONTHLY SNAPSHOT

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

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

(DRAFT) DMH System Snapshot

		Time Period	Actual Value	Current Trend
P	Snapshot **Adult Inpatient Hospitalization**			
PM	How_Much % occupancy of adult inpatient hospital units	FYQ1 2017	92%	↗ 1
PM	Snapshot # of closed adult inpatient beds per day (average)	FYQ1 2017	3	↘ 2
PM	Snapshot % of all adult inpatient bed days used for involuntary care	–	–	–
PM	Snapshot # of EE applications for adults (18+)	FYQ1 2017	137	↘ 1
PM	Snapshot # instances where inpatient placement was unavailable, and adult was held in the emergency dept.	FYQ1 2017	66	↘ 1
PM	Snapshot # of requested Court-Ordered Forensic Observations	FYQ1 2017	47	↗ 2
PM	Snapshot # of screenings Court-Ordered Forensic Observation resulting in an inpatient order	FYQ1 2017	21	↗ 2
P	Snapshot **Level 1 Inpatient Care**			
PM	How_Well % occupancy of Level 1 adult inpatient hospital units	FYQ1 2016	87%	↘ 2
PM	How_Much # Level 1 admissions	FYQ1 2017	32	↘ 1
P	Snapshot **Youth Inpatient Hospitalization**			
PM	Snapshot % occupancy at youth inpatient hospital units	FYQ1 2017	73	↘ 2
PM	Snapshot # instances where inpatient placement was unavailable, and youth was held in the emergency dept.	FYQ1 2017	12	↗ 2
PM	Snapshot # of closed youth inpatient beds per day (average)	FYQ1 2017	5	→ 1
PM	Snapshot # of EE applications for youth (0-17)	FYQ1 2017	12	↗ 2
P	Snapshot **Community Services**			
PM	How_Much % occupancy of Designated Agency adult crisis bed programs	FYQ1 2017	64%	↘ 3
PM	Snapshot % occupancy of Designated Agency youth crisis bed programs	FYQ1 2017	66	↘ 1
PM	How_Well % occupancy of adult intensive residential beds (including MTCR)	FYQ1 2017	84%	↘ 1

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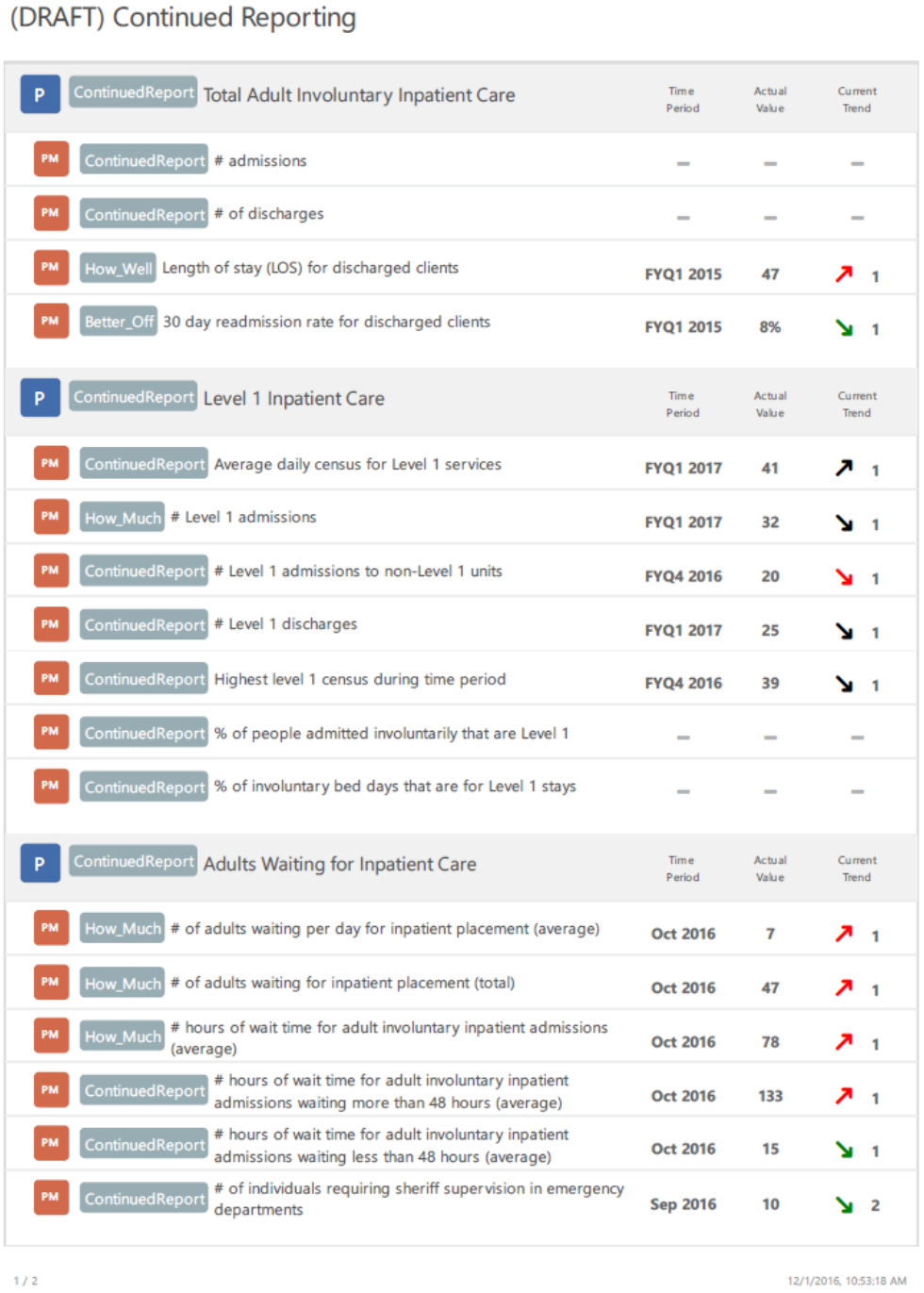
			Time Period	Actual Value	Current Trend
PM	Snapshot	# people enrolled in housing subsidy + care program to date	FYQ1 2017	120	→ 1
P	Snapshot	**Court-Ordered Involuntary Medications**	Time Period	Actual Value	Current Trend
PM	Snapshot	# applications for court-ordered involuntary medications	FYQ1 2017	15	↘ 3
PM	Snapshot	# of granted orders for court-ordered involuntary medications	FYQ1 2017	13	↘ 1
PM	Snapshot	Mean time from filing date to decision date in days	FYQ1 2017	16	↗ 1
P	Snapshot	**Suicide**	Time Period	Actual Value	Current Trend
PM	Snapshot	# of suicide deaths	FYQ1 2017	29	↘ 1
PM	Snapshot	# of suicide deaths who were served by a DA within the previous year	FYQ1 2017	6	↘ 1
P	CareMgmt	**Involuntary Transportation**	Time Period	Actual Value	Current Trend
PM	Snapshot	# of transports to inpatient psychiatric care	FYQ1 2017	76	↘ 1
PM	Snapshot	% of transports to psychiatric inpatient care without using physical restraint	FYQ1 2017	58%	↘ 3
PM	Snapshot	# of transports for adults to inpatient psychiatric care (18+)	FYQ1 2017	67%	↘ 1
PM	Snapshot	# of transports for youth to inpatient psychiatric care (0-17)	FYQ1 2017	9%	↗ 2
PM	Snapshot	% of transports for adults to psychiatric inpatient care using metal restraint	FYQ1 2017	16%	↗ 1
PM	Snapshot	% of transports for youth to psychiatric inpatient care using metal restraint	FYQ1 2017	11%	↗ 1

APPENDIX A: DMH Continued Reporting

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

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



(DRAFT) Continued Reporting

		Time Period	Actual Value	Current Trend
P	ContinuedReport Total Adult Involuntary Inpatient Care			
PM	ContinuedReport # admissions	–	–	–
PM	ContinuedReport # of discharges	–	–	–
PM	How_Well Length of stay (LOS) for discharged clients	FYQ1 2015	47	↗ 1
PM	Better_Off 30 day readmission rate for discharged clients	FYQ1 2015	8%	↘ 1
P	ContinuedReport Level 1 Inpatient Care			
PM	ContinuedReport Average daily census for Level 1 services	FYQ1 2017	41	↗ 1
PM	How_Much # Level 1 admissions	FYQ1 2017	32	↘ 1
PM	ContinuedReport # Level 1 admissions to non-Level 1 units	FYQ4 2016	20	↘ 1
PM	ContinuedReport # Level 1 discharges	FYQ1 2017	25	↘ 1
PM	ContinuedReport Highest level 1 census during time period	FYQ4 2016	39	↘ 1
PM	ContinuedReport % of people admitted involuntarily that are Level 1	–	–	–
PM	ContinuedReport % of involuntary bed days that are for Level 1 stays	–	–	–
P	ContinuedReport Adults Waiting for Inpatient Care			
PM	How_Much # of adults waiting per day for inpatient placement (average)	Oct 2016	7	↗ 1
PM	How_Much # of adults waiting for inpatient placement (total)	Oct 2016	47	↗ 1
PM	How_Much # hours of wait time for adult involuntary inpatient admissions (average)	Oct 2016	78	↗ 1
PM	ContinuedReport # hours of wait time for adult involuntary inpatient admissions waiting more than 48 hours (average)	Oct 2016	133	↗ 1
PM	ContinuedReport # hours of wait time for adult involuntary inpatient admissions waiting less than 48 hours (average)	Oct 2016	15	↘ 1
PM	ContinuedReport # of individuals requiring sheriff supervision in emergency departments	Sep 2016	10	↘ 2

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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 2015 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 per1,000 population	7,448,380	39.27	23.07	58
Community Utilization per 1,000 population	7,288,614	39.19	22.57	57
State Hospital Utilization per 1,000 population	137,956	-	0.44	51
Other Psychiatric Inpatient Utilization per 1,000 population	331,124	-	1.29	36

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	757,780	44.6%	45.4%	57
Employed (percent with Employment Data)**	757,780	25.2%	21.7%	57

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	71.4%	72.3%	49

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	60.5%	69.7%	48

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	7,612	16.7%	8.2%	50
State Hospital Readmissions: 180 Days	17,077	23.8%	18.5%	50
State Hospital Readmissions: 30 Days: Adults	7,069	16.7%	8.4%	49
State Hospital Readmissions: 180 Days: Adults	15,814	23.8%	18.9%	49
State Hospital Readmissions: 30 Days: Children	462	0.0%	5.6%	17
State Hospital Readmissions: 180 Days: Children	1,127	0.0%	13.6%	21

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,120,639	88.1%	76.2%	58
Homeless/Shelter	184,710	3.6%	3.4%	54
Jail/Correctional Facility	77,670	0.2%	1.4%	53

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	71,533	-	2.6%	33
Supported Employment	62,500	29.2%	2.0%	41
Assertive Community Treatment	61,215	-	1.9%	36
Family Psychoeducation	27,706	-	1.8%	14
Dual Diagnosis Treatment	208,811	-	10.5%	24
Illness Self Management	273,289	-	17.3%	21
Medications Management	367,769	81.1%	21.5%	19

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	11,562	-	1.3%	24
Multisystemic Therapy	29,635	-	4.6%	18
Functional Family Therapy	26,949	-	4.8%	13

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	66.5%	71.3%	49
Child/Family Improved Social Connectedness	-	85.9%	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 - 2015 State Mental Health Measures

STATE: Vermont

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	24,580	39.27	7,448,380	23.07	58
Community Utilization per 1,000 population	24,534	39.19	7,288,614	22.57	57
State Hospital Utilization per 1,000 population	-	-	137,956	0.44	51
Medicaid Funding Status	15,476	70%	4,951,678	69%	55
Employment Status (percent employed)	1,351	25%	757,780	22%	57
State Hospital Adult Admissions	68	-	103,703	0.82	51
Community Adult Admissions	6,444	0.44	10,824,986	2.29	49
Percent Adults with SMI and Children with SED	7,030	29%	5,265,828	71%	58

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	70 Days	75 Days	50
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	70 Days	76 Days	49
Percent of Client who meet Federal SMI definition	18%	72%	54
Adults with Co-occurring MH/SA Disorders	13%	23%	53
Children with Co-occurring MH/SA Disorders	1%	7%	49

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	77%	83%	49
Quality/Appropriateness of Services	79%	88%	49
Outcome from Services	71%	72%	49
Participation in Treatment Planning	76%	82%	49
General Satisfaction with Care	83%	88%	49

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	84%	85%	48
General Satisfaction with Care	76%	86%	49
Outcome from Services	60%	70%	48
Participation in Treatment Planning	83%	87%	49
Cultural Sensitivity of Providers	88%	93%	48

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	17,171	88.1%	4,120,639	76.2%	58
Jail/Correctional Facility	46	0.2%	77,670	1.4%	53
Homeless or Shelter	696	3.6%	184,710	3.4%	54

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	7	16.7%	7,612	8.2%	50
State Hospital Readmissions: 180 Days	10	23.8%	17,077	18.5%	50
Readmission to any psychiatric hospital: 30 Days	-	-	27,405	13.5%	23

State Mental Health Finance (FY2014)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community MH *	$182,200,000	89.8%	$30,599,889,110	74.9%	52
SMHA Revenues from State Sources **	$500,000	0.3%	$15,925,507,100	39.5%	52
Total SMHA Expenditures	$203,000,000	-	$40,831,941,068	-	52

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	61,215	1.9%	36
Supported Housing	-	-	71,533	2.6%	33
Supported Employment	740	29.2%	62,500	2.0%	41
Family Psychoeducation	-	-	27,706	1.8%	14
Integrated Dual Diagnosis Treatment	-	-	208,811	10.5%	24
Illness Self-Management and Recovery	-	-	273,289	17.3%	21
Medications Management	2,054	81.1%	367,769	21.5%	19

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	11,562	1.3%	24
Multisystemic Therapy	-	-	29,635	4.6%	18
Functional Family Therapy	-	-	26,949	4.8%	13

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	-	-	27,710	4.8%	36
Juvenile Justice Contacts	265	3.0%	7,705	3.6%	36
School Attendance (Improved)	-	-	17,459	35.3%	26

* Includes Other 24 -Hour expenditures for state hospitals.
** Revenues for state hospitals and community MH