VERMONT2020

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 79

January 15, 2020

Department of Mental Health
AGENCY OF HUMAN SERVICES
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ACT 79 REPORTING REQUIREMENTS

18 VSA 174 § 7256. Reporting requirements

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

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

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

(3) individual experience of care and satisfaction;

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

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

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

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

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

EXECUTIVE SUMMARY: THE MENTAL HEALTH SYSTEM OF CARE

The Vermont Department of Mental Health (DMH), with the Designated Hospitals (DHs), Designated Agencies (DAs), Specialized Services Agencies (SSAs) and other community and Agency of Human Services (AHS) partners, has continued to work throughout the past year to move the system of care forward within Vermont for people with mental health needs. Act 79 reports since 2013 have identified departmental efforts to rebuild a system of care that was initially focused on replacement and augmenting gaps in adult treatment service capacity subsequent to Tropical Storm Irene.

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 the fifth- and sixth-years reports (2017, 2018) DMH continued to highlight our key measures, emerging trends, and point out areas that are still in development. Building on the groundwork laid in 2018 with both the participation of the Department of Vermont Health Access and the Designated and Specialized Services Agencies, in 2019 DMH implemented a significant payment reform initiative.

This alternative payment model is intended to improve the predictability of payments to providers of mental health services, and to increase their flexibility to meet the needs of the Vermonters they serve. The new model places additional focus on quality—at first by providing an incentive for providers to report complete, accurate, and timely information, and in the future by linking a portion of payments to providers' performance on certain quality measures. The new payment model shares many characteristics of other value-based payment models that the State is implementing or considering for future implementation; such alignment should contribute to both State and provider readiness for an increasingly integrated health care delivery system over time and should aid the State in developing a strategy for inclusion of additional services in All-Payer financial targets in future.

2019 also provided significant new commitments for replacement and expansion of the temporary secure residential program through a Buildings and General Services Capital Bill allocation to support siting and planning work necessary to determine permanent location options. Additionally, support for a 12-bed inpatient capacity increase through renovations at the Brattleboro Retreat was authorized and is currently underway. Ongoing resource

investments in the designated agency provider system for workforce retention and service capacity in excess of $4,000,000, as well as supplemental resources for enhanced treatment plans and housing options for complex need individuals served by the mental health system of care were added in 2019.

Throughout 2019 DMH also continued its phase down of federal financial participation for room and board expenditures identified in allocations to service providers, management of decreasing federal investment dollars for any Institutes for Mental Disease (IMD) investments per the state's current Global Commitment to Health waiver, and the application of Home and Community Based Services program requirements for special populations served by designated mental health provider agencies in accordance with Centers for Medicaid and Medicare Services (CMS) guidance.

CURRENT/ONGOING DEVELOPMENTS

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 has included training and mentoring for peer staff using the Intentional Peer Support curriculum, Wellness Recovery Action Plans (WRAP), and Wellness Engagement training. Core Competency Training for peer support workers is also in development. Expansion of service outcomes is reported 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, continues to grow and expand to include further training opportunities for a variety of community responders. This continues to be an area of need for further collaboration across many jurisdictions that are served by multiple law enforcement agencies. The Department welcomes the ongoing 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. Work with towns, hospitals, and police departments to expand mobile outreach to target populations continues in Chittenden County. This capacity originated with a 2018 legislative appropriation and financial support of South Burlington, Colchester, Richmond, Williston, Winooski, Essex and Shelburne communities for a Street Outreach expansion program. This program targets unmet mental health needs of the residents of these towns with four full time staff. Developing ways to work together to address the unique situations in each town and through a "first response" type of manner continues to be its 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 to 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 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 play a large role in helping DAs access higher levels of care for children when needed. This includes residential treatment, both in-state and out-of-state as well as therapeutic foster care through intensive home and community-based services. The CAFU works in close collaboration with families and DAs/SSAs as well as education, child welfare, developmental disability services 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, now newly affiliated under the Northern Vermont University umbrella, is entering its fifth 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 ©". VCPI 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 (Collaborative Network Approach);
- Treatment of Early Episode Psychosis;
- Integrated Mental Health, Health and Wellness Interventions;
- Mental Health First Aid;
- Collaborative Mental Health and Law Enforcement Crisis Response (Team Two);
- Recovery Oriented Cognitive Therapy;
- Act 264 Overview; and
- Children's Health Integration Linkage and Detection (CHILD) Grant.

SECURE RESIDENTIAL BED CAPACITY

During 2019 AHS and DMH worked with the Vermont State Legislature on a bill that formalized plans for replacement of the temporary, secure residential treatment facility in Middlesex, Vermont. The Department proposed as a replacement a permanent, 16-bed, state-run, physically secure, residential facility with increased clinical capacity. The expanded beds and treatment capabilities will further support transition of individuals to community-based services and improve timely access for patients needing inpatient treatment in the system of care.

Replacement planning activities outlined by Act 42 (2019) included:

(a)Exploration with the Department of Disabilities, Aging, and Independent Living (DAIL) to amend its rules pertaining to therapeutic community residences to allow secure residential recovery facilities to utilize emergency involuntary procedures (EIP) and that these rules be identical to the rules adopted by DMH for psychiatric inpatient units

(1) replacement construction of a physically secure state-owned secure residential recovery facility for up to 16 beds that meets the security standards currently used at the Middlesex Secure Residential Recovery Facility; and

(2) exploration of the placement of interim secure residential recovery beds or permanent beds that could be flexible to meet other potential therapeutic community residential uses as determined by the Department of Mental Health.

(b) State-owned Secure Residential Recovery Facility Proposal

(1) On or before October 15, 2019, the Secretary of Human Services and the Commissioner of Buildings and General Services shall develop a proposal that expedites the closure of the Middlesex Secure Residential Recovery Facility and provides for construction of a 16-bed State-owned secure residential recovery facility and shall present this proposal to the House Committee on Corrections and Institutions and the Senate Committee on Institutions.

(2) With approval of the Speaker of the House and the President Pro Tempore, as appropriate, the House Committee on Corrections and Institutions and the Senate Committee on Institutions may meet up to one time when the General Assembly is not in session to evaluate the proposal and make a recommendation on the site location to the Joint Fiscal Committee.

(3) The Joint Fiscal Committee shall review the recommendation of the Committees described in subdivision (2) of this section at its September or November 2019 meeting. If the Joint Fiscal Committee so determines, it shall approve the proposal as recommended by the Committees.

(c) Interim Secure Residential Recovery Beds.

(1) On or before the August 15, 2019, the Commissioner of Mental Health shall conduct an analysis of mental health bed needs in residential programs at secure residential recovery facilities across the State. Based on this analysis, the Secretary of Human Services may commence negotiations for placement of eight interim beds in a secure residential recovery facility or permanent beds that could be flexible to meet other potential therapeutic community residential uses with a target a completion date for negotiations of December 1, 2019. The Secretary shall not execute an agreement without legislative approval.

(2) On or before December 15, 2019, the Agency shall submit a report to the House Committees on Appropriations, on Corrections and Institutions, and on Health Care and to the Senate Committees on Appropriations, on Institutions, and on Health and Welfare on the status of negotiations based on the Department of Mental Health's analysis of bed needs. To the extent the Agency determines it is an appropriate location for an alternative to the Middlesex

Secure Residential Recovery Facility, the report shall include an analysis of operating secure residential recovery beds at Rutland Regional Medical Center and Rutland Mental Health Services.

Toward this planning effort, a total of $4,500,000 was allocated in Act 42 (2019). In FY 20, $3,000,000 was allocated for replacement, land acquisition, design, permitting, and associated construction documents. In FY 21, an additional $1,500,000 is allocated for ongoing costs in each of these associated replacement cost areas. During 2019, Buildings and General Services released Requests for Proposals for possible land acquisition, initially for central Vermont and subsequently for an expanding range including central and northern Vermont in late 2019. Reviews of submissions of possible properties ahd been coordinated with DMH to evaluate the both construction opportunities and suitability for the needs of the permanent program. DMH has been working in coordination with DAIL in the development of amended rules for the provision of EIP's in a replacement residential facility that will be a state-run and physically secure program. DMH has compiled the required bed need analysis and considerations for an entity to operate the program.

BRATTLEBORO RETREAT INPATIENT BED EXPANSION

Renovation of space at the Brattleboro Retreat, formerly the Linden Lodge building, began in 2019 with intent to create an additional 12-bed Level I inpatient capacity to address ongoing wait times in local emergency departments for individuals in need of higher acuity inpatient psychiatric care. Additional funding was allocated by the legislature in support of this capacity. Renovations are anticipated to be complete in spring of 2020.

MOBILE RESPONSE AND SUPPORT SERVICES

The Agency of Human Services continues to work across multiple Departments to explore Mobile Response and Support Services (MRSS) for the child, youth and family system of care. Representatives from the Agency, along with representatives from a family advocate organization and a Designated Agency who participated in a state-to-state peer learning and technical assistance event in December 2018 continue to explore the viability of implementing MRSS and resources necessary to achieve targeted and/or state-wide capacity.

Drawing upon the National Association of State Mental Health Program Directors' report, *Making the Case for a Comprehensive Children's Crisis Continuum of Care* (2018), "[i]n 2013 the Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Medicaid and CHIP Services (CMCS) recognized Mobile Crisis Response and Stabilization Services as "not only clinically effective but cost effective as well". MRSS differs from

traditional crisis services in that it's more "upstream." A mobile face-to-face response is provided to a family-defined crisis to provide support and intervention earlier for a child or youth and family before emotional and behavioral difficulties escalate. An MRSS response has been shown in other states to "avert unnecessary" higher levels of care in settings such as emergency departments, inpatient psychiatric care, or residential treatment (NASMHPD 2018).

Grants

Two Federal Grant initiatives referenced in the 2019 Act 79 Report have continued through 2019 and focus on early childhood development and school age youth. One of the grants is a Health Resources and Services Administration (HRSA) grant through the Vermont Department of Health (VDH) for Screening, Treatment and Access for Mothers and Perinatal Partners (STAMPP). In partnership with the VDH Maternal Child Health Division, effective screening, intervention and treatment of maternal depression and related behavioral disorders has been the focus of the 5-year, $627,525 federal cooperative agreement. The second grant is a 5-year Substance Abuse and Mental Health Services Administration (SAMHSA) award for up to $1,582,371 to the Agency of Education (AOE) for Project AWARE Vermont undertaken in partnership between AOE and DMH. The Child, Adolescent, and Family Unit of DMH is working to increase awareness of youth mental health issues; enhance wellness and resiliency skills for school age youth; and support system improvements for school based mental health services. Grant funding for both initiatives continues through September 2023.

SHERIFF SUPERVISION

Since closure of the former Vermont State Hospital, DMH had absorbed the cost of sheriff supervision services for those small hospitals without readily available security or safety personnel for patients presenting for a psychiatric admission pending appropriate inpatient placement. Pursuant to Act 72 (2019) Sec. C. 100 (a) (13) - the Department of Mental Health (DMH) was directed to provide one-time grant funds to hospitals to build capacity to provide supervision in their Emergency Departments for person under the care and custody of the Commissioner of Mental Health, to ensure the safety of patients and hospital staff within compliance with federal regulations. Hospitals supported by these one-time grant awards could then assure that any intervention/s applied in an Emergency Department for a patient awaiting placement would be deployed by appropriately trained personnel in a manner fully compliant with applicable hospital certification or accreditation standards.

10-YEAR VISION

Through summer, fall, and early winter 2019, DMH has been engaging in a public planning and development process, soliciting stakeholder involvement and feedback as an integral part of planning. The Plan, "Vision 2030: A 10-Year Plan for An Integrated and Holistic System of Care",

will be delivered to the Vermont State Legislature in January 2020. The “Planning for the Future” section of this document outlines the work underway to move the mental health system forward.

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 156 beds are used for **Non-Level 1 Involuntary** and **Voluntary** inpatient stays. As of this report, approximately 87% of these bed days were used for **Voluntary** stays.

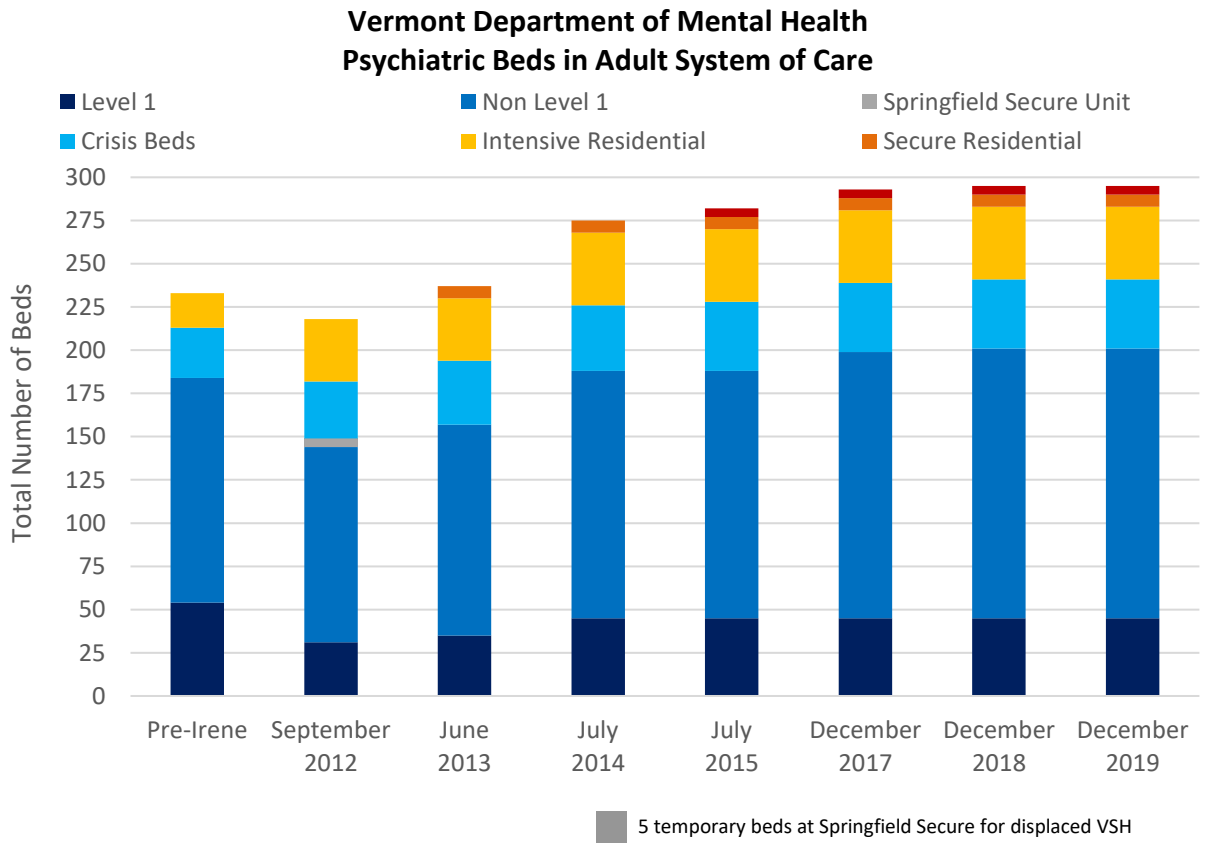
Hospital	Location	Total Adult Inpatient Beds
Brattleboro Retreat	Brattleboro, VT	89
Central Vermont Medical Center	Berlin, VT	14
University of Vermont Medical Center	Burlington, VT	28
Rutland Regional Medical Center	Rutland, VT	23

Windham Center at Springfield Hospital[1]	Springfield, VT	10
Vermont Psychiatric Care Hospital	Berlin, VT	25
White River Junction VA Medical Center	White River Junction, VT	12*

**The VA Medical Center has 12 beds total for Veteran's psychiatric inpatient care. A subset of these beds (2-3) are allocated for involuntary care at the discretion of the Medical Center.*

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



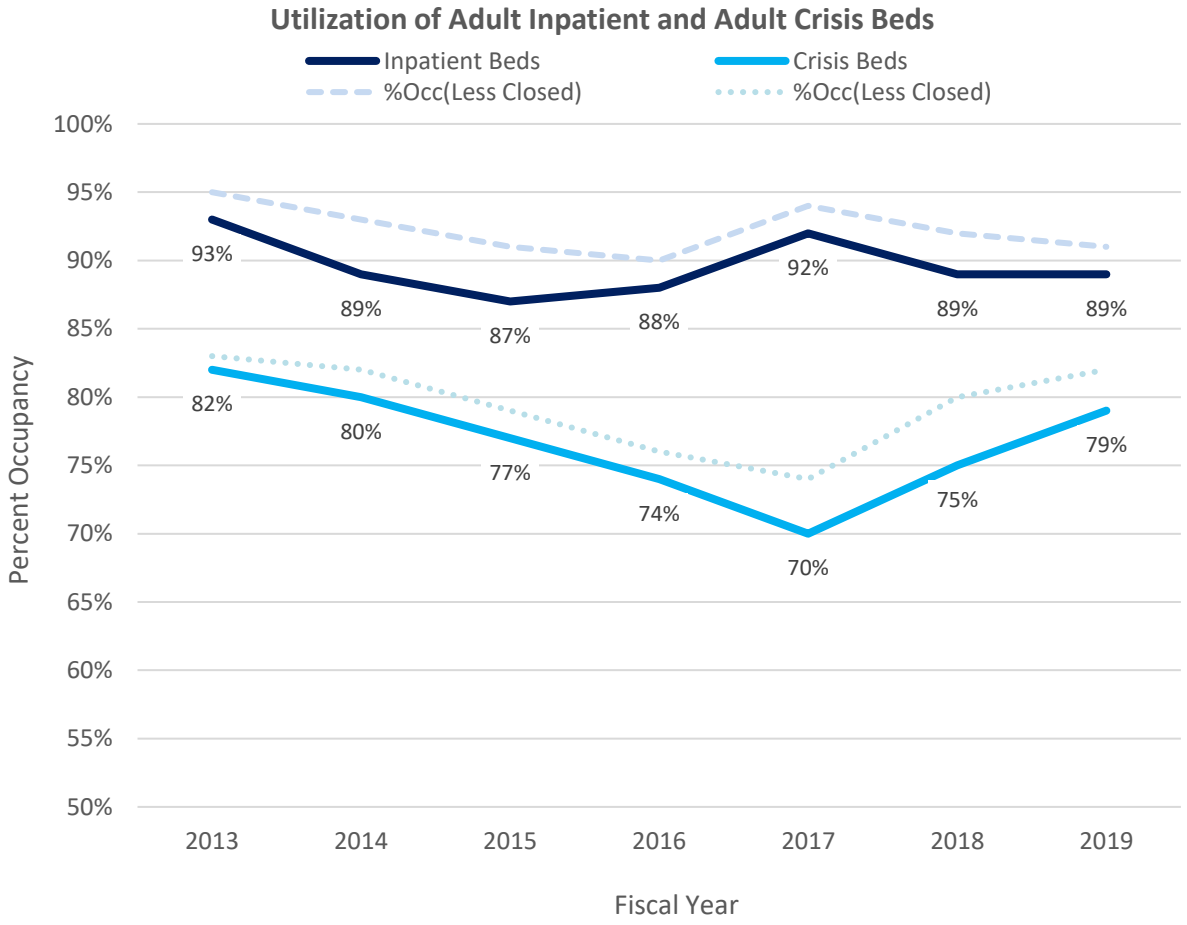
[1] Windham Center at Springfield Hospital is no longer a Designated Hospital as of 1/1/2020.

Vermont has increased its capacity for mental health care substantially since August 2011. Overall, the system capacity for psychiatric beds has increased by over 60 beds since August 2011. Vermont's adult psychiatric inpatient system has a total of 201 beds, which is seventeen (17) more than before tropical storm Irene closed the Vermont State Hospital. The Designation of White River Junction VA Medical Center added 10 adult inpatient beds to the system of care at last report. As of December 2018, the VA Medical Center increased to 12 psychiatric inpatient beds and continues to allocate 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 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.

Act 190 (2018) provided $5.5 million dollars for the development of 12 inpatient Level I beds at the Brattleboro Retreat. A construction agreement was completed between the Retreat and Department of Buildings and General Services (BGS) in December 2018. Renovation of building space has been ongoing through 2019. Additional inpatient bed capacity is currently anticipated to come online in 2020.

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.

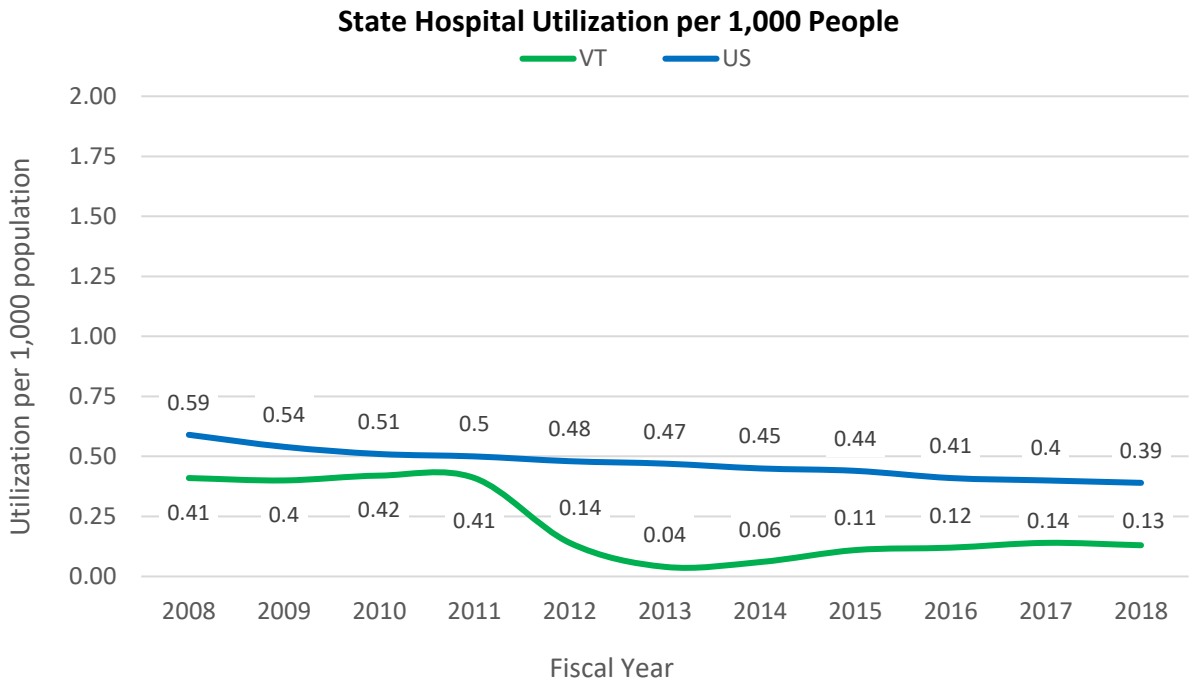
Occupancy of adult crisis beds declined consistently since FY 2013 and utilization was further impacted by hospital and community provider risk management concerns in the wake of the Kuligoski Supreme Court decision (2016). Both 2018 and 2019 have shown an upward trend and slow return in utilization of crisis beds for individuals assessed as appropriate for this support and stabilization option, as an alternative to extended ED wait time. The department

continues to explore voluntary alternative service or bed options that may better meet the needs of Vermonters experiencing a mental health crisis.

Adult inpatient bed occupancy decreased slightly in 2018 and has remained level in 2019. During FY 2019, involuntary inpatient lengths of stays have seen an upward trend from the two preceding fiscal years. Readmission rates were relatively unchanged, a trend that remains below the national readmission rate trends. Additionally, adults being referred to involuntary inpatient care remained elevated consistent with the prior year's report.

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 2018 is the most recent data available.

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

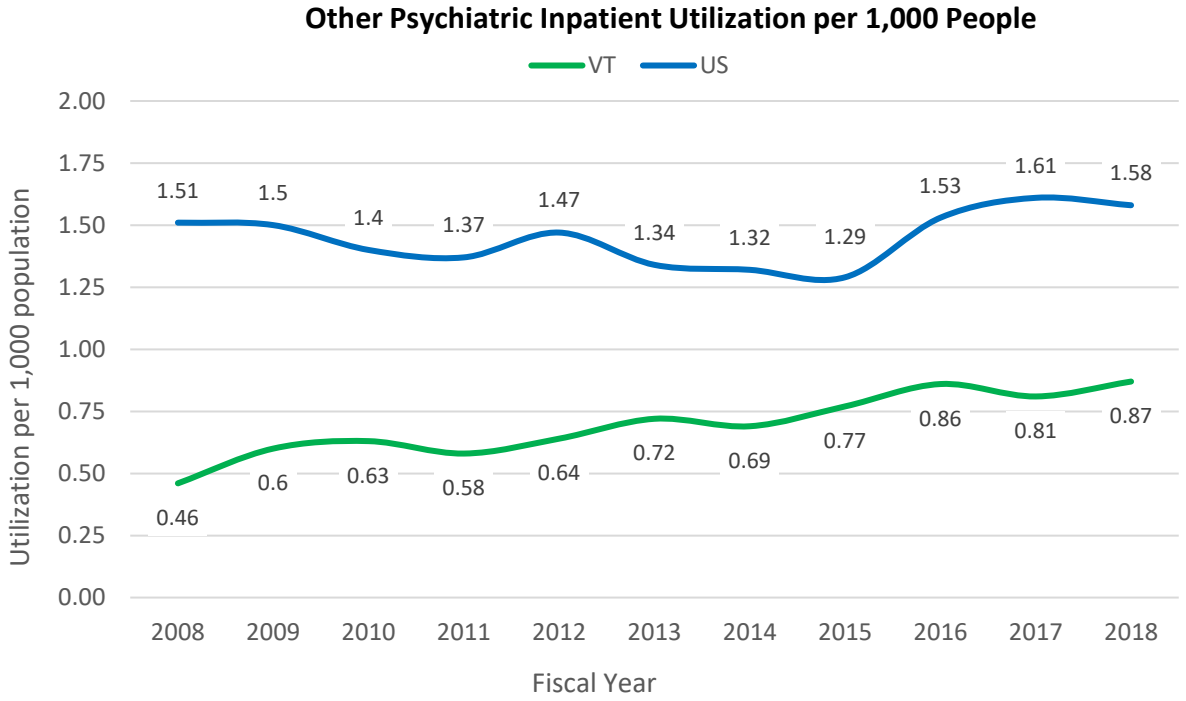


Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2018.

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. The Vermont hospital utilization data shows a slow upward trend through 2014, and then a somewhat flattened trend through 2018. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds has seen a slow declining trend since 2008.

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

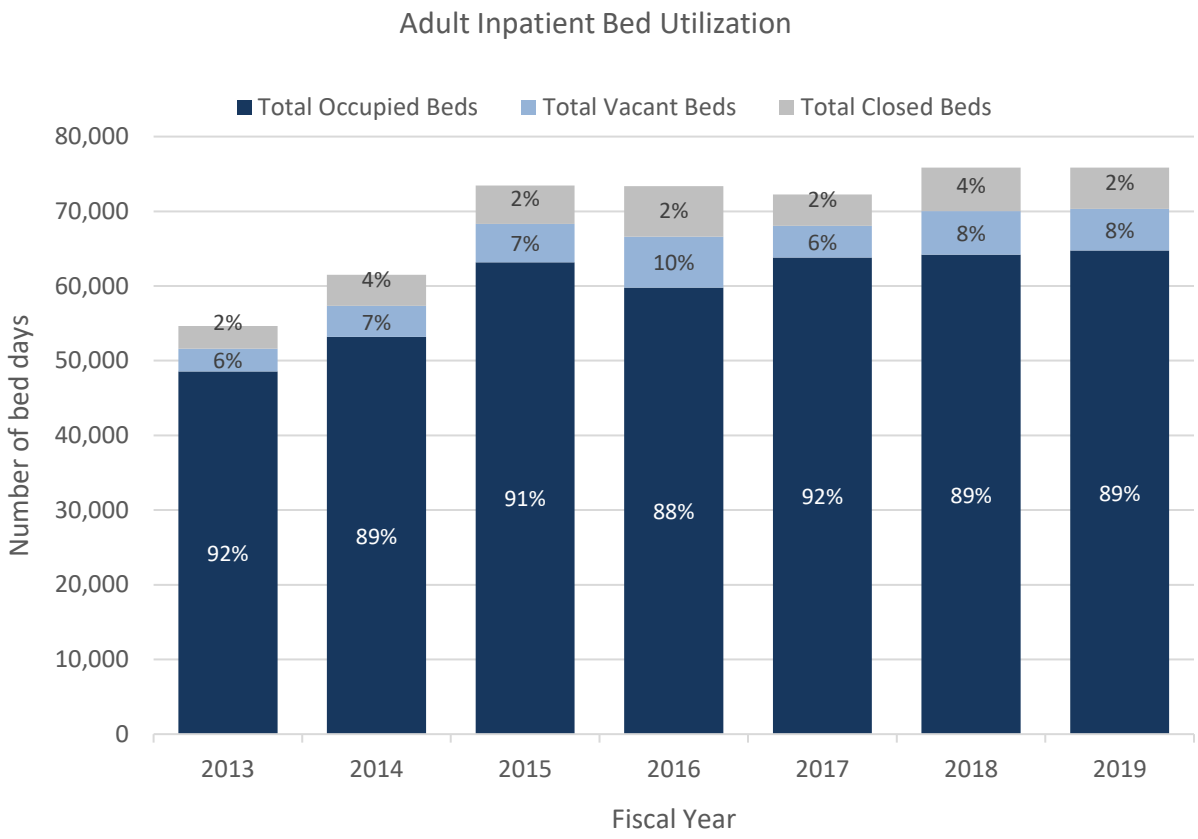


Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2018.

Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in chart above. Since 2008, the national rate of psychiatric hospital utilization had generally declined year-over year through 2015. In the three most recent years, however, the trend has been upward with 2016-2018 returning to utilization levels higher than 2008. In contrast, Vermont's rate of utilization has seen a slow upward trend since 2008. However, in both 2017 and 2018 there have been substantial increases in national utilization of psychiatric hospital beds. Vermont's inpatient utilization is still below the national averages while rates of community services utilization in Vermont continues to be markedly higher than national averages (

Chart 24: Community Utilization per 1,000 Populations).

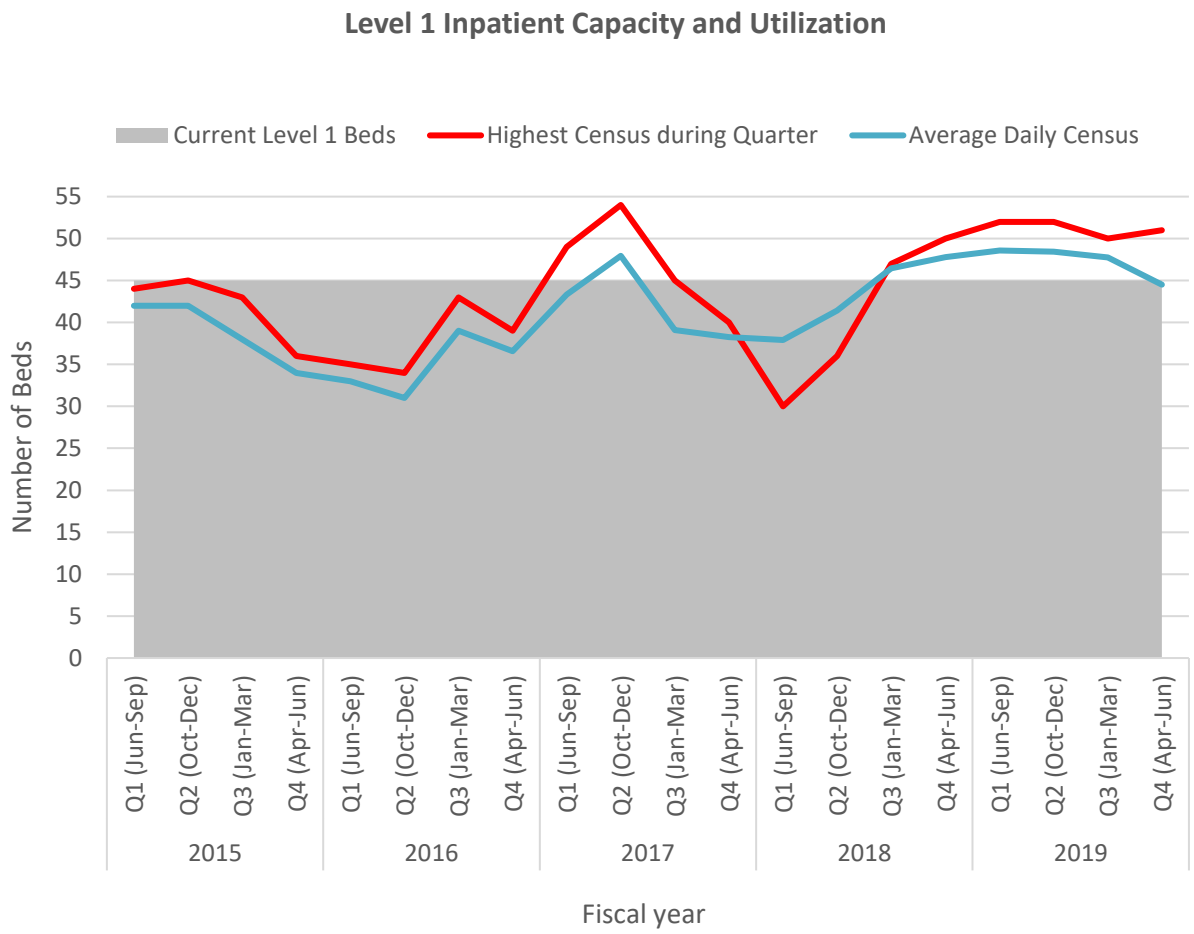
Chart 5: Adult Inpatient Utilization and Bed Closures



This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2019. The total bed day availability across the system has remained relatively constant in 2018 and 2019 with new bed capacity coming online in 2020. In 2019, bed closures represented 2% of adult inpatient utilization. Vacant beds have remained consistent at 8% in the two most recent years and have fluctuated between a low of 6% (2013,2017) and a high of 10% in 2016. Adult inpatient bed utilization has remained consistently at 88% or above during this seven-year period. The Department, in concert with the Designated Hospitals, works to maximize utilization of inpatient beds through the bed board system.

LEVEL 1 AND NON-LEVEL 1 INVOLUNTARY INPATIENT CARE

Chart 6: Level 1 Inpatient Capacity and Utilization



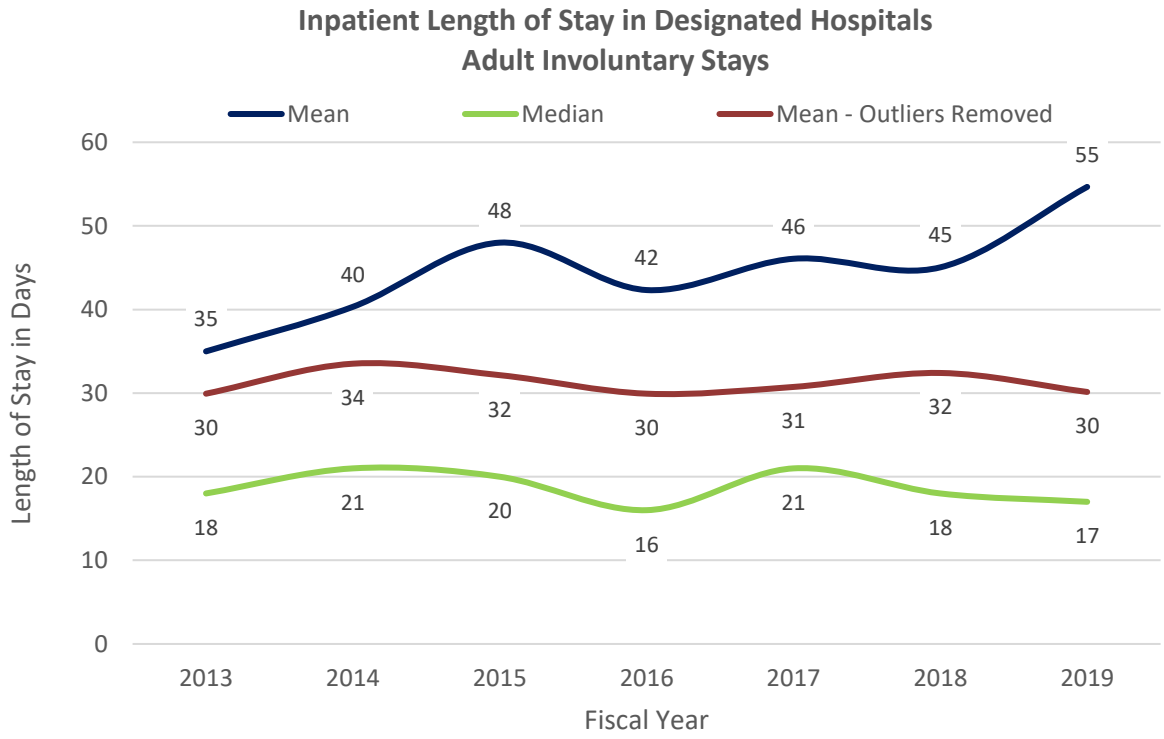
Level 1 patients require the highest level of care and services within the inpatient system. The chart above represents the average number of Level 1 patients receiving acute inpatient care in any hospital setting and the single combined one-day highest number each quarter. As a reminder, Level 1 involuntary 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. While still elevated, FY 19 Level I inpatient utilization reflects a more stabilizing or predictable census trend with less fluctuation between highest inpatient census and average daily census.

Chart 7: Inpatient Length of Stay in Designated Hospitals

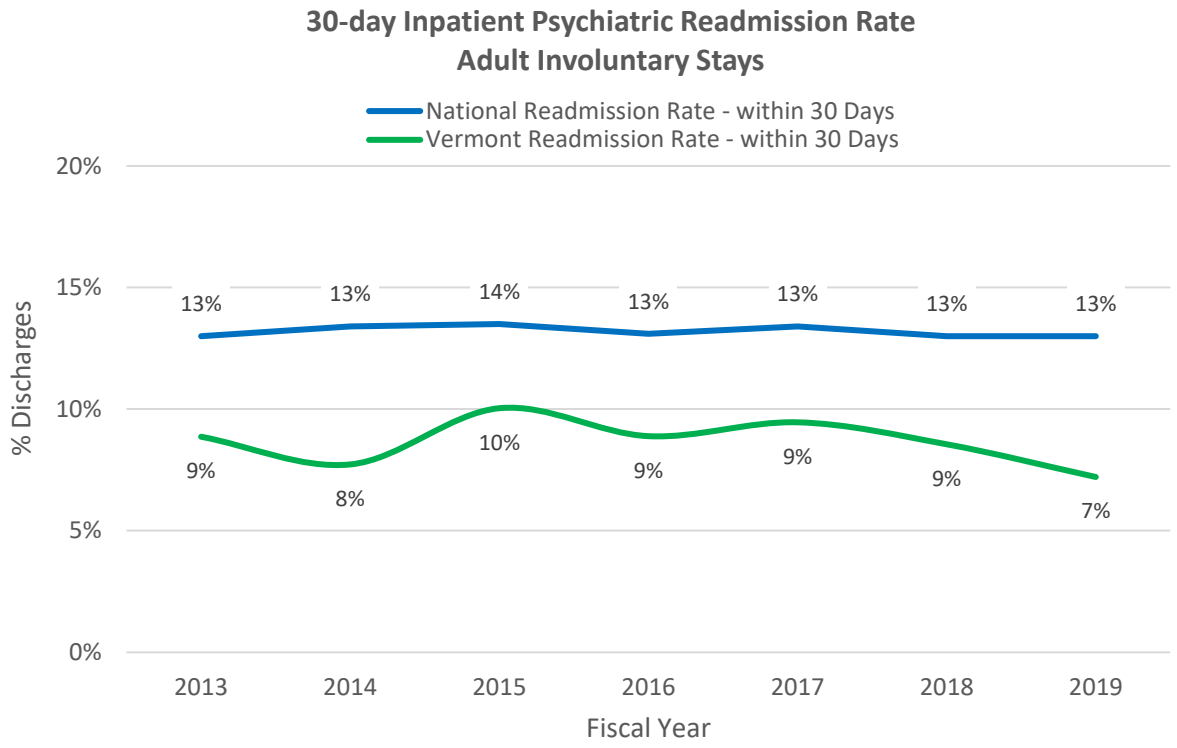


This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients from FY 2013 through FY 2019. A mean length of stay of 55 days is a more noticeable upward trend in FY 2019 when compared to prior fiscal years with a highest average of 48 days in 2015 to the two most recent averages of 46 days in 2017 and 45 days in 2018. 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 remains generally stable between 30-34 days over the seven-year period. Likewise, median length of stay has remained reasonably stable between 16-21 days.

This seven-year period also encompasses the introduction of the Level 1 system of care, which started in Designated Hospitals in FY 2013. This system has seen an increase from 25 Level 1 patients per day (on average) to 45 Level 1 patients per day. Level 1 patients can also have

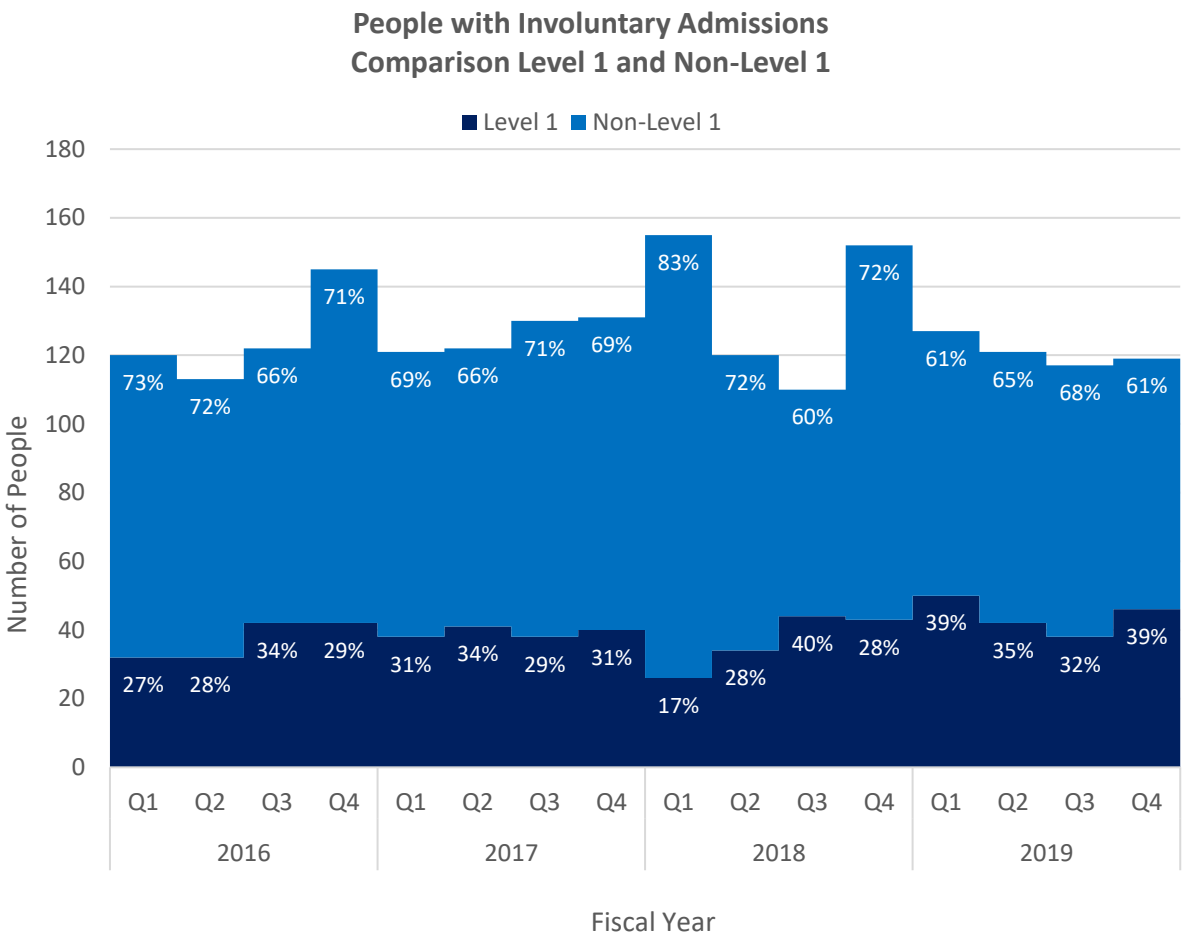
longer lengths of stay than non-Level 1 patients, which may be a contributing factor to the FY 2019 length of stay as adult inpatient bed capacity has remained unchanged in the two most recent years. Maximizing effective use of inpatient hospitalization, availability of aftercare supports and treatment services, and community connection and resources post-discharge are central to reducing length of stay.

Chart 8: Inpatient Readmissions in Designated Hospitals



Readmission rates within 30 days of discharge were calculated and compared to national benchmarks. More stability in readmission rates is seen in this seven year look back period. This data continues to show that Vermont readmission rates remain low and are 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

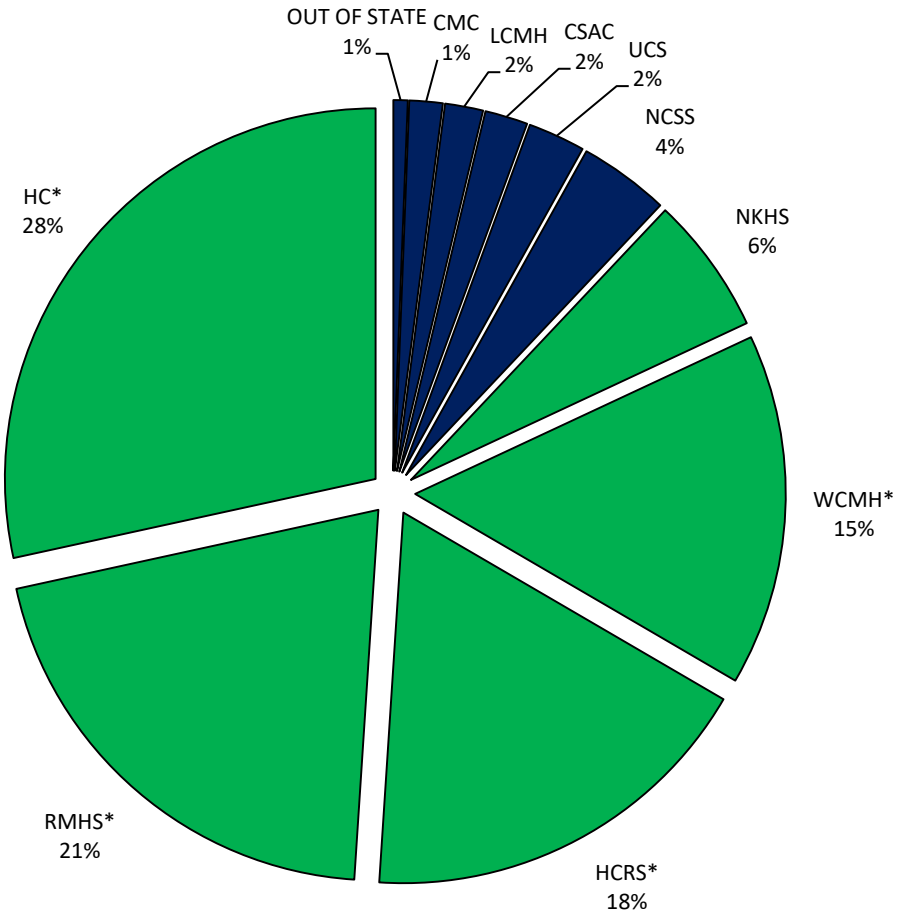


Over the past four fiscal years, the number of people involuntarily admitted to non-Level 1 inpatient care was elevated in three quarters of the sixteen quarters, Q4 (2016) and Q1 and Q4 (2018). The percentage of Level 1 involuntary admissions in 2019 inched upward ranging between 32-39%. In the six most recent quarters Q3 (2018) – Q4 (2019), four of the six quarters exceeded the previous high point of 34% seen two of the ten previous quarters. Even while Level I utilization percentages were up in 2019, non-level 1 admission levels remained reasonably stable between 61-68%.

It is an expected result to see fewer people with the Level 1 designation since lengths of stay can be 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. The introduction of new adult inpatient bed capacity in 2020 may mitigate an increase in length of stay in 2019 Level I inpatient admissions. Earlier quarters of information can be found in previous Act 79 reports.

Chart 10: Involuntary Admissions by Catchment Area of Residence

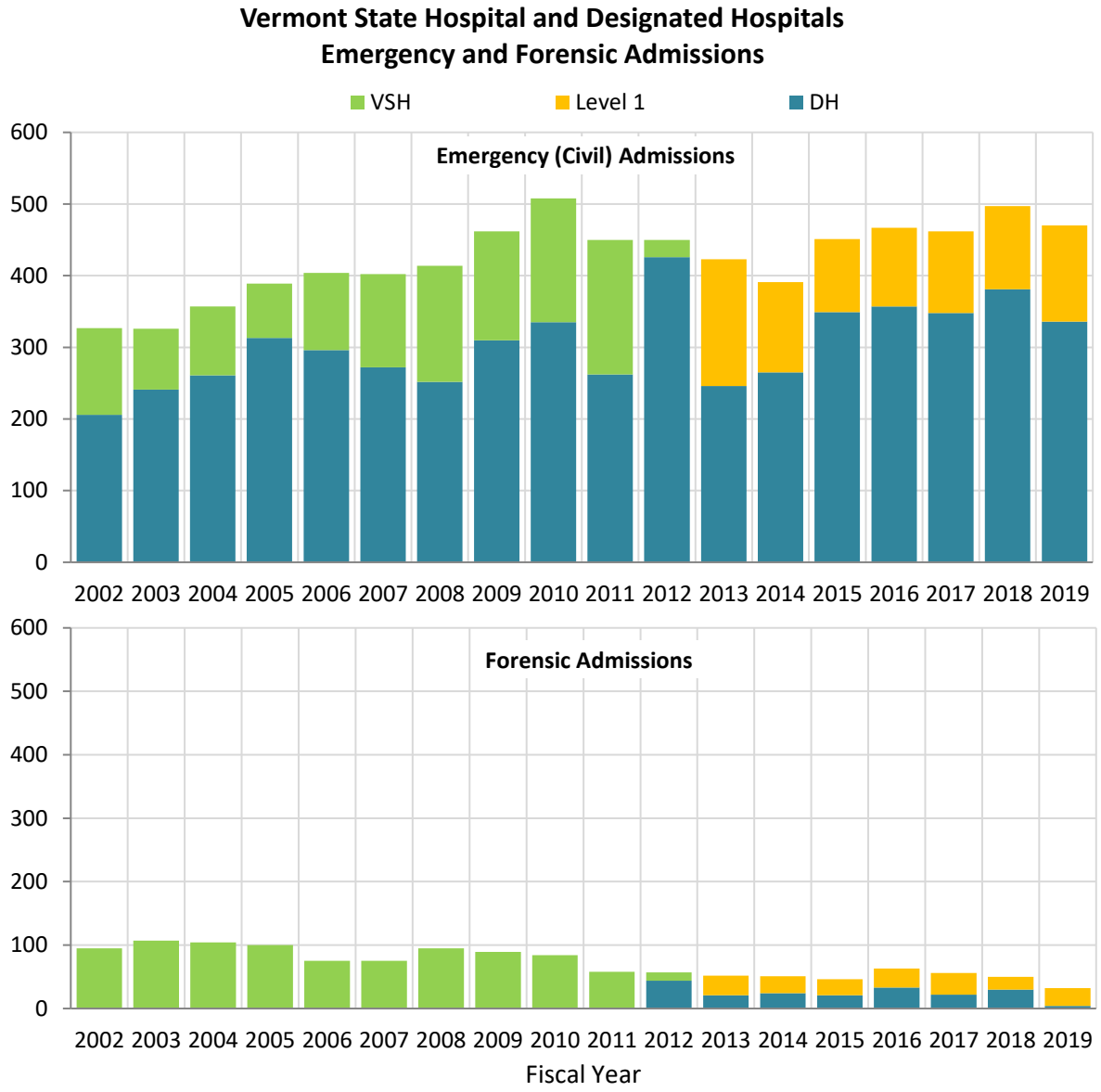
% of All Involuntary Admissions by Catchment Area of Residence
FY 2019



* Designated Hospital is located within Catchment

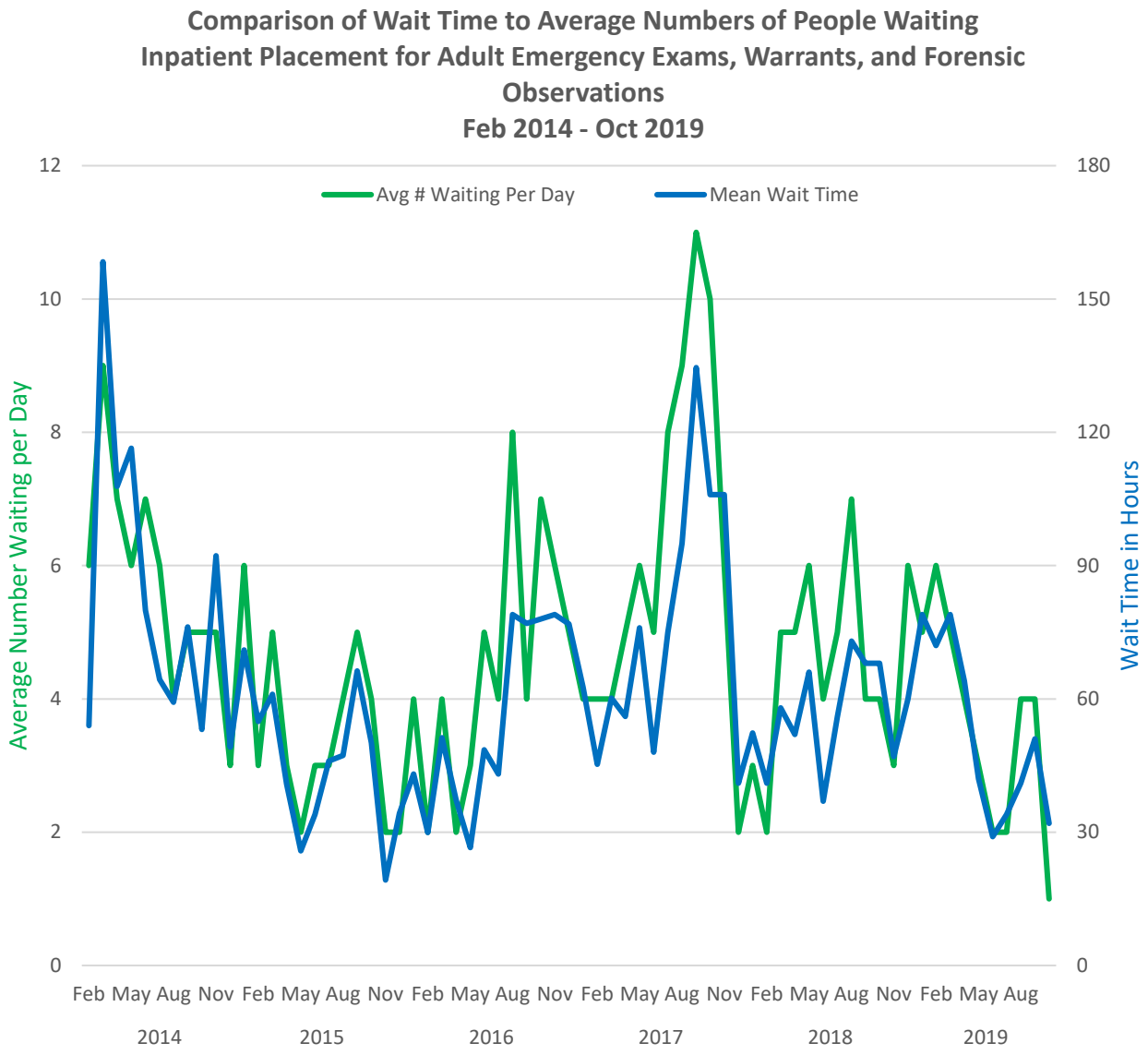
This chart provides information on the location of individuals who are admitted to an inpatient setting. As expected, larger agencies have a greater number of admissions as they are serving more individuals. This chart also suggests that the placement of hospitals in the decentralized system of care 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 total number of emergency (civil) and forensic admissions decreased by nearly 6% in FY 2019 bringing it more in line with the three of the four most recent fiscal years, with FY 2018 at higher rates. Designated hospital emergency admissions decreased by nearly 12%, as well as, a noticeable reduced number of forensic admissions (28 admissions in FY 2018 and only 4 admissions in FY 2019) since closure of the former Vermont State Hospital. Level I inpatient forensic bed use reflects this shift with an increase of about 40% for forensic bed admissions.

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.

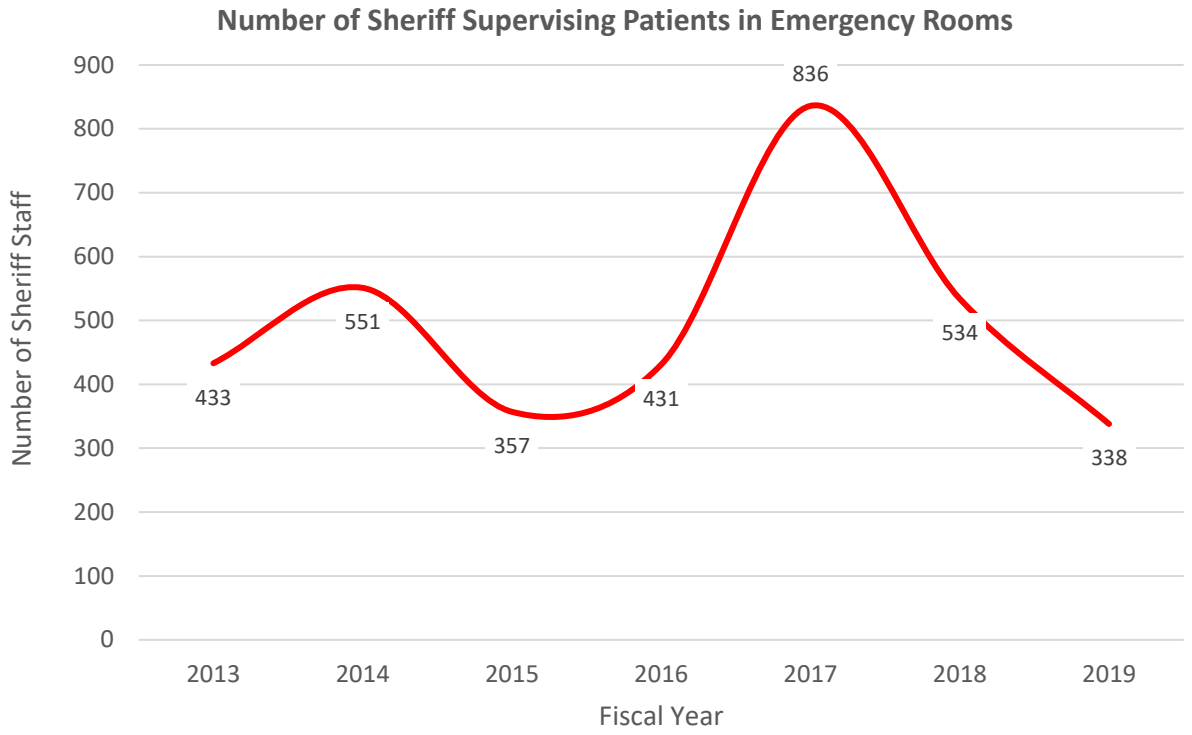
This chart reports the mean wait time and the average number of adults waiting per day from February 2014 to October 2019. The department's goal is to continue to place individuals in appropriate beds as soon as they are available.

Sharp increases that periodically occur coincide with increases in adults presenting for admission during the same period. As context, in July – September 2018, the number of adults held via emergency exam or warrant reached its highest level in the six-year reporting period, 177 adults. Numbers again spiked in October – December 2018 at 167. The five most recent quarters, while still demonstrating wait time for inpatient placement, show less fluctuations in people waiting of between 141 and 159 each quarter.

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 track and coordinate individual case flow and support the relevant systems in moving people needing care through the system. The system is comprised of several points along a continuum which represent appropriate levels of care. As the acute mental health treatment system was decentralized, placement considerations became more complex and contingent on all service providers closely coordinating the different levels of care. The care management team also works on longer term planning for individuals needing more or ongoing support and treatment services, monitoring availability of placements in various levels of community-based programs across the state.

Since the closure of the former Vermont State Hospital, hospitals caring for patients awaiting placement in a psychiatric hospital inpatient bed have requested and utilized local sheriff department personnel in their emergency departments. For hospitals without security personnel, this has been a service paid through the department until legislation passed in 2019. The chart below illustrates utilization of sheriff supervision.

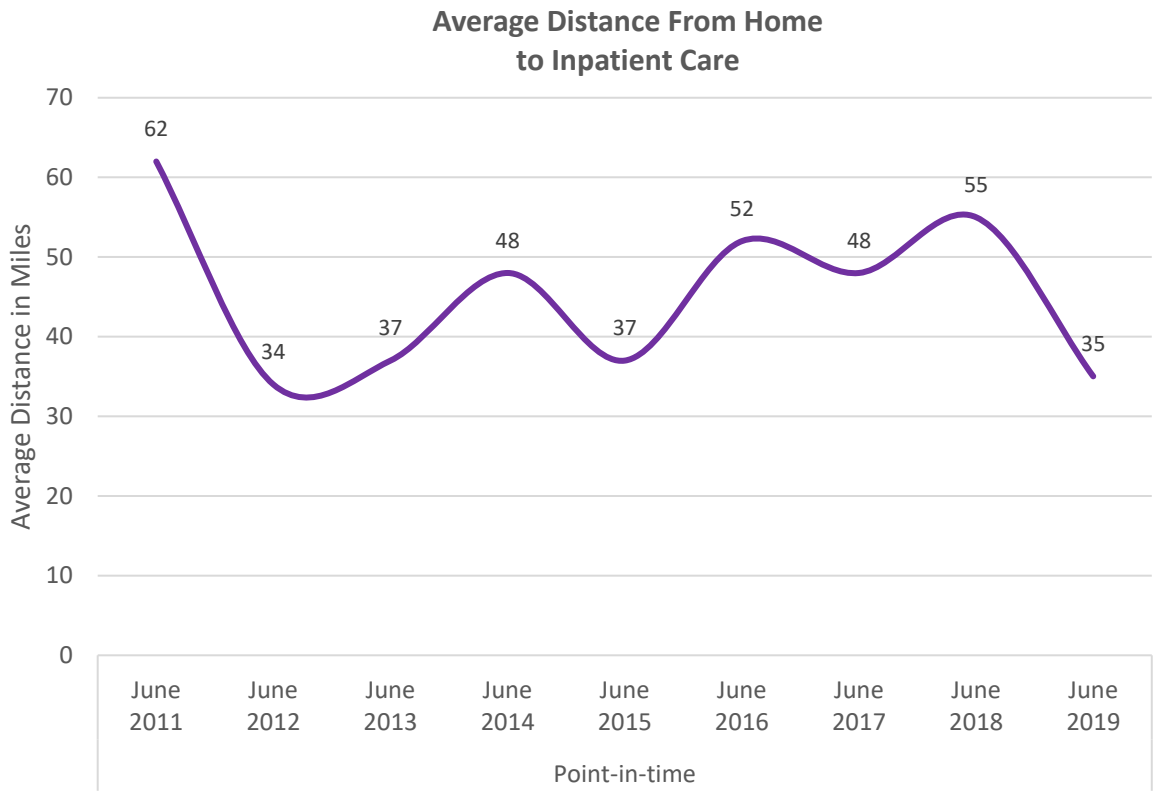
Chart 13: Sheriff Supervision in Emergency Departments



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. Legislation passed in 2019 required that DMH provide one-time grant funding to hospitals for supervision services at these hospitals. Pursuant to Act 72 (2019) Sec. C. 100 (a) (13) - the Department of Mental Health (DMH) allocated one-time grant funds to hospitals to build capacity to provide supervision in their emergency departments for persons under the care and custody of the Commission of Mental Health, to ensure the safety of patients and hospital staff within compliance with federal regulations.

Communication of this change to hospitals was done in coordination with the Vermont Association of Hospitals and Health Services. The DMH also provided the change notification to all local sheriff's departments throughout the state. Since FY 2017, the use of sheriff supervision has been in decline and continues to decrease through 2019 as hospitals have been developing alternative supervision strategies based on local needs and consistent with hospital standards of care for patients presenting to hospitals for emergency mental health inpatient services.

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 around the state for involuntary psychiatric hospitalizations. The distance required to travel to an inpatient bed post-Irene, as demonstrated in the graph above, reflects the use of beds at Designated Hospitals. While more regionalized care is available, the highest acuity hospital capacity is still located centrally and in the southern part of the state. The department considers timely treatment and treatment within one's community to be important factors in successful recovery. These two factors are incongruous when a hospital farther away from home is the most appropriate clinical alternative to remaining in an emergency department waiting for a closer inpatient bed. This year, however, did see less average distance for inpatient care than the three most recent prior years.

The DMH care management team works to arrange patient transfers between hospitals if clinically appropriate, so that people can continue or finish their inpatient treatment nearer to their follow-up services and home community. The graph reflects the fluctuating distance to services pattern inherent in not having locally available beds for presenting psychiatric inpatient

treatment needs. This is also reflected in *Chart 10: Involuntary Admissions by Catchment Area of Residence*.

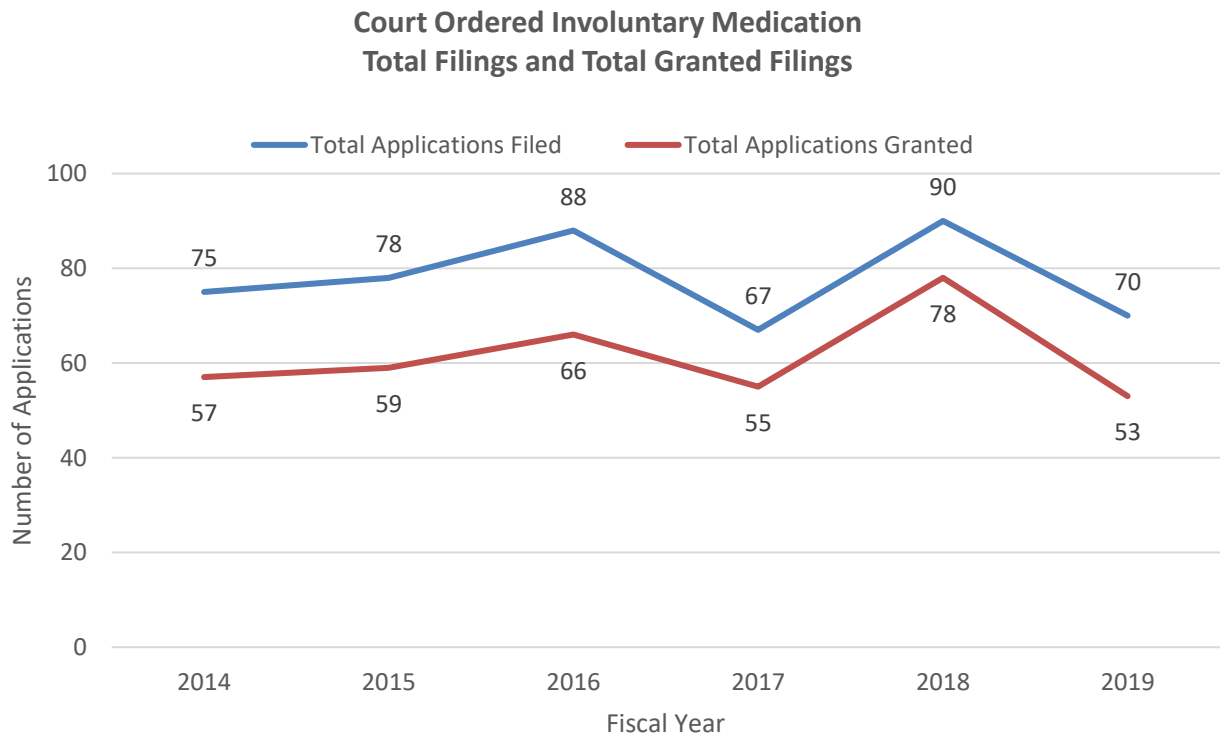
INVOLUNTARY MEDICATIONS

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

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



Total People, Total Filings, and Total Granted Filings

	Fiscal Year					
Court-Ordered Medication	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Number of people	57	60	73	61	79	65
Total Applications Filed	75	78	88	67	90	70
Total Applications Granted	57	59	66	55	78	53
% Granted	76%	76%	75%	82%	87%	76%

This chart represents the total number of court-ordered involuntary medication orders filed, the total granted, and the total number of people with filings. The number of persons with fillings annually for court-order medication in comparison to all persons admitted through civil or forensic legal proceedings in the most recent six years varied between a low of 11.77% (2017) and a high of 13.77% (2016). The percent of filings granted annually varies from 75% (2016) and 87% (2018) for the same period.

During 2019, the total number of court-ordered medication applications and applications granted decreased by, 22% and 32% respectively. The data shows that the number of filings trend at higher levels since the closure of the Vermont State Hospital in 2011 with more Designated Hospitals seeking involuntary court-ordered medication. This is most evident in 2018 with a high of 90 applications being made for court-ordered medication and an equally high number (78) of applications being granted at designated hospitals. This number closely coincides with data reflected in Chart 11 (381 emergency examination admissions and 30 forensic admissions at designated hospitals) for 2018. While 2019 Chart 11 data indicates a noticeable shift in numbers of emergency examination and forensic admissions away from designated hospitals for the first time since 2014 to Level I inpatient settings, this shift did not contribute to higher numbers of court-ordered applications overall.

While this trend continues to require examination in upcoming years, especially as additional Level I inpatient bed capacity comes on line in 2020, the close monitoring for inpatient length of stay given the increase noted earlier in 2019 (Chart 7: Inpatient Length of Stay in Designated Hospitals) will also be an indicator of system capacity needs for inpatient, outpatient, or both. Further length of stay information specific to court-ordered involuntary medication in FY 19 follows.

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

Court Ordered Involuntary Medication
Length of Stay for Discharged Patients

		FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Total Discharges	Overall	55	56	56	76	64
	Inp. Stays with One Filing	44	52	53	70	60
	Inp. Stays with Multiple Filings	11	4	3	6	4
Mean LOS (days)	Overall	191	103	161	136	155
	Inp. Stays with One Filing	155	98	150	130	147
	Inp. Stays with Multiple Filings	334	165	355	204	306

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

Court Ordered Involuntary Medication
30 Day Readmission Rate for Discharged Patients

		FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Total Discharges	Overall	55	56	56	76	64
	Inp. Stays with One Filing	44	52	53	70	60
	Inp. Stays with Multiple Filings	11	4	3	6	4
30 Day Readmission Rate	Overall	5%	5%	11%	1%	1%
	Inp. Stays with One Filing	7%	6%	11%	0%	1%
	Inp. Stays with Multiple Filings	0%	0%	0%	1%	0%

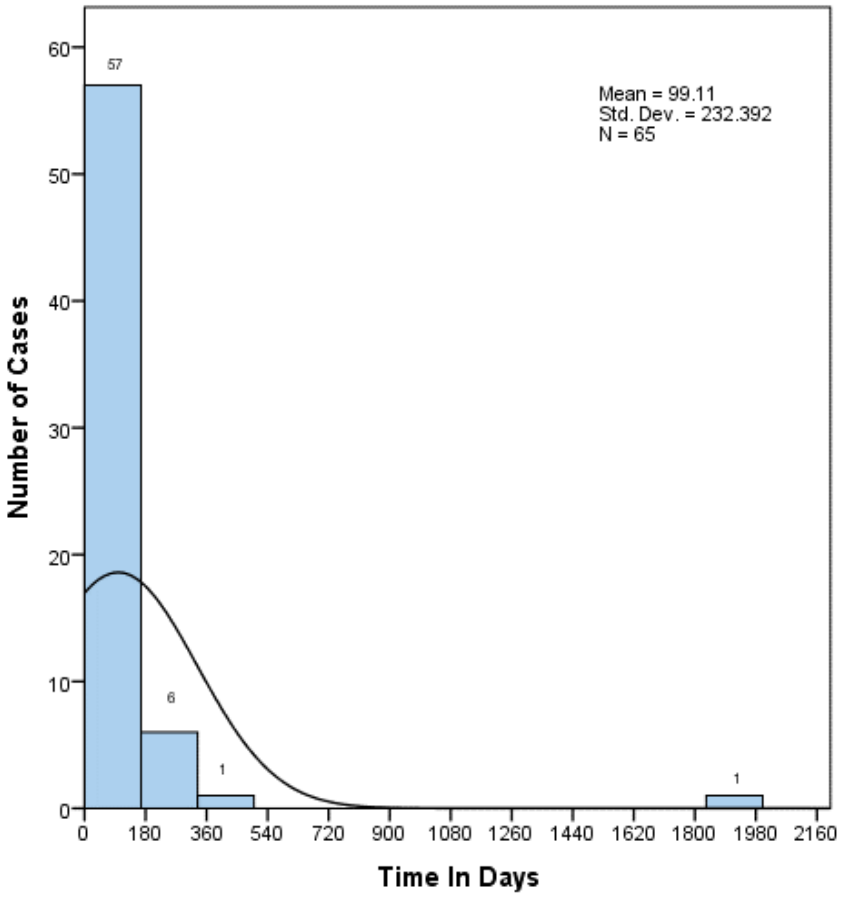
The Department has worked to provide lengths of stay and 30-day readmission rates for people that had a court-ordered involuntary medication filing at any time during their hospital stay and were discharged during the fiscal year. The number of people who have met these criteria have

been consistent each fiscal year. Of those, the number with multiple medication filings decreased from 11 (20% in 2015) to 4 (6.25% in 2019), only surpassed by FY 2017 (5.36%).

Multiple filings can occur in a variety of circumstances: the court order has expired but the patient was not willing to continue medications; the patient agrees to take medications between hospital filing and the court date but is not willing to continue once the court process has been discontinued; or the medication ordered by the court is not effective and a new order has to be pursued for different medication.

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. While all of the preceding five years of 30-day readmission rates has been low, in the two most recent fiscal years, the 30-day remain has been 1% compared with the prior three years of 5% - 11% for involuntary readmission rates. The Department will continue to monitor this information going forward to identify trends.

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



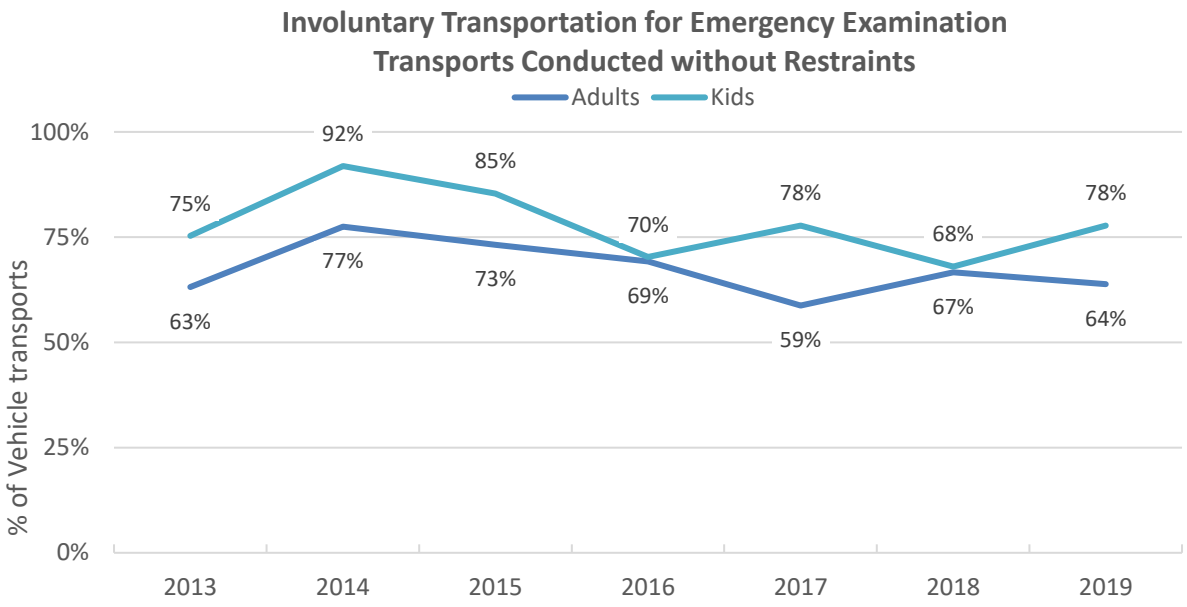
This graph illustrates all initial cases (65) filed for involuntary medication in FY 2019. The average (mean) length of time between an admission to the hospital and to the medication decision is approximately 99 days, with only a very small number of outliers on the longer end of the curve. The mean of 99 days in FY 19 represents 24 more days on average than FY 18 and 11 days fewer than FY 17. In FY 19, 66% of cases resolved in under 60 days and nearly 90% resolved in less than 200 days.

TRANSPORTATION

Since April 2012, the Department has developed a more intentional 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. For many years, secure transport was defined as a transport by sheriffs. Act 180, Title 18 §7511, recognized the need to take steps to reduce trauma for people who are found to need sheriff transport for involuntary psychiatric hospitalization. The current definition of secure transport is defined as the application of mechanical restraints, either soft or metal.

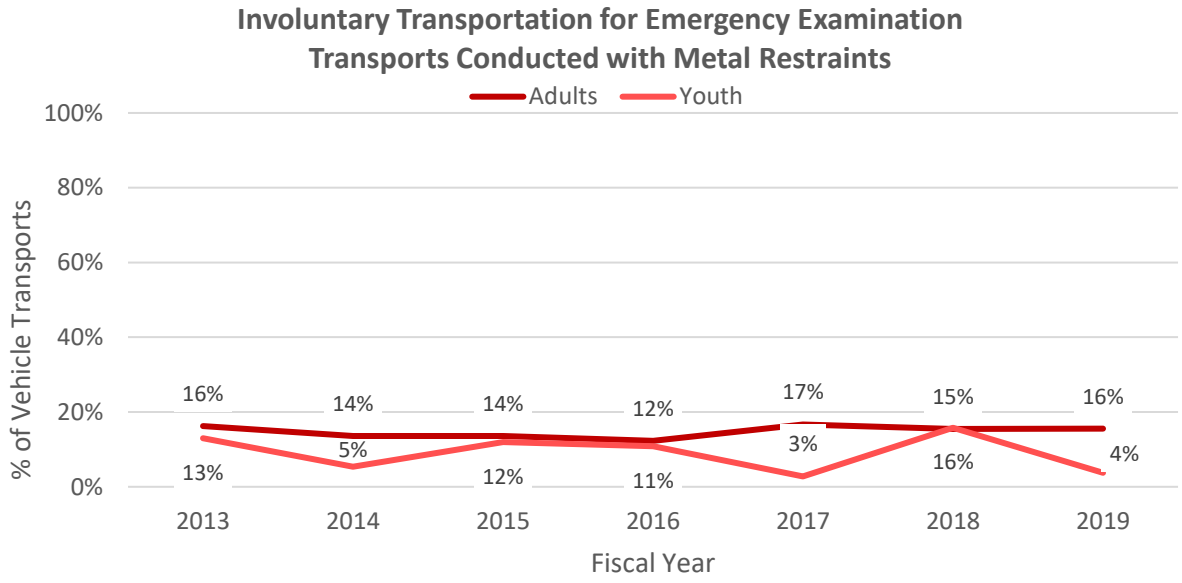
Grants to support pilot programs with sheriffs in Lamoille and Windham Counties using a least-restrictive approach by deputies in plain clothes with an unmarked van have continued throughout this period of time. Subsequently the passage of Act 85 (2017), Section E. 314 required that any new or renewed contracts entered into by AHS with designated professionals or law enforcement officers for transport of persons pursuant to 18 V.S.A. § 7511 would include the requirement to comply with the Agency's policies on the use of restraints. During FY 19, Act 200 (2018) Section 6 as passed by the legislature requires the AHS Secretary to submit a written report in January 2019 describing specifications that support the requirements of Act 85 and provide oversight through expectations in new AHS sheriff contracts for patient transports.

Chart 19: Involuntary Transports Conducted without Restraint



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

Chart 20: Involuntary Transports Conducted with Metal Restraint



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

A review of the data provided shows that the majority of transports are conducted without restraint for both adults and youth. When examining the use of metal restraints in FY 19 and prior years, levels for adult transport with metal restraints has remained relatively level over a seven-year period ranging between a low of 12% in FY 2016 and a high of 17% in FY 2017, averaging 14.86% overall. Metal restraint usage for youth took a sharper decrease between FY 2018 and FY 2019, declining from 16% in FY 2018 to a low of 4% in FY 2019. Historically, however, this has fluctuated for youth averaging 9.14% over the seven-year period.

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

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 2019

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	11	8	12	11	8	5	4	3	5	6	7	4	**84**
Non-Restrained	6	12	11	9	11	15	15	14	13	17	10	15	**148**
Missing													
Restraints Used in Transport													
None	6	12	11	9	11	15	15	14	13	17	10	15	**148**
Metal	4	3	7	4	1	3	2	2	3	3	1	3	**36**
Soft	7	5	5	7	7	2	2	1	2	3	6	1	**48**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	24%	15%	30%	20%	5%	15%	11%	12%	17%	13%	6%	16%	**16%**
Vehicle Used in Transport													
Ambulance	0	3	1	1	3	3	1	2	1	0	1	1	**17**
MH Van Alternative	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Private Transport													
Sheriff Alternative	6	11	16	19	15	7	11	8	15	21	16	10	**155**
Sheriff Cruiser	11	6	6	0	1	10	6	7	0	1	0	7	**55**
Other	0	0	0	0	0	0	1	0	2	0	0	1	**4**
Not Applicable ("Walk Up")													
No Data													
%Vehicle Transports that use Ambulance		15%	4%	5%	16%	15%	5%	12%	6%		6%	5%	**7%**
%Vehicle Transports that use MH Van Alternative										4%		0%	**0%**
%Vehicle Transports that use Sheriff's Alternative	35%	55%	70%	95%	79%	35%	58%	47%	83%	91%	94%	53%	**67%**
%Vehicle Transports that use Sheriff's Cruiser	65%	30%	26%		5%	50%	32%	41%		4%		37%	**24%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	17	17	22	19	16	17	17	15	15	22	16	17	**210**
TOTAL EE Transports	17	20	23	20	19	20	19	17	18	23	17	19	**232**

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: 11/04/2019

Chart 22: One-Year Overview of Youth Involuntary Transport

Vermont Department of Mental Health
Youth Involuntary Transportation for Emergency Examinations
Fiscal Year 2019

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	0	1	0	0	1	1	1	0	0	2	0	0	**6**
Non-Restrained	4	0	4	2	3	0	3	2	1	1	0	1	**21**
Missing													
Restraints Used in Transport													
None	4	0	4	2	3	0	3	2	1	1	0	1	**21**
Metal	0	1	0	0	0	0	0	0	0	0	0	0	**1**
Soft	0	0	0	0	1	1	1	0	0	2	0	0	**5**
Missing													
% All vehicle transports that use Metal	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	**4%**
Vehicle Used in Transport													
Ambulance	2	0	2	0	2	1	1	2	0	0	0	0	**10**
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	2	0	2	2	2	0	2	0	1	3	0	0	**14**
Sheriff Cruiser	0	1	0	0	0	0	1	0	0	0	0	1	**3**
Other													
Not Applicable ("Walk Up")													
No Data													
%Vehicle Transports that use Ambulance	50%		50%		50%		25%	100%				0%	**37%**
%Vehicle Transports that use MH Van Alternative												0%	**0%**
%Vehicle Transports that use Sheriff's Alternative	50%		50%	100%	50%		50%		100%	100%		0%	**52%**
%Vehicle Transports that use Sheriff's Cruiser		100%					25%					100%	**11%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	2	1	2	2	2	0	3	0	1	3	0	1	**17**
TOTAL EE Transports	4	1	4	2	4	1	4	2	1	3	0	1	**27**

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: 11/04/2019

ADULT OUTPATIENT CARE AND UTILIZATION

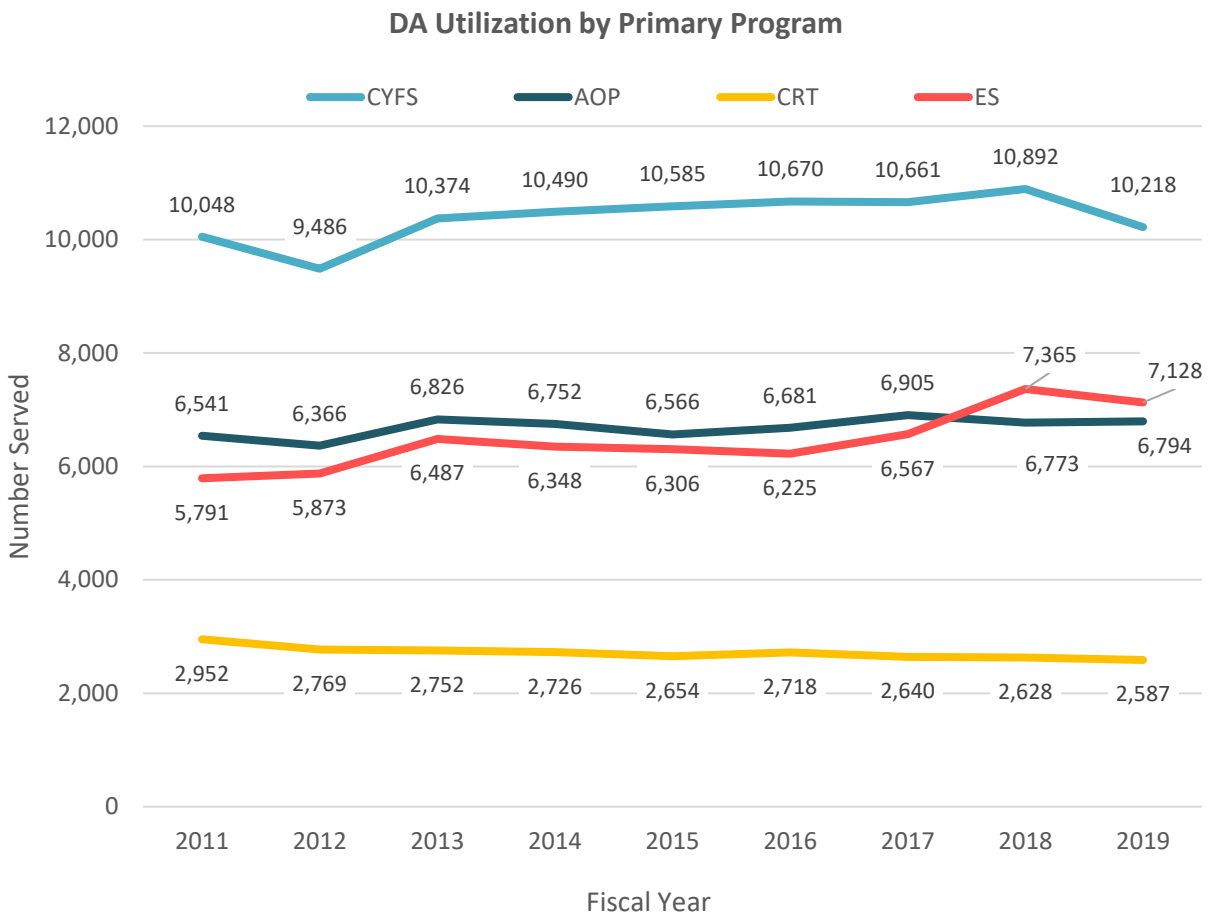
Outpatient services are provided through a system of care that includes the Designated Agencies, a Specialized Service Agency (Pathways Vermont), private practitioners, and other state and local social services agencies. The Designated Agencies provide comprehensive services to individuals through the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

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

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

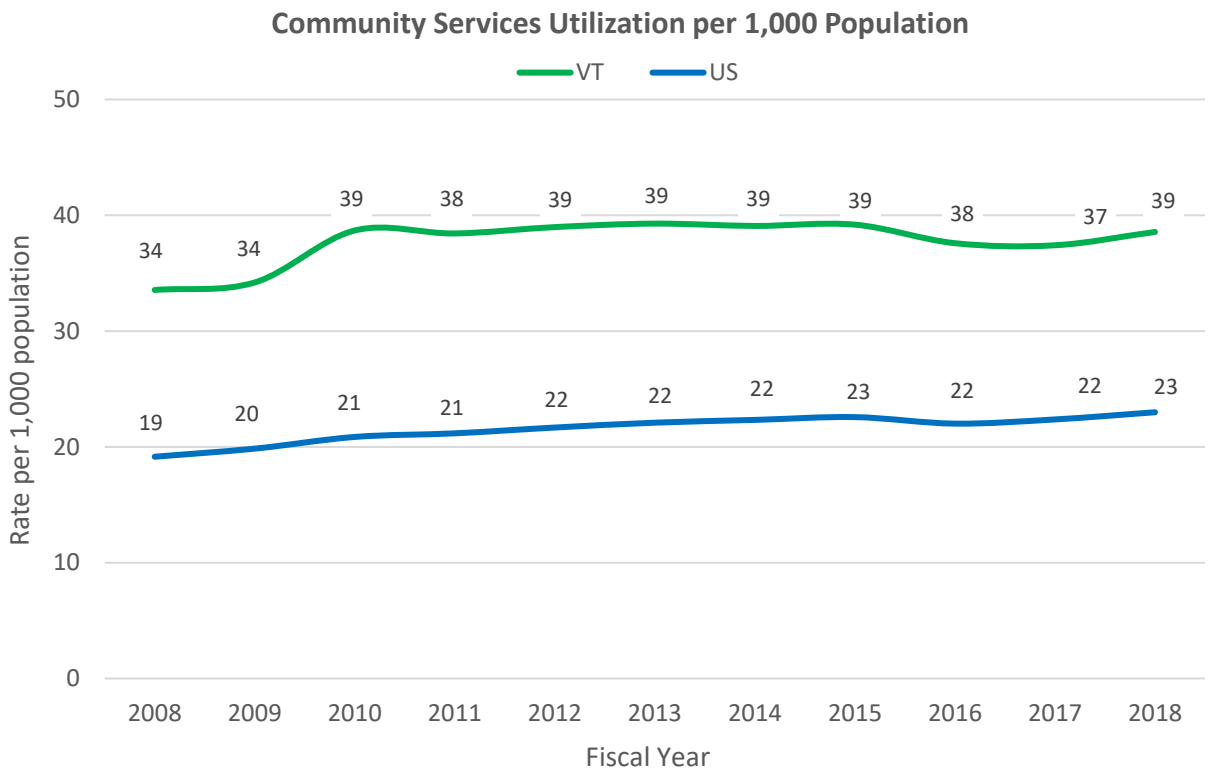
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle. The payment reform initiative beginning 1/1/2019 has also been an effort to reduce barriers to access and promote more “needs” driven service delivery that can be more responsive to individuals seeking mental health services. The new payment reform methodology, more flexible service delivery, and value-based incentive payment framework focused on quality and outcomes supports a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Chart 23: Designated Agency Volume by Program



The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. This program has until FY 2019 shown a slow upward trend for a seven-year period with FY 2019 showing a nearly 6% decrease in numbers serve. The Emergency services Programs also experienced a slow upward progression over a number of years and likewise demonstrated a slight decline in FY 2019 of just 3%. Adult Outpatient programs remain reasonably level in performance to resources available. Community Rehabilitation and Treatment (CRT) programs continue a slow overall declining trend in adults engaged in the services of this program.

Chart 24: Community Utilization per 1,000 Populations



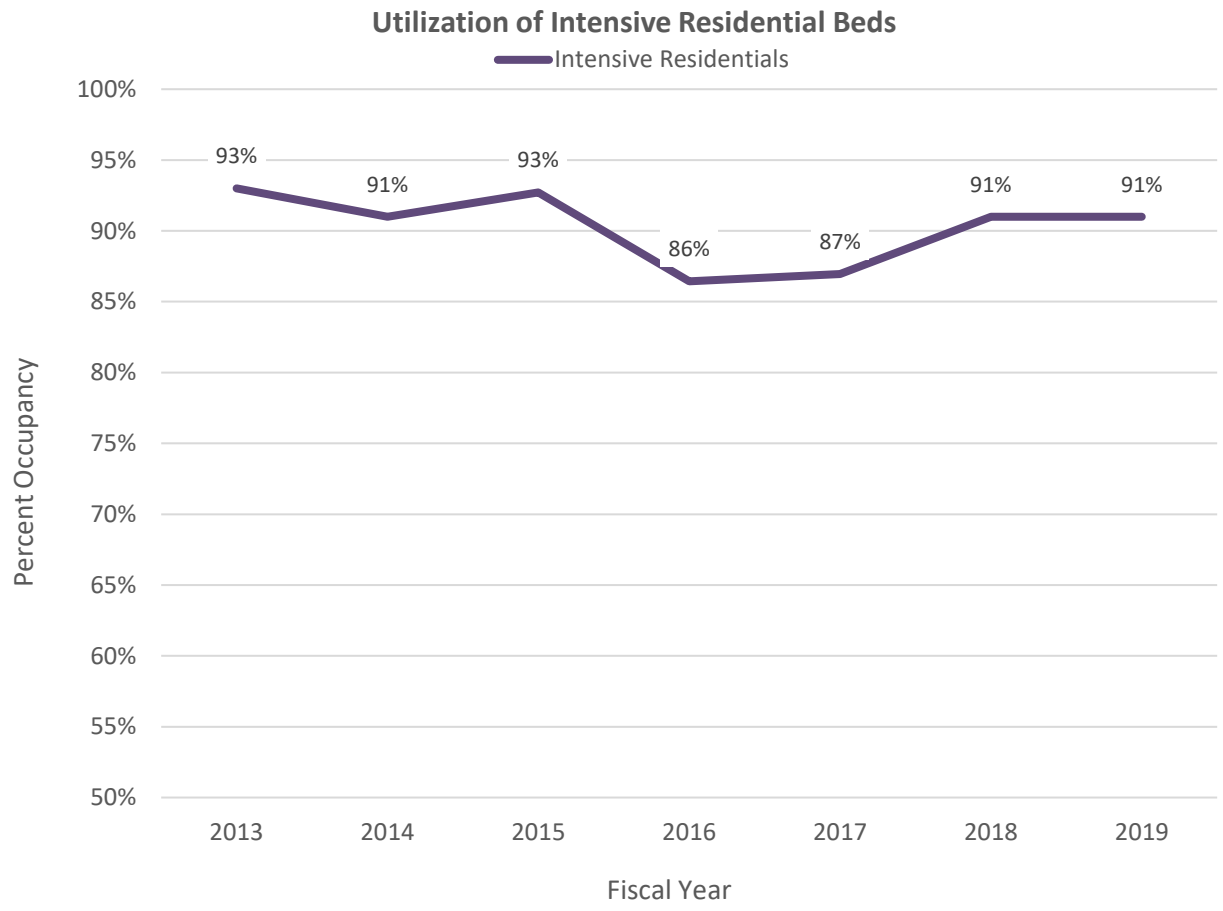
Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2018.

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national figure. The most recent national data available through 2018 shows that Vermont has a strong and fairly consistent record of service delivery in community-based programs. While the progress appears to be static, data shown in

Chart 26: Non-Categorical Case Management indicates that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care. This number however is also showing a downward trend since 2015.

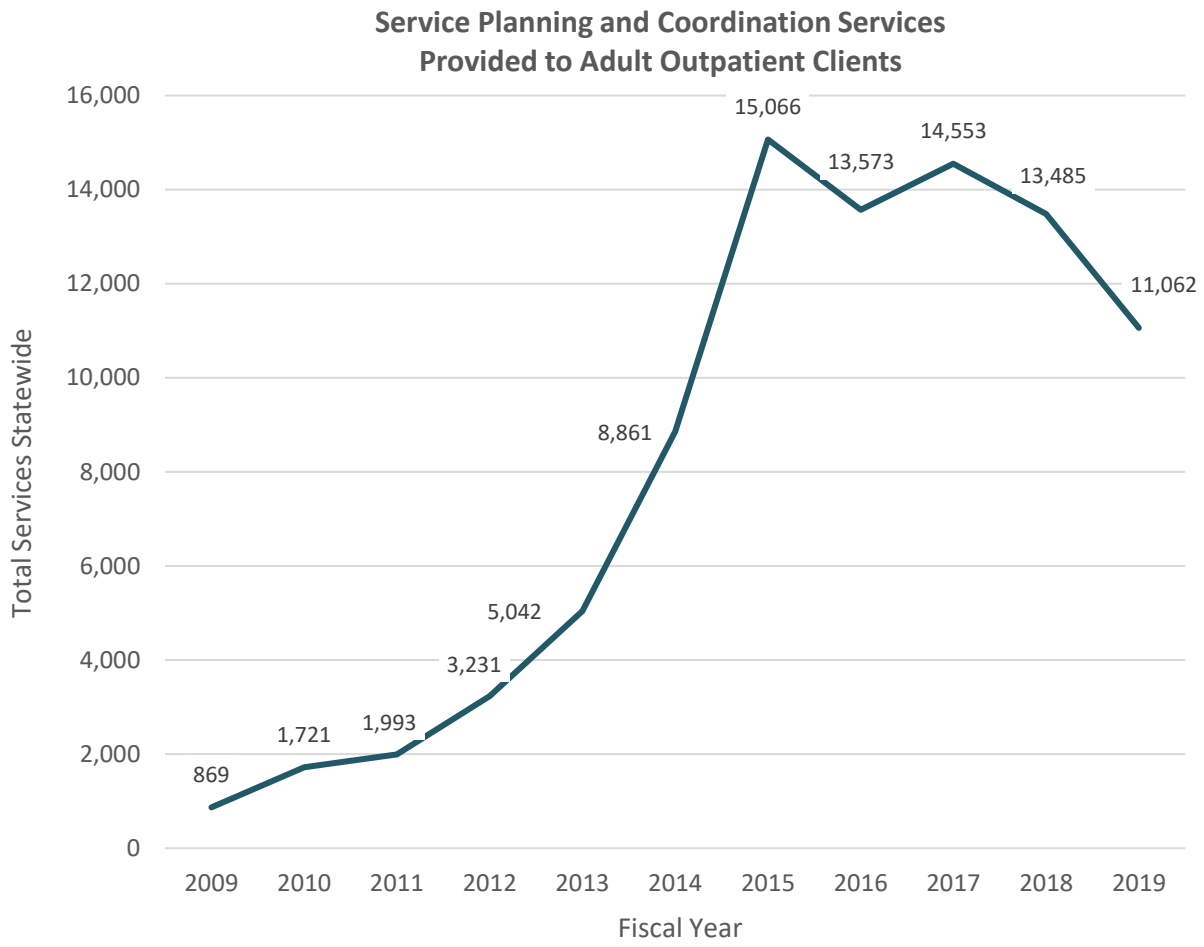
The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic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



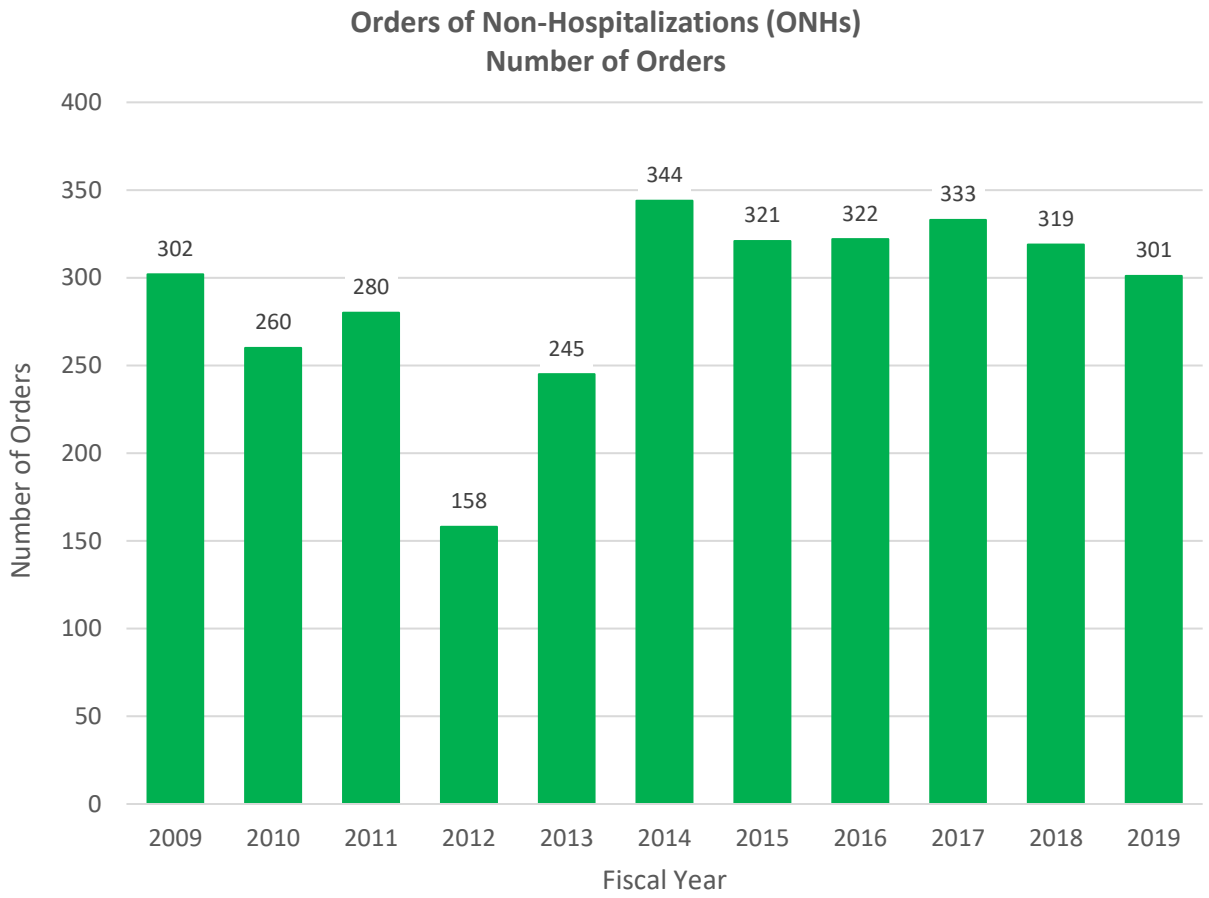
The Intensive Residential Recovery Programs (IRRs) continue to meet a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward independent living. The chart above illustrates the utilization of beds in these programs. FY 2018 and FY 2019 reflect a plateauing of utilization at 91% with a seven-year utilization history averaging between 86-93%. The IRR 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 led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services through FY 2015. Levels remain elevated for this population FY 2016 through FY 2018, but the data shows a decline in recent years. It is still worth noting that the expansion of services provided for service planning and coordination has met a population need for this level of case management services for adults. The Department's payment reform launched in January 2019 continues to support flexible service delivery including case management services.

Chart 27: Orders for Non-Hospitalizations



The number of Department of Mental Health Orders of Non-Hospitalization (ONHs) hovers around 277 in the six most recent fiscal years. FY 2019 also represents the lowest number of ONH's in the past six years, from a high of 344 in FY 2014 to 301 (12.5% decrease) in FY 2019.

Departmental legal staff members work closely with clinical staff and Designated Agency (DA) clinicians to monitor treatment participation and maintain communication with providers. The Care Management Team monitors community care through the DAs which provide direct services in the community. Through this process, community service providers are required to provide clinical justification of the ongoing need and their efforts to engage individuals in the treatment planning process and in understanding and following treatment conditions imposed by the Court. The Department provides oversight and case consultation regarding options or resources that may be needed for more effectively serving individuals who are on ONHs. DAs closely coordinate with the care management team regarding requests for continuation or discontinuation of ONHs as well.

ENHANCED OUTPATIENT AND EMERGENCY SERVICES

The impact of the enhancements allocated by the legislature in Act 79 has been significant in retooling some of the ways in which mental health services are delivered at the community level. All the Designated Agencies participated in developing additional services and enhancing those services that were already in place to provide more timely access to and response for those in crisis. The list of services covered by the changes was broad, with common themes and best practices identified and implemented across all the Designated Agencies. In total, over 50 unique initiatives at Designated Agencies have emerged since 2012.

Previously reported, enhanced funds were utilized at Designated Agencies in various ways and fell into several major categories:

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

As reported in the Act 79 2019 Report over 83% of initiatives were reporting that they were fully implemented and over 97% of initiatives were reporting that they had full coverage of the initiative across their geographical catchment area. Ongoing reporting of initiatives and progress will be reported annually to DMH under its 2019 master grant agreement with Designated Agencies, by Vermont Care Partners on behalf of the Designated Agencies. A final, ongoing reporting format for comprehensive annual update submission is still in development. For the Act 79 2020 Report, Vermont Care Partners has provided FY 2018 outcomes data for any new initiatives and other noteworthy outcome updates:

ACT 79 ENHANCED FUNDING:

- Close coordination between agency mobile crisis response and local law enforcement teams
- Embedded social workers in police departments and street outreach services working closely with law enforcement to support at-risk individuals
- Opiate Alliance meetings between community providers and law enforcement to develop a coordinated community response to the opiate crisis

- Support for Mental Health and Substance Use Courts and related programs using evidenced-based approaches with nonviolent offenders to achieve recovery
- Peer programs supporting people who are experiencing mental health crises
- The Northeast Kingdom Human Services, Inc. (NKHS) Emergency Services Program served over 800 individuals in FY 2018 with almost 600 of those individuals served in settings other than the hospital. This team provides mobile outreach and is embedded with local police for a team approach to a community crisis.

CRISIS BEDS – COST EFFECTIVE ALTERNATIVES TO HOSPITALIZATION:

- The number of crisis beds have increased from 49 pre-Irene to 87, contributing to a drop in psychiatric admissions for CRT clients from 375 in FY 2011 to 245 in FY 2017.
- Maple House is a peer run crisis program operated by Washington County Mental Health Services. This past year fiscal year had 49 admissions, 18 of which diverted the individual from a higher level of care either at a psychiatric hospital unit or home intervention. All staff are trained in the provision of peer support, with an expectation that they will be trained in the internationally recognized Intensive Peer Support model within their first two years of hire.
- In FY 2018, 14,439 crisis bed days were used by people served by the Designated Agency network.

TRANSITION FROM HOSPITAL:

- 46% of CRT clients were seen the same day as they were discharged from a psychiatric hospitalization.
- 81% were seen within one week of discharge.

HOUSING SUPPORT

- 3.6% of people served by Designated Agencies were homeless or in a shelter.
- 85.4% of clients with serious mental Illness, adults with mental illness, and children with serious emotional disturbance live in a private residence.
- 30% of people with intellectual and developmental disabilities report that they own their residence.
- 92% report they like where they live.

EVIDENCE BASED PRACTICES:

Over 40 different evidenced-based practices are provided, including:

- Child and Family Traumatic Stress Intervention
- Trauma Focused Cognitive Behavioral Therapy
- Trauma Focused Integrated Play Therapy
- Attachment, Regulation, and Competency Model
- Motivational Interviewing
- Acceptance Based Therapy
- Cognitive Behavioral Therapy
- Person-centered Planning
- Recovery-Oriented Cognitive Therapy
- Evidence-Based Supported Employment
- Dialectical Behavior Therapy
- Applied Behavioral Analysis
- Open Dialogue
- Parent Child Interaction Therapy (PCIT).

PEER INVOLVEMENT

People with lived experiences (peers) provide critical services and supports across agencies, increasing access to services and decreasing stigma by:

- Participating in 24/7 crisis response teams around the state
- Providing warm line telephone support to people experiencing mental health crises or who need support
- Staffing residential programs including crisis programs and transitional living shelters
- Managing and staffing wellness centers and programs
- Supporting individuals with employment/educational goals
- Advocating and educating communities and individuals
- Providing Family Consult Teams who support other families who have a loved one experiencing a crisis.
- START (Stabilization, Treatment, And Recovery Team) is a community program within Howard Center's crisis services that provides support to individuals ages 18 and older who are experiencing emotional distress and/or an increase in mental health symptoms. The goal of the program is to help prevent the need for higher levels of care, such as the hospital or police, through short term supports. The program relies on peers to provide face-to face contact and draws on the personal experiences of staff to connect with clients and work with them in their homes or in the community to develop the skills and receive the support necessary to maintain stability.

POLICE

Promoting knowledge of mental health conditions with First Responders Team Two is a statewide training curriculum where law enforcement and mental health crisis workers train together to strengthen collaboration when responding to a mental health crisis.

In FY 2018 140 people were trained by 37 instructors:

- 61 were law enforcement officers
- 38 were crisis workers
- 35 were dispatchers, legislators, recovery center staff, judiciary members, peers, school staff, and an advocate.
- Act 80 trainings were provided to police academy students to increase awareness and understanding of mental health conditions.
- Entities trained include Vermont State Police, 5 new police departments, the Medical Reserve corps.

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 something that has a long standing presence with individuals with mental health and other co-occurring issues. In their 2004 article *Peer Support: What Makes It Unique?* Shery Mead and Cheryl MacNeil write:

"Peer support for people with similar life experiences (e.g., people who've lost children, people with alcohol and substance abuse problems, etc.) has proven to be tremendously important towards helping many move through difficult situations (Reissman, 1989; Roberts & Rappaport, 1989). In general, peer support has been defined by the fact that people who have like experiences can better relate and can consequently offer more authentic empathy and validation. It is also not uncommon for people with similar lived experiences to offer each other practical advice and suggestions for strategies that professionals may not offer or even know about. Maintaining its non-professional vantage point is crucial in helping people rebuild their sense of community when they've had a disconnecting kind of experience."[2]

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

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

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

- positive risk taking,
- reciprocity,
- support,
- sense of community,
- self-help,
- developing awareness.[3]

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

IMPLEMENTATION OF PEER SERVICES

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

Chart 28: Vermont Peer Services Organizations

Organization	Services Provided
Alyssum	Operates two-bed program providing crisis respite and hospital diversion and

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

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

	step-down.
Another Way	Provides community center offers peer support services including outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, employment and housing supports, and community meals. Specializes in serving individuals who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services. Another Way also partners with the Good Samaritan Haven as a center of support for people staying in Montpelier's emergency shelter.
Copeland Center	Supports training, mentoring and groups focused on the use of the Wellness Recovery Action Plan (WRAP) self-management and recovery tool among peer and professional service providers. Also offers training in Wellness Engagement.
NAMI-VT	Statewide family and peer organization providing support groups, educational and advocacy groups for individuals with mental health conditions and their families.
Pathways Vermont Support Line	Statewide telephone peer support to prevent crisis and provide wellness coaching.
Vermont Psychiatric Survivors	Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings (patient representatives).
Pathways Vermont Community Center	Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, employment and housing supports, exercise classes, and community meals. Specializes in serving young adults who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services.
Wellness Workforce Coalition including Peer	Provides infrastructure and workforce development for organizations that provide peer supports. Activities include:

Core Competency curriculum development	o Coordinating peer support trainings (e.g. Intentional Peer Support, WRAP, Peer Core Competency trainings) o Support for workforce development (e.g. recruitment, retention, career development) o Mentoring and co-supervision/reflection for peer support workers o Tracking of peer services and peer workers in Vermont o Communication and networking among peer organizations o Systems advocacy

SPOTLIGHT: PATHWAYS VERMONT COMMUNITY CENTER

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

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

In Fiscal Year 2019, the Community Center staff offered a total of 1,902 individual and group peer supports. The peer support groups included a Writing Circle, a Hearing Voices group, Alternatives to Suicide group, an Employment Seekers support group, and a group for Conversations about Coming Off Psychiatric Medication. The Supported Employment team worked with an average of 50 unique individuals each quarter, providing assistance with

resume and cover letter writing, mock interviews, job development (outreach to potential employers), job matching services, and peer employment supports. Overall for fiscal year 2019, 42% of individuals had a job start within the first 60 days of enrollment in employment services. An average of 43% of individuals receiving peer employment supports maintained stable employment for at least 6 months.

The Community Center staff provide two nutritious meals a week: Wednesday dinner and a Thursday lunch. Thursday leftovers are available for lunch on Friday. The total number of meals served over fiscal year 2019 was 1,567.

SPOTLIGHT: ANOTHER WAY

Another Way is a community drop-in center in Montpelier operated for and by individuals with the lived experience of mental health challenges, mental illness, or psychiatric disability. It provides a safe and friendly place for individuals struggling with mental health challenges to share community, to network, and to learn from each other. The culture of Another Way is based on the principles of Intentional Peer Support, which promotes mutually accountable relationships. Staff include a peer support specialist, an peer employment specialist, a house manager, and a workshop/maintenance manager.

The services provided by Another Way include peer support services and outreach, peer crisis interventions, wellness promotion and self-management of health issues, employment supports, education based on Wellness Recovery Action Plan (WRAP) to help create natural supports, and collaboration with other local service providers.

In fiscal year 2019, Another Way served 566 unique individuals, with a total of 10,241 visits at the center. 301 (56%) individuals participated in groups at the Another Way, with 4,289 visits for group activities. Group activities included Accu-Wellness, art, community meetings, fitness room, Friday night dinners, gardening, karaoke, music, outings, Wednesday breakfast, WRAP and Share (psychiatric survivors' support), woodshop, and yoga. 98% of individuals reported that they "are better off due to participation" and 98% of individual reported "positive connections made". 93% of individuals reported positive staff interactions. 81 employment seekers were supported during fiscal year 2019, with a total of 30 job starts.

Another Way collaborates with the Good Samaritan Haven Overflow Shelter at the Bethany Church in Montpelier during the cold winter season. The partnership includes Another Way remaining open 9am – 8pm every day from November 10 – April 15.

EMPLOYMENT

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

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[5] IPS Employment Center: Evidence for IPS (2018). Retrieved on 5/30/18 from https://ipsworks.org/index.php/evidence-for-ips/

[6] Mathers, C. and Schofield, D. (1998). The health consequences of unemployment: The evidence. *Medical Journal of Australia*, 168 (4) 178–82.

Libby, A. M., V. Ghushchyan, et al. (2010). Economic Grand Rounds: Psychological Distress and Depression Associated with Job Loss and Gain; the Social Costs of Job Instability. *Psychiatric Services* 61(12): 1178-1180.

Dance, A. (2011). The unemployment crisis. *American Psychological Association Monitor*, 42(3).

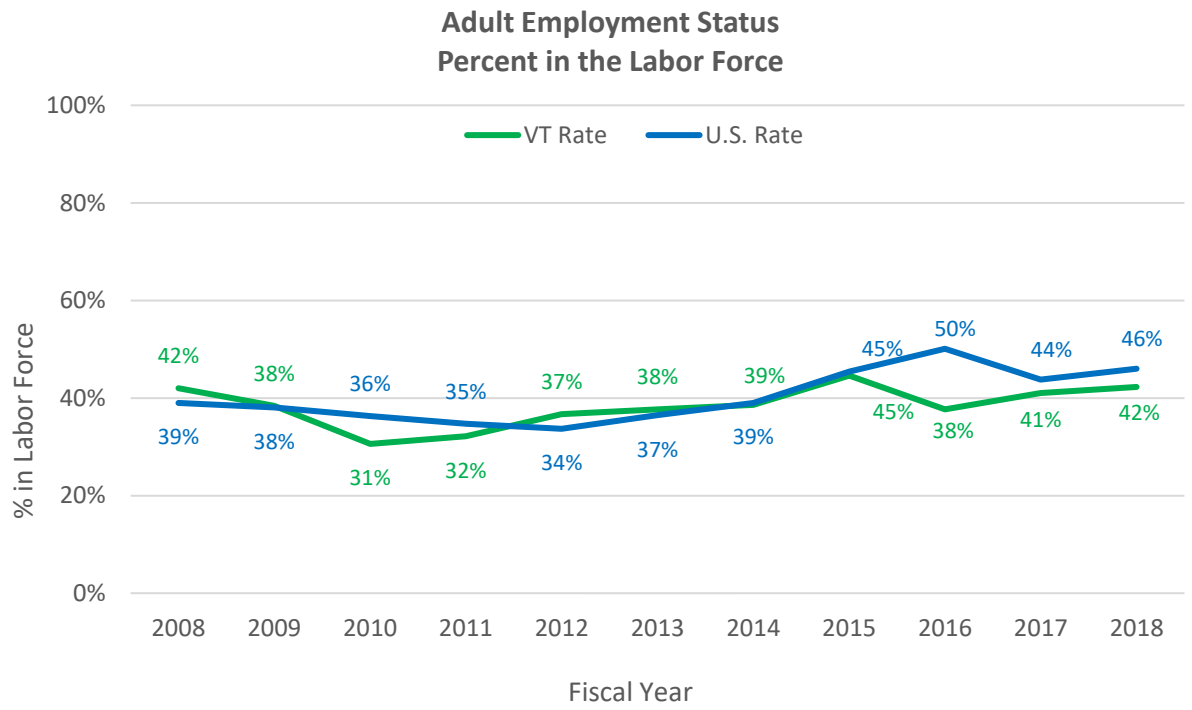
Warr, P. (1987). *Work, unemployment, and mental health*. Oxford: Oxford University Press.

[7] Schuring, M., Mackenback, J., Voorham, T., Burdorf, A. (2011). The effect of re-employment on perceived health. *Journal of Epidemiology and Community Health*, 65(7), 639-644.

Waddell, G. & Burton, K. (2006). Is work good for your health and wellbeing? *The Stationary Office*, Norwich, England.

[8] Marshall, T., Goldberg, R.W., Braude, L., Dougherty, R.H., Daniels, A.S., Ghose, S.S., et al. (2014). Supported employment: Assessing the evidence. *Psychiatric Services*, 65, 16-23.

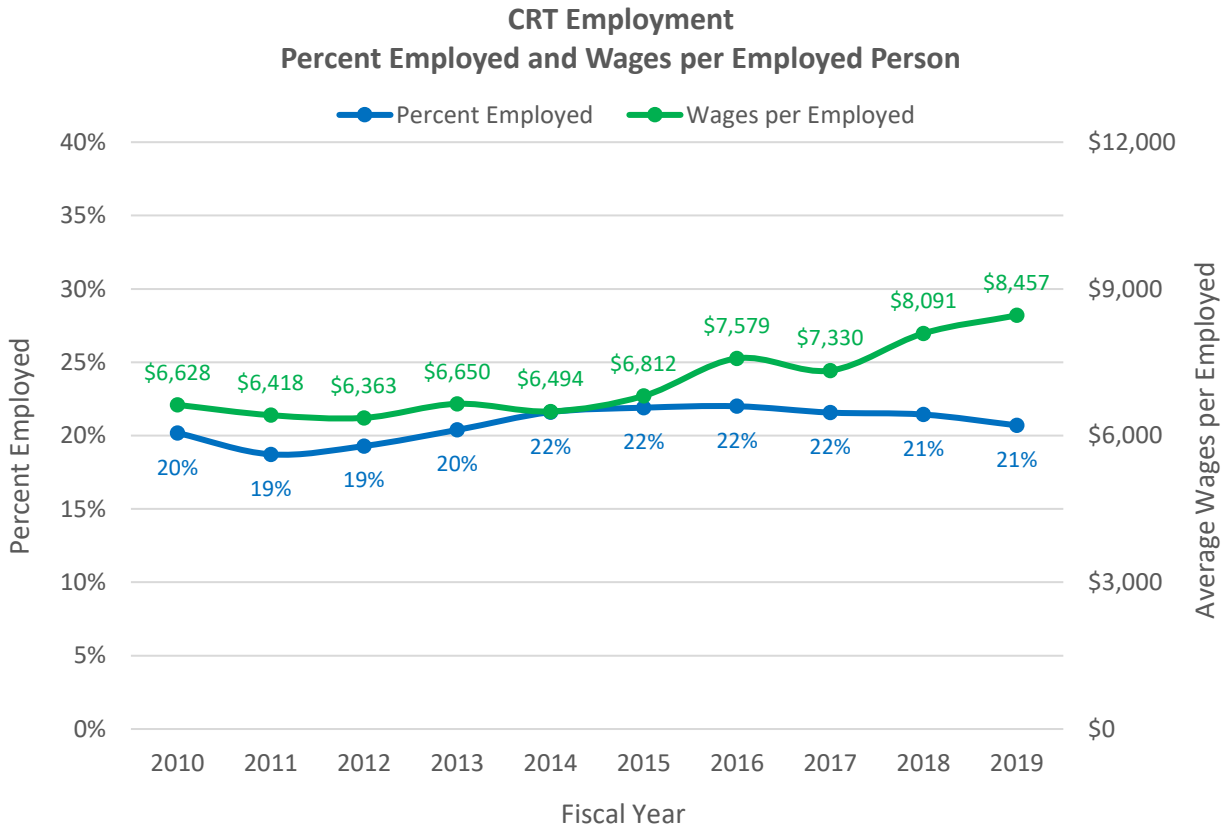
Chart 29: Percentage of All Adults with Mental Illness Employed in U.S. and VT



Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2018. 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 - 2018. US totals are calculated uniquely based on those states who reported. Percentage in Labor Force includes all eligible adult mental health clients with SMI and is calculated as the percentage of those employed divided by the total number of adult clients (unemployed plus competively employeed). Workers who are excluded from DOL reporting are the self-employed,firm owners not incorporated and the following employee groups: elected officials, employees of nonprofit religious, charitable and educational organizations, unpaid family members, farm workers (with some exceptions), railroad employees, and individuals who work out of state.

The employment rate for all adults with mental illness in Designated Agencies—Adult Outpatient and Community Rehabilitation and Treatment combined—reflects a slow upward trend from 38% to 42% from 2016. This number has been ticking back up from a previous high of 45% in 2015 and dip to 38% in 2016. Nationally, data on the rate of employment for adults with mental illness declined through 2018, but is on a slow parallel track with Vermont, moving from a high of 50% in 2016 with subsequent drop to 44% in 2017 and a 2% gain to 46% in 2018. U.S. and Vermont data are more alike with U.S. rate slightly ahead.

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 fairly level trend of employment of between 21-22% rate of employment in Community Rehabilitation and Treatment employment outcomes between FY 2014 and FY 2019. Wages that slowly grew between FY 2011 – FY 2016 dipped slightly in FY 17 but have continued to rebound upward in FY 2018 and F 2019 despite the slightly lower employment percentages. Community Rehabilitation and Treatment programs continue to support individuals with employment goals despite continued challenges within the system of care. Individuals, on average, earned $8,457 per year in FY 19 up from $8091 per year in 2018.

INDIVIDUAL EXPERIENCE AND RECOVERY

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

Person centered care is focused upon the individual needs and movement towards stabilization and recovery. The individual needs of clients are the focal point at all the levels of care in the system. The Department of Mental Health tracks clinical, social and legal measures to assess experience and recovery. There are many measures used to quantify individual experience and recovery including employment information, consumer surveys, housing, and other metrics.

In addition to supporting people to obtain employment, which is one of the most effective interventions for improving recovery and reducing stigma, the Department currently supports and continues to expand several other non-medical interventions for the management of and recovery from distressing symptoms associated with mental illness. Interventions such as *Wellness Recovery Action Planning, Wellness Engagement*, *Open Dialogue,* and the *Hearing Voices* curriculum support individuals in reducing or eliminating the negative effects of their psychiatric symptoms. These approaches may, in some cases, give the individual an opportunity to work with their physician to reduce the medications that are being taken to manage those same symptoms. These types of interventions are available to a varying degree at the Designated Agencies and are an essential component of the peer service program described above. Currently, across the state, there are many initiatives underway to expand the availability of several of these interventions.

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

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

first experiencing psychosis could prevent or reduce long-term disability, and, in some cases, reduce long-term reliance on psychotropic medication. In 2015, the DMH began working with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) to identify and promote evidence-based practices for this population. A multi-stakeholder Advisory Committee reviews practice recommendations and funding allocations.

Vermont is using these MHBG funds to support implementation of Open Dialogue (Collaborative Network Approach in Vermont), which is a promising evidence-based practice supported by SAMHSA. VCPI has collaborated with Howard Center and the Counseling Center of Addison County to provide training and consultation to staff from several DA's including residential programs, Pathways Vermont, Vermont's Psychiatric Care Hospital, and Middlesex Secure Residential Program.

PERCEPTION OF CARE SURVEYS

Starting in January 2019, a component of the Department's Mental Health Payment Reform initiative includes a value-based payment measure reviewing consumer satisfaction surveys submitted by Vermont Care Partners on behalf of all of the Designated Agencies. These surveys have a significantly higher response rate than that garnered historically through the DMH effort (587 total surveys for both children and adult returned to DMH annually in the previous surveys, compared to 6,142 collected annually by the VCP network). Given the increased representation of the surveys utilized through payment reform, DMH is submitting the latest survey data from that method. This data is not broken out by children and adults currently, but there is a proposal to make that change in the coming 1-2 years.

Survey Question: "% of clients indicating they received the help they needed"

DA	% Disagree	% Neutral	% Agree
1	2%	7%	93%
2	3%	2%	98%
3	3%	7%	93%
4	5%	6%	94%
5	2%	6%	94%
6	2%	9%	91%
7	3%	8%	92%

8	3%	9%	91%
9	8%	13%	87%
10	3%	5%	95%
Overall	3%	7%	93%

A total of 5,896 responses to this survey question were received from adults and child and youth program participants served in 2018. The percent who agreed they received the help they needed ranged from a low of 91% to a high of 98% across the designated agency system. The percent who disagreed ranged from 2% to 8% during this same time period.

Survey Question: "% of clients indicating services made a difference"

DA	% Disagree	% Neutral	% Agree
1	5%	15%	80%
2	1%	5%	94%
3	3%	7%	90%
4	4%	7%	89%
5	2%	8%	90%
6	3%	12%	85%
7	3%	7%	90%
8	3%	11%	86%
9	6%	9%	85%
10	4%	6%	90%
Overall	3%	9%	88%

A total of 6,142 responses to this survey question were received from adults and child and youth program participants served in 2018. The percent who agreed their services made a difference ranged from a low of 80% to a high of 94% across the designated agency system. The percent of disagreed ranged from 1% to 6% during this same time period.

Survey Question: "% of clients indicating they were treated with respect"

DA	% Disagree	% Neutral	% Agree
1	3%	4%	94%
2	2%	1%	97%
3	3%	5%	92%
4	2%	3%	95%
5	1%	2%	98%
6	1%	3%	96%
7	1%	3%	96%
8	1%	2%	97%
9	3%	3%	93%
10	2%	3%	95%
Overall	2%	3%	95%

A total of 6,026 responses to this survey question were received from adults and child and youth program participants served in 2018. The percent who agreed they were treated with respect ranged from a low of 92% to a high of 98% across the designated agency system. The percent of disagreed ranged from 1% to 3% during this same time period.

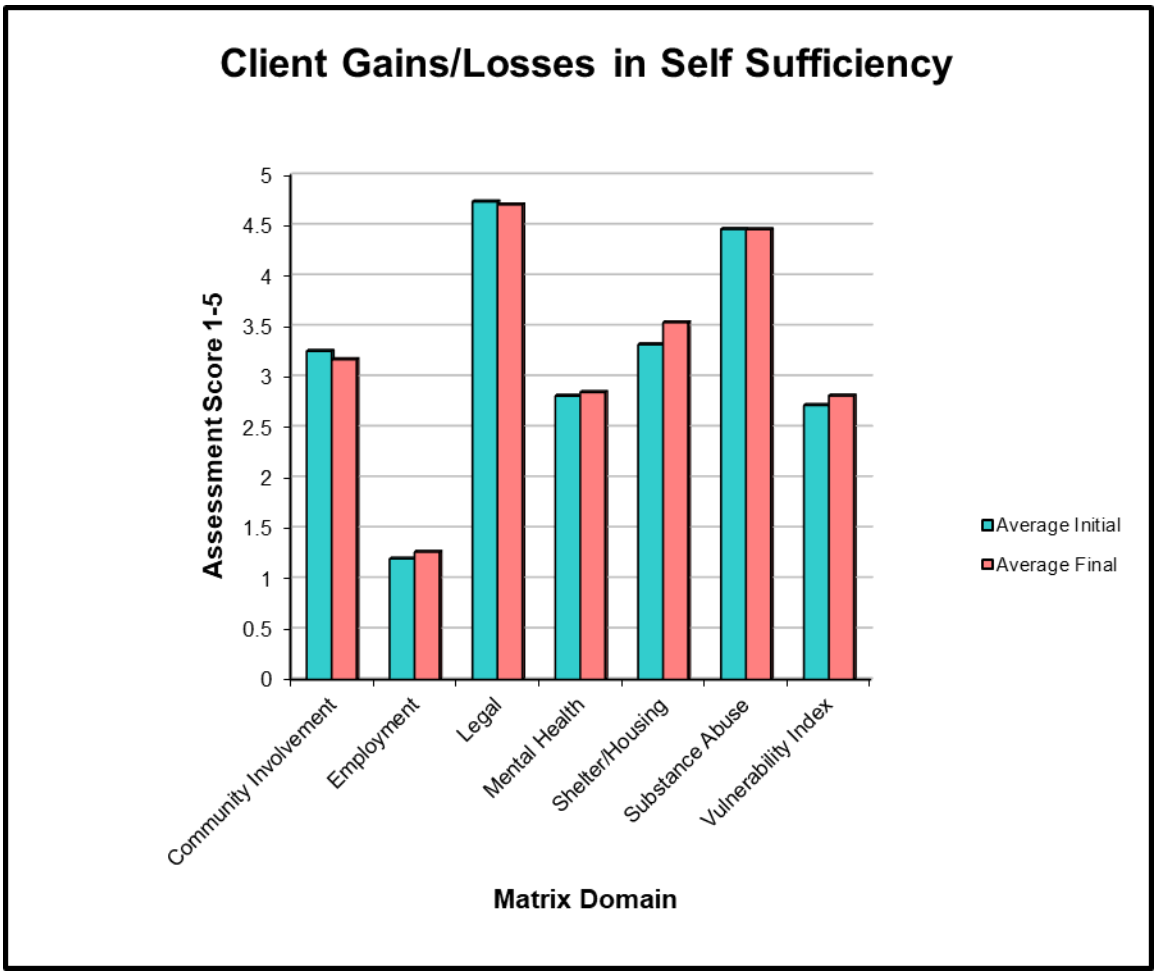
Survey Question: "% of clients indicating services were right for them"

DA	% Disagree	% Neutral	% Agree
1	2%	10%	90%
2	2%	6%	94%
3	4%	9%	91%
4	4%	7%	93%

5	2%	8%	92%
6	2%	9%	91%
7	4%	7%	93%
8	3%	9%	91%
9	7%	14%	86%
10	4%	6%	94%
Overall	3%	8%	92%

A total of 5,906 responses to this survey question were received from adults and child and youth program participants served in 2018. The percent who agreed the services were right for them ranged from a low of 86% to a high of 94% across the designated agency system. The percent of disagreed ranged from 2% to 7% during this same time period.

Chart 33: Housing



Since its creation in December 2011, a total of 250 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 performance indicator the department seeks to achieve is one-year housing retention. The lengths of stay in housing since the program began range from 6 days for those more recently enrolled to 2,905 days for long term tenants, greater than 88% have lengths of stay for more than one year. Just over 55% of those served are men versus woman (45%) served by the program. Of the 250 served, more than 75% were literally homeless, meaning on the streets, in a shelter, or in a hospital. Roughly, 72% of individuals were chronically homeless. Less than 22% of those assisted came from psychiatric hospitalization. Of the 250 housed since December 2011, 115 persons have exited. 28% of those exiting had positive outcomes and 13% exiting died during tenancy.

In 2019, 147 clients in total were served. Of those 147 served throughout 2019, 80% have been in the program over one year. The average length of stay was 1,589 days and median length of stay was 1,912 days. Nearly, 70% were chronically homeless. There were only 10 exists in 2019 with only two exits without interviews by tenants. Four individuals left for other suitable housing and 4 deaths occurred during tenancy.

The Vermont State Housing Authority continues in its role as the Department's collaborating partner verifying client income, setting rent payments, and working with participating landlords. The effort continues to ensure ongoing availability of housing to individuals who are homeless, severely and persistently mentally ill, and in acute care settings.

DMH continues the focus of efforts with Community Mental Health Centers and Pathways Vermont collaborations with local not-for-profit housing developers.

The Self Sufficiency Outcome Matrix is required as part of a subsidy allocation. All self-sufficiency outcome measures recorded demonstrate improvement for the individuals participating in the Housing Subsidy & Care program (Chart 33 above). SSOM measures for individuals housed reflected gains in employment, mental health, housing stability, and vulnerability index domains. Measures of community involvement, legal, and substance abuse domains were relatively unchanged between initial and final measure.

All ten Designated Agencies and the Department's adult Specialized Service Agency (Pathways Vermont) are service providers for Housing Subsidy and Care, as well as the participating providers listed below:

- Another Way

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

PLANNING FOR THE FUTURE

VISION 2030: 10-YEAR PLAN

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

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

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

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

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

SECURE RESIDENTIAL CAPACITY:

In the first quarter of the calendar year the Department worked with the Vermont State Legislature on a bill that formalized plans for replacement of the temporary, secure residential treatment facility in Middlesex, Vermont. The Department proposed as a replacement a permanent, 16-bed, state-run, physically secure, residential facility with increased clinical capacity. The intended outcome is to improve flow and inpatient bed availability in the system of care.

Funds to support the planning and development of a larger, permanent facility are included in the proposed Fiscal Year 2020 Capital Bill to the Vermont Legislature. Specifications include a better permanent facility design and footprint for a next generation, physically secure residential facility, ideally located somewhere in Central Vermont.

INPATIENT CAPACITY

The University of Vermont Health Network has undertaken parallel planning activities through 2019 for meeting the unmet needs of individuals requiring mental health treatment services. Their work below represents steps taken and work that will continue through the upcoming year and beyond.

UVM HEALTH NETWORK STRATEGIC PLAN

Early in 2019 The University of Vermont Health Network presented a Mental Health Strategic Plan (2018 – 2022) as a springboard for a broad and comprehensive response to unmet mental health needs that included inpatient, outpatient and community-based solutions needed to address these challenges. The plan was generated to identify, prioritize, and carry out steps necessary for the creation of a sustainable network-wide care delivery system. Initial planning

was launched with proposed development of new inpatient psychiatric capacity on the Central Vermont Medical Center campus which is part of the UVM Health Network.

This strategic plan also intended to align the All Payer Model and accountable care organization structures – promoting investments in primary care and population health management. Specifically, the move away from fee-for-service payments to a per-member, per-month payment system under the All Payer Model (APM) aligns financial investments with doing what's best to keep patients healthy. The APM includes three priorities: 1. improve access to primary care, 2. reduce chronic disease, and 3. reduce suicide and drug overdoses. Several key areas of focus and key strategies were outlined:

INTEGRATION OF MENTAL HEALTH INTO PRIMARY CARE

Adopt and build out a Collaborative Care Model of Mental Health Care in Primary Care settings across the Network. Add additional team members to provide comprehensive management of each patient with mental health and substance use disorders: Care Managers, Mental Health Specialists – a mix of psychiatrists, psychiatry trained advance practice practitioners, and psychologists. Expand the medical home team to include these new providers.

INPATIENT MENTAL HEALTH

Invest $21 million to "measurably increase inpatient mental health in Vermont" per a directive from the Green Mountain Care Board. Use a data-driven, evidence-based planning process to develop a plan to design and build an appropriately sized inpatient facility on the Central Vermont Medical Center Campus. Engage a broad and inclusive group of stakeholders to inform the planning and design process. Seek state approval for the facility in 2019 with the goal of completing the project in three to four years.

PEDIATRIC/ADOLESCENT CARE

Optimize use of existing pediatric inpatient capacity at CVPH to improve access across Network. Work with public and private partners in VT (Brattleboro Retreat and others) and NY to develop strategies to improve access. Increase the size of Child/adolescent Psychiatry Fellowship Program. Improve Inpatient Pediatric Consult and Pediatric Emergency Department Psychiatry Coverage at UVMMC.

GERIATRIC CARE

Develop Network plan to address growing population of geriatric psychiatry patients (our inpatient length of stay for these patients is among longest in nation). Include strategies for expanding post-acute resource in caring for this population.

WORKFORCE DEVELOPMENT

Integrate mental health training for all Network caregivers. Partner with institutions of higher education such as UVM, Vermont State Colleges, Community Colleges of Vermont, SUNY and Clinton County Community College to create educational/training opportunities. Focus on VT-NY reciprocity.

COMMUNITY COLLABORATIONS & INVESTMENTS

Continue to collaborate with community partners on projects related to mental health and the social determinants that go hand in hand with mental health, including Substance Use Disorder and Supportive Housing. Align investments in community mental health with strategic plans to maximize impact.

ALL PAYER MODEL AND MENTAL HEALTH: Vermont's health care reform efforts -- specifically the All Payer Model and accountable care organization structures – promote investments in primary care and population health management. Specifically, the move away from fee-for-service payments to a per-member, per-month payment system under the All Payer Model (APM) aligns financial investments with doing what's best to keep patients healthy.

The UVM Health Network Mental Health Strategic Plan aligns with these priorities and takes advantage of the APM's payment model to improve outcomes and control costs while providing our mental health patients with the right care, at the right time, at the right place.

As of the November 2019 quarterly report, the UVM Health Network planning continues. The site initially selected for the inpatient psychiatric project on the Central Vermont Medical Center Campus (CVMC) required the teardown of a medical office building which has not been secured, so an alternative location is being considered. The UVM Health Network does not anticipate that this change will delay the overall completion of the project. One significant evaluation currently underway is a parking study as the alternate location for the construction will result in the elimination of approximately 87 parking spaces.

Emergency Department (ED) facility programming was also been reviewed in 2019. In addition to patient volume and flow data, the team explored the various needs of mental health patients who arrive in the ED and how this relates to the mix of room types in the ED program. The goal

is to provide an adequate supply of general treatment beds and beds that can be flexed to serve as transitional care space. The recommendation of a planning workgroup was to create a 4-bed transitional care area, with an adjacent 4-bed treatment area that can flex to meet the needs of the patient population at any given time. The total number of ED beds will increase slightly for a total of 30 ED beds in the new build.

The new layout addresses a number of operational efficiency issues present in CVMC's current ED. With the completion of the programming work for the ED the team has transitioned into schematic design with an anticipated end date of January 2020 for both the ED and Inpatient Psychiatry units.

The Business Plan and associated content development for the Certificate of Need application process to the Green Mountain Care Board is pending the reconciliation of final project budget and finalized design and construction documents. The UVM Health Network indicates a commitment to a 3-4-year timeframe to "significantly improve access to inpatient psychiatric care." Ongoing stakeholder engagement is planned. To date, UVM Health Network reports that it has expended $183,057.96 of the $21 million of its FY2017 net patient revenue overage, without taking account of the significant internal resources already devoted to the planning process. A May 2020 CON submission is anticipated and updated quarterly report in February 2020.

MOBILE OUTREACH CAPACITY

DMH, encouraged by the 10-Year vision work and degree of stakeholder interest, plans to continue exploration of opportunities to launch a more robust Mobile Response and Support Services (MRSS) capacity in Vermont. Contributors to the visioning and report development for long-range planning recommended that one of the strategies for enhancing crisis intervention and discharge planning services could be achieved in the short-term through The Crisis

Intervention Team (CIT) program that has become a globally recognized model to safely and effectively assist people with mental and substance use disorders who experience crises in the community. The CIT Model promotes strong community partnerships among law enforcement, mental health and substance use treatment providers, people with mental and substance use disorders, along with their families and others. While law enforcement agencies have a central role in program development and ongoing operations, a continuum of crisis services available to citizens prior to police involvement is part of the model. These other community services (e.g., mobile crisis teams, crisis phone lines) are essential for avoiding criminal justice system involvement for those with mental health challenges.

Likewise, The Parachute Project (NYC)- is an innovative program based out of New York City that uses the evidence-based practice of Open Dialogue to provide need-adapted treatment. It has various levels of support including mobiles crisis, outreach and respites programs to help support people with serious mental health concerns to learn how to live with acute stress. Teams of people including social workers, psychiatrists, peers and family members work together in a non-hierarchical manner to encourage people living with mental health issues to develop their own route to recovery. The teams encourage open and equal dialogue with in the individual and their family /support network to help individuals learn to live their lives with acute stress and develop ways to manage their own health and mental health. This program has a focus on meeting people where they are with their readiness to engage in treatment and offer different solutions for people that are not interested in full engagement in treatment. There is significant peer involvement in every component of Parachute NYC; besides mental health services, peers work as peer health navigators to integrate medical health into the continuum of care. This model is consistent and complimentary with Open Dialogue practices already being prioritized by a portion of the state's Mental Health Block Grant funds.

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

DMH System Snapshot

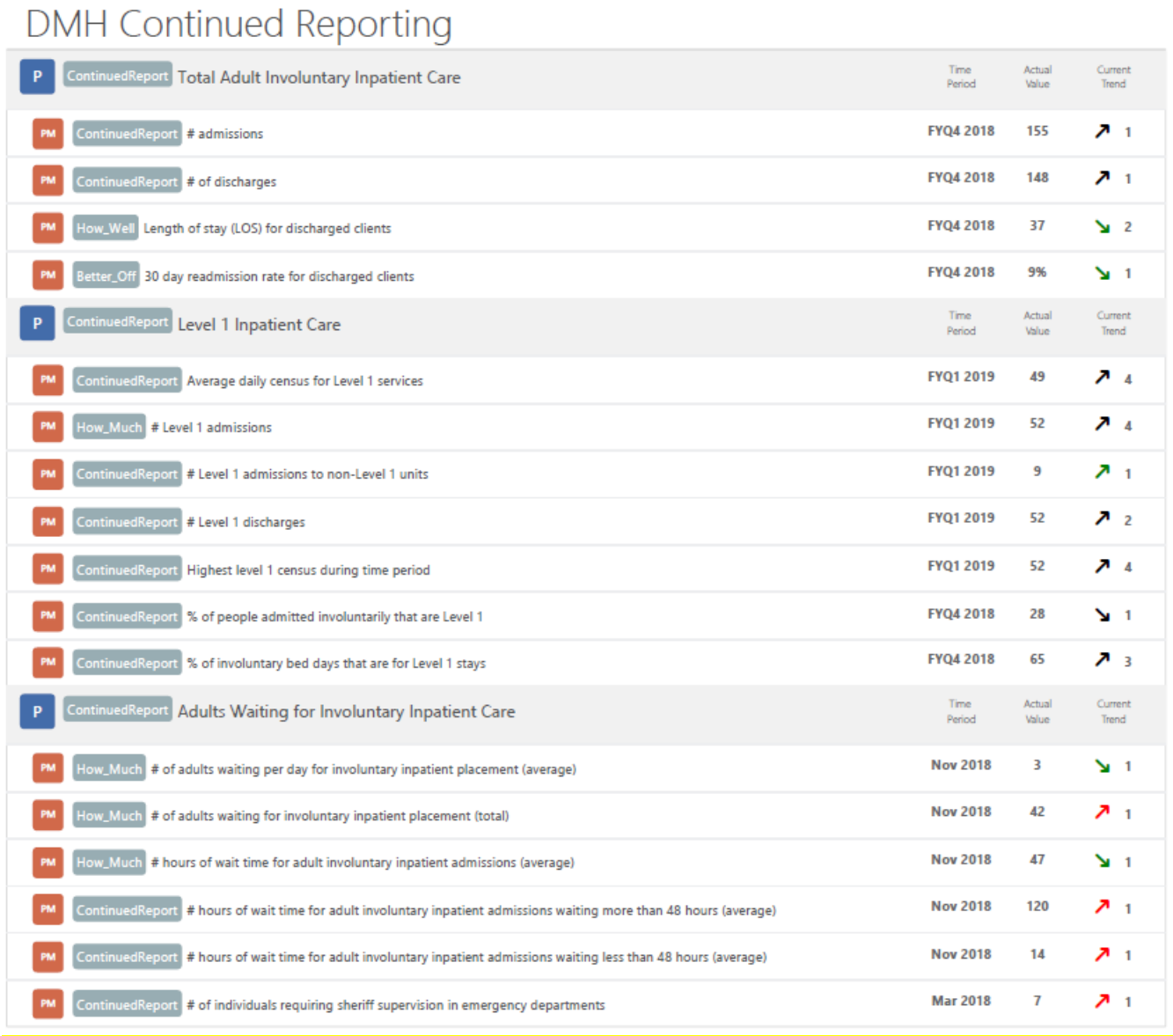
		Time Period	Actual Value	Current Trend
P	Snapshot **Adult Inpatient Hospitalization**			
PM	How_Much % occupancy of adult inpatient hospital units	FYQ1 2019	91%	→ 1
PM	Snapshot # of closed adult inpatient beds per day (average)	FYQ1 2019	8	↗ 1
PM	Snapshot % of all adult inpatient bed days used for involuntary care	FYQ3 2018	40%	↘ 1
PM	Snapshot # of EE applications for adults (18+)	FYQ1 2019	150	↘ 1
PM	Snapshot # instances where involuntary inpatient placement was unavailable, and adult was held in the emergency dept.	FYQ1 2019	74	↘ 1
PM	Snapshot # of requested Court-Ordered Forensic Observations	FYQ1 2019	21	↘ 1
PM	Snapshot # of screenings Court-Ordered Forensic Observation resulting in an inpatient order	FYQ1 2019	10	↘ 1
P	Snapshot **Level 1 Inpatient Care**			
PM	How_Well % occupancy of Level 1 adult inpatient hospital units	FYQ1 2016	87%	↘ 2
PM	How_Much # Level 1 admissions	FYQ1 2019	52	↗ 4
P	Snapshot **Youth Inpatient Hospitalization**			
PM	Snapshot % occupancy at youth inpatient hospital units	FYQ1 2019	81%	↘ 2
PM	Snapshot # instances where inpatient placement was unavailable, and youth was held in the emergency dept.	FYQ1 2019	10	↘ 1
PM	Snapshot # of closed youth inpatient beds per day (average)	FYQ1 2019	1	↘ 1
PM	Snapshot # of EE applications for youth (0-17)	FYQ1 2019	14	↘ 1
P	Snapshot **Community Services**			
PM	How_Much % occupancy of Designated Agency adult crisis bed programs	FYQ1 2019	79%	↗ 2
PM	Snapshot % occupancy of Designated Agency youth crisis bed programs	FYQ1 2019	58%	↘ 2
PM	How_Well % occupancy of adult intensive residential beds (including MTCR)	FYQ1 2019	94%	↗ 2
PM	Snapshot # people enrolled in housing subsidy + care program to date	FYQ2 2017	121	↗ 1

			Time Period	Actual Value	Current Trend
P	Snapshot	Court-Ordered Involuntary Medications			
PM	Snapshot	# applications for court-ordered involuntary medications	FYQ1 2019	20	↘ 1
PM	Snapshot	# of granted orders for court-ordered involuntary medications	FYQ1 2019	15	↘ 1
PM	Snapshot	Mean time from filing date to decision date in days	FYQ1 2019	12	↗ 1
P	Snapshot	Suicide			
PM	Snapshot	# of suicide deaths	FYQ4 2018	30	↗ 1
PM	Snapshot	# of suicide deaths who were served by a DA within the previous year	FYQ4 2018	3	↗ 1
P	CareMgmt	Involuntary Transportation			
PM	How_Much	# of transports to inpatient psychiatric care	FYQ3 2018	64	↗ 1
PM	How_Well	% of transports to psychiatric inpatient care without using physical restraint	FYQ3 2018	56%	↘ 1
PM	Snapshot	# of transports for adults to inpatient psychiatric care (18+)	FYQ3 2018	55	↗ 1
PM	Snapshot	# of transports for youth to inpatient psychiatric care (0-17)	FYQ3 2018	9	→ 2
PM	Snapshot	% of transports for adults to psychiatric inpatient care using metal restraint	FYQ3 2018	24%	↗ 2
PM	Snapshot	% of transports for youth to psychiatric inpatient care using metal restraint	FYQ3 2018	33%	→ 1

APPENDIX B: DMH CONTINUED REPORTING

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

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



DMH Continued Reporting

		Time Period	Actual Value	Current Trend
P	ContinuedReport Total Adult Involuntary Inpatient Care			
PM	ContinuedReport # admissions	FYQ4 2018	155	↗ 1
PM	ContinuedReport # of discharges	FYQ4 2018	148	↗ 1
PM	How_Well Length of stay (LOS) for discharged clients	FYQ4 2018	37	↘ 2
PM	Better_Off 30 day readmission rate for discharged clients	FYQ4 2018	9%	↘ 1
P	ContinuedReport Level 1 Inpatient Care	Time Period	Actual Value	Current Trend
PM	ContinuedReport Average daily census for Level 1 services	FYQ1 2019	49	↗ 4
PM	How_Much # Level 1 admissions	FYQ1 2019	52	↗ 4
PM	ContinuedReport # Level 1 admissions to non-Level 1 units	FYQ1 2019	9	↗ 1
PM	ContinuedReport # Level 1 discharges	FYQ1 2019	52	↗ 2
PM	ContinuedReport Highest level 1 census during time period	FYQ1 2019	52	↗ 4
PM	ContinuedReport % of people admitted involuntarily that are Level 1	FYQ4 2018	28	↘ 1
PM	ContinuedReport % of involuntary bed days that are for Level 1 stays	FYQ4 2018	65	↗ 3
P	ContinuedReport Adults Waiting for Involuntary Inpatient Care	Time Period	Actual Value	Current Trend
PM	How_Much # of adults waiting per day for involuntary inpatient placement (average)	Nov 2018	3	↘ 1
PM	How_Much # of adults waiting for involuntary inpatient placement (total)	Nov 2018	42	↗ 1
PM	How_Much # hours of wait time for adult involuntary inpatient admissions (average)	Nov 2018	47	↘ 1
PM	ContinuedReport # hours of wait time for adult involuntary inpatient admissions waiting more than 48 hours (average)	Nov 2018	120	↗ 1
PM	ContinuedReport # hours of wait time for adult involuntary inpatient admissions waiting less than 48 hours (average)	Nov 2018	14	↗ 1
PM	ContinuedReport # of individuals requiring sheriff supervision in emergency departments	Mar 2018	7	↗ 1

APPENDIX C: NATIONAL OUTCOME MEASURES

The National Outcome Measures (NOMS) report can be found in its entirely-for Vermont and other states—on SAMHSA's website: http://www.samhsa.gov/data/ under "State and Metro Reports"

Vermont 2018 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per 1,000 population	7,808,416	38.69	23.69	58
Community Utilization per 1,000 population	7,577,095	38.56	22.99	58
State Hospital Utilization per 1,000 population	129,300	0.13	0.39	52
Other Psychiatric Inpatient Utilization per 1,000 population	447,545	0.87	1.58	41

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

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

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

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

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

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

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

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

*Denominator is the sum of consumers employed and unemployed.
**Denominator is the sum of consumers employed, unemployed, and not in labor force.

SAMHSA Uniform Reporting System - 2018 State Mental Health Measures

Vermont

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

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

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

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

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

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

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

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

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

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

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