

Vermont Department of Mental Health

Fiscal Year 2014

Budget Request

February 5, 2013

Department of Mental Health

VISION

Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to, the mental-health needs of all citizens. Vermonters will have access to effective prevention, early intervention, and mental-health treatment and supports as needed to live, work, learn, and participate fully in their communities.

MISSION

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters.

VALUES

We support and believe in the Agency of Human Services values of respect, integrity, and commitment to excellence and express these as:

Excellence in Customer Service

- People receiving mental health services and their families should be informed and involved in planning at the individual and the system levels
- Services must be accessible, of high quality and reflect state-of-the-art practices.
- A continuum of community-based services is the foundation of our system.

Holistic approach to our clients

- We can promote resilience and recovery through effective prevention, treatment, and support services.

Strength Based Relationships

- It is important to foster the strengths of individuals, families, and communities.

Results Orientation

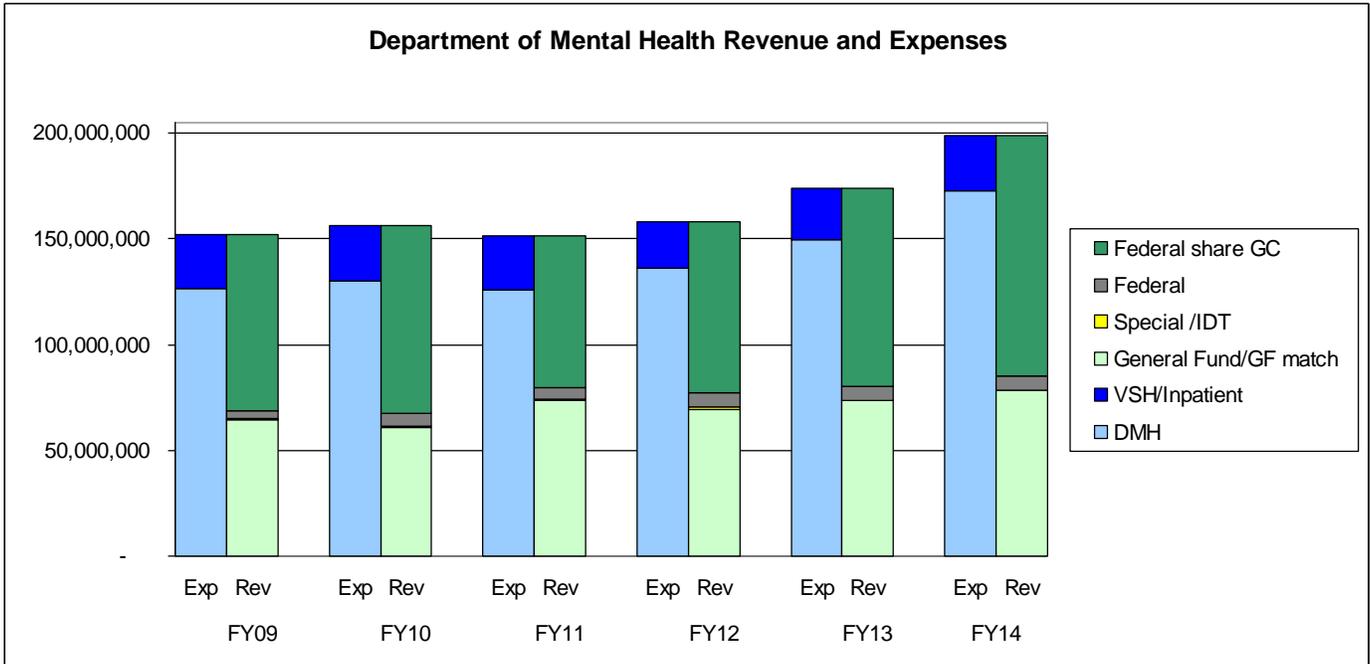
- Strong leadership, active partnerships and innovation are vital strategies to achieve our mission.
- We are accountable for results.

Organizing Functions of DMH

The Department of Mental Health (DMH) commitment to direct services and community-based mental health care and treatment is reflected by the following organizing functions:

- A key organizing function for DMH is the operations of the central office for the identification of mental health service and development needs, resource acquisition and budget allocation, and oversight of the system of mental health service delivery and care.
- The Designated Agency (DA) community-based mental health service delivery system holds the organizing functions for the system of care.
 - The system of care for the Community Rehabilitation and Treatment (CRT) programs serving adults with severe and persistent mental illness (SPMI) and children and adolescents with severe emotional disturbances (SED).
 - The availability of the 24/7 mental health crisis response capability of the Emergency Services Programs at each DA.

- The final organizing function of the DMH is supporting access to acute inpatient psychiatric care for persons who would otherwise have been hospitalized at the VSH within the designated hospitals system of care.



DMH Program expenses have increased \$33M (net intra-departmental transfers) post Hurricane Irene. In that same time the GF increased \$4.4M, all of which is due to the increased state Medicaid match rate (from .4128 to .4356)

DEPARTMENT OPERATIONS AND PROVIDER MANAGEMENT

State law specifies that Vermont's publicly-funded community services system for individuals of all ages with mental health disorders be provided through contracts between the DMH and private, nonprofit community provider agencies. Currently, DMH contracts with 11 such provider agencies, ten of which are known as Designated Agencies (DA s) and one of which is a Specialized Service Agency (SSA). There is only one DA per geographic region. The DA's have, by statute, bottom line responsibility for assuring that a comprehensive range of services is available for the following priority populations within their defined service area: Adults with severe and persistent mental illness (SPMI) and children and adolescents with severe emotional disturbances (SED). The DMH also contracts with one SSA to provide services only for children and adolescents.

Operations

The central office of the Vermont Department of Mental Health ensures that internal and external program operations pursuant to its statutory responsibilities under 18 V.S.A. Chapter 173 are adequately resourced, monitored, and that development activities sustain and promote the existing public mental health adult and child services network. Operations functions include administrative support, financial services, legal services, provider monitoring, care management and utilization review, system development and technical assistance, and community housing.

The **Administrative Support Unit** staff are often the first point of contact and triage for incoming inquiries from consumers, family members, and service providers. Administrative Support Services staff respond to the daily internal and external communication flow with operations and clinical services staff, AHS and our community partners. Support staff work closely with program staff in the development and execution of service provider contracts and grants, as well as, ordering, production, document management, and other clerical services necessary to support their respective units within the DMH. The **Financial Services Unit** works closely with all staff; internally overseeing the budget development process as well as invoicing, coding, accounting, and ensuring payment authorizations for sub-contractors and grantees while externally tracking and monitoring financial reporting and accountability of the DMH, the DA provider system and community-based advocacy, family, and consumer-run organizations. The **Legal Services Unit** is comprised of staff from the Attorneys General Office and DMH paralegals. It supports the DMH with legislative and policy review activities, tracking individual court orders and petitions, and various other proceedings requiring attorney representation.

Provider Oversight/Performance Indicators

Central office staff members from both the Adult Unit and the Child and Family Unit (CAFU) are responsible for monitoring community program services, designating agencies every four years as outlined in the Administrative Rules for Agency Designation, and designation of hospitals for involuntary psychiatric care through various oversight activities of the DMH. Additionally, the DMH, under the statutory responsibilities of the Commissioner of Mental Health (18 V.S.A. § 7408), oversees Electroconvulsive Therapy (ECT) treatment. Staff members ensure that review activities for DA's and hospitals are conducted and corroborating program, policy, and outcomes information compiled. Research and Statistical Unit personnel provide routine and ad hoc data review and analysis from various provider services information and data submissions. The activities include agency reviews, records documentation minimum standards, and tracking agency or hospital information reporting for the ten DA's, one SSA, and the five Designated Hospital psychiatric inpatient programs.

Quarterly, key financial performance indicators are composed and reviewed for signs of fiscal weaknesses. In particular, days of net assets, current ratio, gain/loss, days of cash, and admin cost ratio are closely examined. Monthly financial data and client-level encounter data are submitted to DMH for purposes of tracking both financial health of the organization and service delivery to persons served by the DA. Any agency highlighted as having potential shortfalls is contacted and dealt with on an individual basis. Provider grant agreements are developed annually to outline service delivery level expectations.

Clinical Care Management and Utilization Review

Formerly, the review activities of this unit were guided by the State's Medicaid Global Commitment Waiver and Managed Care Organization (MCO) requirements and focused on the use and authorization of inpatient care for adult clients with the most intensive mental health services needs Community Rehabilitation and Treatment (CRT) program clients and notification of persons subject to involuntary emergency examination hospitalization. Subsequent to the closure of the VSH, the care management team has been required to expand its support activities with the Designated Hospitals to facilitate both admission and diversion to clinically appropriate alternative care settings as well as timely transfer to community services from inpatient care.

Two staff members are directly responsible for acute CRT and Medicaid psychiatric inpatient authorization and continued stay reviews with five Designated Hospitals (DH's). The remaining care coordinators work directly with the Designated and community hospitals to address the needs of any person in the care and custody of the Commissioner of Mental Health with complex mental health needs or voluntary psychiatric inpatients who are experiencing barriers to community services and timely discharge. This team works closely with Emergency Services Programs to identify needed community services and alternative levels of care to respond to crises. This unit, in conjunction with legal services, provides training to the Qualified Mental Health Professionals who screen admissions into involuntary care and the custody of the Commissioner of Mental Health.

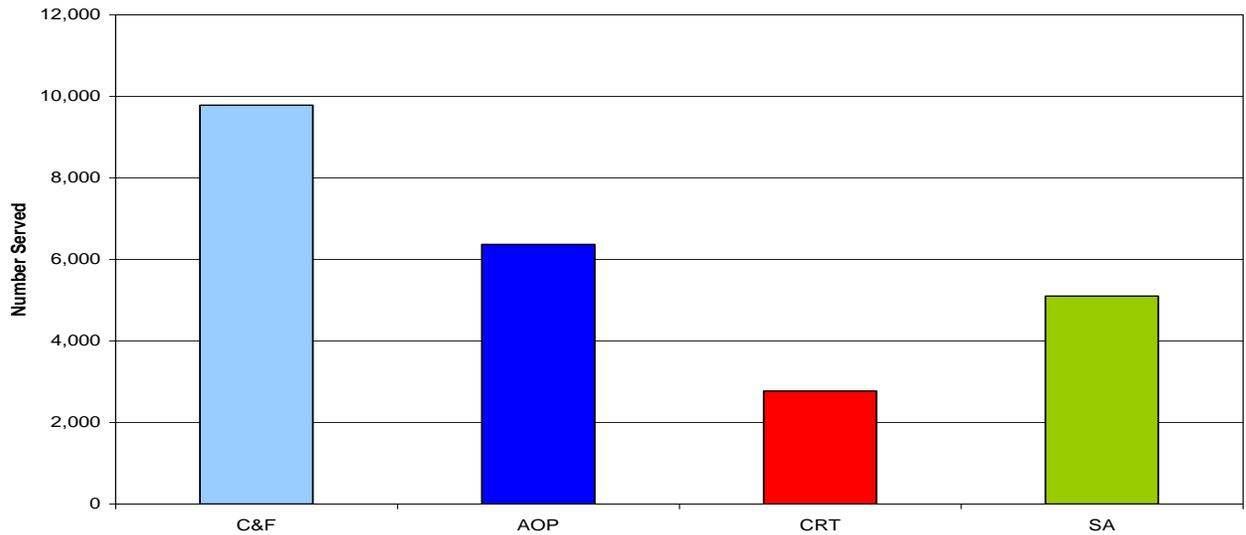
System Development and Technical Assistance

The DMH actively explores funding opportunities, as well as, community collaboration and mental health practice improvement initiatives. These efforts are designed to bring supplemental federal and other grant resources to our mental health provider system and assure that the work force is current with new treatment approaches and evidence-based practices in the field of community mental health services. In addition, the DMH staff provide consultation to program development initiatives and technical assistance for the implementation of specific practices.

Community Housing

Access to safe, affordable housing is critical to the well being of Vermonters with disabilities and who live on extremely limited incomes. The DMH assumes a leadership role in the development and preservation of, and access to affordable housing. Staff coordinates the continuation of existing HUD funding and actively pursues opportunities for new funding for housing. These activities require close working relationships with Vermont's not-for-profit housing developers and with the local and state housing authorities. In addition, DMH works closely with the shelters and service providers who assist Vermonters who are homeless to gain housing.

**DA Utilization by Primary Program
FY2012**

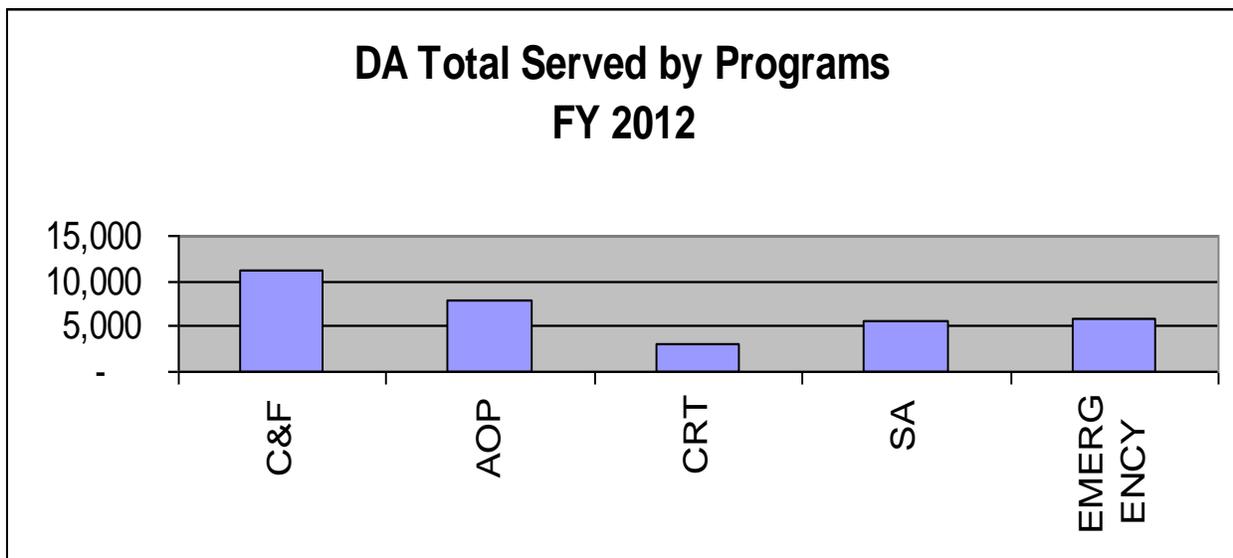


Based on Monthly Service Report (MSR) data submitted to DMH by designated community agencies for FY 2012 for clients served by the Children's Services (C&F), Adult Outpatient (AOP), Community Rehabilitation and Treatment (CRT), and Substance Abuse (SA) Programs.

The highest number of persons served by a program offered by the DAs is in services for children and families, while the lowest numbers of persons served by a DA program are those in the CRT programs. The volume of clients served in CRT programs has been fairly static over time. It is too early to see changes from enhanced funding that began in May 2012.

The chart below reflects all individuals served, including emergency services, regardless of program. The numbers therefore are somewhat higher than the first graph that reflects the numbers served by primary program assignment only. While duplicating individuals, the numbers served, regardless of program assignment, better indicates the demand for program services. Individuals may cross program lines to receive services (e.g. an individual may be open as an Adult Outpatient, but also be served in Emergency Services). The variation represents an additional capacity need from 4,187 individuals for services outside of their primary program assignment.

**DA Total Served by Programs
FY 2012**



ADULT MENTAL HEALTH SERVICES

PROGRAM: COMMUNITY REHABILITATION AND TREATMENT (CRT) PROGRAM

WHAT IS THE PROGRAM?

The CRT Program provides a range of comprehensive mental health services through Designated Agencies to clients with severe and persistent mental illness. Adults served by the program must meet eligibility criteria that include psychiatric diagnosis, service utilization and hospitalization history, severity of disability, and significant functional impairments. Psycho-social services include: case management, evidence-based interventions to support recovery, psychiatric care, employment support and life skills, medication management and other supportive care.

HOW DOES THIS PROGRAM MEET A CORE MISSION?

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters. Pursuant to 18 V.S.A. § 7401 and § 8907, the Department of Mental Health, under the authority of the Commissioner of Mental Health and contracts with designated public or private non-profit agencies, assures planning and coordination of services “to individuals with mental illness to become as financially and socially independent as possible.”

WHAT DOES SUCCESS LOOK LIKE FOR THE PERSON?

Individuals served by the program are engaged in their personal course of mental health recovery and utilize their individualized support systems. Individuals have access to stable housing and economic benefits necessary to meet their basic needs. Individuals participate in meaningful daily activities and social relationships.

WHAT DOES SUCCESS LOOK LIKE TO THE COMMUNITY?

Services for individuals with complex mental health service needs are seamlessly interwoven and readily available from any referral point within the community. The individual’s needs are met with an array of formal and informal assessment and support services that bring about positive outcomes for the individual decreasing potential for negative attention and stigma.

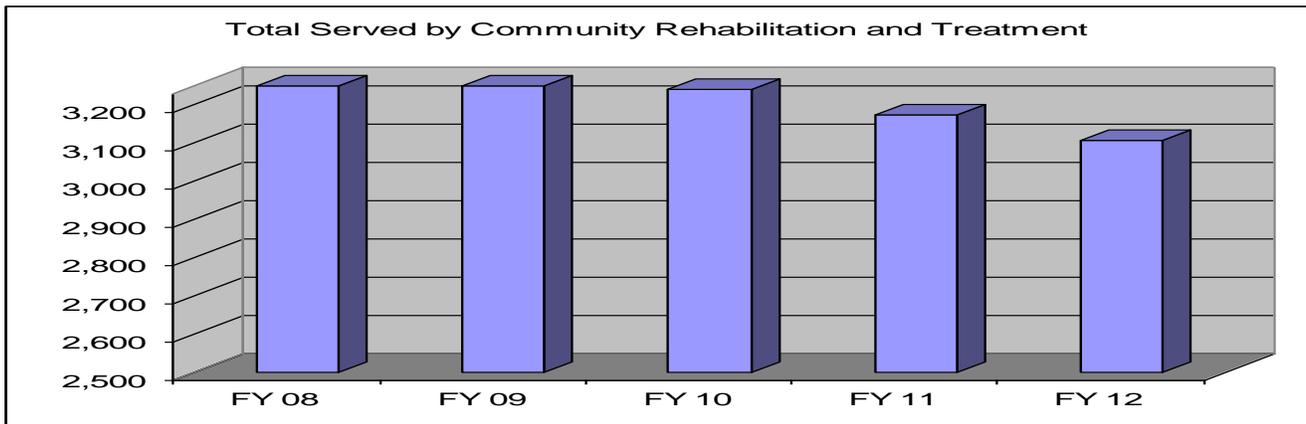
WHAT PERFORMANCE MEASURES ARE USED TO DETERMINE PROGRESS?

- Reduction in acute psychiatric symptoms
- Annual visits for health care
- Ability to maintain functioning without need for hospitalization
- Employment skills and work
- Stable living situation
- Social supports
- Reduced law enforcement involvement
- Follow-up from hospitalization

WHAT BASELINE DATA IS AVAILABLE?

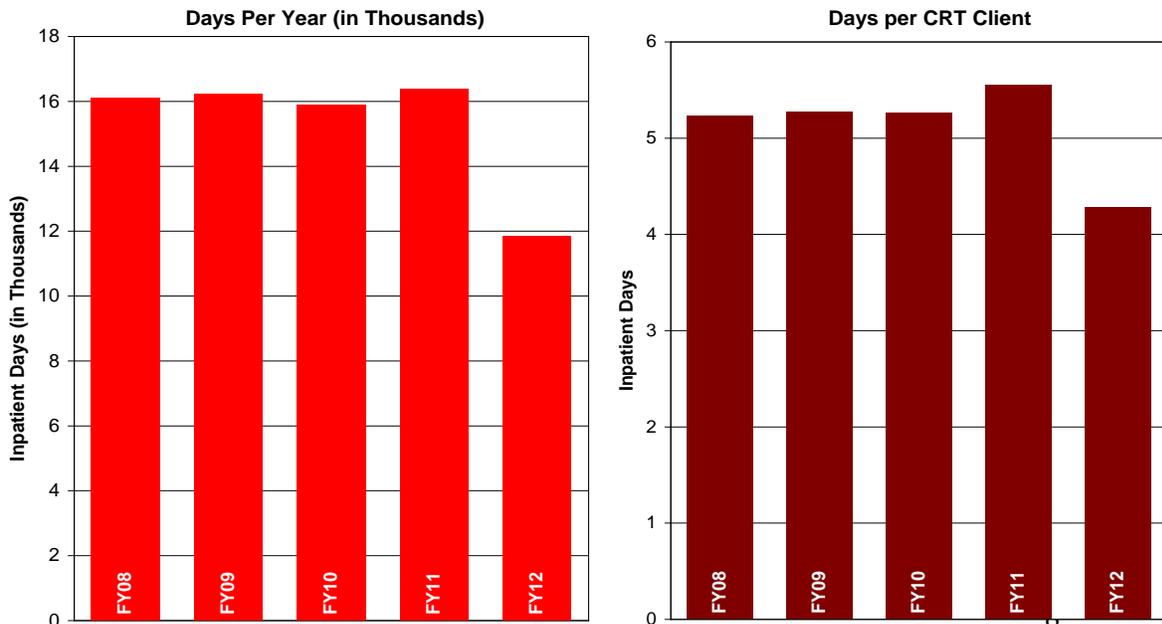
- CRT programs are reviewed and monitored based on the Administrative Rules for Agency Designation.
- Designated Agencies providing CRT programs are under contract to provide service deliverables for the CRT Program enrollees.
- Monthly Service Data and financial reports are submitted on a monthly basis and analyzed through the DMH Research and Statistics Unit and the Business Office.

Over the past five years, the Designated Agencies are decreasingly serving just under **3000** CRT eligible clients per year.



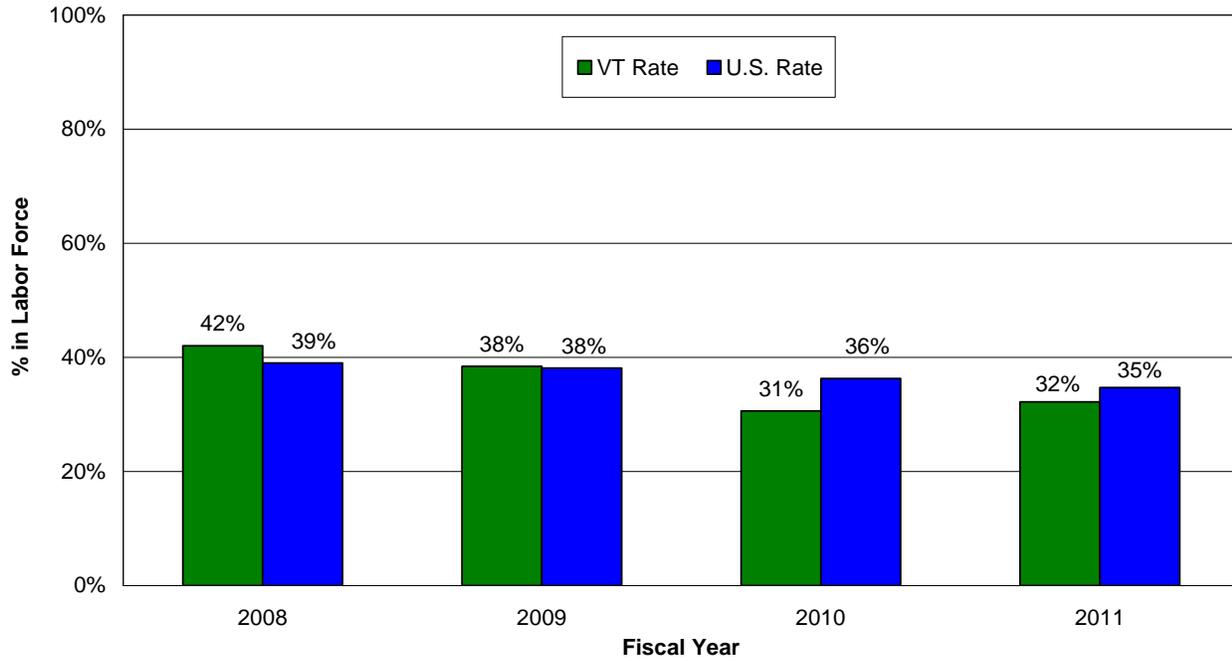
The CRT Program Statewide has experienced just over 6% decline in its enrolled population over the past five years. Increasingly, program resources are serving individuals with more challenging and complex mental health support needs impacting program capacity to bring in new individuals who may need comprehensive mental health support services. The decline, combined with the average age of CRT enrolled service recipients, might also suggest that the traditional CRT Program services are not engaging as effectively with younger individuals who might prefer different treatment and support options.

Inpatient Psychiatric Utilization by CRT Programs Statwide: FY2007-FY2012



Analysis based on the "CRT Inpatient Data" set maintained by the VT Department of Mental Health (DMH) Care Management Team and Monthly Service Record (MSR) data provided to DMH by the designated community agencies (DA). Includes CRT client patient days at the Vermont State Hospital (VSH) and other hospitals during each fiscal year during July 2006 through June 2012. Community Rehabilitation and Treatment (CRT) status based on program status at admission to inpatient. Days include the day of admission but exclude the day of discharge. Days per CRT client is based on the number of clients with a program assignment of CRT and the total number of psychiatric inpatient days during each fiscal year.

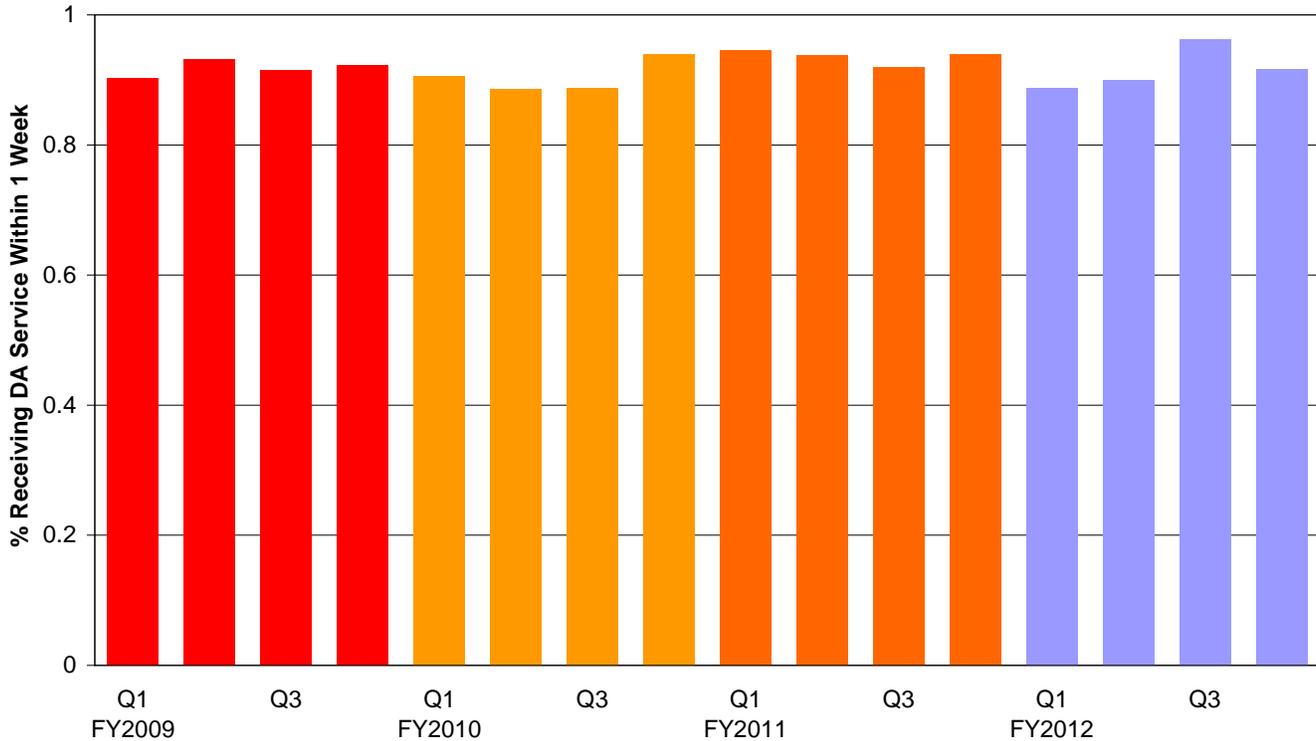
Adult Employment Status Percent in Labor Force



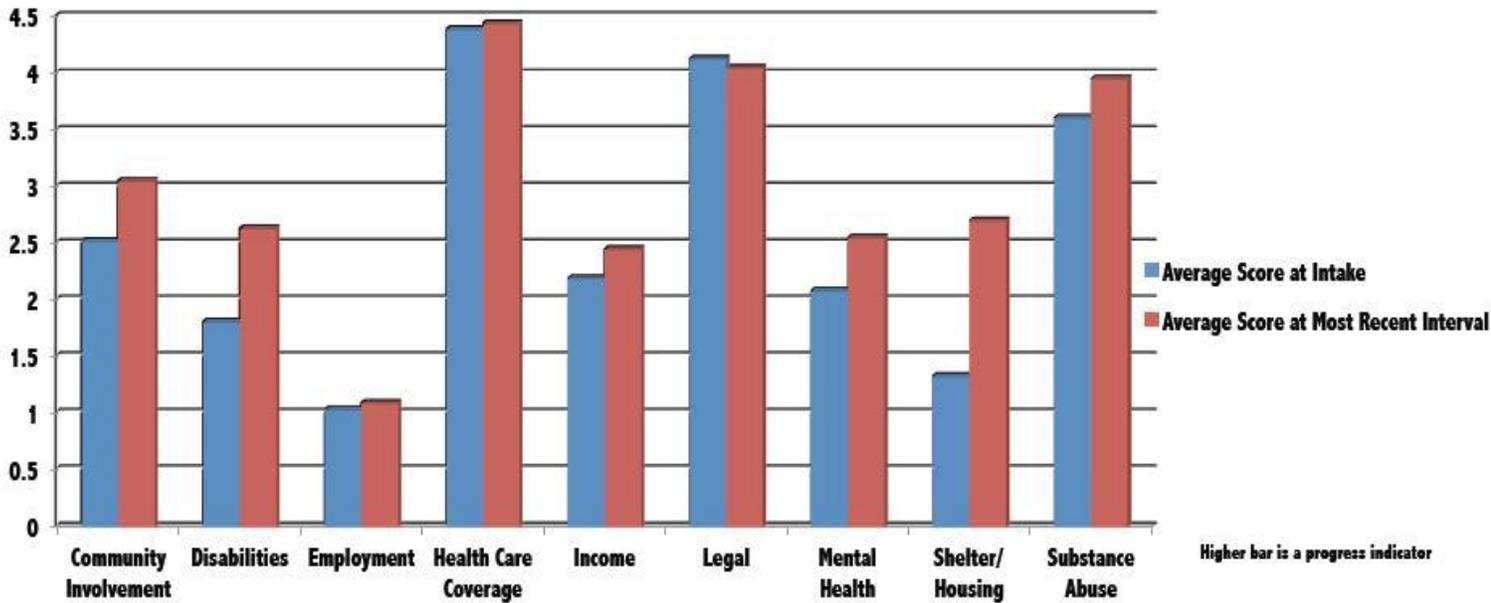
Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2011. Employment status for other mental health clients is based on case manager monthly service reports. Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2011. US totals are calculated uniquely based on those states who reported.

The employment rate for all people with mental illness has dropped across Vermont and the nation over the past four to five years, likely due to the economic downturn and decreased employment services.

CRT Inpatient Time from Discharge to DA Services FY2009 - FY2012



Self Sufficiency Outcome Matrix Report



Eight of the nine self-sufficiency outcome measures recorded here demonstrated improvement for the individuals participating in the Housing Subsidy & Care program. Most notable was the improvement in community involvement, improvement in disability, income, housing, mental health, and substance-abuse outcome measures.

IS THERE A BETTER WAY?

The efficiency of blending CRT programs and AOP programs combined with more flexible service delivery may be a way to expand access and meet the needs of more individuals in communities. DMH believes it is less important what we name the program than to have sufficient service provision.

Continue the DMH technical support team consisting of two psychologists, one psychiatrist, and a nurse care manager to build on individualized and intensive residential placements for individuals who need extensive mental health and substance abuse supports. The direct outreach to service providers on a regular basis to maintain newly developed wraparound programs has proven to be a pivotal support in helping individuals to be successfully supported in their communities.

Training throughout the community and hospital systems is an ongoing need. In addition to the training opportunities made available this year through DMH at two statewide conferences, the new DMH Coop for Workforce Development and Practice Improvement is getting underway through a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and will be accessible to the entire state provider community. The program development thus far exemplifies the partnerships that have been forged between DMH, other state departments, and public and private providers.

Continue efforts to include stakeholders in change processes through various communication and input forums. Peer services have expanded in the past year and will continue to expand. DMH has increased funding for peer programs to provide additional outreach, community support, crisis intervention and respite, linkages to Recovery Turing Point Centers, hospitals, and the correctional system, and a statewide telephone warm-line support has been set up.

PROGRAM: ADULT OUTPATIENT SERVICES

WHAT IS THE PROGRAM?

As defined by 18 V.S.A. § 7252 “Adult outpatient services means flexible services responsive to individual’s preferences, needs, and values that are necessary to stabilize, restore, or improve the level of social functioning and well-being of individuals with mental health conditions, including individual and group treatment, medication management, psychosocial rehabilitation, and case management services.”

The Adult Outpatient Program (AOP) provides counseling and psychotherapy services to individuals experiencing a variety of stressors and coping difficulties and are requesting mental health services. Services may include evaluation, individual, family and/or group counseling, medication prescription and monitoring. This service is also provided by individual private practitioners who operate independently throughout the state as well.

Increasingly the Designated Agency adult mental health programs are expanding services as funding levels appropriated by the legislature and allocated by DMH allow for the expansion of services to more complex individuals with ongoing mental health needs. People in AOP’s have a wide range of problems including having attempted suicide within the past year, or having thoughts they may do so. Alcohol and drug abuse is often an additional challenge to many persons in AOP services. Many also have histories of psychological trauma, with lingering impairments to their ability to cope with everyday living, or disabling depression which may pose challenges with such basic activities as eating, bathing, and dressing daily. Other common difficulties include maintaining a household, parenting, managing money, accessing community supports, and needing access to medication prescribing and supports. An additional challenge to the capacity of the AOP’s is the priority population of individuals with severe functional impairments who are eligible for release from the Department of Corrections. These individuals often have complex needs that require significant investments in resources and staff time, further competing with the availability of services to the general public. Expansion of “non-categorical” case management services to adults with traditional Medicaid benefits was added and has been growing in availability within DA’s.

HOW DOES THIS PROGRAM MEET A CORE MISSION?

Pursuant to the same provision referenced above, the Department of Mental Health provides program funding for “individuals with mental illness” who experience a lesser degree of severity and ongoing disability from the mental health condition than individuals served by the CRT Programs, but still have needs requiring stabilization, restoration and functional improvement.

WHAT DOES SUCCESS LOOK LIKE FOR THE PERSON?

Much like individuals served by the CRT Programs, individuals served by AOP are often seeking the same level of mental health recovery, stability, and engagement in meaningful interpersonal and social activities.

WHAT DOES SUCCESS LOOK LIKE TO THE COMMUNITY?

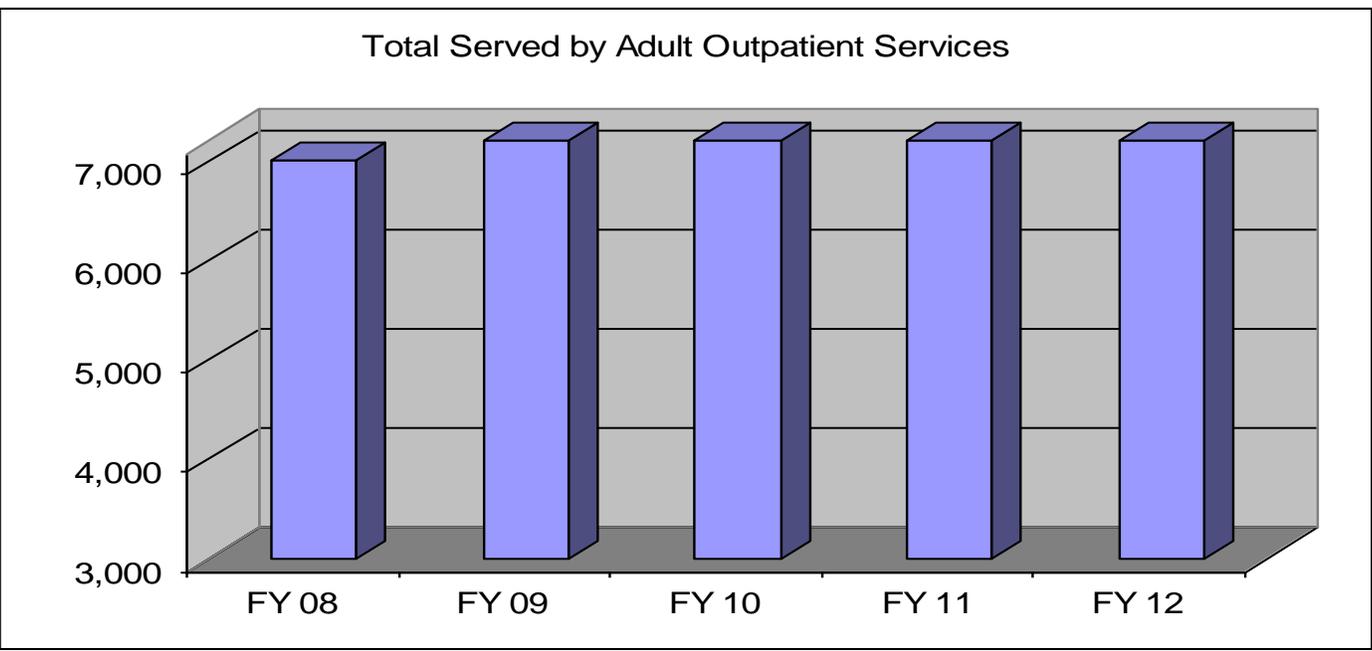
Services for individuals seeking mental health treatment, whether publicly funded or through private providers, are seamlessly interwoven and readily available from any referral point within the community.

The individual's needs are met with an array of formal and informal assessment and support services that bring about positive outcomes for the individual.

WHAT PERFORMANCE MEASURES ARE USED TO DETERMINE PROGRESS?

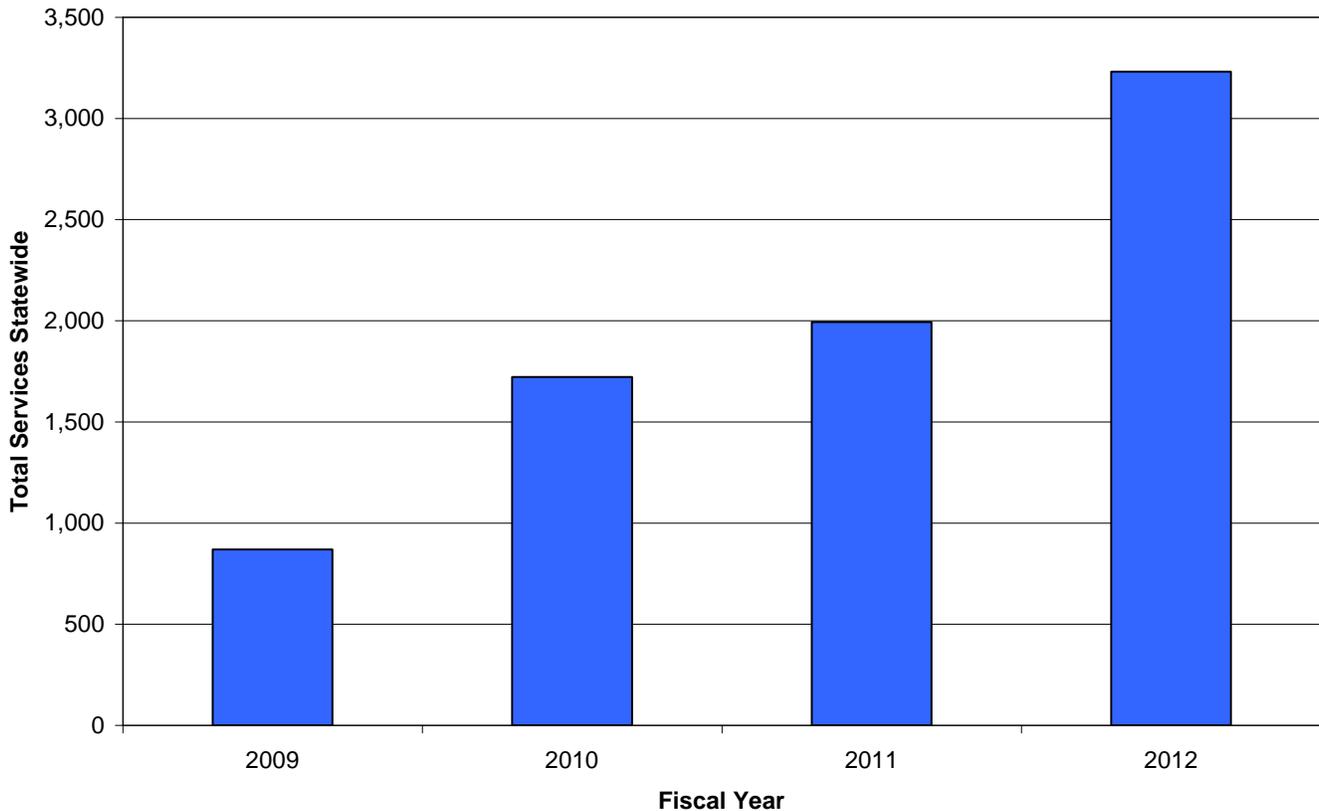
Lesser levels of funding historically have Quarterly, key financial performance indicators are composed and reviewed for signs of fiscal weaknesses. In particular, days of net assets, current ratio, gain/loss, days of cash, and admin cost ratio are closely examined. Monthly financial data and client-level encounter data are submitted to DMH for purposes of tracking both financial health of the organization and service delivery to persons served by the DA. Any agency highlighted as having potential shortfalls is contacted and dealt with on an individual basis. Provider grant agreements are developed annually to outline service delivery level expectations.

WHAT BASELINE DATA IS AVAILABLE?



The total served by the Adult Outpatient Program has remained relatively stable over the past five years. This overall stability may reflect that the program has been at capacity, neither growing nor shrinking substantially, and contributing to longer waiting lists for individual services and referrals to the equally stressed private practitioner community. The allocation of additional resources late in FY 2012 should have some impact on individual access to Designated Agency community mental health services funded by DMH.

**Service Planning and Coordination Services Provided to Adult Outpatient Clients
FY2009 - FY2012**



Fiscal years 2009 through 2012 have shown an upward trend in the amount of case management services, called “non-categorical” case management, available to clients assigned to Adult Outpatient programs,. When first introduced without additional funding for this service, there was a 98% increase in services into FY 2010 across 70% of the DAs. Service levels remained steady through 2011 and showed a sharp increase again in FY 2012 with the introduction of enhanced funding levels allocated into FY13. Service levels between FY2011 and FY2012 again showed a 62% increase in case management services expanded across 90% of the DAs. In contrast with FY2009 service levels, FY 2012 case management services showed a 350% increase as more DAs developed this capacity in their Adult Outpatient programs. These numbers are expected to remain steady or show an upward trend in FY13 as well.

IS THERE A BETTER WAY?

- Funding needs to be maintained and expanded over time for outpatient case management programming
- Funding streams are still separate for mental health and substance abuse services. While many DA’s are expanding their co-occurring treatment (mental health and substance abuse) capabilities, funding stream limitations can impact service availability. Steps may be:
 - Increasing access to mental health and substance use screening, early intervention, referral, support and treatment within the Vermont Blueprint for Health primary care practices, as well as increasing care coordination between DAs and primary care practices.

- Working with community mental health and substance abuse providers to support the inclusion of mental health and substance abuse health information into Vermont's development of a comprehensive Health Information Exchange.
- Developing capacity within specialty substance abuse and mental health settings to provide coordinated health care services for individuals who are receiving significant treatment services through a designated/preferred community provider.
- Providing leadership within Vermont's health care reform efforts to ensure that mental health and substance abuse care is accessible and integrated within the unified health system that is being developed (this includes current efforts to integrate public mental health and substance abuse services into Vermont's unified health system).
- Needs of Refugee Resettlement program mental health needs are growing exponentially for these diverse groups. DMH will participate in focus groups throughout the year to discern need, assist area providers with supports, and develop a report with recommendations to meet needs of these groups by September 2013
- A plan utilizing current resources through the care management team is underway to augment current services within correctional facilities for inmates who need inpatient hospitalization
- Identification of individuals receiving non-categorical case management who are also experiencing in-patient hospitalization. 60% of involuntary hospitalization is attributed to non-CRT clients.

PROGRAM: PEER SUPPORT SERVICES

WHAT IS THE PROGRAM?

“Peer”, according to Act 79, means an individual who has a personal experience of living with a mental health condition or psychiatric disability. “Peer Services” means support services provided by trained peers or peer-managed organizations focused on helping individuals with mental health and other co-occurring conditions to support recovery. Peer support services are a growing area of individuals and support resources provided by persons with “lived mental health experience”.

HOW DOES THIS PROGRAM MEET A CORE MISSION?

Within the principles for mental health care reform outlined by Act 79, a coordinated continuum of care that includes peer partners is codified as part of ensuring that individuals with mental health conditions receive care in the most integrated and least restrictive settings available.

WHAT DOES SUCCESS LOOK LIKE FOR THE PERSON?

Individuals accessing peer services exercise choice in selecting the necessary component of their support and services network and how they choose to improve their health and wellness or strive to reach their full potential.

WHAT DOES SUCCESS LOOK LIKE TO THE COMMUNITY?

Services for individuals, whether peer-based or through formal service systems, are readily known, easily accessible, and effective in meeting the individual’s needs within the community. The support services bring about positive outcomes for the individual.

WHAT PERFORMANCE MEASURES ARE USED TO DETERMINE PROGRESS?

Over the past year, DMH has expanded the availability of services provided by individuals with the lived experience of mental illness, referred to as “peers”. These services include: community outreach, support groups, local peer-run initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings. DMH also funds family-to-family peer support for people who have a family member with severe mental illness. The following Chart depicts the Programming that is currently being implemented across the State, in various treatment and recovery settings.

DMH is piloting the use of individual recovery outcomes tools at contracted peer-run programs through a federal Mental Health Transformation grant. Two programs are currently collecting National Outcome Measures (NOMS) and the Peer-Operated Protocol (POP), and outcome data will be available in the coming months.

WHAT BASELINE DATA IS AVAILABLE?

Peer Organization	Services Provided	Utilization
Another Way	Community center providing outreach, community and network building, support groups, service linkages, employment supports.	Serves an average of 100 unduplicated individuals each month.
Alyssum	2-bed program providing crisis respite and hospital diversion.	Serves approximately 6 unduplicated individuals per month.
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.	Provides a per month average of: -150 outreach visits in the community for support and advocacy; -100 warm-line support calls; -65 calls for information or referral.
NAMI-VT	Statewide organization providing support groups, educational and advocacy groups.	Serves an average of 232 unduplicated individuals per month

IS THERE A BETTER WAY?

Continuing to develop collaborations between the existing mental health services network and/or further development of peer-run service organizations.

Peer-provided transportation services is still an area for exploration and development.

Continue efforts to implement a “warm line” operated by trained peers for the purpose of active listening and assistance with problem-solving.

Peer supported alternative treatment options for individuals seeking to avoid or reduce reliance on medications in a recovery- oriented housing program (Soteria House) is still to be developed.

Opportunities for training and supervision for peer providers needs further development.

PROGRAM: EMERGENCY SERVICES

WHAT IS THE PROGRAM?

The program provides mental health emergency services twenty-four hours a day, seven days a week to individuals, organizations, and communities. Essential emergency services include telephone support, face-to-face assessment, referral, and consultation. Emergency Services Programs provide assistance to people who are in need of crisis services for emergent issues such as depression, suicidal thoughts, dangerous behaviors, family violence and symptoms of serious mental illness. Emergency Services Programs also serve communities, schools, or other organizations trying to cope with events such as suicide, natural disaster and other traumatic events. By definition, emergency services respond quickly to avoid poor outcomes so that average response time is within 5 minutes by phone and within 30 minutes when face-to-face assessment is needed. The primary purpose of these crisis programs is to assess the immediate mental health situation and arrange for care as necessary.

HOW DOES THIS PROGRAM MEET A CORE MISSION?

Emergency Services Programs serve as a key portal in accessing the publicly funded mental health system of care, as well as, often being the emergency response for individuals seeking psychiatric inpatient admission who are in treatment with private practitioners in the community.

WHAT DOES SUCCESS LOOK LIKE FOR THE PERSON?

Individuals experiencing a mental health crisis know who to call and can quickly access a qualified individual to assess and support them with their emergency, offer information and options, and help them in taking control of decisions/actions necessary to stabilize their crisis

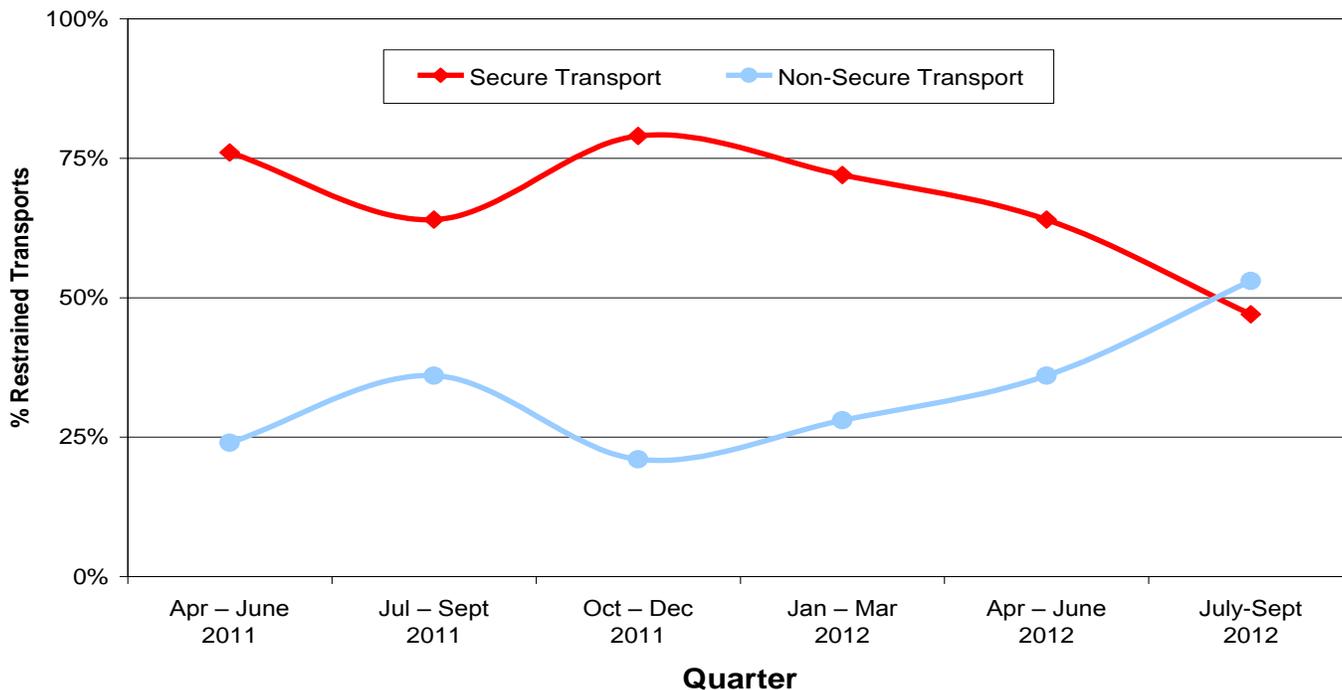
WHAT DOES SUCCESS LOOK LIKE TO THE COMMUNITY?

In addition to individual success, communities look for service that promotes education, support, and safety for significant others who may be the support system to the individual and the community, individual and public services, at-large who may continue to interact with the individual.

WHAT PERFORMANCE MEASURES ARE USED TO DETERMINE PROGRESS?

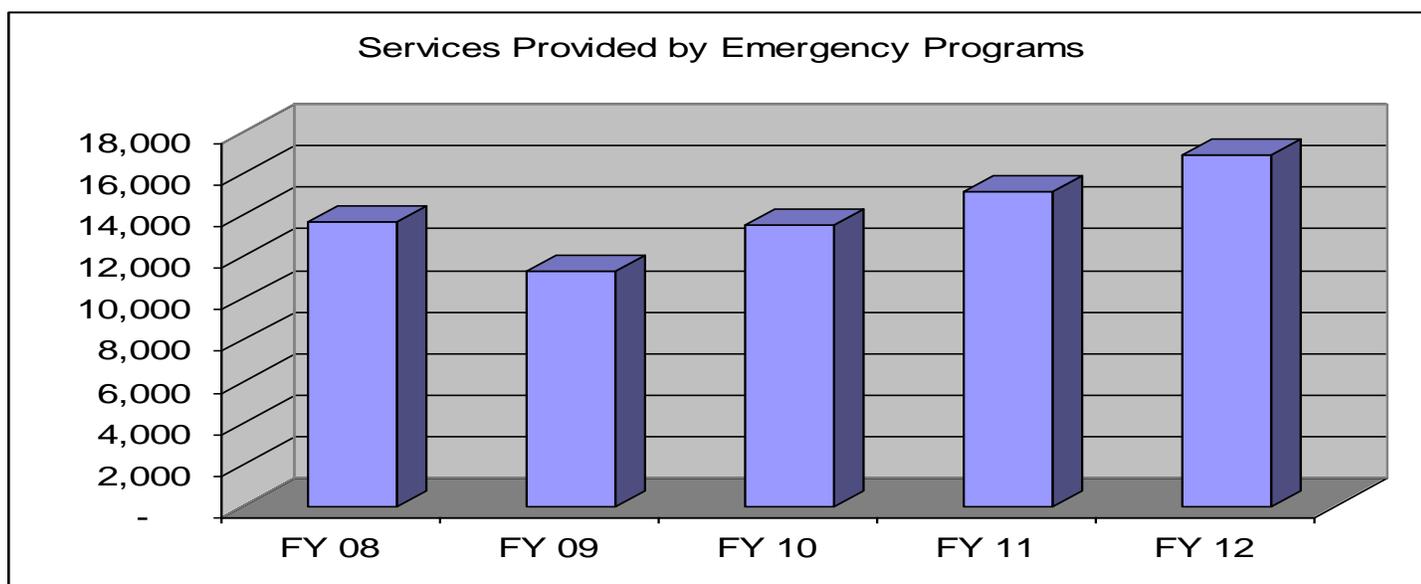
- Emergency Response time
- Reduction in Secure Transport

Adult Involuntary Transportation for Emergency Examination Use of Restraints in Transportation



Based on the Adult Involuntary Transportation Data Set maintained by the Vermont Department of Mental Health for adults transported to involuntary inpatient treatment when placed under the care and custody of the Commissioner.

WHAT BASELINE DATA IS AVAILABLE?



Services provided by Designated Agency Emergency Services Programs have been steadily rising since FY 2009. Responses to emergency and crisis needs have risen just over 50% during the four year period. Funding for the Emergency Services programs, which operate 24/7 and are available to anyone in a mental health crisis have experienced a 39% increase per capita in the most recent three fiscal years. This increase, which roughly elevated DMH funding from a low of \$6.28 per capita to \$9.00 per capita, remained in most need of resources in FY 12.

Baseline data is being collected in the areas of outreach response, particularly collaboration with law enforcement, and mobile crisis response capability being developed across the designated agency system. Increases in allocations late in FY 12 to support greater emergency services outreach and mobility of emergency services teams should be reflected in these service capacities in this current and upcoming fiscal years.

IS THERE A BETTER WAY?

Baseline data is being collected in the areas of outreach response, particularly collaboration with law enforcement; and mobile crisis response capability is being developed across the designated agency system.

PROGRAM: CHILD, ADOLESCENT, AND FAMILY SERVICES

WHAT IS THE PROGRAM?

The Child, Adolescent, and Family Unit (CAFU) oversees a system that provides evidenced-based mental health services and supports to families so that children can live, learn, and grow up healthy in their family, school, and community. CAFU works closely with its network of DAs and one SSA to provide services that include prevention and early intervention, family supports, treatment, immediate response, acute care, and intensive residential placement. CAFU also works closely with interagency partners, including the state's 60 supervisory unions and 12 AHS regional offices for child welfare, to assure that needed supports and services are available when and where needed.

HOW DOES THIS PROGRAM MEET A CORE MISSION?

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters. Pursuant to 18 V.S.A. § 7401 and § 8907, the Department of Mental Health, under the authority of the Commissioner of Mental Health and contracts with designated public or private non-profit agencies, assures planning and coordination of services "needed to assist children and adolescents with or at risk for a severe emotional disturbance". In addition, under Vermont's Act 264, DMH is mandated to work with families, child welfare, and education as partners at both the state and regional levels for this population. Under the 2005 Interagency Agreement between the Agency of Human Services and the Department of Education pursuant to the federal Individuals with Disabilities Act (IDEA), the scope of the interagency system of care expanded to include children and adolescents with any of the 14 disabilities covered by state and federal special education law.

WHAT DOES SUCCESS LOOK LIKE FOR THE PERSON?

Children and adolescents develop the ability to accept and overcome challenging or adverse circumstances, supporting their "resiliency" which is a fundamental and natural characteristic essential to healthy development. Resiliency can be nurtured and supported by caring adults who take a strength-based approach to foster and empower a child's efforts to cope with hardships.

WHAT DOES SUCCESS LOOK LIKE TO THE COMMUNITY?

Community members, organizations, and schools know available resources for children and families that can be readily accessed for assessment and support. They work together to build and maintain an interagency system of care that provides high quality services and supports so that children, adolescents, and young adults develop the skills necessary to be contributing and caring members of their communities.

WHAT PERFORMANCE MEASURES ARE USED TO DETERMINE PROGRESS?

As part of its on-going efforts to more effectively and efficiently support Vermont's families as they work to raise healthy children, the CAFU is pursuing the following initiatives:

Trauma – Developing effective treatment and support services for children and adolescent who are experiencing or experienced severe and/or complex trauma. CAFU received a Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services grant and has:

- ◆ joined a new national network of grantees—the *National Child Traumatic Stress Network*.
- ◆ established the *Vermont Child Trauma Collaborative* to implement and sustain the Attachment, Self-Regulation and Competency (ARC) Framework in Vermont’s community mental health system.
- ◆ consulted with The Trauma Center at the Justice Resource Institute in Massachusetts for the statewide dissemination of ARC
- ◆ Trained over 600 individuals in the ARC framework.
- ◆ Over 70 clinicians received 2 years of additional training and consultation.
- ◆ Currently training 20 individuals to become official trainers of the framework which will allow Vermont to sustain the training of professionals without relying on outside providers.

Youth Adults in Transition - DMH applied for and was awarded a \$9 million, 6-year, competitive grant to assist adolescents and young adults who have experienced mental health issues and provide the supports necessary to access health care, post-secondary education, employment, housing, and caring relationships with adults who nurture positive youth development. Strategies used by all 12 regions include:

- ◆ Young adults will be empowered throughout the state to help design a young adult driven system of care.
- ◆ All agencies/departments serving young adults aged 16 – 23 will work together to create a young adult driven system of care.
- ◆ Mental health and substance abuse services will be designed for this young adult driven system of care.
- ◆ Address Vermont State Outcome #7: “Youth Successfully Transition to Adulthood” and the following goal: Vermont’s young adults of transition-age with SED will have adequate preparation and the necessary supports to be productively engaged in the community and free from incarceration.
- ◆ Reach out to young adults with SED who are out-of-school at least through teen centers, recovery centers, homeless youth programs, and by intercepting them at critical intervention points with the juvenile and criminal justice systems.
- ◆ Improve access to mental health services for the young adults most at risk for poor outcomes and use the power of the courts to increase their likelihood of use of those services.
- ◆ Provide cross-system case management and individualized service plan development, ensuring that young adults are engaged in planning for their own futures.
- ◆ Link and/or provide young adults and their families/adult allies with:
 - a. Access to health care (including insurance and especially for co-occurring mental health and substance abuse treatment)
 - b. Post-secondary education (also training, and options for completing high school)
 - c. Employment
 - d. Housing (safe, stable, and adequate)¹, and
 - e. Caring relationships (with adults who nurture positive youth development).

¹ Though the federal grant funds cannot be used to pay for housing *per se*, they can be used for the service coordination and community supports that may make it possible for youth to stay in housing.

Making these linkages requires efforts to integrate AHS services for young adults of transition-age and to collaborate with other public and private service (including housing) providers, substance abuse prevention coalitions, Workforce Investment Boards, law enforcement, and criminal and juvenile justice officials.

- ◆ Adopt one or more evidence-based practices that are consistent with and build upon the JOBS program in the region.

Youth Suicide Prevention - Working in collaboration with the Center for Health and Learning, CAFU was awarded a \$1.5 million grant for youth suicide prevention from the SAMHSA which included the following objectives, all of which have been achieved:

- ◆ Created the *Vermont Youth Suicide Prevention Platform* with strategies that can be used by individuals, communities, and collaborative groups to prevent deaths by suicide.
- ◆ Developed a public education program about mental health entitled *UMatter*. It is aimed at individuals and service professionals and based on the concept that it is important to get and to give help when people are in emotional pain.
- ◆ Administered the evidenced-based Gatekeeper Program's *Lifelines* curriculum in selected schools.
- ◆ Established protocols using the *Connect* curriculum for first responders, faith-based organizations, and primary care providers in selected communities.

Family Mental Health Model - The DMH, the Vermont Children's Health Improvement Project (VCHIP), and the Department of Child Psychiatry at the University of Vermont (UVM) have been collaborating for several years to develop a collaborative vision of family mental health. This vision includes the following elements.

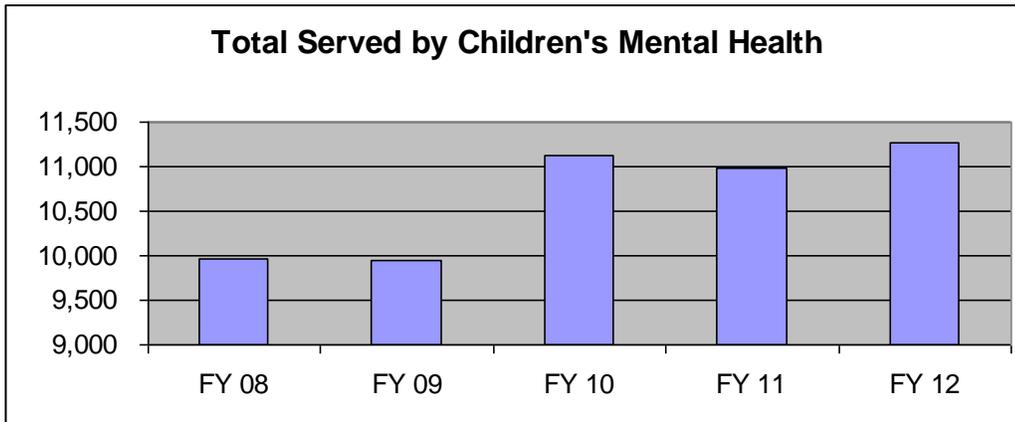
- ◆ Child Psychiatric Fellowship Program at UVM to train and retain child psychiatrists.
- ◆ A Family Mental Health Program that includes evidenced-based practices to provide mental health wellness, prevention, and treatment services.
- ◆ The Family Mental Health model is being discussed with the developers of the Vermont Blueprint for Health for use with pediatric practices.
- ◆ Co-location of mental health professionals in primary care offices; currently in 8 sites.
- ◆ Psychiatric consultation provided for complex cases, currently in 41 sites.
- ◆ Psychiatry telemedicine in 4 sites.
- ◆ UVM Child Psychiatric Fellow worked with DMH's child psychopharmacology workgroup on academic detailing.

Integrated Family Services (IFS) - AHS children's services fall in 11 divisions across 6 departments and multiple divisions of the agency. Divisions and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for serving specialty populations. The Integrated Family Services Initiative seeks to bring all agency child, youth, and family services together in an integrated and consistent continuum of services for families. The premise is that giving families early support, education, and interventions will produce more favorable outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access *high end funding* streams which often result in out of home or out of state placement.

Success Beyond Six (SBS) - Vermont has been actively developing its partnerships between mental health, education, and students and their families under the Success Beyond Six (SBS) partnership since 1992. In Success Beyond Six, school districts or supervisory unions contract with their region's community mental health center. SBS now operates from a basic state-wide contract template with

detailed local work requirements, provides state-wide training and skills guidelines for the position of Behavioral Interventionist, collects data on children served, and works to support the Department of Education's efforts to implement Positive Behavioral Interventions and Supports (PBIS, also known as PBS), an education evidence-based practice.

WHAT BASELINE DATA IS AVAILABLE?

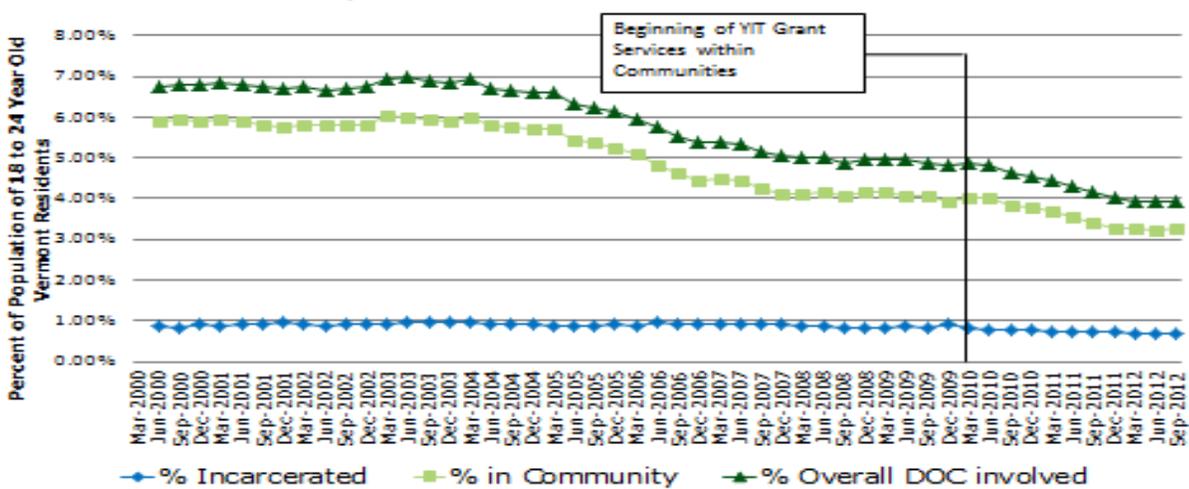


The collaboration of mental health services and school programs has contributed to an increased demand for school-based mental health services and supports. Since 2009, services have increased by 13%.

Focus on building an interagency system of care for youth transitioning to adult life is helping to keep young adults out of corrections, in school or employed, and living successfully in their communities.

Statewide Data from Vermont's Dept. of Corrections

Proportion of Population of 18 to 24 Year Olds Involved in the Department of Corrections Over Time



IS THERE A BETTER WAY?

DMH CAFU continues to be a key partner in the development of Integrated Family Services, an AHS effort to consolidate all child and family services so that IFS can issue one contract to each of the AHS regions. The goal will be to achieve overall wellness for all children and families in each region, allowing providers more flexibility in meeting each family's needs while improving the system's effectiveness and efficiency.

AHS with DMH is currently piloting IFS in Addison County; Franklin and Grand Isle Counties will follow soon.

PROGRAM: INPATIENT HOSPITALIZATION

WHAT IS THE PROGRAM?

The Department of Mental Health, pursuant to 18 V.S.A. § 7205 operated the Vermont State Hospital (VSH) until August 29, 2011. Subsequent to closure, former patients of VSH were discharged, moved to hospitals, recovery residences or crisis bed programs, and secure facilities throughout Vermont. The Commissioner of the Department of Mental Health remains statutorily responsible for the supervision of patients receiving involuntary mental health treatment at the five designated hospitals throughout the state:

- Fletcher-Allen Health Care
- Central Vermont Medical Center
- Rutland Regional Medical Center
- Windham Center
- Brattleboro Retreat

The Commissioner's responsibilities include persons undergoing emergency examinations, court-ordered or forensic evaluations, and ongoing treatment for individuals whose mental health needs are beyond the community's capacities.

For people who are most acutely ill, Brattleboro Retreat, Rutland Regional Medical Center, and Fletcher Allen Health Care entered into contracts with DMH to identify and treat most acute, patients, now identified as Level I patients. Reimbursement for these enhanced services has been developed based on real, actual costs. Expansion and strengthening of this system is underway and will be in place within the first quarter of 2013. This now includes the Green Mountain Psychiatric Care Center, a new 8-bed state-operated psychiatric unit in Morrisville, Vermont that opened in January, 2013. A new 25-bed state-run hospital will be built in Berlin and is scheduled for opening in early 2014.

HOW DOES THIS PROGRAM MEET A CORE MISSION?

Pursuant to 18 V.S.A. § 7401, the powers of the Commissioner of Mental Health include the authority to "designate, control, and supervise the property, affairs, and operation of hospitals and institutions equipped and otherwise qualified to provide inpatient care and treatment for individuals who are mentally ill."

WHAT DOES SUCCESS LOOK LIKE FOR THE PERSON?

An individual admitted to a hospital, whether voluntary or involuntary, feels safe, supported, respected, and an active participant in their treatment and aftercare plans during their admission.

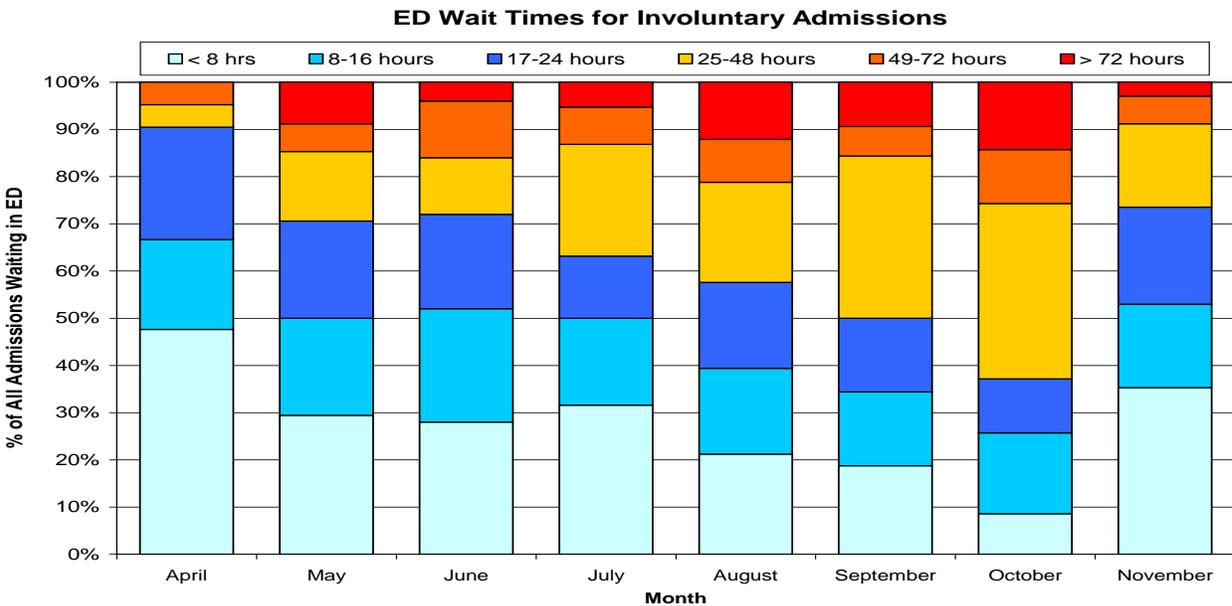
WHAT DOES SUCCESS LOOK LIKE TO THE COMMUNITY?

Individuals in need of psychiatric hospitalization, whether voluntary or involuntary, are able to access the right level of care when they need it and receive treatment, stabilization services, and have an aftercare plan that will allow them to successfully return to their community when discharged.

WHAT PERFORMANCE MEASURES ARE USED TO DETERMINE PROGRESS?

- Hospitals providing involuntary treatment services are monitored for adherence with legal and statutory requirements for involuntary hospitalization, current policies and procedures for delivering care, and other guidelines outlined under hospitalization designation for designation by the DMH Commissioner.
- Decreasing wait time for hospitalization
- Adherence with requirements of Act 114, administration of court-ordered involuntary medication

WHAT BASELINE DATA IS AVAILABLE?

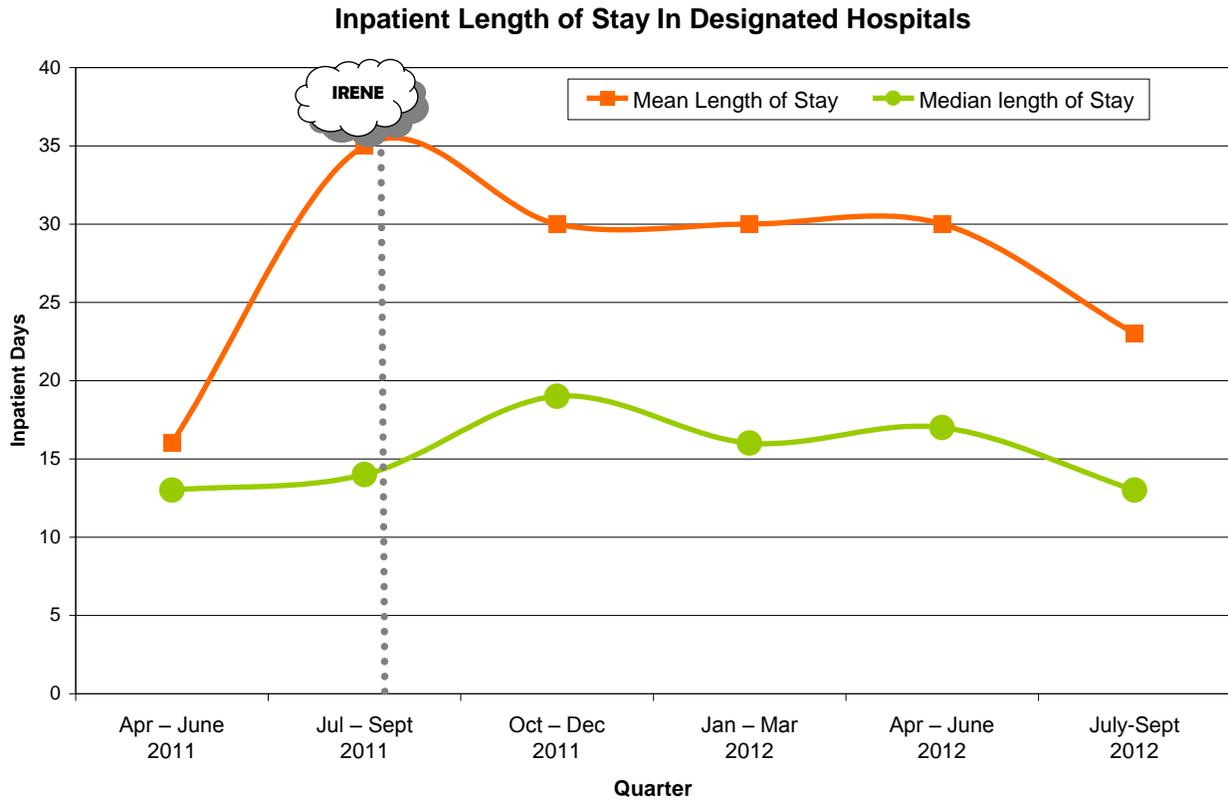


Emergency Room holds tracked over the past nine months shows the number of persons proposed for emergency examination admissions and wait times ranging from less than 8 hours to over 72 hours as acute care inpatient bed capacity remains constrained.

ED wait time calculates the time an individual enters the ED for services until placement in a psychiatric bed or discharge from the unit. ED screening routinely includes medical assessment in conjunction with considering a psychiatric admission, so wait times above do not differentiate the routine wait for medical assessment that anyone experiences in the ED from the wait time associated with psychiatric bed availability. While any wait is undesirable, wait time for ED services nationally is in excess of 4 hours on average, with longest waits of over 8 hours for emergency care (Press Ganey Health Report 2010).

The rate of inpatient placement being delayed in Vermont has increased over time, though the number of involuntary applications has remained stable. This is due to the overall reduction in inpatient beds and the intensity of services required. Of the 252 waits identified during this time frame, 63% (158) were placed within 24 hours of presenting to the ED. Over the 35-week period, on average, only one wait per week

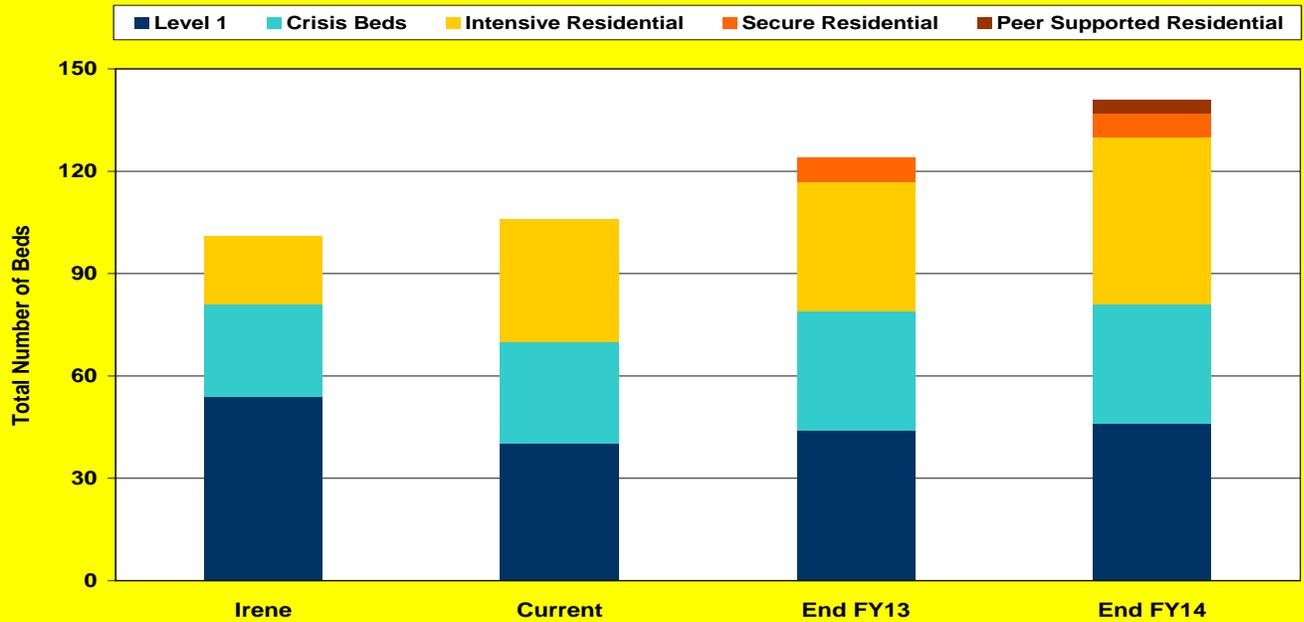
exceeded 24 hours. Efforts to expand crisis-bed utilization when clinically possible facilitated the movement of inpatients to step-down facilities. In addition assertive care management and the collaboration of inpatient providers reduced the wait times overall. In November 2012, wait time improved significantly and is expected to continue to improve as the eight new beds at GMPCC begin to address some of the demand for inpatient services.



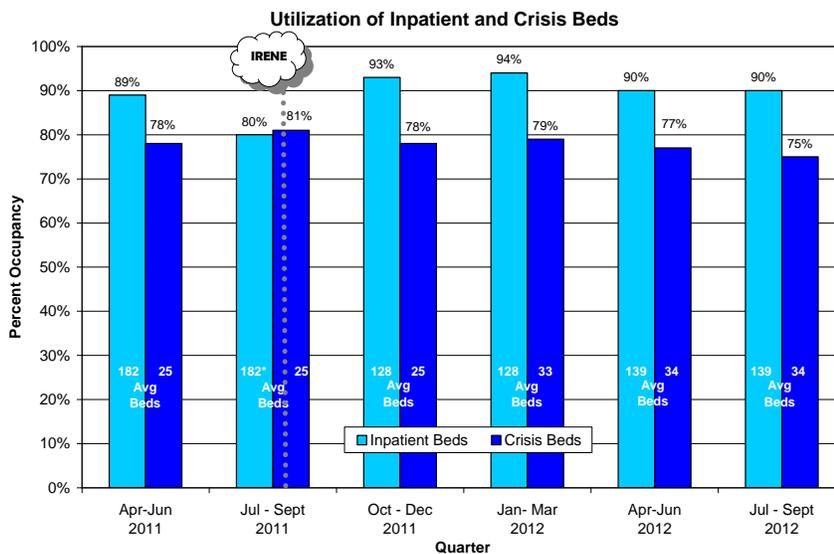
Based on analysis of the involuntary inpatient data set maintained by the Vermont Department of Mental Health for adult patients admitted to involuntary care at Designated Hospitals.

This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients since the 4th Quarter of FY 2011, before the closing of VSH, to the most recent 2nd Quarter of FY 2013. The trend is to a decreased length of stay in hospital settings, despite some initial concern after the closing of VSH that the length of stay would possibly increase as a result of the systemic changes including the decrease in available beds. It appears that patients with higher acuity are being treated on an inpatient basis and others are appropriately being treated in the community through continuum-of-care alternatives such as crisis beds and/or enhanced wraparound services through the DA programs. The median length of stay is fairly stable while the average length of stay has steadily declined over the reporting period. The Care Management Team’s active facilitation of discharge planning might be reflected in the decrease LOS figures.

Vermont Department of Mental Health Psychiatric Beds in System of Care



Occupancy of inpatient and crisis beds is shown over time preceding the closing of VSH to the present. It is important to note that occupancy is determined at a moment in time (midnight) and does not include the time to “turn over” a bed. Occupancy reached its highest level immediately following the closure of VSH and is now stabilizing. Occupancy of crisis beds has remained fairly consistent with the addition of new crisis beds (25 to 34 beds) documenting the need for the increased capacity at this level of care. As the care management team better identifies the level of care available at crisis bed programs, it is anticipated that the overall occupancy rates will increase.



* Following Tropical Storm Irene (end of August) the average number of inpatient beds dropped to 128.

Care Management

An electronic bed board was established in August 2012 as a means to track availability of inpatient and crisis bed capacity for placement of patients in need of treatment. The new system replaced the previous daily bed tracking system operated by DMH's Acute Care Team. It is used by the screeners and others at the DAs, DMH care management staff, and the DHs for daily monitoring and management of the needs and resources for patients, and it provides key measures of capacity. Each weekday morning DMH leadership and care management team staff meets to discuss individuals in need of or in the process of hospital placement. The staff works collaboratively with the DAs, the hospital staff, law enforcement, Corrections and other involved agency personnel. DMH provides 24/7 admissions information and support services through DMH Admissions Unit staff and after-hours clinical and administrative staff availability to community providers.

IS THERE A BETTER WAY?

Addressing High utilizers of hospital:

- DMH will initiate a process to review readmission trends in order to identify specific factors and develop a plan to reverse the increase in readmission rates.
- All cases readmitted three times to a hospital will be referred to the technical support team for review
- The care management and technical support team will work together to identify the best living environment match to assist a person in gaining stability within the community.
- DMH will consider more wraparound programs; although expensive, these programs are highly successful investments in the recovery of the individual. Among the individuals placed in wraparound programs, hospitalization rates are negligible.
- A few individuals move from hospital to high-cost community-based wraparound programs and require significant supervisory resources, and yet they accept little in the way of treatment and present significant safety concerns. Evaluation of the numbers in this category, as well as a public-policy discussion regarding the cost of individualized programming versus congregate housing, is planned for the coming year.