VERMONT2018

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 79

January 15, 2018

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Act 79 Reporting Requirements

18 VSA 174 § 7256. Reporting requirements

Notwithstanding 2 V.S.A. § 20(d), the Department of Mental Health shall report annually on or before January 15 to the Senate Committee on Health and Welfare and the House Committee on Human Services regarding the extent to which individuals with a mental health condition or psychiatric disability receive care in the most integrated and least restrictive setting available. The Department shall consider measures from a variety of sources, including the Joint Commission, the National Quality Forum, the Centers for Medicare and Medicaid Services, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration. The report shall address:

(1) use of services across the continuum of mental health services;

(2) adequacy of the capacity at each level of care across the continuum of mental health services;

(3) individual experience of care and satisfaction;

(4) individual recovery in terms of clinical, social, and legal results;

(5) performance of the State's mental health system of care as compared to nationally recognized standards of excellence.

(6) ways in which patient autonomy and self-determination are maximized within the context of involuntary treatment and medication;

(7) performance measures that demonstrate results and other data on individuals for whom petitions for involuntary medication are filed; and

(8) progress on alternative treatment options across the system of care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications. (Added 2011, No. 79 (Adj. Sess.), § 1a, eff. April 4, 2012; amended 2013, No. 96 (Adj. Sess.), § 101; 2013, No. 192 (Adj. Sess.), § 2; 2015, No. 11, § 19.)

Executive Summary: The Mental Health System of Care

The Vermont Department of Mental Health (DMH), with the Designated Hospitals (DHs), Designated Agencies (DAs), 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 in 2012 by the 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. Additionally, work with towns, hospitals, and police departments to expand mobile outreach is beginning. Developing ways to work together to address the unique situations in each town and through a “first response” type of manner will continue to be an important focus.

The departmental adult 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 receiving inpatient psychiatric services. The utilization review care managers also review all Medicaid involuntary and Level 1 admissions, regardless of whether they are enrolled in any DA programs. In the Child, Adolescent and Family Unit (CAFU) the care managers plan a large role in helping DAs access higher levels of care for children when needed. This includes residential care, both in-state and out-of-state as well as therapeutic foster care settings. The CAFU works in close collaboration with families and DAs/SSAs as well as education, child welfare, developmental disabilities and early childhood.

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 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.

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

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 c
- Children, Youth, and Family 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.

However, providers within the mental health system continue to respond to growing demand and pressures to the best of their ability and within the current resources. Over the past two years emergency departments experienced an influx of individuals seeking care and the system was also experiencing challenges in the flow – moving individuals, when appropriate, to lower levels of care.

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 since the enactment of 2012 Act 79 include, but are not limited to:

- Hospital Services
  - 45 Level 1 beds with a total of 199 adult psychiatric inpatient beds across the system of care
  - Operating a new 25 bed psychiatric hospital that is both CMS certified and TJC accredited
  - Operational capacity for Level 1 inpatient care at both Rutland Regional Medical Center and Brattleboro Retreat
  - Emergency Involuntary Procedure Rule-making process completed with Legislative Committee on Administrative Rules (LCAR)
  - Designation of the White River Junction Veterans Administration Medical Center to provide involuntary inpatient care

- 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
  - Expansion of warmline hours
- 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
  - Exploration of visualization tools to create more responsive reporting
  - Participation in development of the AHS Community profiles
- 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
  - Revision of the emergency services standards

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 continues to work on payment reform building off the Medicaid Pathways work and aligning necessary changes in the provider system with the All-Payer Model. The Department is working toward a FY 2019 timeline to have several—if not all—children's mental health programs in a model similar to Integrating Family Services. Work is beginning on a similar initiative for adult mental health services. The goal of this work is to move toward a simple, but accountable system that reduces the complexities of payment and shifts the focus of the providers and the department on outcomes and quality. 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 six Designated Hospitals throughout the state. Designated Hospitals provide treatment to both voluntary and involuntary patients.

These beds provide three levels of service for adults:

- **Level 1 Involuntary**– involuntary hospitalization stays paid at-cost to contracted and state providers for people who are the most acutely distressed who require additional resources
- **Non-Level 1 Involuntary** – involuntary hospitalization stays for individuals who do not require additional resources
- **Voluntary** – voluntary hospitalization stays

Level 1 Involuntary care is provided at specific units across three hospitals for a total of 45 beds. These beds require admission and concurrent review by the Department utilization review and care managers. These beds are located at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and Vermont Psychiatric Care Hospital (25 beds).

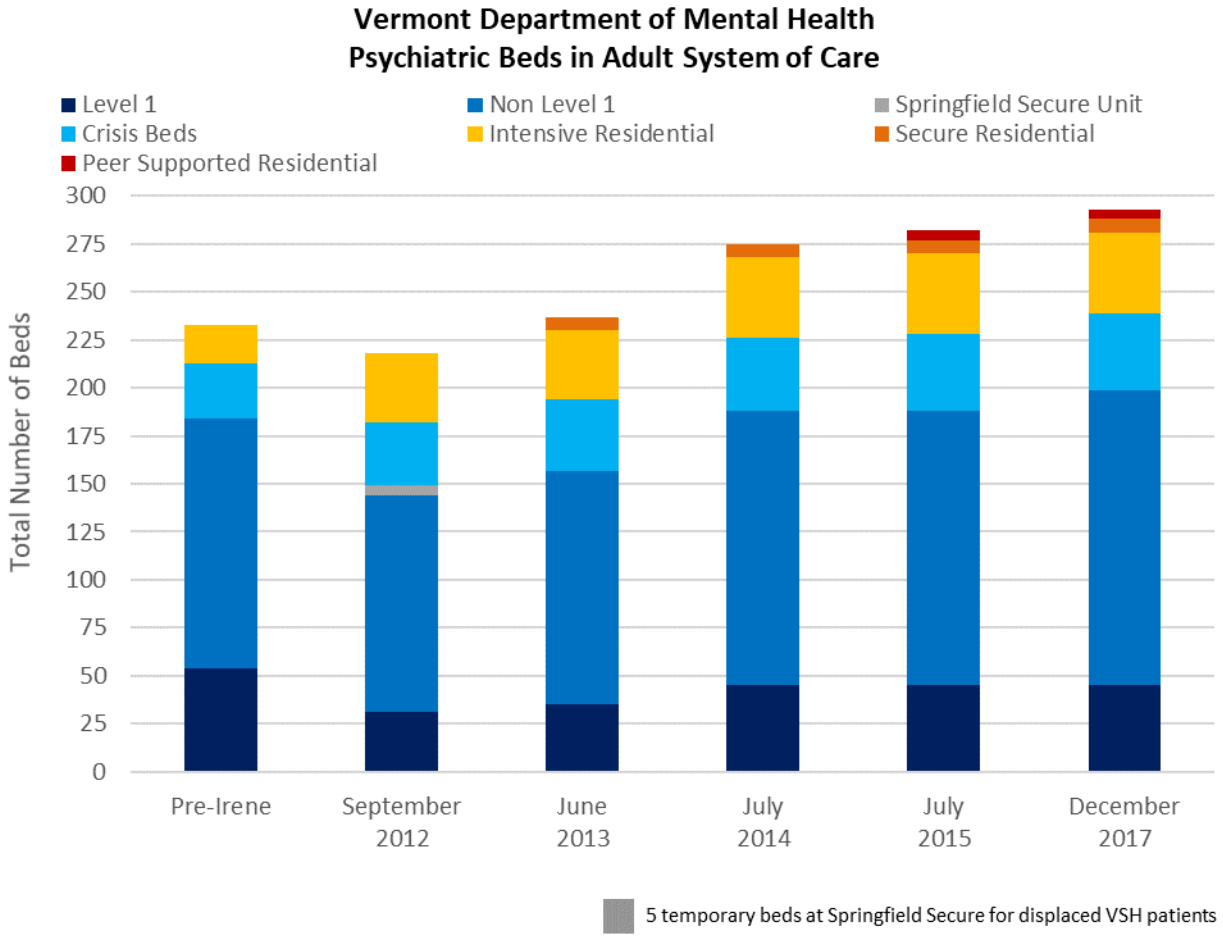
The remaining 154 beds are used for **Non-Level 1 Involuntary** and **Voluntary** inpatient stays. At our last estimation, approximately 80% of these beds days were used for **Voluntary** stays.

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	28
Rutland Regional Medical Center	Rutland, VT	23
Windham Center at Springfield Hospital	Springfield, VT	10
Vermont Psychiatric Care Hospital	Berlin, VT	25
White River Junction VA Medical Center	White River Junction, VT	10*

**The VA Medical Center has 10 beds total for Veteran's psychiatric inpatient care. A subset of these beds (2-3) are allocated for involuntary care at the discretion of the Medical Center.*

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.

Chart 1: Psychiatric Beds in the System of Care

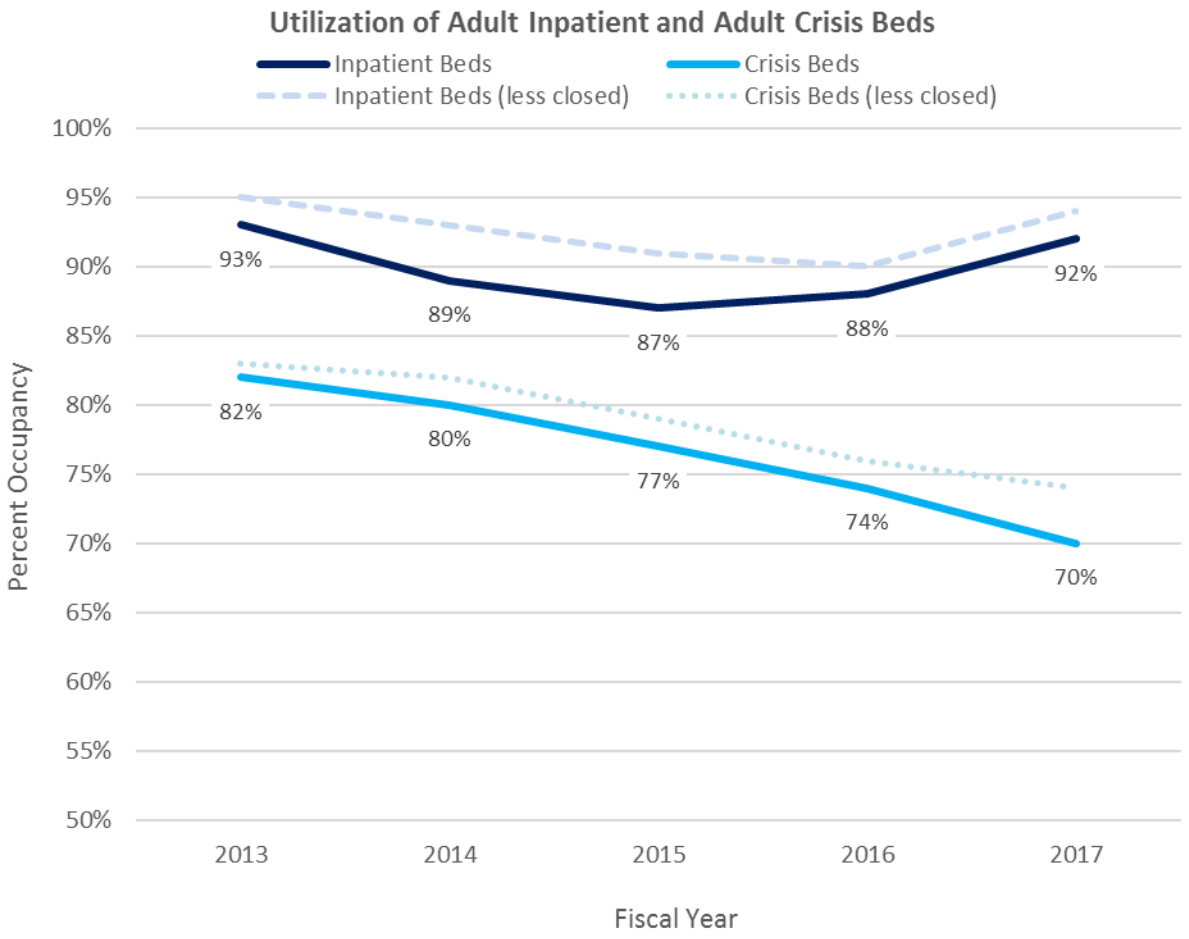


Vermont has increased its capacity for mental health care substantially since August 2011. Overall, the system capacity for psychiatric beds has increased by almost 50 beds since August 2011. Vermont's adult psychiatric inpatient system has a total of 199 beds, which is four (4) more than before tropical storm Irene closed the Vermont State Hospital. The Designation of White River Junction VA Medical Center has brought another hospital into the adult involuntary inpatient system of care. The VA Medical Center has 10 psychiatric inpatient beds and allocates two to three beds for involuntary care for Veterans.

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 continue to work together to identify and develop permanent replacement capacity for the Secure Residential Recovery Program. The current planning considerations of this collaborative work are outlined in the Act 84 AHS Major Facilities Report submitted in January 2018 to the House Committees on Appropriations, Corrections and Institutions, Health Care, and Human Services, and the Senate Committees on Appropriations, Health and Welfare and Institutions.

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



The Department calculates percent occupancy in two ways and both calculations are important to understanding bed utilization. The first calculation called "occupancy" is calculated using total bed days occupied by clients and total facility capacity. It helps the Department determine what percent of planned system capacity beds are occupied by clients. The second calculation called "occupancy (less closed)" is calculated using total bed days occupied by clients and available capacity, which is total facility capacity minus any closed beds reported to the Department. It helps the Department determine what percent of actual beds available are occupied by clients.

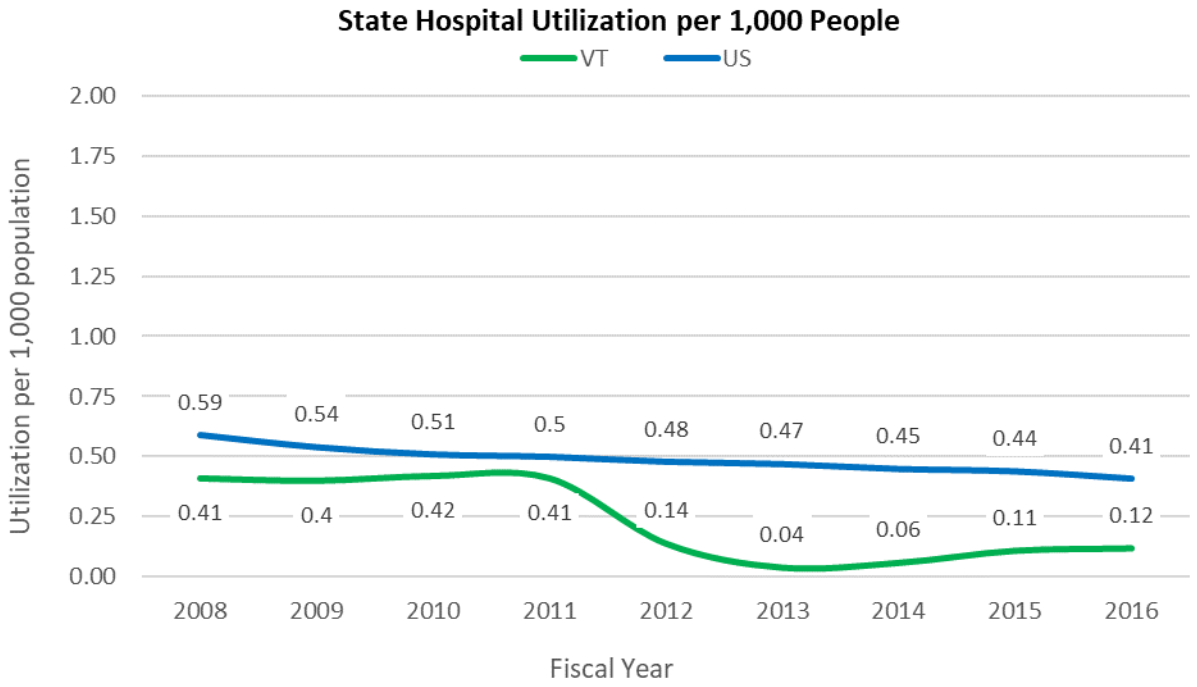
Occupancy of adult crisis beds has declined consistently since FY 2013. While the target has been set at 80%, there are many factors that influence this trend, including the time to move people in and out of the facility, staffing, preparation for new admissions, and assuring clients' needs are met. This under-utilization trend has only been further exacerbated by community provider concerns in offering complex

care to individuals through voluntary programs when risks may be present but involuntary treatment is not warranted, as spotlighted in the Kuligoski Supreme Court decision (2016). The department is 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 decreased and then increased during the time period. During FY 2017, involuntary inpatient lengths of stays increased, as well as readmission rates. Additionally, more adults were being referred to involuntary inpatient care than in previous years.

The Department also compares the utilization of our system of care to national benchmarks. The following two charts provide information on Vermont utilization as compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMSHA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). FY 2016 is the most recent data available.

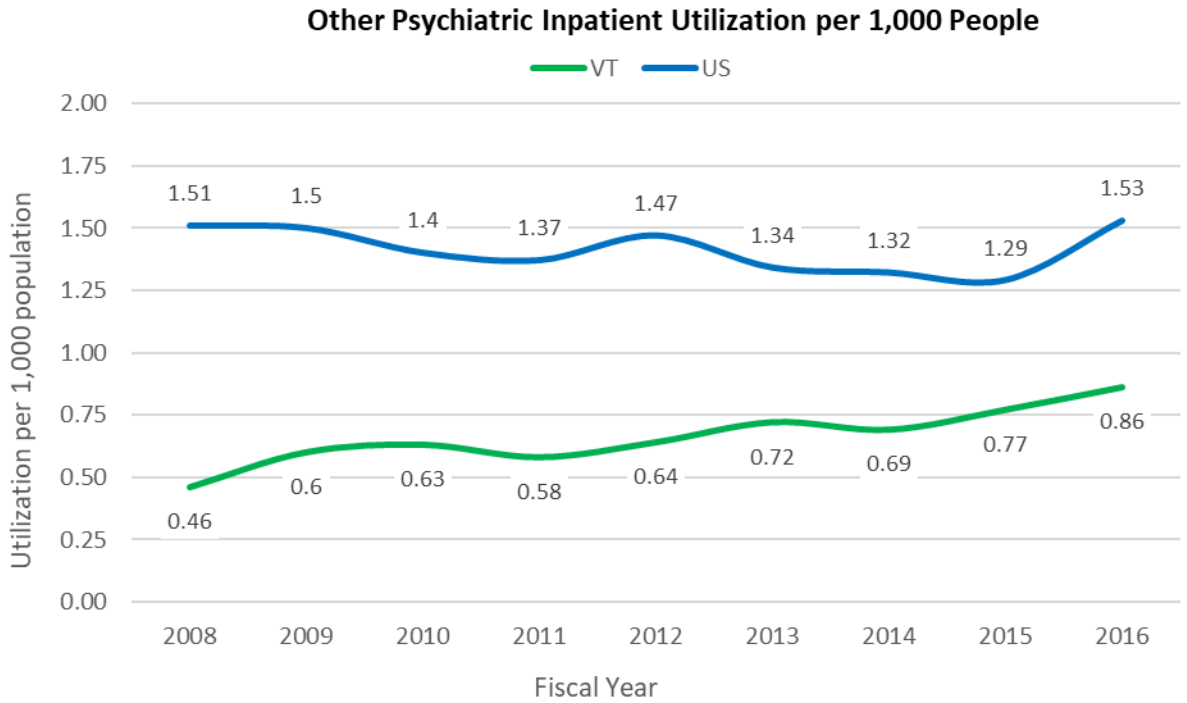
Chart 3: State Hospital Utilization per 1,000 people (in Vermont and the United States)



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2016.

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. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing.

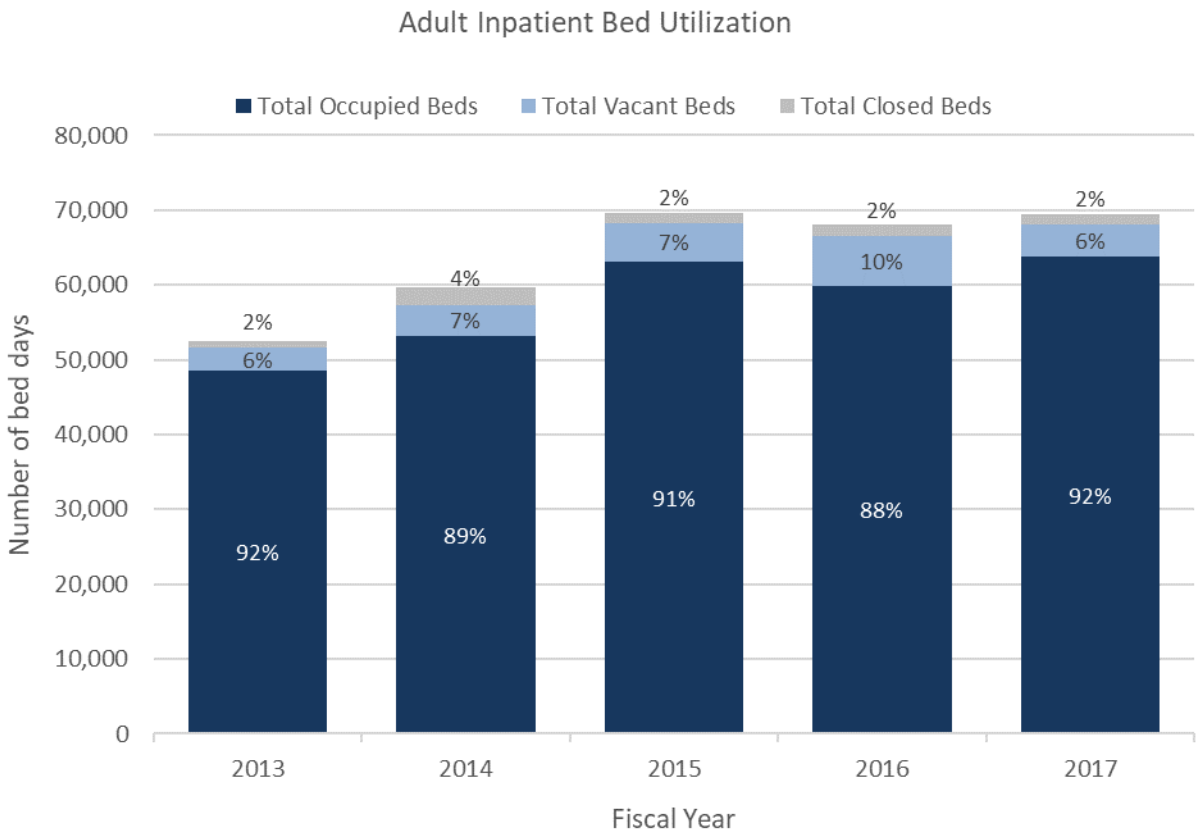
Chart 4: Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2016.

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. However, there appears to be a substantial increase in national utilization of psychiatric hospital beds in 2016. 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*).

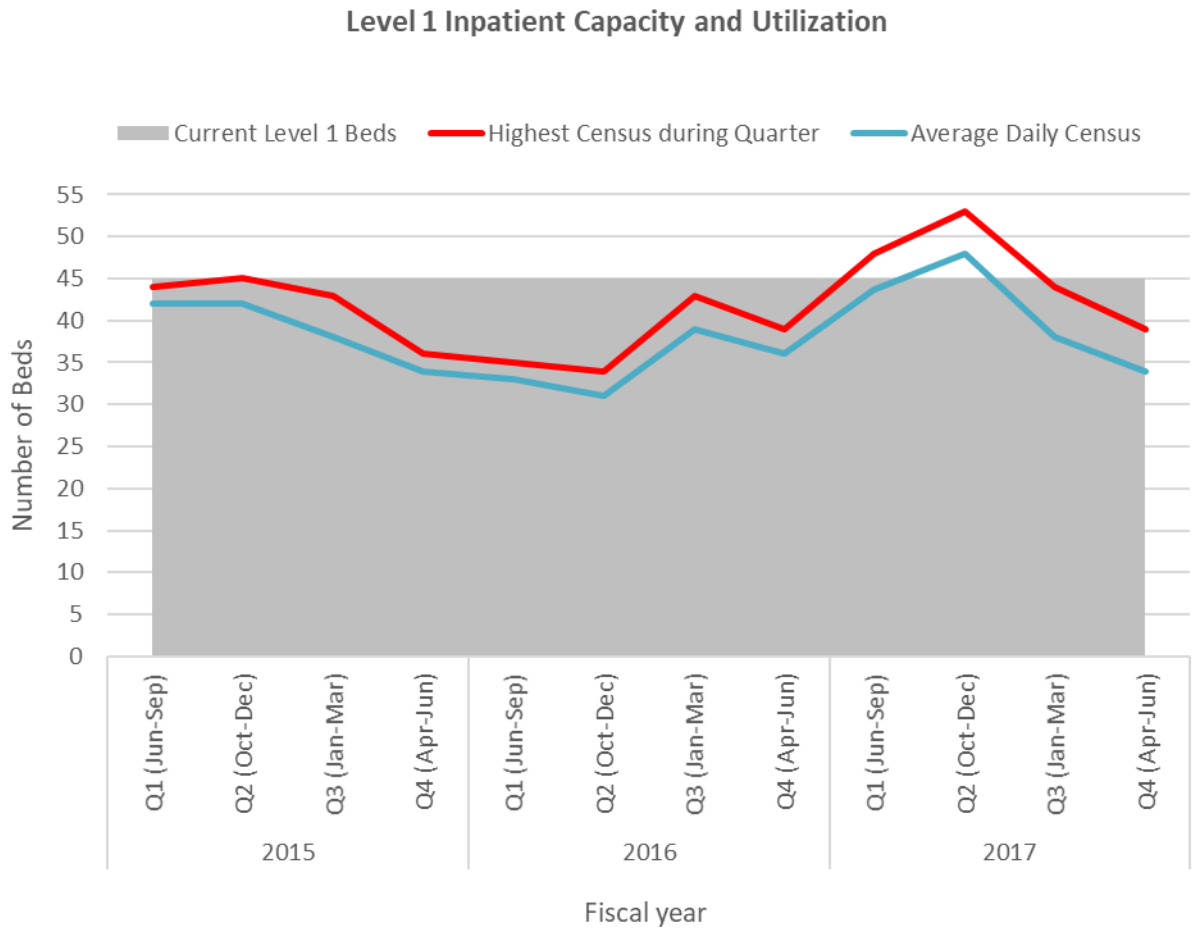
Chart 5: Adult Inpatient Utilization and Bed Closures



This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2017. The total bed day availability across the system has increased with additional beds opened at VPCH and the designation of Write River Junction VA Medical Center. On average, approximately 2% of all available bed days are closed during a fiscal year. 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

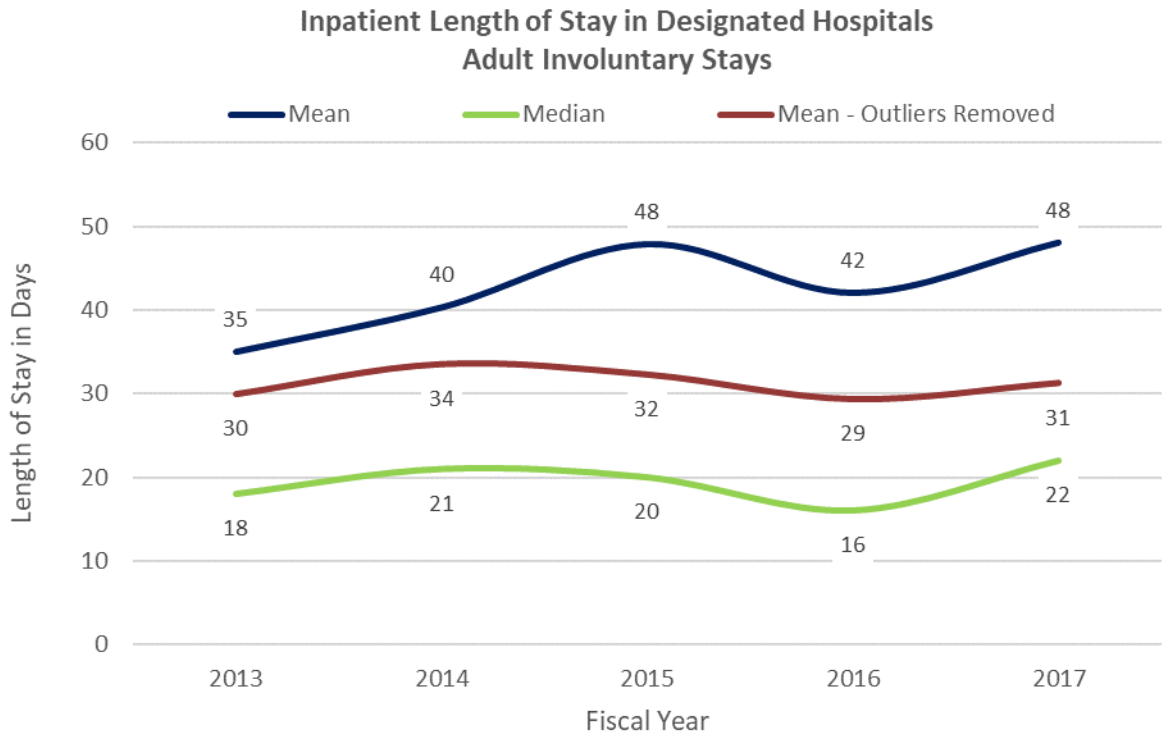


Level 1 patients require the highest level of care and services within the inpatient system. The chart above represents the average number of Level 1 patients receiving acute inpatient care in any hospital setting and the single combined one-day highest number each quarter. As a reminder, Level 1 involuntary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

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.

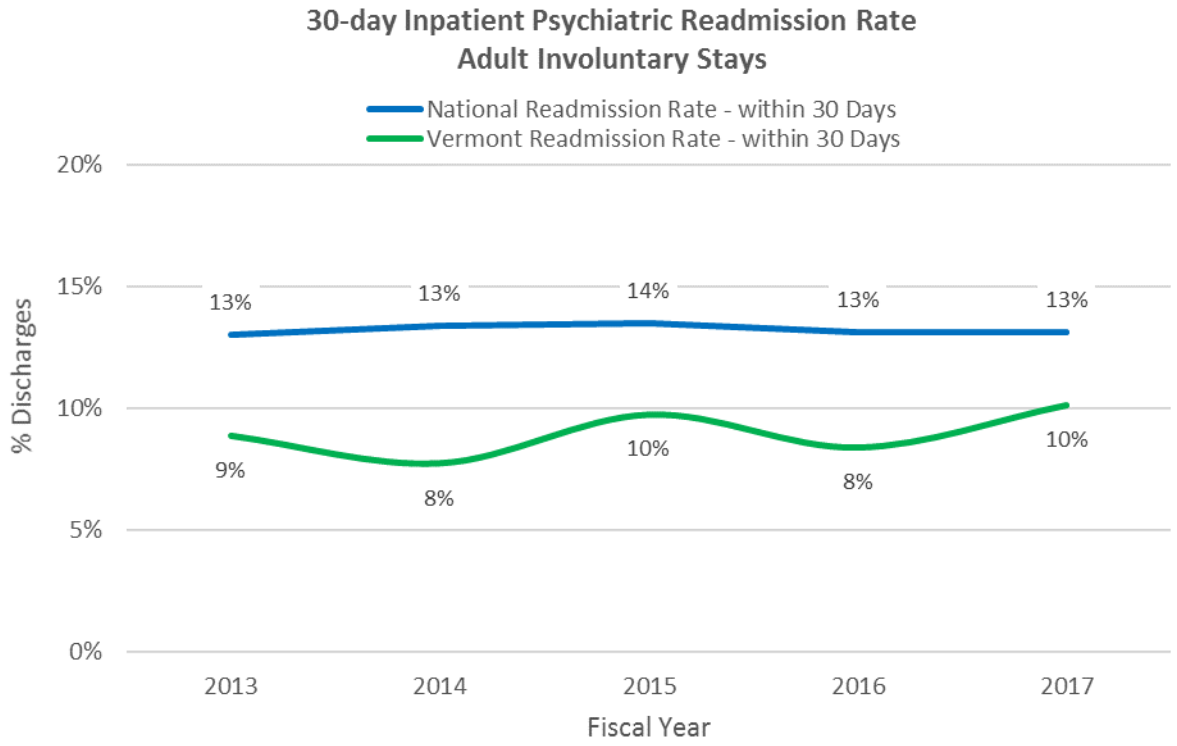
Chart 7: Inpatient Length of Stay in Designated Hospitals



This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients from FY 2013 through FY 2017. The trend indicates an increase in length of stay in hospital settings, from an average of 30 days to 48 days overall. Mean length of stay is also calculated by removing outliers, patients whose overall length of stay exceeds 180 days, which was two standard deviations from the average based on a five-year selection of inpatient stays. When removing outliers, mean length of stay is consistent at approximately 30-34 days. Addressing factors such as patient acuity, participation in treatment, and the availability of resources post-discharge are central to reducing length of stay.

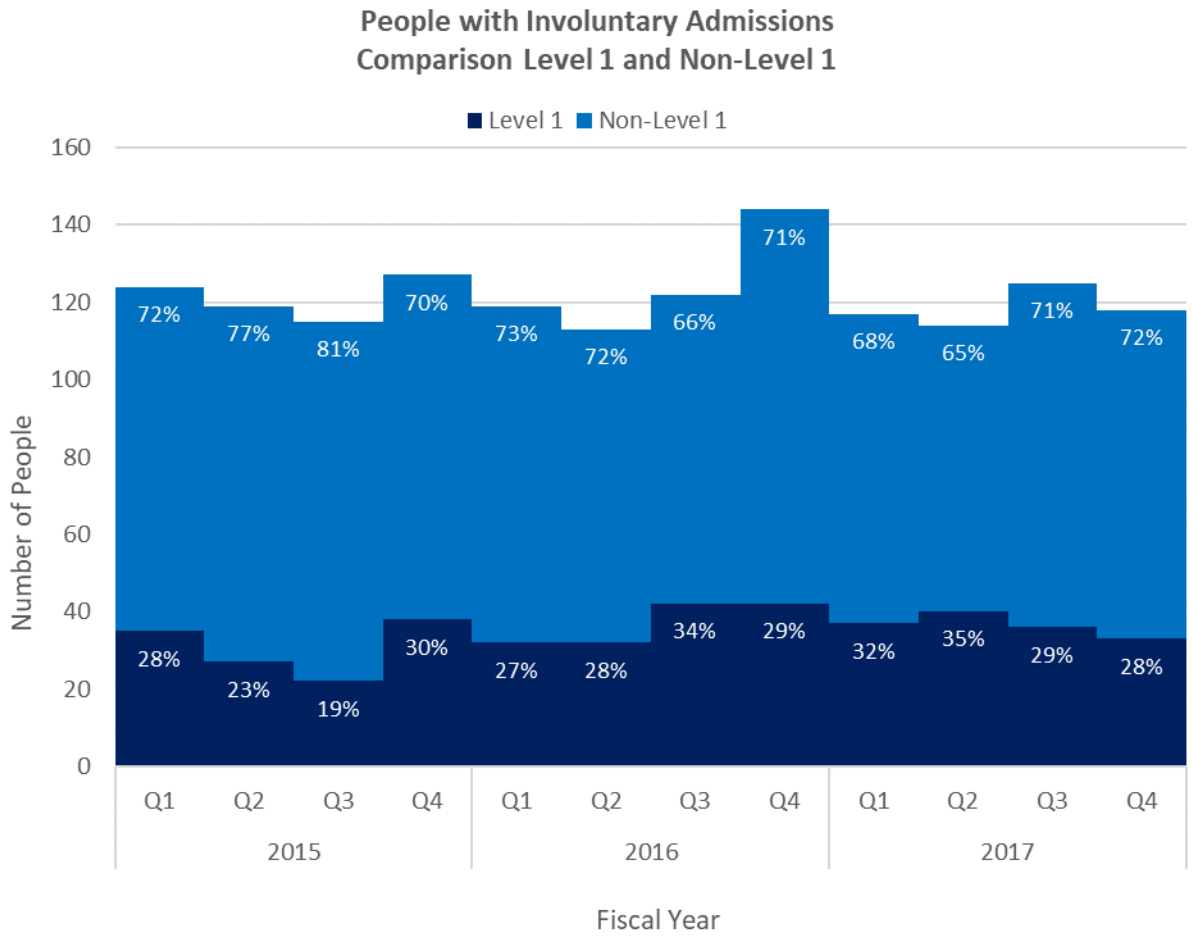
Additionally, this period also encompasses the introduction of the Level 1 system of care, which started in Designated Hospitals in FY 2013. From this initial start date, the system has seen an increase from 25 Level 1 patients per day (on average) to 45 Level 1 patients per day. Level 1 patients also 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).

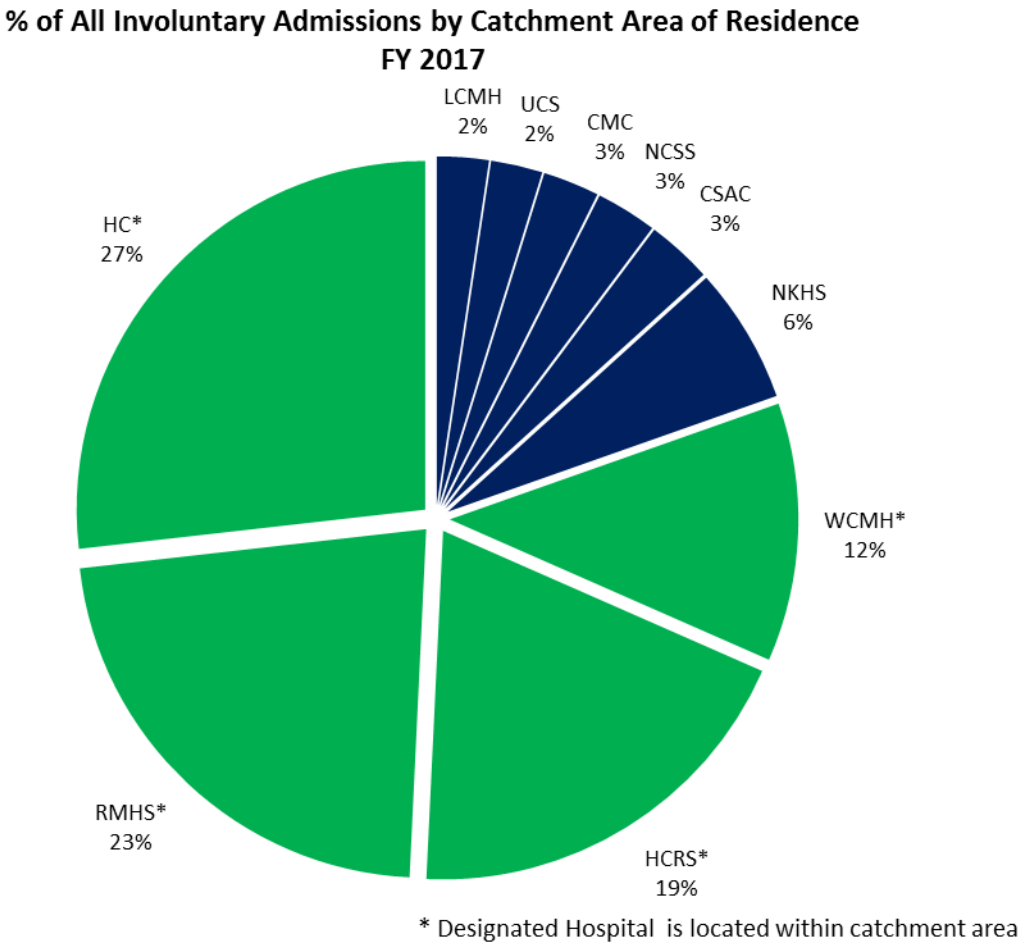
Chart 9: Involuntary Admissions – Comparison of Total Number and Level 1 patients



During the past three fiscal years, the number of people involuntarily admitted to inpatient care was at its highest during Q4 FY 2016; 29% of all people admitted were for Level 1 stays. As can be seen on this graph, the overall percent of patients admitted to psychiatric care with a Level 1 designation has been less than 35% of all adult involuntary patients. The actual numbers of people admitted has held relatively stable through FY 2015 to FY 2017, apart from one quarter.

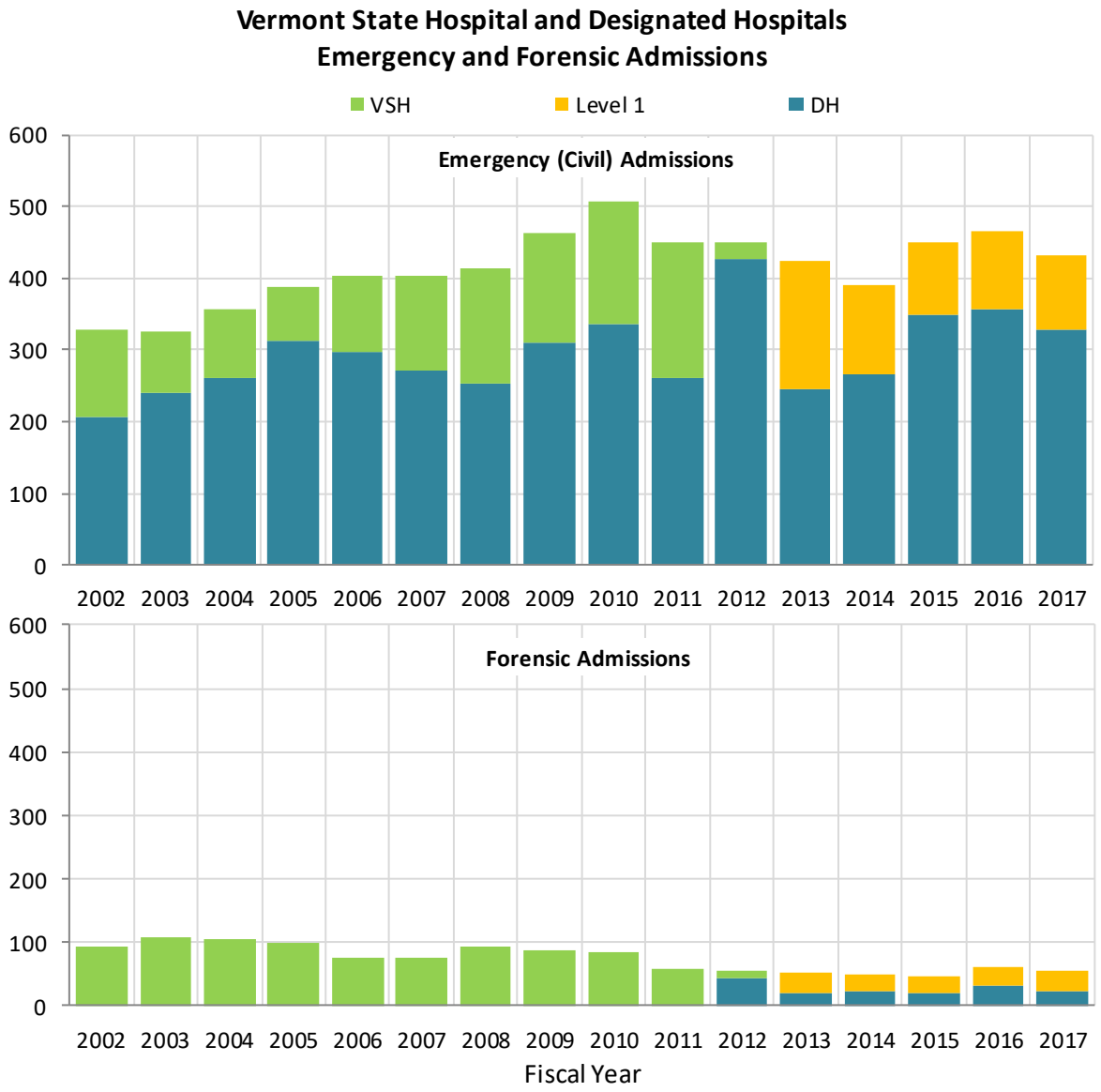
It is an expected result to see fewer people with the Level 1 designation since lengths of stay are longer than the non-Level 1 cohort. In other words, the capacity of the Level 1 system is limited by longer lengths of stay for the population, while the non-Level 1 system experiences more people moving through the system with shorter lengths of stay. Earlier quarters of information can be found in previous Act 79 reports.

Chart 10: Involuntary Admissions by Catchment Area of Residence



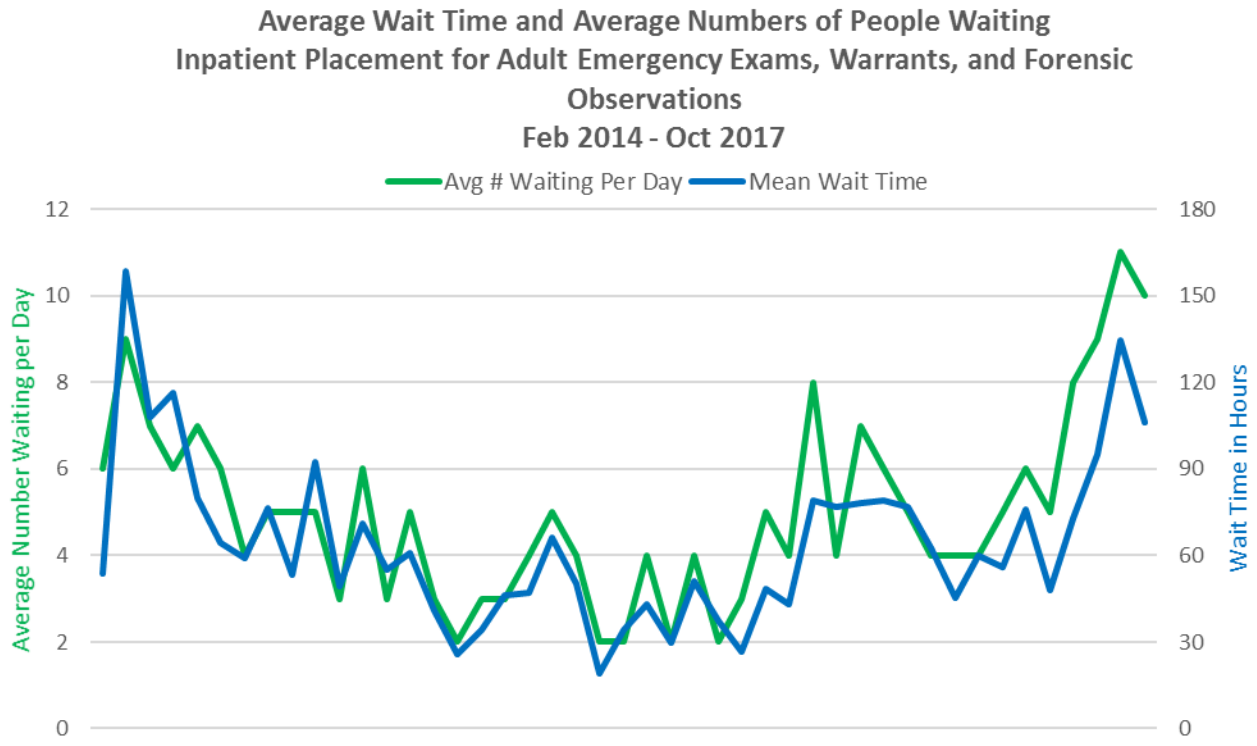
This chart provides information on the location of individuals who are admitted to an inpatient setting. As expected, larger agencies have a greater number of admissions as they are serving more individuals. This chart also suggests that the placement of hospitals in the decentralized system of care 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 decreased slightly in FY 2017 overall and for each category. While this figure appears to contradict the experience of mental health care access in FY 2017, a few additional data points explain this slight decrease. Although more adults have been referred to inpatient care during FY 2017 than any other time period, the percentage of adults not ultimately admitted to inpatient care has also increased. Additionally, the overall lengths of stay for inpatient care have increased during FY 2017.

Chart 12: Average Number of People Waiting Inpatient Placement



The average number of adults per day waiting for admission to a psychiatric treatment bed is monitored monthly. Timely transition of people to inpatient care requires active management daily for individuals of all statuses in need of hospital care.

This chart reports the mean wait time and the average number of adults waiting per day from February 2014 to October 2017. 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 before increasing through October 2017.

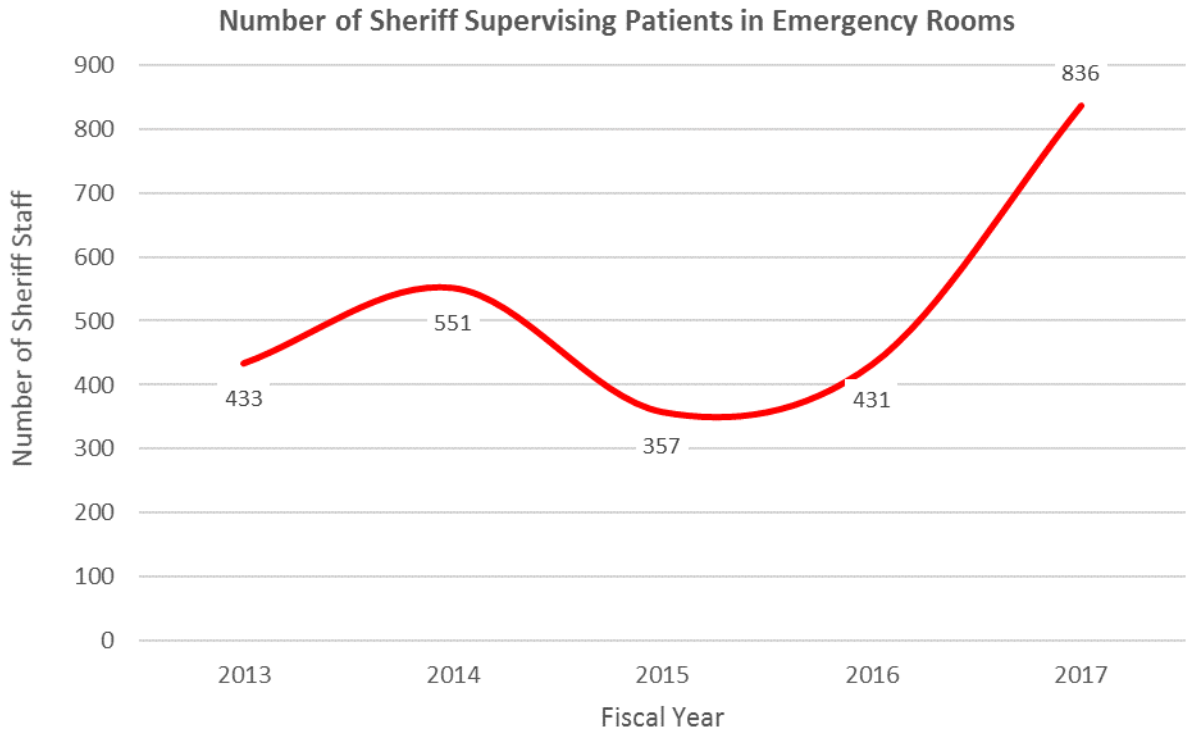
The average wait time and numbers waiting per day are highly correlated with the numbers of adults referred to inpatient care. For example, the sharp decrease from October to December 2015 coincides with a sharp decrease of adults held (15% decrease) for inpatient care via emergency exam or warrant. In April-June 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. In July-September 2017, the Department had 177 adults held via emergency exam or warrant, almost 40 more adults than the average.

The Department of Mental Health has a cadre of experienced care managers in the 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.

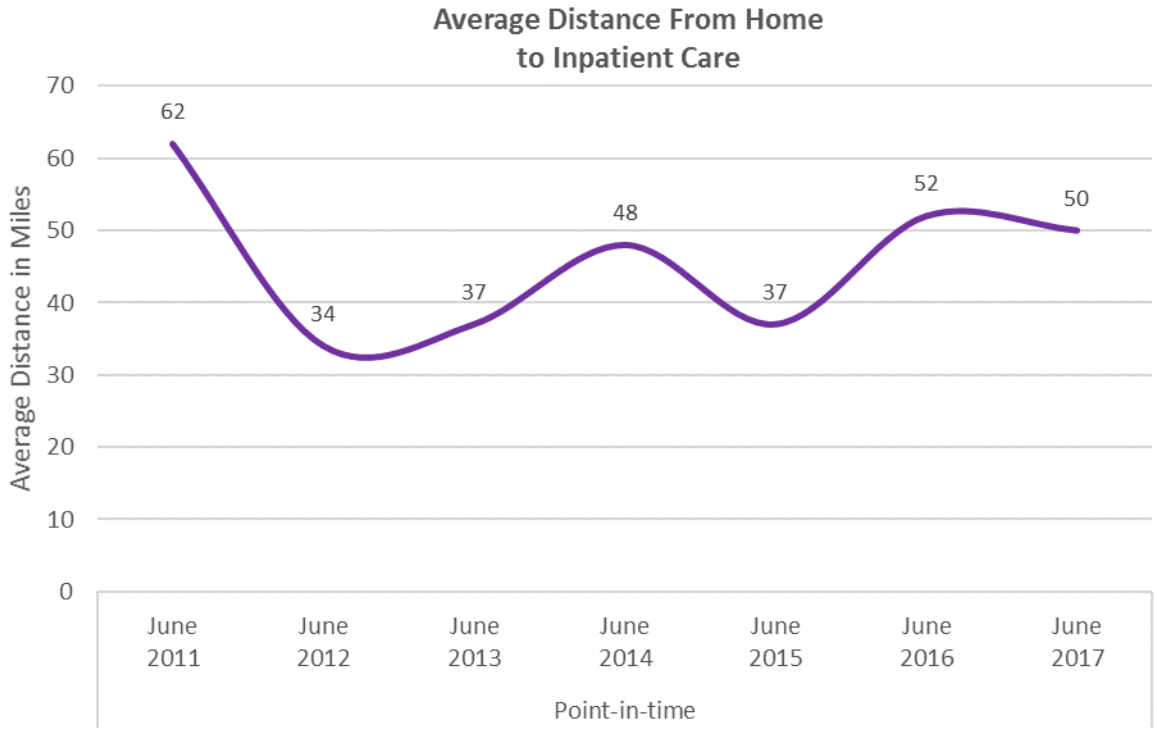
When patients are awaiting placement for treatment in a psychiatric hospital setting, supervision assistance by sheriff departments is sometimes required. This is a service funded through the department and the chart below illustrates utilization of sheriff supervision.

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. 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. 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. This past year also had many high profile, violent events involving persons with mental health concerns and this may be impacting increased requests for Sheriff supervision in emergency departments. 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

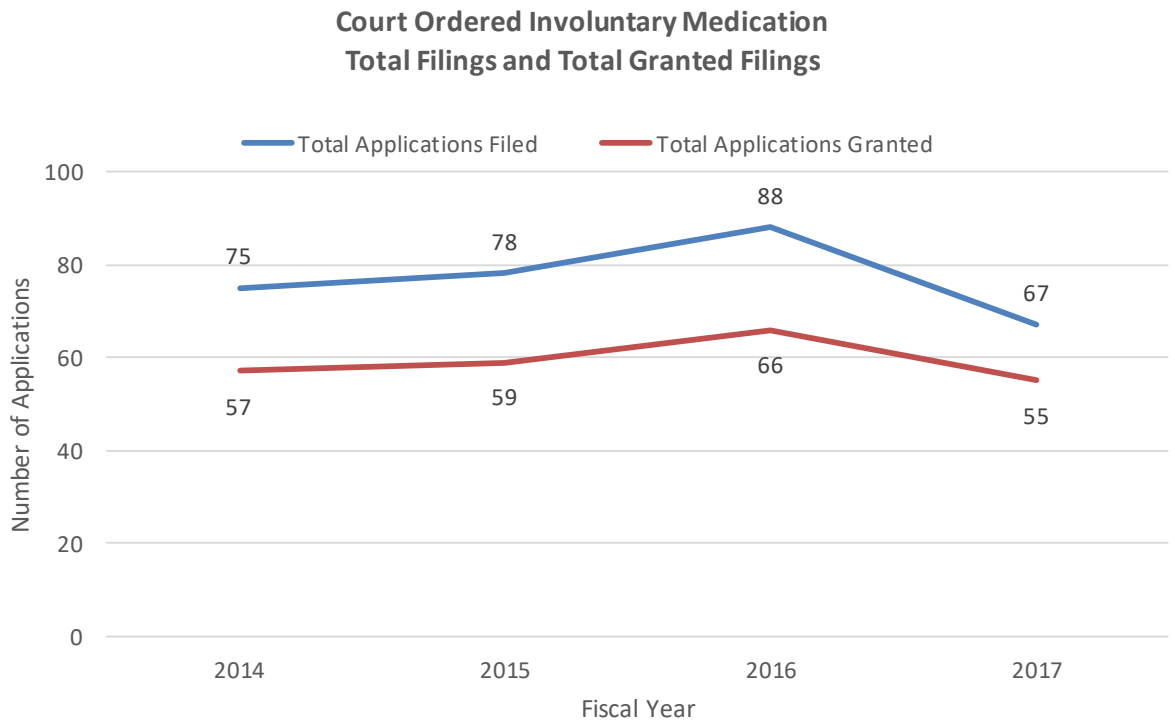
The ability to care for those most acutely ill individuals may require the need for the Designated Hospital to seek the ability to provide medication to a patient against their wishes. This is an issue which has garnered state-wide attention by multiple stakeholder groups, the Administration, and the 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 needing treatment in accordance with V.S.A. Title 18

§7624-7627. Involuntary medication in a non-emergency situation may be administered to an involuntarily admitted person only through a court order. 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

	Fiscal Year			
Court-Ordered Medication	**2014**	**2015**	**2016**	**2017**
Number of people	57	60	73	61
Total Applications Filed	75	78	88	67
Total Applications Granted	57	59	66	55
% Granted	76%	76%	75%	82%

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 75%-82%.

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	FY 2017
Total Discharges	Overall	55	56	56
	Inp. Stays with One Filing	44	52	53
	Inp. Stays with Multiple Filings	11	4	3
Mean LOS (days)	Overall	191	103	161
	Inp. Stays with One Filing	155	98	150
	Inp. Stays with Multiple Filings	334	165	355

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

Court Ordered Involuntary Medication
30 Day Readmission Rate for Discharged Patients

		FY 2015	FY 2016	FY 2017
Total Discharges	Overall	55	56	56
	Inp. Stays with One Filing	44	52	53
	Inp. Stays with Multiple Filings	11	4	3
30 Day Readmission Rate	Overall	5%	5%	11%
	Inp. Stays with One Filing	7%	6%	11%
	Inp. Stays with Multiple Filings	0%	0%	0%

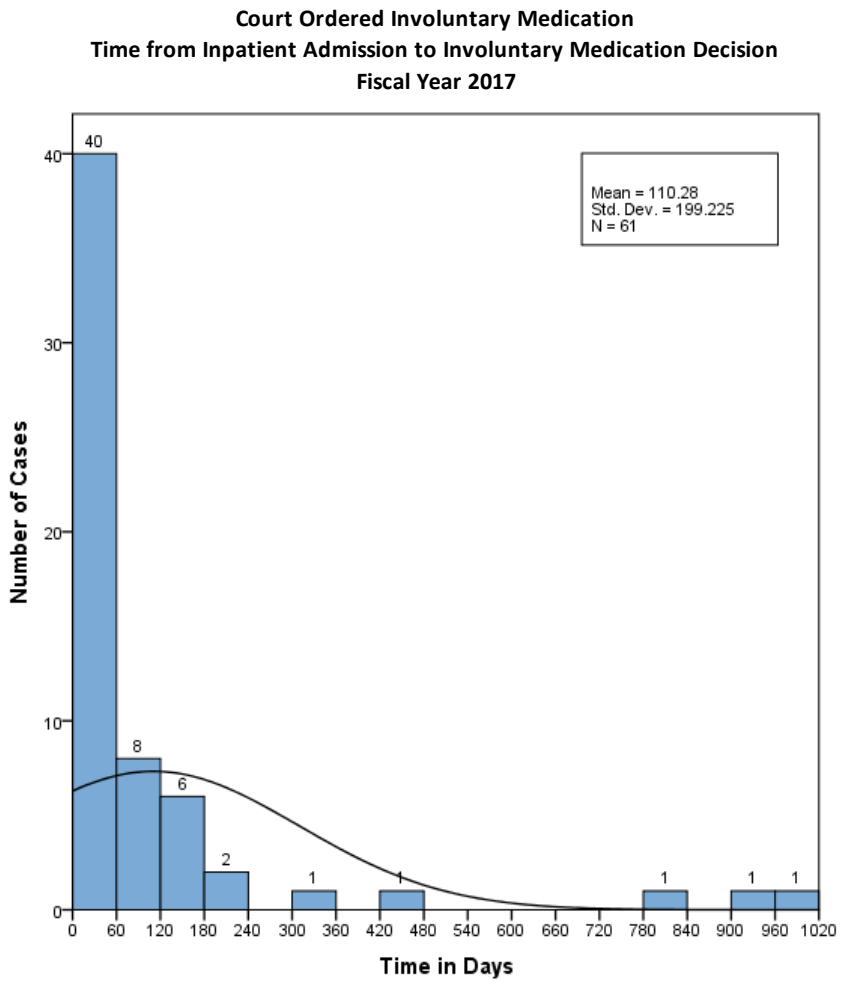
The Department has worked to provide lengths of stay and 30-day readmission rates for people that had a court-ordered involuntary medication filing at any time during their hospital stay and were discharged in during the fiscal year. The number of people who have met these criteria have been consistent each fiscal year. Of those, the number with multiple medication filings decreased from 11 (20%) to 3 (7%) between FY 2015 and FY 2017.

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



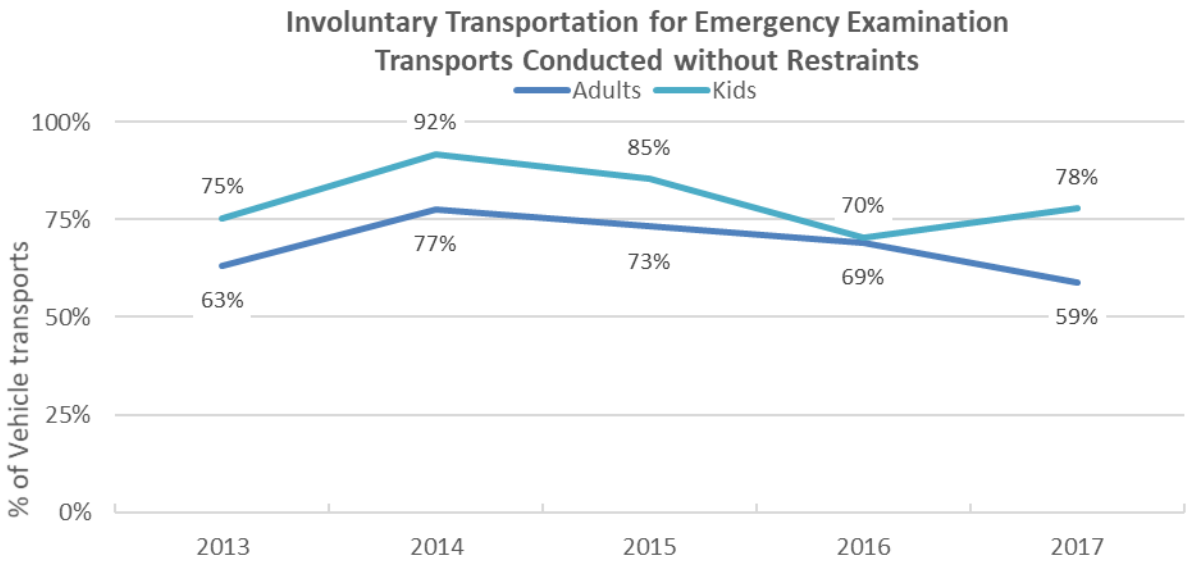
This graph illustrates all initial cases (61) filed for involuntary medication in FY 2017. The average (mean) length of time between an admission to the hospital and to the medication decision is approximately 110 days, with a small number of outliers on the longer end of the curve. This illustrates the variability in this measure across time and jurisdictions, with approximately 65% of cases resolved in less than 60 days and 78% of cases resolved in less than 120 days.

Transportation

Since April 2012, the Department has developed an aggressive implementation plan for changing the way individuals are transported to inpatient hospitalization with the goal of reducing metal restraints and providing options for transport whenever possible. 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.

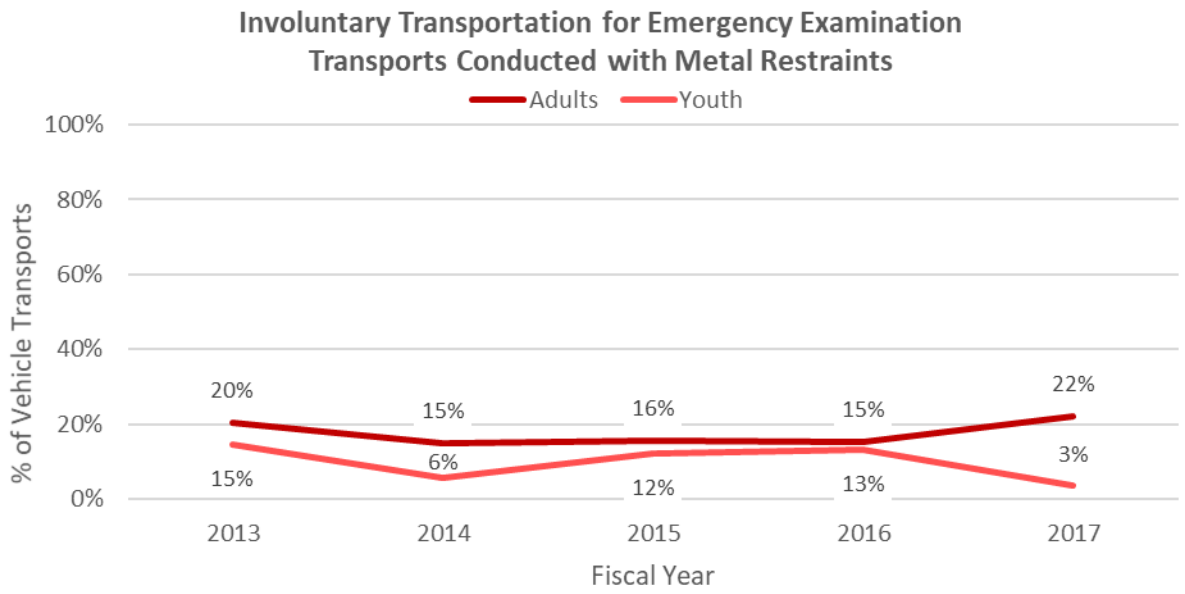
Grants to support a pilot program with sheriffs in Lamoille and Windham Counties using a least-restrictive approach by deputies in plain clothes with an unmarked van have been continued. Progression to some type of restraint is utilized only when a no-restraint approach fails.

Chart 19: Involuntary Transports Conducted without Restraint



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

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, less than 25% of transports are conducted with metal restraint. The Department continues to work with transport authorities 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 2017

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	9	7	8	13	4	11	4	13	8	6	8	8	**99**
Non-Restrained	9	18	14	9	9	9	15	12	12	12	12	10	**141**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport													
None	9	18	14	8	9	9	15	12	12	12	12	10	**140**
Metal	2	3	3	6	2	6	2	6	2	1	2	5	**40**
Soft	7	4	5	8	2	5	2	7	6	5	6	3	**60**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	11%	12%	14%	27%	15%	30%	11%	24%	10%	6%	10%	28%	**17%**
Vehicle Used in Transport													
Ambulance	2	5	2	4	1	3	3	1	1	3	4	2	**31**
MH Van Alternative	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Private Transport	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Sheriff Alternative	4	9	11	7	5	6	8	8	4	7	8	4	**81**
Sheriff Cruiser	11	11	9	10	7	11	8	16	15	8	8	12	**126**
Other	0	0	0	1	0	0	0	0	0	0	0	0	**1**
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	11%	20%	9%	18%	8%	15%	16%	4%	5%	17%	20%	11%	**13%**
%Vehicle Transports that use MH Van Alternative	6%											0%	**0%**
%Vehicle Transports that use Sheriff's Alternative	22%	36%	50%	32%	38%	30%	42%	32%	20%	39%	40%	22%	**34%**
%Vehicle Transports that use Sheriff's Cruiser	61%	44%	41%	45%	54%	55%	42%	64%	75%	44%	40%	67%	**53%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	15	20	20	17	12	17	16	24	19	15	16	16	**207**
TOTAL EE Transports	18	25	22	22	13	20	19	25	20	18	20	18	**240**

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: 11/29/2017

Chart 22: One-Year Overview of Youth Involuntary Transport

Vermont Department of Mental Health
Youth Involuntary Transportation for Emergency Examinations
Fiscal Year 2017

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	0	2	3	1	0	0	0	0	1	0	0	1	**8**
Non-Restrained	2	1	1	5	2	1	1	2	2	4	3	4	**28**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport													
None	2	1	1	5	2	1	1	2	2	4	3	4	**28**
Metal	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Soft	0	2	2	1	0	0	0	0	1	0	0	1	**7**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	0%	0%	25%	0%	0%	0%	0%	0%	0%	0%	0%	0%	**3%**
Vehicle Used in Transport													
Ambulance	1	1	0	1	1	1	0	1	1	4	1	3	**15**
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	3	1	0	1	0	0	0	1	0	**7**
Sheriff Cruiser	1	2	3	2	0	0	0	1	2	0	0	1	**12**
Other	0	0	0	0	0	0	0	0	0	0	1	1	**2**
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	50%	33%		17%	50%	100%		50%	33%	100%	33%	60%	**42%**
%Vehicle Transports that use MH Van Alternative													**0%**
%Vehicle Transports that use Sheriff's Alternative			25%	50%	50%		100%				33%		**19%**
%Vehicle Transports that use Sheriff's Cruiser	50%	67%	75%	33%				50%	67%			20%	**33%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	1	2	4	5	1	0	1	1	2	0	1	1	**19**
TOTAL EE Transports	2	3	4	6	2	1	1	2	3	4	3	5	**36**

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: 11/29/2017

Adult Outpatient Care and Utilization

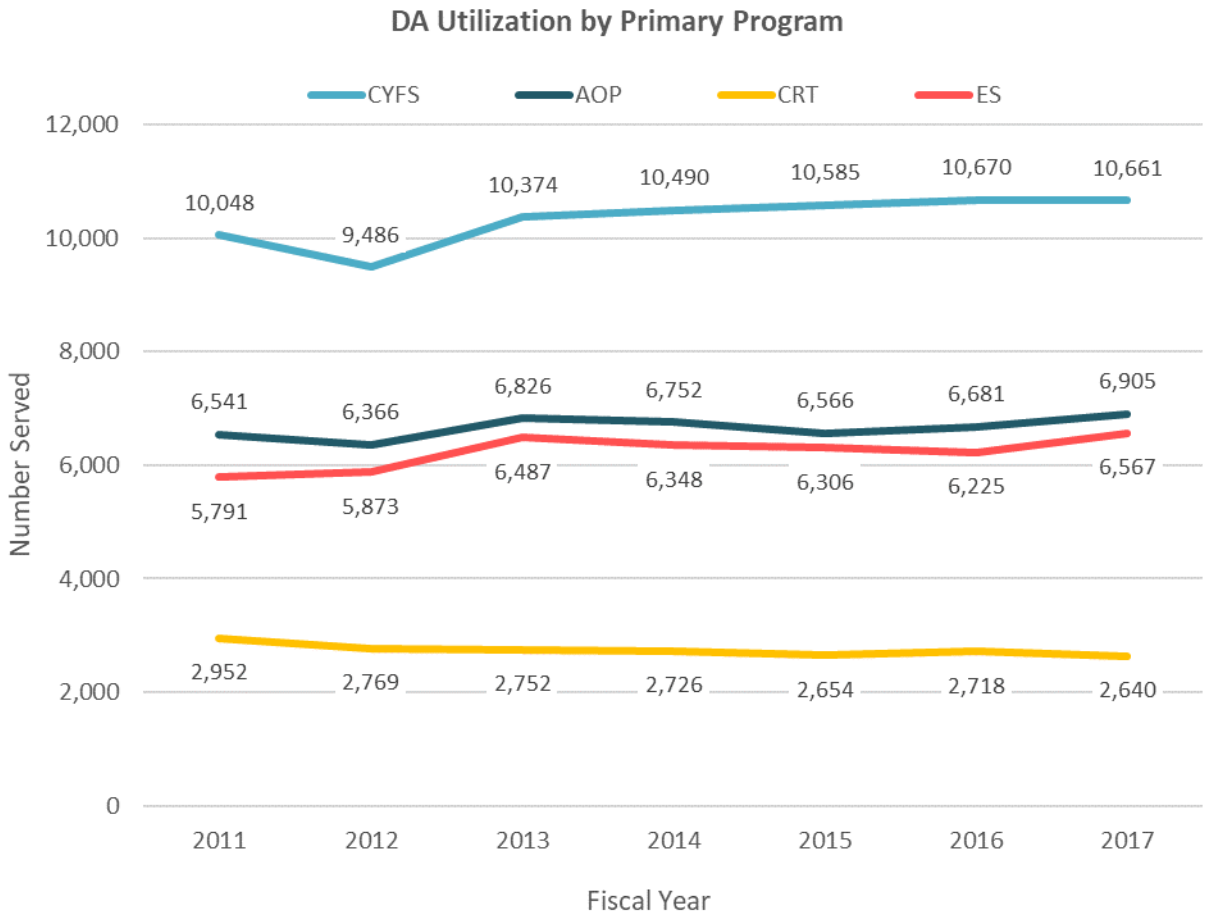
Outpatient services are provided through a system of care that includes the Designated Agencies, private practitioners, and other state and local social services agencies. The Designated Agencies provide comprehensive services to individuals through the Community Rehabilitation and Treatment programs, 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.

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 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.

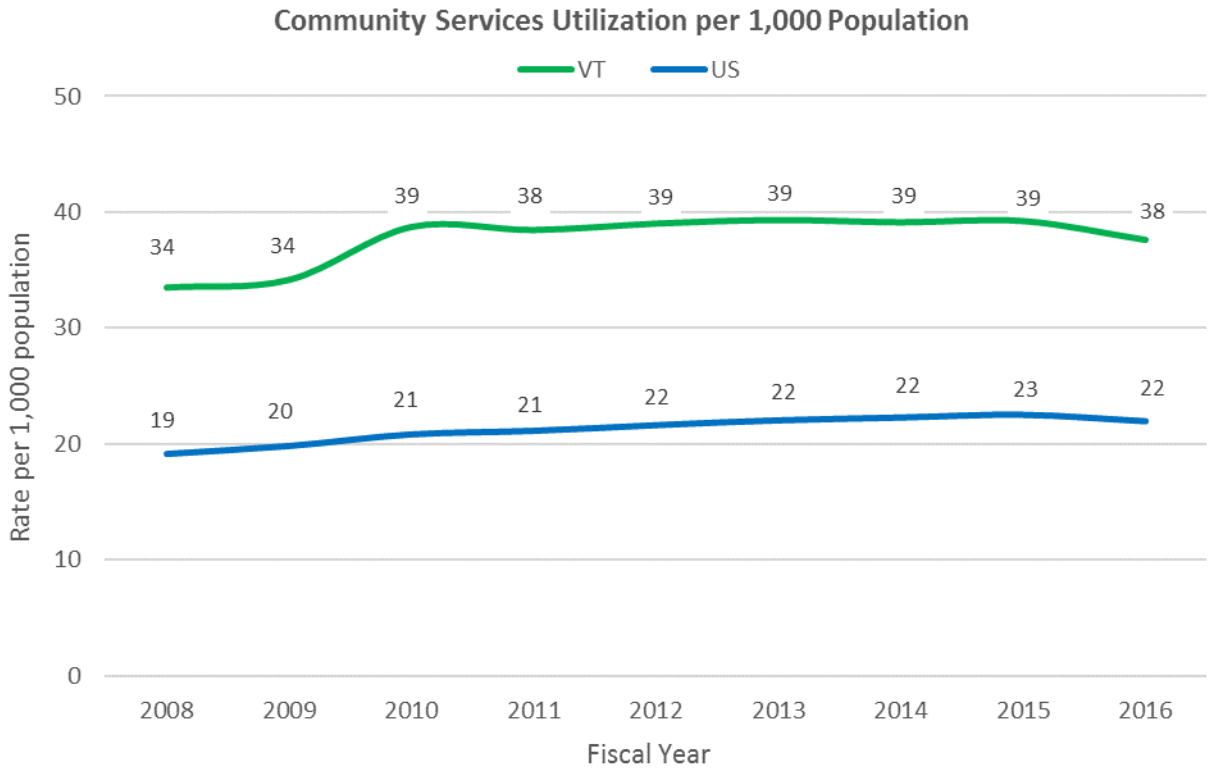
Although the Department provided enhanced community services funding through increased appropriations to key mental health programs in the community in FY 2013 and FY 2014, staff recruitment necessary to expand these service levels has continued to be a struggle. Information provided by the Designated Agencies in the Local System of Care Plans continues to identify staffing, both recruitment and retention, as a major barrier to increasing services.

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, youth, 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 the program areas has been 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

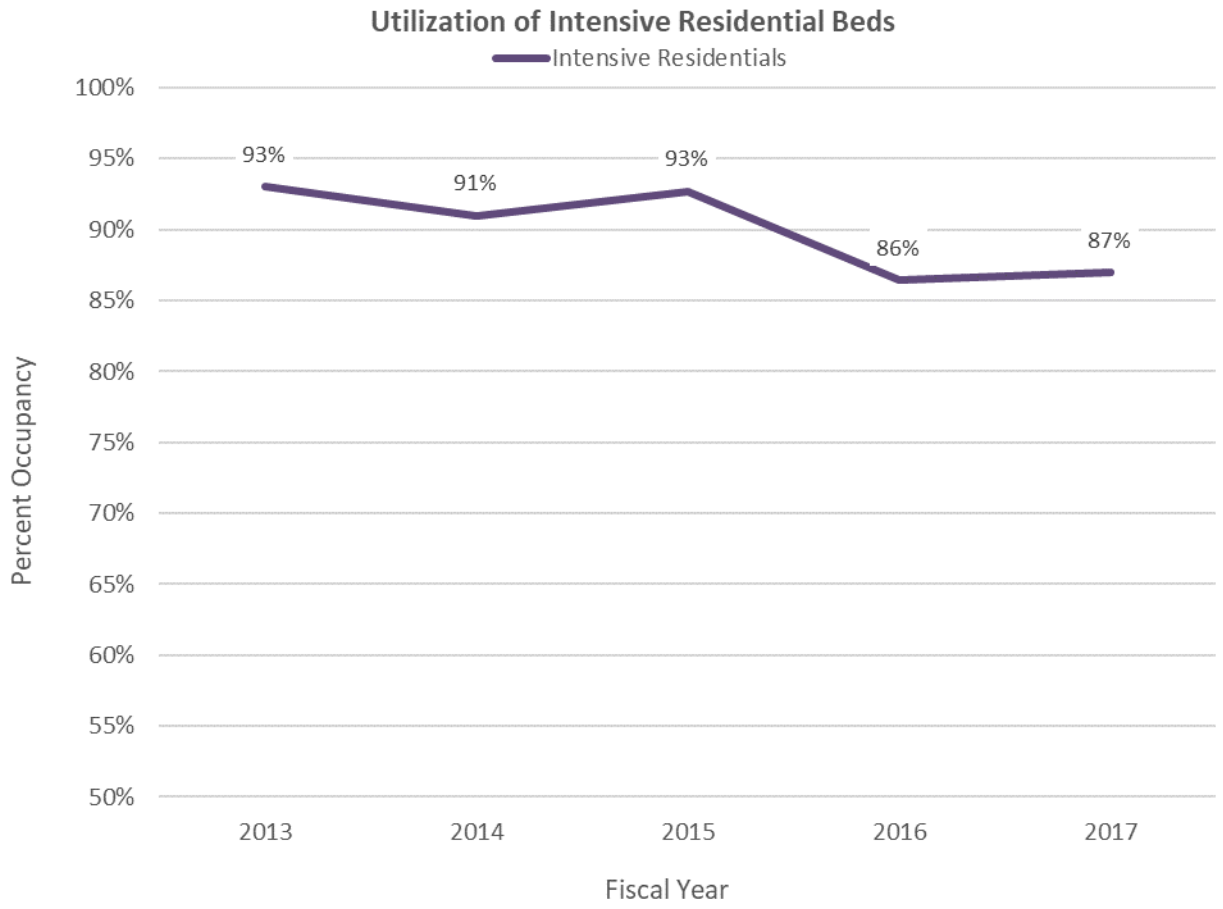


Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2016.

The Vermont community mental health system serves almost 40 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.

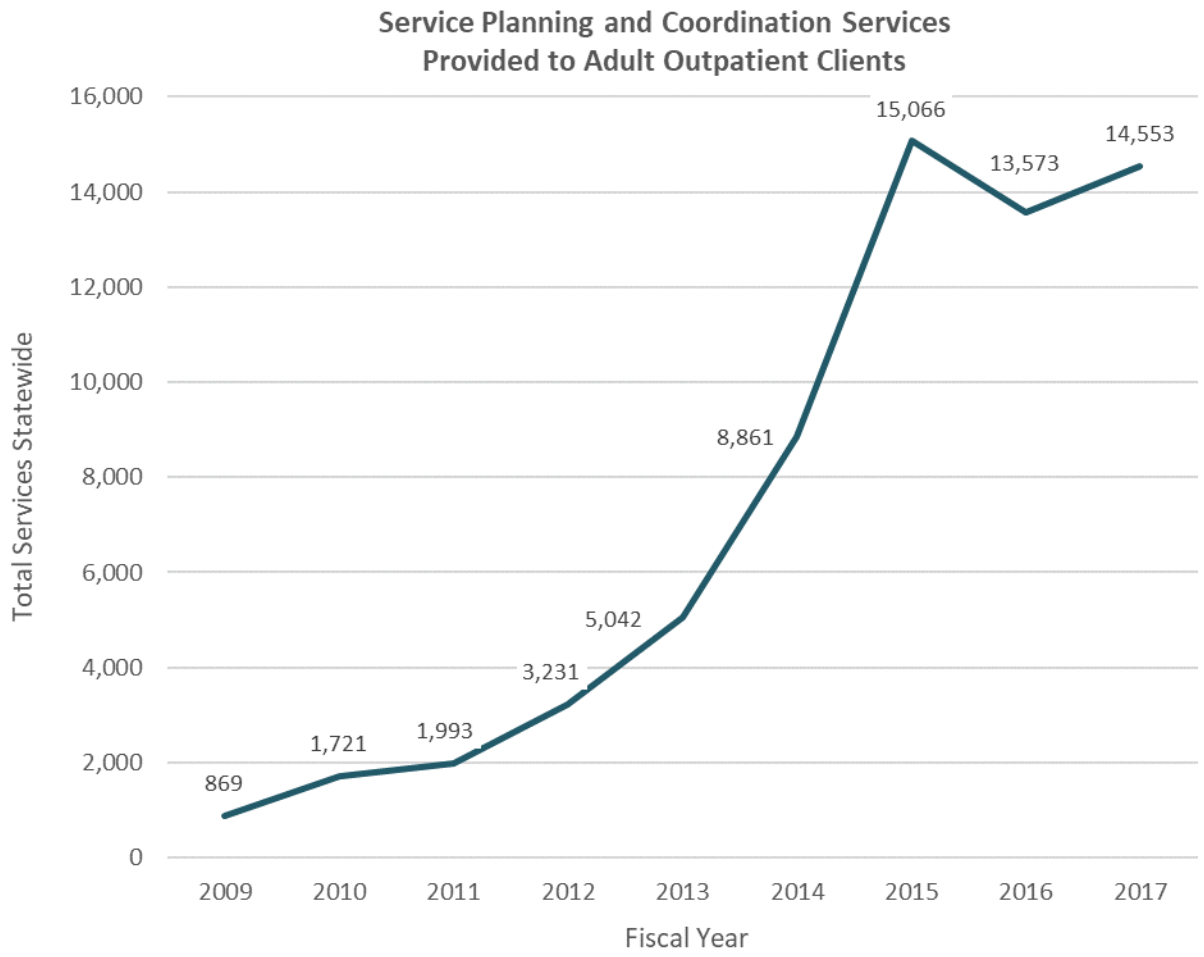
The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic 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



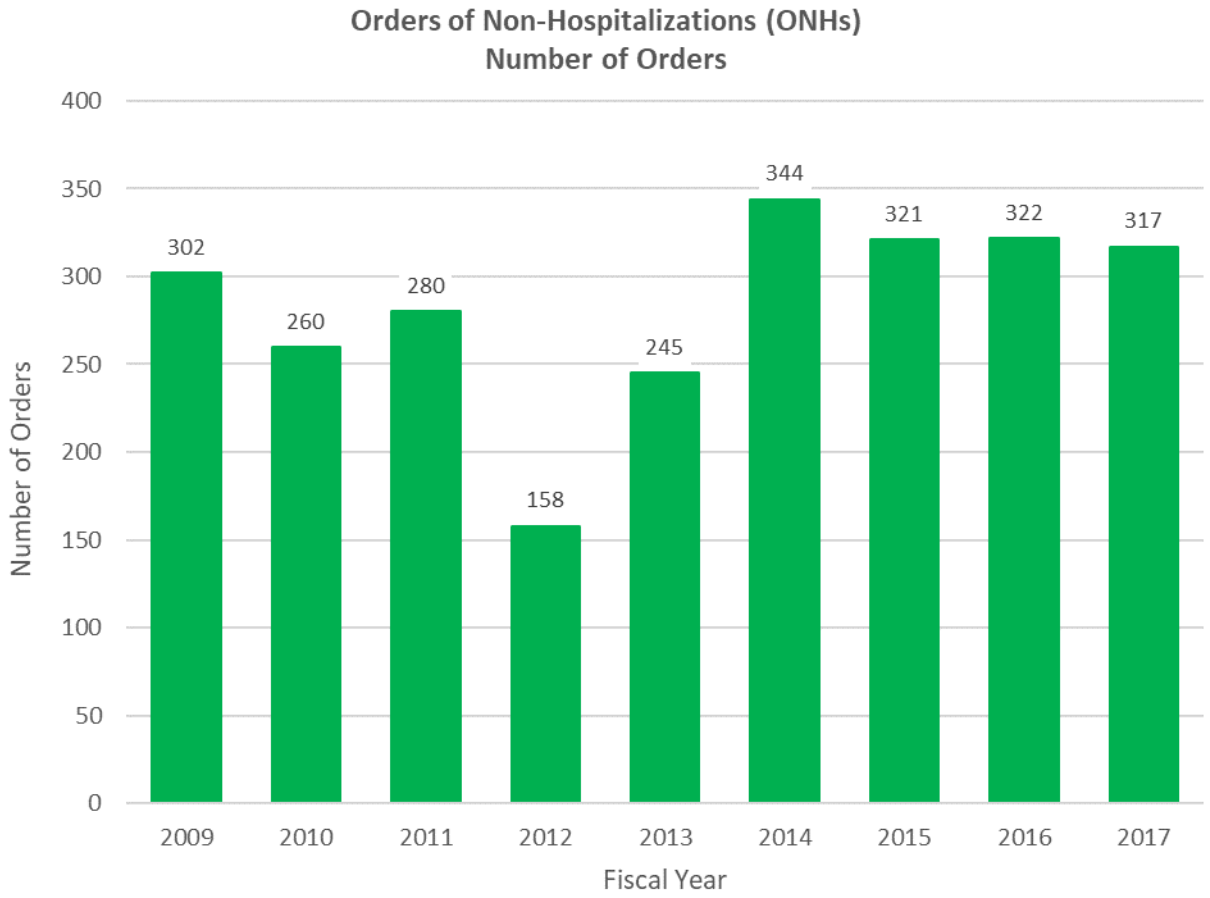
The Intensive Residential Recovery Programs (IRRs) are continuing to meet a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward independent living. The chart above illustrates 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 Department of Mental Health Orders of Non-Hospitalization (ONHs) continues to be around 320, with 320 orders starting during FY 2017. 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 regarding 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.

Enhanced Outpatient and Emergency Services

The impact of the enhancements allocated by the legislature in Act 79 has been significant in retooling some of the ways in which mental health services are delivered at the community level. All the Designated Agencies participated in developing additional services and enhancing those services that

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

Enhanced funds are utilized at Designated Agencies in various ways but fall into several major categories (listed in order of frequency):

- Evidenced-based and/or innovative clinical practices and/or treatment programs
- Expansion of Mobile Crisis Capacity
- Non-categorical Case Management
- Programs/Initiatives with Law Enforcement
- Peer Services
- Increased housing options for people at risk of hospitalization
- Expansion of Crisis Beds

At the end of FY 2017, Act 79 enhanced funding was supporting over 50 unique initiatives at Designated Agencies. Over 80% of initiatives are reporting that they are fully implemented and over 75% of initiatives are reporting that they have full coverage of the initiative across their geographical catchment area.

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, but over 80% of Act 79 funded mobile crisis initiatives are reporting full implementation and almost 90% are reporting full overage in their geographical catchment area. 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. Currently, 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 need and desire additional recovery support from those with lived experience; and
2. Improving Vermont's infrastructure to ensure that individuals and organizations providing peer services are supported through training, continuing education, mentoring, co-supervision, technical assistance, administrative support, organizational consultation and development, and collaborative networking with peer and other providers.

The Importance of Peer Support in Vermont

The concept of "peer support" is 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."[2]

While there is great diversity in the ways in which peer support is provided for individuals with mental health and other co-occurring issues, Mead and MacNeil (2004) have identified core elements of mental health peer support that make it unique and an alternative form of support for individuals who have not been able to achieve recovery through traditional, professional services. These include:

- being free from coercion (e.g. voluntary),
- consumer run and directed (both governmentally and programmatically),
- an informal setting with flexibility, and a non-hierarchical, and non-medical approach (e.g. not diagnosing),
- the peer principle (finding affiliation with someone with similar life experience and having an equal relationship),
- the helper principle (the notion that being helpful to someone else is also self-healing),
- empowerment (finding hope and believing that recovery is possible; taking personal responsibility for making it happen),
- advocacy (self and system advocacy skills),
- choice and decision-making opportunities,
- skill development,
- positive risk taking,
- reciprocity,
- support,
- sense of community,
- self-help,
- developing awareness.[3]

Peer support can take many different forms such as self-help and mutual support groups, peer crisis respite, warm lines, inpatient peer services, wellness planning and skill development, peer-driven housing supports, peer drop-in and community centers. This support has been shown to be effective in supporting recovery. As stated by the Substance Abuse and Mental Health Services Administration (SAMHSA), "evidence shows that consumer-operated services are supporting people in their wellness and recovery while also contributing to the entire mental health service system."[4] For these reasons, it is the goal of the Department of Mental Health to make a variety of peer supports available to anyone in the state struggling with mental health and other co-occurring issues. The implementation of the programs described below is helping the Department move closer to this goal.

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

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

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

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

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.

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 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 after 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 28,235 individual instances of completed support through November of this year.

To support more Vermonters, VSL stopped taking out of state calls at the beginning of FY 2017. This allowed for our percentage of incoming calls answered to rise from 18% in FY 2016 to 22% in FY 2017. As of November 2017, VSL has diverted 1,134 callers from emergency level services (crisis, emergency room, hospital, 911, etc.). So far in 2017, 87% 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. Alyssum is a trauma informed program and staff make it a point to turn a crisis into an opportunity of growth and change. For 97% of guests, trauma was cited as the primary cause for admission. Many program guests reported more than one type of trauma: 53% reported psychosis/spiritual emergence, 50% provider system trauma, 58% physical, emotional and/or sexual trauma, 40% unsafe relationships, and 73% reported loss and grief. As one resident stated, "*I came to Alyssum feeling beat down and worthless. Through working on some hard truths I came to realize that I'm not really worthless. I'm carrying a lot of guilt around and for me that is something I can work through in time. I learned that I was able to set boundaries and not feel bad about it. Was an awesome stay."*

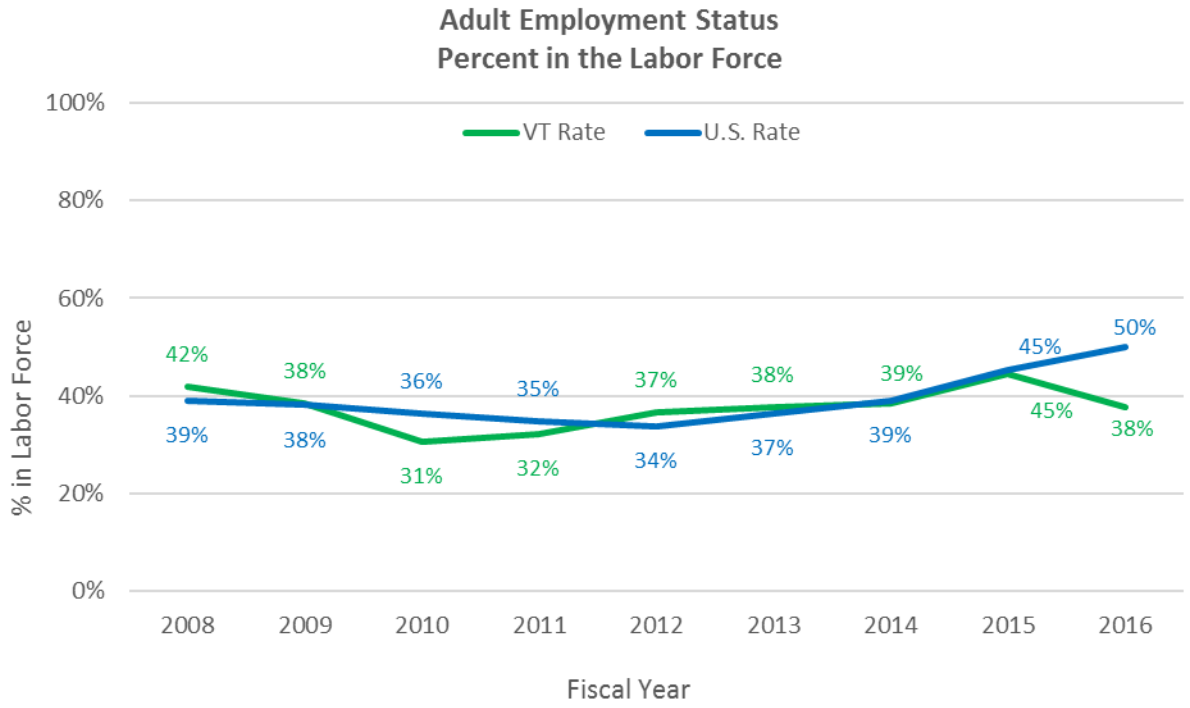
For FY 2017, Alyssum has had a total of 77 admissions and served 50 individuals (unduplicated). Over this period, Alyssum had an 91% occupancy rate and an average length of stay of 6 days. Demand for the program has been high—a total of 33 unique individuals were denied a bed due to full occupancy. 90% of admissions were for hospital diversion and 10% were for transition from a hospital (step-down).

The staff turnover rate at Alyssum is less than 10% annually. Out of a possible 100% satisfaction rate, guests report 91% satisfaction with the progress made on personal goals and 94% overall program satisfaction while at the program. Upon departure from Alyssum, 72% of guests self-reported feeling better, 19% say they felt the same, while 8% say they felt worse. Of the returning (repeat) guests at Alyssum 92% report reduced acute(crisis) service needs and cite both tools learned and support provided by Alyssum staff as a reason for this. Alyssum staff provided 918 support calls this year.

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.

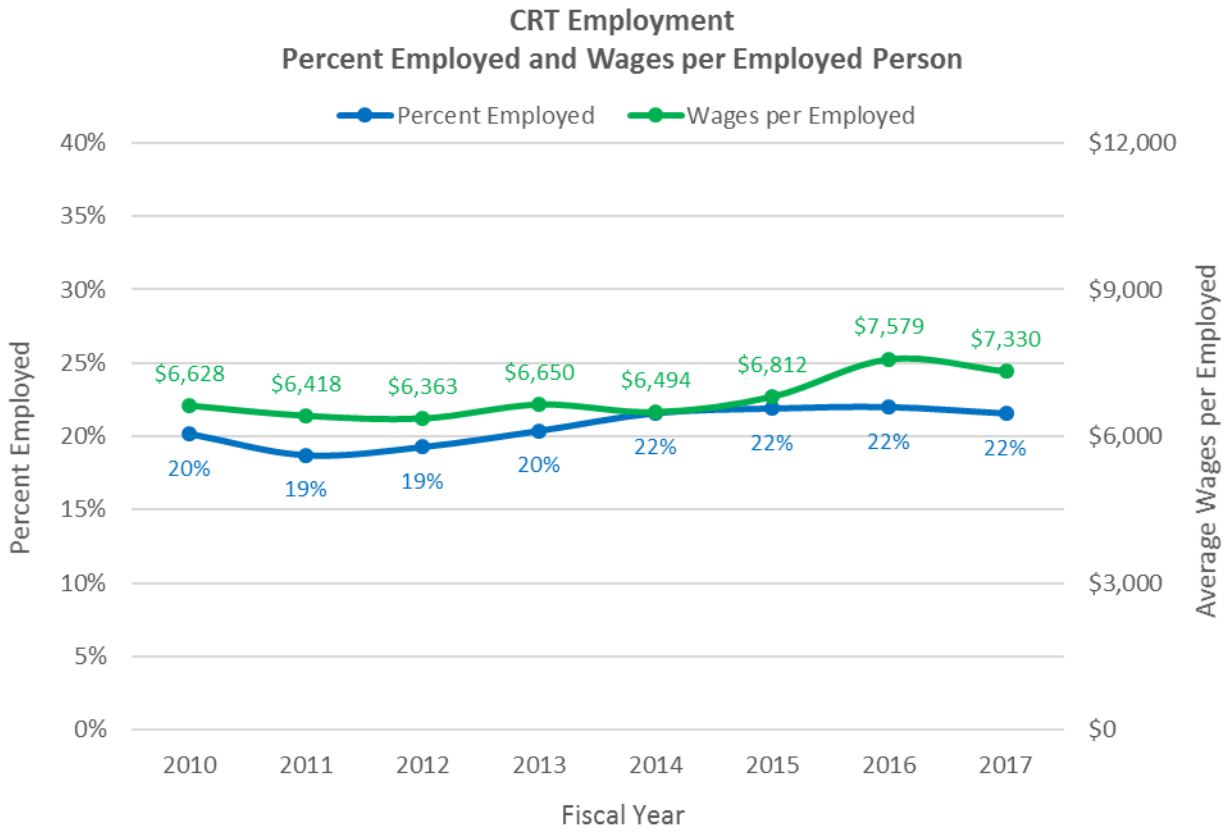
Chart 29: Percentage of All Adults with Mental Illness Employed in U.S. and VT



Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2016. 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.

The employment rate for all adults with mental illness in Designated Agencies—Adult Outpatient and Community Rehabilitation and Treatment combined—decreased and is lower than the national rate, but is consistent with historical percentages.

Chart 30: CRT Annual Employment Rates and Average Earnings



Analysis includes Community Rehabilitation and Treatment clients aged 18 - 64 who were active during any part of the annual reporting periods and includes all employment reported for the annual reporting periods.This report is based on analysis of the Department of Mental Health (DMH) and the Department of Labor (DOL) databases. DMH client data are submitted by Community Rehabilitation and Treatment Programs in conformance with contractual requirements. DOL data are submitted by employers in conformance with state and federal unemployment laws. Workers who are excluded from DOL reporting are the self-employed, firm owners not incorporated and the following employee groups: elected officials, employees of nonprofit religious, charitable and educational organizations, unpaid family members, farm workers (with some exceptions), railroad employees, and individuals who work out of state.

The chart above indicates a 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 2017. Wages dipped slightly for the period but have increased substantially in FY 2016-17. 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 $7,330 per year (*14 hours per week for full year at Vermont's current minimum wage of $10.00 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 the levels of care in the system. The Department of Mental Health tracks clinical, social and legal measures to assess experience and recovery. There are many measures used to quantify individual experience and recovery including employment information, consumer surveys, housing, and other metrics.

In addition to supporting people to obtain employment, which is one of the most effective interventions for improving recovery and reducing stigma, the Department currently supports and continues to expand several other non-medical interventions for the management of and recovery from distressing symptoms associated with mental illness. Interventions such as *Wellness Recovery Action Planning, 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 many initiatives underway to expand the availability of several of these interventions.

The Department has continued to support options for individuals seeking to avoid or reduce reliance on medications through funding of the residential program *Soteria – Vermont*, which provides specialized treatment and support for individuals experiencing first break psychosis who are seeking to avoid or reduce their reliance on medications. This program, which opened in the spring 2015, includes care from a psychiatrist to support withdrawal from medications. The intensive residential program *Hilltop,* which has been in operation since 2012, also provides treatment and support using the *Soteria* model.

Lastly, Vermont is still awaiting a final budget for the current fiscal year of the Mental Health Block Grant (MHBG) and has been directed to operate under level funding until further notice. However, the proposed federal budget for the MHBG called for significant cuts. DMH is prepared to enact the proposed budget cuts, which called for a decrease in MHBG funds by approximately 22% or $255,338. In the event of future cuts to the budget, all agencies receiving MHBG funds would see a cut of 22% across the board. The current MHBG budget still calls for 10% of the funds to be allocated to evidence based practices for early interventions for Early Serious Mental Illness (ESMI). Current research indicates that early intervention and treatment of individuals who are first experiencing psychosis could prevent or reduce long-term disability, and, in some cases, reduce long-term reliance on psychotropic medication.

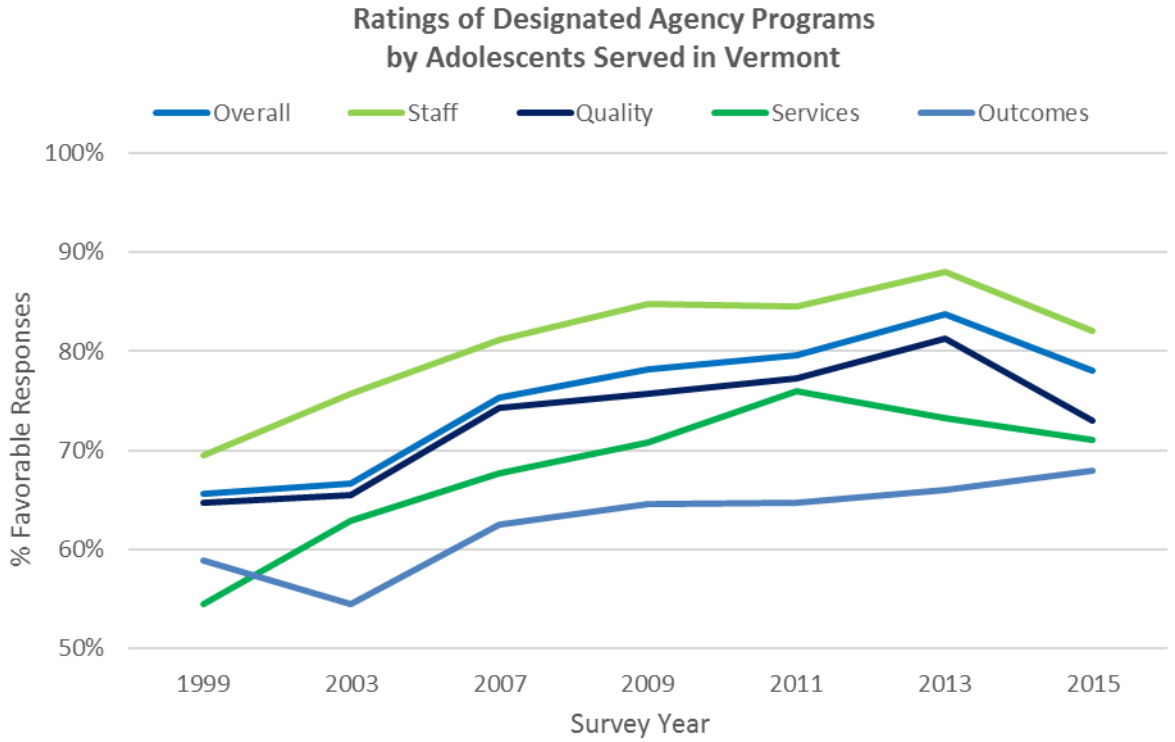
In 2015, the Department began working with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) to identify and promulgate specific evidence-based practices for this population.

Vermont has recently chosen to pursue the practice of Open Dialogue, which is gaining recognition among Vermont's practitioners and clients and is a promising evidence-based practice supported by SAMHSA. VCPI has provided training and consultation to staff from several DA's, Vermont's Psychiatric Care Hospital, and a secure residential program on Open Dialogue. Vermont will begin to evaluate the effectiveness of this approach in 2018.

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.

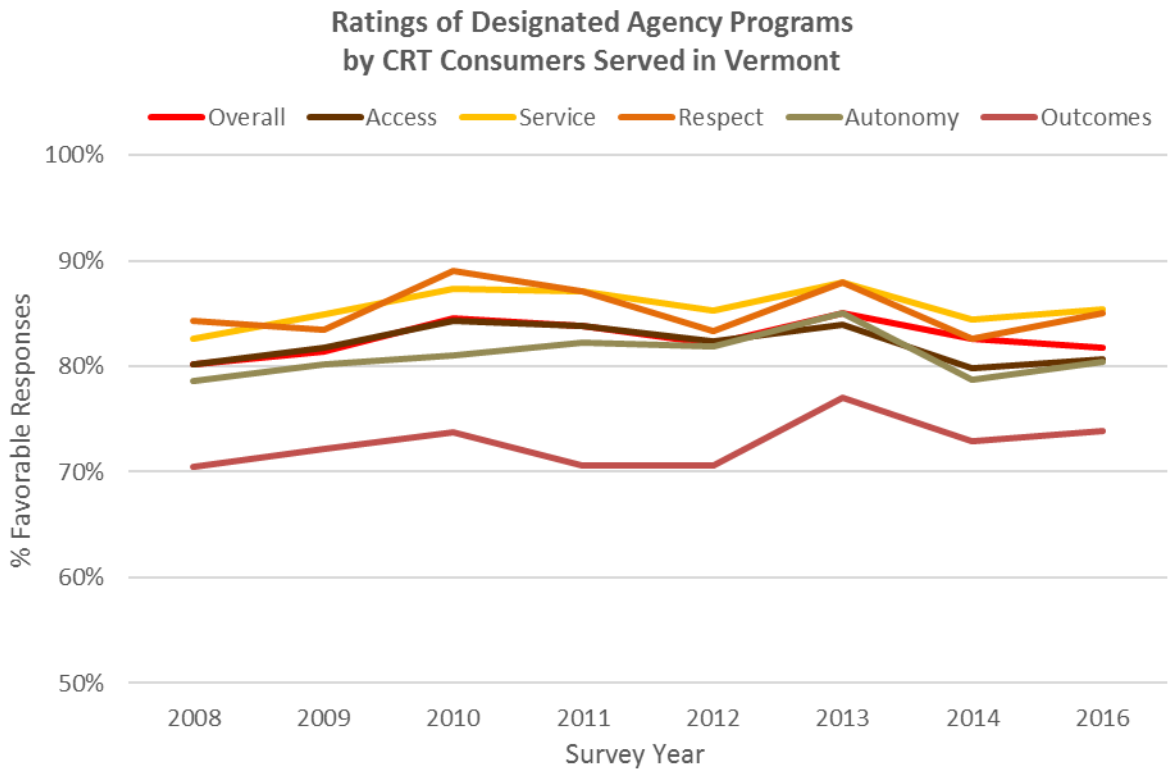
Chart 31: Ratings of Child, Youth, and Family Services Programs by Adolescents Served



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

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



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

Satisfaction with Community Rehabilitation and Treatment programs has shown less improvement, but remains close to the eightieth percentile for all domains, except for the outcomes domain. 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.

Housing

Since its creation in December 2011, a total of 207 persons who were homeless, mentally ill, and needing an acute care bed have been allocated a rental assistance subsidy and have subsequently been housed with community supportive services as part of the Department's Housing Subsidy & Care Program. The Vermont State Housing Authority continues in its role as the Department's collaborating partner verifying client income, setting rent payments, and working with participating landlords.

The 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 57 days for those more recently enrolled to 2,197 days for long term stayers, greater than 88% (184/207) having lengths of stay of more than one year. Slightly more males were served, 105 vs 96 female. Of the 207 served, more than 87% (181/207) were literally homeless, meaning on the streets, in a shelter, or in a hospital 76% (158/207) were chronic. Less than 16% (35/207) of those assisted came from psychiatric hospitalization. Of the 207 housed since December 2011, 75 persons have exited. Forty percent (30/75) of those have positive outcomes. Eleven percent (8/75) are deceased.

The effort to insure ongoing availability of housing to individuals who are homeless and mentally ill DMH continues the focus of efforts with Community Mental Health Center and Pathways to Housing collaborations with local not-for-profit housing developers.

The Self Sufficiency Outcome Matrix has been updated tested and implemented. All self-sufficiency outcome measures recorded demonstrate improvement for the individuals participating in the Housing Subsidy & Care program. The improvement in legal, housing, mental health, substance abuse and community involvement continue.

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

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

Planning for the Future

The landscape of the Mental Health System of Care has been changing and evolving as new system resources are implemented within community-based care or inpatient care settings. 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 were opened. 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.

Examining the Mental Health System of Care

In response to challenges arising in the mental health system of care, the Vermont legislature passed Act 82, an act relating to examining mental health care and care coordination. This act tasked the Department with identifying many of the challenges and opportunities within the current mental health system of care.

Many of the report's identified needs for the system represent expanded ideas and responses that have been worked on for some time prior to the enactment of Act 82. The Department has approached the directives of Act 82 with an emphasis on stakeholder input and ideas and held two all-day meetings and numerous stakeholder sub-committee meetings to engage with stakeholders and providers. DMH embraces stakeholder perspectives as pivotal to the work while simultaneously providing leadership and directing efforts. The report is available through the Vermont legislature (https://legislature.vermont.gov/assets/Legislative-Reports/) and is available on the Department's website (http://mentalhealth.vermont.gov/reports/legislative-and-budget).

The information described in this report, as well as the content outlined in the Act 82 report, reflects the work of the Department of Mental Health to continuously improve the state's mental health system of care.

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

P Snapshot Adult Inpatient Hospitalization	Time Period	Actual Value	Current Trend
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	**Time Period**	**Actual Value**	**Current Trend**
PM How_Well % occupancy of Level 1 adult inpatient hospital units	FYQ1 2016	87%	↘ 2
PM How_Much # Level 1 admissions	FYQ1 2017	32	↘ 1
P Snapshot Youth Inpatient Hospitalization	**Time Period**	**Actual Value**	**Current Trend**
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	**Time Period**	**Actual Value**	**Current Trend**
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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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

P	ContinuedReport	Total Adult Involuntary Inpatient Care	Time Period	Actual Value	Current Trend
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	Time Period	Actual Value	Current Trend
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	Time Period	Actual Value	Current Trend
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 2016 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	7,399,821	37.71	22.73	59
Community Utilization per 1,000 population	7,166,128	37.59	22.01	59
State Hospital Utilization per 1,000 population	134,301	0.12	0.41	54
Other Psychiatric Inpatient Utilization per 1,000 population	392,410	0.86	1.53	38

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	838,510	37.7%	50.1%	58
Employed (percent with Employment Data)**	838,510	25.8%	24.5%	58

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	71.4%	75.7%	50

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	60.5%	73.5%	47

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	7,715	14.5%	8.8%	50
State Hospital Readmissions: 180 Days	17,365	23.6%	19.7%	51
State Hospital Readmissions: 30 Days: Adults	7,260	14.5%	9.2%	49
State Hospital Readmissions: 180 Days: Adults	16,200	23.6%	20.4%	50
State Hospital Readmissions: 30 Days: Children	393	0.0%	5.0%	18
State Hospital Readmissions: 180 Days: Children	1,027	0.0%	13.1%	20

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,074,919	85.2%	82.5%	58
Homeless/Shelter	191,204	3.5%	3.9%	53
Jail/Correctional Facility	85,835	0.1%	1.7%	53

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	86,206	-	3.1%	35
Supported Employment	64,987	27.7%	2.1%	43
Assertive Community Treatment	68,820	-	2.1%	40
Family Psychoeducation	31,676	-	1.9%	15
Dual Diagnosis Treatment	204,574	-	10.5%	26
Illness Self Management	295,788	-	19.0%	21
Medications Management	467,273	85.8%	32.0%	19

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	10,730	-	1.5%	19
Multisystemic Therapy	28,138	-	3.6%	19
Functional Family Therapy	26,027	-	6.9%	13

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	66.5%	74.4%	50
Child/Family Improved Social Connectedness	-	86.4%	44

*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 - 2016 State Mental Health Measures

STATE: Vermont

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	23,604	37.71	7,399,821	22.73	59
Community Utilization per 1,000 population	23,531	37.59	7,166,128	22.01	59
State Hospital Utilization per 1,000 population	73	0.12	134,301	0.41	54
Medicaid Funding Status	15,615	72%	4,575,093	70%	56
Employment Status (percent employed)	2,295	26%	838,510	24%	58
State Hospital Adult Admissions	60	0.82	101,635	0.83	52
Community Adult Admissions	6,356	0.46	9,890,419	2.31	50
Percent Adults with SMI and Children with SED	2,630	11%	4,979,257	67%	59

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	85 Days	77 Days	50
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	91 Days	71 Days	50
Percent of Client who meet Federal SMI definition	19%	71%	56
Adults with Co-occurring MH/SA Disorders	22%	27%	56
Children with Co-occurring MH/SA Disorders	-	6%	51

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	77%	87%	50
Quality/Appropriateness of Services	79%	90%	50
Outcome from Services	71%	76%	50
Participation in Treatment Planning	76%	85%	50
General Satisfaction with Care	83%	90%	50

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	84%	86%	47
General Satisfaction with Care	76%	89%	48
Outcome from Services	60%	73%	47
Participation in Treatment Planning	83%	91%	47
Cultural Sensitivity of Providers	88%	95%	47

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	17,164	85.2%	4,074,919	82.5%	58
Jail/Correctional Facility	30	0.1%	85,835	1.7%	53
Homeless or Shelter	704	3.5%	191,204	3.9%	53

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	8	14.5%	7,715	8.8%	50
State Hospital Readmissions: 180 Days	13	23.6%	17,365	19.7%	51
Readmission to any psychiatric hospital: 30 Days	-	-	24,829	13.1%	23

State Mental Health Finance (FY2015)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community MH *	$190,300,000	87.8%	$28,514,735,678	75.5%	50
SMHA Revenues from State Sources **	$1,300,000	0.6%	$14,822,947,003	39.3%	50
Total SMHA Expenditures	$216,800,000	-	$37,767,897,721	-	50

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	68,820	2.1%	40
Supported Housing	-	-	86,206	3.1%	35
Supported Employment	706	27.7%	64,987	2.1%	43
Family Psychoeducation	-	-	31,676	1.9%	15
Integrated Dual Diagnosis Treatment	-	-	204,574	10.5%	26
Illness Self-Management and Recovery	-	-	295,788	19.0%	21
Medications Management	2,190	85.8%	467,273	32.0%	19

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	10,730	1.5%	19
Multisystemic Therapy	-	-	28,138	3.6%	19
Functional Family Therapy	-	-	26,027	6.9%	13

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	-	-	24,254	3.7%	35
Juvenile Justice Contacts	270	3.0%	4,730	2.5%	34
School Attendance (Improved)	-	-	10,645	33.5%	24

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