LOCATION: Brattleboro

System Needs

Category	Themes	Detail
Wellness	Housing	*Needs* - Supportive housing. *Needs* - Better access to healthy foods across age spectrum and outdoor activities – focus on wellness
	Wellness vs. Diagnosis	*Needs* - Greater focus on whole-body wellness. How can we leverage the person's strengths and abilities to maximize what they can do? Being able to build strengths that allow you to be able to navigate a space and meet your needs on your terms without being more vulnerable. Focusing on the individual's capacity. Allowing people the time, space, and support to learn new things. This would require a much more flexible mental health system. *Needs* - Removing a diagnostic label allows providers to work with people and see them as they are without labeling them. This allows people to focus on and strive for wellness. It also allows people to access treatment freely and without restrictions. [also under Access]
Prevention	Funding	*Needs* - Spend assets on prevention – spend money on those who aren't in crisis to get supports *Needs* - As a community, don't have funding for healthy communities, supporters, mentors, etc. but crisis is the wrong place to go. Need to build resilience. [also under funding]
	Across the age-span	*Needs* - Real prevention – think about services for really young children, not just therapy or 10 min with a psychiatrist. How are we supporting communities, have BB games with positive role models. Services in elementary schools. Really early family based intervention. *Needs* - Early prevention. Parent education. Support of new parents.
	Timeliness	*Needs* - Having 1:1 support readily available. From a preventative standpoint, having more support immediately available when someone is struggling. Specifically, this would be available in the community to provide mental health services for adults. This could reduce barriers to employment, support people in accessing needed treatment at various levels of care, etc. *Needs* - Lack a lot of prevention. Help people when they are absolutely on fire. Don't get in front of a crisis that we see unfolding.
	Street Outreach	*Strengths* - Howard enter has street outreach people. That is preventive.

Treatment	Shared care planning	*Needs* - Every agency that has ever worked with this individual. Historical perspective is key. Shared care plans is there, but not really working.
	Trauma informed	*Needs* - Trauma-informed care absolutely necessary. New providers were ignoring his past history. Didn't want to hear about it.
	Programs	*Needs* - More resources for peer support services. There is an assumption that you need to go to a professional to get help, but sometimes people want to talk with someone who has lived experience. The Hive Support Network is a good example of a peer community. *Strengths* - Housing first – outreach workers
Recovery	Post-crisis capacity	*Needs* - Post crisis care (after patient hospitalization) should involve a place to go that is less formal than the DA but can help keep people on track from going back into crisis (maybe a life coach/peer support - Bachelor level degree).
	Peer	*Strengths* - Increasing use of peer services.
Integration	Shared care planning	*Needs* - Blueprint started shared care plans, community health teams. Everyone was pulled in. meant to reduce overuse of services. Was a step I the right direction. OneCare conversation now, but that's in the ether. Hasn't landed here. That is shared data. 423 CFR and HIPAA problems. Some states can flag homeless, ER issues, among all providers. *Needs* - Shared network so all providers know what is happening. Preventing the hemorrhaging. Not just add more beds. Have to think in different ways. *Strengths* - The Blueprint for Health.
	Navigator	*Needs* - If somebody came into the ED and the person who greeted them then walked them through the entire process, that would help a great deal. Then connect you to all new people you have to deal with. Ideally that would be with someone who knows the entire process and can explain that. *Needs* - When someone has a baby, they wind up in an entirely new system. Yet you are in a time of great transition and then you have this other transition. *Needs* - Collaboration and accountability. There are a lot of services in this community that all do something well. Frequently, there is no gap analysis. Why are all of us trying to be everything to everybody. Why not focus on what we do well and then connect with others who do other things well. We shouldn't be our own barriers. *Needs* - Understanding how to navigate the system of care. Navigators/peers in ED's and state offices or other area agencies; model patient health care; navigators are knowledgeable and provide referrals and access to providers/crisis person. Add responsibilities to DA Master Agreements. *Needs* - I knew what the system was yesterday, I do this for a living, then I tell someone something is going to happen a certain way, and it turns out it no longer is that way. They don't trust you when you do that. Hard to guarantee access to anything.

Access	Remove barriers	*Needs* – take down barriers to mental health treatment and finding therapists in this region and in Vermont to find qualifying providers and Drs *Needs* - Same day access. Get services when ask. Have access to peers. Supportive housing options. If someone doesn't want a roof and wants to live in a tent, where can they do that safely and with support. *Needs* - Multiple access points. Who is your trusted person? Library as an access point. Childcare providers. *Needs* - transportation *Needs* - It is impossible to draw a diagram of the MH system in Vermont. Astonishingly complex. Yet I work within it every day. How some pieces relate to other pieces is not clear. We have one dimensional maps of the system, but there are eligibility requirements, etc. that blow it out into a 3D map. *Needs* - When trying to support people in accessing services 24/7 it is not possible. More support available on weekends and after hours. Increased access to support when you need it *Needs* - Removing a diagnostic label allows providers to work with people and see them as they are without labeling them. This allows people to focus on and strive for wellness. It also allows people to access treatment freely and without restrictions. [also under Wellness] *Strengths* - Have success in getting people out of ED fairly quickly.
	Housing	*Needs* - Greater access to housing and improved housing security. Could the DAs purchase more properties to ensure that their clients have access to housing and that they are not under the whim or landlords? One concern though is that the DAs could then use this housing to be coercive to clients to need to engage in treatment and that clients would still be "under the thumb" of the DAs. We do need more income-based and affordable housing. The Housing Trusts in counties often have incredibly long waitlists (e.g. three years!) so the access to housing is deeply limited. *Needs* - More access to long-term housing that affords people dignity and improved quality of life. Accessing this housing is the exception and not the norm.
	Transportation	*Needs* - Greater support with transportation so that people can attend their appointments and access services. There are a lot of barriers to transportation resources, such as only being available for medical appointments and being contingent on no one in the house being able to drive. We end up having all of these different vans driving around, each with their own funding stream and intended population to serve, and each mostly empty while there are people who need housing and cannot access a ride.
	Community	*Needs* - Don't want anyone to have to walk into a DA – DA services should be in the community where people are.

	Eligibility	*Needs* - Not just transparency of the system, but of interdepartmental and partner contingency planning for when people do not meet eligibility requirements. *Needs* – lower the bar to define "crisis" *Needs* - difficult for middle class [not Medicaid eligible, but may not earn enough to afford care] who may not be able to access mental health supports. *Needs* - Many people have been dropped from services because they did not attend meetings. Where is the outreach to make sure someone is doing okay, or to identify and reduce barriers to attending an appointment?
Quality		*Needs* - Think of people and families challenged and needing support, think about how to make their lives better, help support them – that would make our system far more effective. *Needs* - Be flexible. Not rigid. *Needs* – have a philosophy of care – policies and procedures need to be flexible enough to make it work. *Needs* - Imbue care with more lived experience. *Needs* - On a national level – community treatment model. Two most effective things are housing and people with lived experience. *Needs* - All parties need to know what one another does. I should know a lot more people in this room than I do. There should be a MH bible. A book with everything everyone does with contacts. Get things done better. *Needs* - MH system needs to be broken down step by step. This is the next step in the process, etc. *Needs* - Even if you don't ask for help, people recognize that you might need help and offer it. *Needs* - Someone having pride and respect for what they're doing and enough intellectual context and training to communicate that. Having the time and attention to do that, as well. *Needs* - Relationship based – yet we don't take care of staff, constant turn over, not just due to low pay – it's everything. *Needs* - Someone who is willing to speak my language rather than expecting me to speak their language. *Needs* - Being able to connect me to other people who can be helpful. And connecting to other people in a warm hand-off kind of way. *Needs* - Instructions have to be very clear, step-wise and tell them how long each step will take. For someone who is struggling, telling them to call one stranger and then go to somewhere else, nothing will happen. *Strengths* - Pathways to Housing culture is one example. *Strengths* - We are all here because we care, want to help people get through to a better place. *Strengths* - We are able to talk honestly about these issues.
Person-centered and Culturally Competent	Transparency	*Needs* – Transparency helps so much with building trust and loyalty – discussing diagnosis with clients so that they are part of the process *Needs* – for clients to have access to all their information. Need truly informed consent. HMIS – Homeless Management Information System. The client can note who can see specific information. *Strengths* - Overall respect for individuals and relationships with one another compared to other states o Vermonters care and want others to be happy and healthy o Neighbor helping neighbor – community partners/agencies working together – RELATIONAL

		- Vermont does well serving for low income Vermonters who are at risk - Better access to healthy foods across age spectrum and outdoor activities – focus on wellness - UVM – building on making successful, research based, established health/mental health system more accessible to more people *Needs* – knowing how things work is reassuring. Include people in that process. *Needs* - Greater trust and openness. Once you leave the mental health system you can't go back in and thank the people who worked with you. *Needs* - Making safe childcare available when someone is accessing mental health or substance abuse treatment. Having supports for parents to meet their own needs. *Needs* - Full explanation and involvement of the patient in mental health decision making. When someone is forced into an experience that does not feel helpful, it is a recipe for disaster. Being open and transparent and clear with the patient about the treatment and all aspects of decision making. Coercion is never a good way to bring about mental or physical health. We all have the right to participate in our healthcare, yet people lose this opportunity with certain mental health diagnoses. We are the people who need healthcare and we need to be able to participate in our treatment. This is what we need in order to be able to live our lives. Shared decision making with your provider makes a big difference. Diagnoses can be used to limit people's involvement and agency in their own decision making. *Strengths* - More Alyssum programs. This program also does not search you or go through your belongings when you arrive, which takes away the shame that many people experience arriving at programs. Alyssum does not talk about symptoms but rather about experiences. *Needs* - Not labeling people as "disabled" or telling them that they are mentally ill. Using strengths-based language. *Needs* - More in-home support for people with intellectual disabilities or mental health issues, who cannot live alone, but who need access to housing and may not benefit from being in a group living situation *Needs* - Removing all barriers that stand between a person and the health decisions that they want to make for themselves (employment, transportation, housing, etc.).
Parity and Stigma		*Needs* - If no stigma, comfortable sharing your information with everyone. Trauma informed. *Needs* - The entire healthcare and educational systems need to change. The labeling starts in schools because this is the only way for students to access help. People then start to believe in these labels and feel limited by them. The system needs to move away from being based on profit and on diagnostic labels and to focus on streamlining access to resources. The system is so fragmented. Instead of changing the systems we seem to try to make people fit into the systems.
Structure	Payment reform	*Needs* - The payment structure that currently exists can create a huge barrier to build relationships and going extra steps – I can't bill for services that I would normally bill for. Payment reform does not touch all the systems so it can allow us to do the best interest of all services. *Needs* - Having in-home supports more available *Strengths* - Need to make sure resources are as flexible as possible. Payment reform is a good step. *Needs* - No economy of scale – some grants are $1,000 – how much does it cost to get that money and use it?
	Alternatives	*Needs* - work location flexibility for staff and consumers *Needs* – transportation/telepsych and providers available via text as well as voice. Have walk-in hours. *Needs* - Something in between inpatient and outpatient, a partial hospital program, respites, etc., to address the gaps in levels

		of care. Stability should be more about instilling coping skills and less about medication. Utilize more peer support and life coaches (dedicated professionals); insurance reform. *Needs* - Having mental health doulas, who would be able to support people going through mental health issues. *Strengths* - More clubhouse programs, run by the people who use it. There could be more optional therapy programs and support groups, connections to mental health professionals or people who specialize in housing supports. These programs offer a lot of healthy social time and potential for early intervention. The clubhouses in Vermont offer home cooked meals, resources to help people find jobs and a transitional employment program, have two people on staff with lived experience, offer groups, etc. Look up the International Clubhouse Model. SAMSHA endorses this program as evidence-based. Can we fund more of these programs in communities statewide, including in Brattleboro? (We currently have just three: Westview in Burlington, Sunrise in Montpelier, and Evergreen in Middlebury.) Anyone can join a clubhouse, but you need a referral to get into it. This is a drawback! Clubhouses should be open and available and accessible to anyone in the community without a referral being needed.)
Funding	Increase needed	*Needs* - hard to be efficient when don't know what the resources is. Or you think you know the resource and then find out it is very limited. Not enough funding, not enough staff. *Needs* - State committees with no staff or budget. How do you get people to stay and weave them into your community network. A piece of that is money. Knowing who to schmooze with to get things done should not be the foundation of a system of care. *Needs*- Not enough capacity in the ACT model here. Staff has turned over every year. No consistency, no deep knowledge. *Needs* - Crisis team does go out when someone does not "meet criteria." But capacity is a challenge. *Needs* - a therapist who was working with a child with me – she was the hub connecting the child for everything. Case management approach. But very few do that. No funding for that work. Can't bill for that work. Not sustainable. *Needs* - As a community, don't have funding for healthy communities, supporters, mentors, etc. but crisis is the wrong place to go. Need to build resilience. [also under prevention] *Needs* - Funding for sober living. Recovery housing. *Needs* - Resources. Don't have an unending supply of whatever it is that is needed. Having the right people in the ED at the right time. At 2:30 AM when someone says they need help, they should get help – right then. Central repository to direct questions of what resources are available when. *Needs* - State contract – so little money we don't completely fulfill the contract – so much shame attached to that. *Needs* - Have to be able to provide it well. Stretching to provide services in a way that is suboptimal to patients is unconscionable. That is what we're all doing because there is no alternative. *Needs* - Medicaid rates should be high enough to attract providers. Move away from Brick/Mortar. *Needs* - More resources. When the resources are not there, no matter how hard we want them to be there and work we don't anything to work with. *Strengths* - The Medicaid rates in Vermont are much better than in NH. So there is a willingness to support/invest in the citizens of Vermont.

		Needs - Changing the parameters around SSDI, because people cannot earn more than a very small amount of income or they risk losing their SSDI. This does not support people in seeing themselves as "able" rather than "disabled." In order to access a lot of the needed services, you need to keep yourself poor. If you don't, then you won't qualify for programs and housing and medical care under Medicaid or SSDI. If you could work, then fear of losing your SSDI could be a disincentive to working, which is counterintuitive. *Needs* - Change in policy around health insurance so that everyone can access health insurance and afford and access their healthcare. We need universal healthcare!
	Community	*Needs* - Local navigators on site who know all the services in the area and can connect people; bill Medicaid as an outpatient, preventative service. *Strengths* - Community Support worker, or care managers. They know what is out there, know the landlords, the shop keepers. But when they leave lose that knowledge.
Coercion		*Needs* - not coercing people into mental health treatment or into taking medications. There is a concern that medications actually cause or exacerbate a lot of the symptoms that they are intended to treat
Technology and data sharing		*Needs* - More secure technological communication – to communicate w/clients via text messages, social media etc. *Needs* - Expanding Care Navigator software to allow for collaborative networking when you aren't available to attend and provide feedback to meet the needs of your clients

System Vision and Ideals: Brattleboro

Category	Themes	Detail
Wellness	Housing	Supportive Housing readily available. Great River is a great model. Strength to build on. Doesn't have to be over the top. Wellness is a Way of Life MH is Now Associated with Joy Rather than Disability Connectedness – Vermonters Feel Supported and Connected. All children are nurtured by friends, family and other relatives. Change the way we approach life. Not just MH or hc. The way we interact as people. Holistic – looking at all the needs – whole person care – looking at generation of poverty and prevention Lengthen maternity leave to be with kids longer and earlier; small goal setting (more achievable equals more motivation) Caregiver and family information/education - maybe kept on DMH website; continue to help people create small achievable goals to improve their own mental health. Expanded Brattleboro time trade, which allows people to flex their employment within the time trade network.
Prevention		Toolbox is made up of peers, relationships, outdoors, music and dance – things that are health-giving. Early intervention in schools – what are the ways we are using PBIS. Mindfulness and meditation. Things that have been proven to work incredibly well for many things. How are we incorporating those things into our system of care so people do have choices. Partnerships with state park services, any publicly funded events, etc. getting out in nature more. All different kinds of venues. Free statewide daycare More "Cares" organizations in communities (e.g. "Dummerston Cares"). These are volunteer groups that help community members to stay successfully in their homes and in the communities. There is not a "Brattleboro Cares" group, but this would be great. These services are available for anyone in need, not just the elderly. • Start at a young age to intervene with bullying and support youth who are bullied. • Educate everyone in non-violent communication. • More focused intervention and education for parents, especially parents who have experienced trauma. Otherwise traumatized parents are likely to perpetuate trauma for their children.

Treatment	Alternative treatments	Low barrier housing works for substance use disorder. Alternative to ER – community based, proactive, upstream efforts. Living room concepts – another option. Support, peers, whole concept. Wasn't inex but less expen than Peer support, Open Dialogue, CANs model. Risk assessment. Community treatment is the biggest bang for your buck. We have had two people in our ER that have cost $110,000 since January 1st. Could fund an ACT team for that. Soteria is a good concept. Inner Fire in Brookline. Good option, but inflexible. Could there be funding for those kinds of alternatives. Drugs are last resort. More eastern medicine rather than western medicine.
	Support	Case managers at DAs vary a lot in their presence, attentiveness, and level of support when their clients are inpatient. Having a greater ability to be present and engaged to meet with clients in the hospital and in the community with a focus on outreach and accessibility keeps people supported and stable. Having teams of providers who will go out and meet with people wherever they are would be ideal. Prisons, jails, hospitals, mental health care facilities, and foster care systems should develop and implement plans for discharging people from those institutions or systems of care directly into housing with supportive services as necessary. A much stronger common sense effort to "reassess [the] discharge planning process ... to ensure … responsive[ness] to discharge needs" [cf. 42 CFR 482.43]. Common sense should dictate that immediate follow up after a period of inpatient treatment is crucial. There needs to be a clearly identified "go to" person so that the recently discharged person can work to resolve issues as they arise.
	Substance Use	Substance use focus/prevention/treatment recovery – need more skilled staff – barriers to certification and affordability Substance use services more available across age spans Injection sites for people who struggle with IV drug addition as well as mental health issues. Medical attention would be immediately available if someone did overdose. Counselors and mental health programming could also be available to provide additional supports.
Recovery		Expand peer respite programs. Having peers embedded throughout areas of the mental health system to support people in understanding what their options are.
Integration		Have more tolerance for medical needs in psych facilities, and in med units have more tolerance for psych issues. Brain health and body health – all part of health. The division of "mental health care." Should not be that division. It's health care. Truly integrated care, not co-located. Levels of care – every level of care now is being pushed through the same funnel. But if you were able to access care at your PCP, could have more choices. Annual check-up includes mental health is meaningful way (not just questions about suicide). Accountable Community for Health, ACO, some good things there. We can't do it in a vacuum. Wraparound holistic services – collaboration of health, mental health, basic needs o not discharging to homelessness, or PCP, or insurance

		o without PCP/Mental health appts with transportation plan to appts o step-down programming from higher level of care/sober living homes o not being penalized for MH services – if they miss their appt 3x they shouldn't be dropped from services (not be a fiscal issue so it doesn't need to happen) o transitional services between age spans – TAY, transitioning out of DCF custody, recent divorce, having kids, becoming elderly, etc. School counselor/social worker goes to the home; incorporating PCPs/MH; 3rd space (6-26 yr olds) both formal and informal settings - school is not responsible for all kid's needs; VCP type organization for educating counselors/admins that is partnered with VCP (teacher/admin training in MH); open up services to non- DA's; dissolve DA's - bring it to AHS/DMH for navigation and connection to all area services, not primarily DA. More fluid partnerships between all of the various agencies and groups involved to create a shared umbrella and improve coordination of service delivery. There is a lot of fragmentation between the DAs and people have to be within a specific catchment area to get services. There isn't always consistency between the DAs in how they practice and support people in accessing services. Nothing is standardized in terms of process, service delivery, or even the services that are available. We need more consistency in practice between DAs and more flexibility within each DA in figuring out how to meet someone's needs in a timely way. We need more services and supports available.
	ER Use	1. Partnerships needed - more informed relationships between hospitals and DAs. Too often ED is a ping-pong table between community and docs. In patient and community based sections. If someone is going to VPCH or Retreat, conversation begins in ER, here is the medication we would start with, will that work? Or start DBT in ER to support what will happen. Increase in respite programs. Healthworks Collaborative – Groundworks - in Brattleboro very helpful. Nurse works with DA clients. Set them up with PCP so patient didn't have to come back to ER for 4th time that week. Great River Terrace. Hospitalization diversion. NFI program as an ex. Saves money and less trauma on patient. Modified community treatment team made up of culturally diverse staff. ACT Team Vidoc Society – retired detectives from around country who meet annually and discuss unsolved cases. They often solve the crimes. In a perfect situation, people from every agency would form a Vidoc Society – all sit down and do this. Will never get answers if we don't discuss the problem. There is lots of talking and not much doing. Same meetings over and over again. 2. Infrastructure needed to reach ideal state? IT for shared care plans. Google hang-outs for Vidoc meet-ups. Tele-medicine ability. Encrypted technology. 3. Staffing and personnel - Provider and clinician shortage. Staff needs to value shared care plans. Need to value collaboration. Leadership priority.

		Turn-over costs to the clients, the system. Clients have to keep telling their stories. DAs – 90% of funding is Medicaid. Rates are not going up 12/5% like BCBS is. Challenge for hiring and retaining people. Salaries too low. Staff are on food stamps, have two jobs. One staff person with social work degree cannot take a social work job. Working in IT because of pay. Tuition reimbursement. Getting people to come to Vermont for jobs. Training – making sure consistent, trauma informed training. Right fit, understand importance of relationships, collaboration. People who are hired are the right people. People with compassion, who are well-matched to the work. Caseloads are manageable. Holistic care. 4. Practice changes – something like what Pathways does. Vouchers to meet with worker at least once a week every week. Supports limits needs for crisis services. Hands on approach. Community based – whether mobile outreach or other options to go for services – we are doing some of it, but not enough. Have many promising practices – making sure staff are trained. Mutuality, peer support – make sure staff have appropriate training to support them to do the kind of community-based work with communication as key to supporting people. More ACT Team approach. Shifting to a focus on prevention and wellness. Think about Great River Terrace. Not super far upstream, but there is a lot of support there for people. Harm reduction. Same day access – real time access. Would involve centralized scheduling, technology to support this. For a therapist to see someone for 10 years – that's where the community can come in. 5. Policy changes – community-based funding streams. Well-funded, robustly supported. Community decides. If you use 6,700 crisis beds in a year, what would it take to change the model so you only use 5,600 beds in a year? Look at system as a whole – every part has something that is good. Find that good and learn from that and build on that. Collaboration is the most important word. People's physical health care does not differ based on their psychiatric status. Too often people with a record of psychosis or anxiety, if they go to the ER having a heart attack may be told it's anxiety, not a heart attack.
Access	Providers/General	A larger pool of psychiatrists and therapists who are experienced with a wide variety of people/conditions/issues, etc. No more waiting lists. Greater access to specialists. People need both – regular times to check in, and also support when there is a crisis. Need prescribers, need case managers, psychiatrists, outreach Training opportunities Streamlined intake process – easily understood, transparent, and timely Community based therapy HIPAA blocks more than it protects (can life coaches/peers not have to follow HIPAA); how insurance is billed to cover

		all services (whatever insurance doesn't cover, state assists); vet releases and waivers, etc. with an attorney to allow use of technology. Mental health care navigators by phone, can be in the office or home; a 1-800 number not for crises , more than 211, helps person to fill out forms or make calls; create a consortium that includes all stake holders within districts/schools. Transportation would be available to everyone regardless of the program or funding source.
	Alternatives	More modalities, so you can access anything you need whenever you need it. navigators located in the community such as libraries, city hall with private spaces to meet; when people come into the state AHS agencies to apply for cash/food there are navigators available right then and there if needed/ wanted that insurance will cover. Greater spectrum of services. Greater training and focus on Open Dialogue.
Quality		Exchange programs – train in other countries and get different vision of how approach. Need support and to be treated well – promotes professional development, strengths based, supportive, safety, Supporting work/life balance – allowing for self-care, wellness EAP more accessible ex. THRIVE Empathy building for staff Work culture should be more positive. Practice what you preach Proactive vs reactive – prevention – Schools pre-k ACES training
Person-centered and Culturally Competent		Kindness. Anybody in any state of need is treated kindly. Future Released from Past and Circumstances Have true informed consent. Wide variety of good modalities available so people really have a choice, know pros and cons of each. People would speak honestly and welcome full range of choices. Whole issue of coercion would not exist.[also below under coercion] There are many people who for whatever reason cannot live in a nuclear family, but need to live in a community. How do we support that? At all ages, all capacities? People need a balance of independence and community. So need to be able to set it up to suit yourself. How do they want their life to be? And you don't start as an inpatient and titrate out. Could just say, I need this right now, and do that for 6 months or 20 years. Full buffet of choices for medications – which include physical activity, music, etc. Addictive nature of drugs is clearly described before prescribing. Work pools – some type of a local site that a person could go and work for two days and next day they go back and do two days of something else. Phase in when healthy. Public housing structure breaks up families. Have to change that. MH system of care splits people up. Let people live together even if some family members don't have MH issues.

		AZ has a residential treatment center for people who want to come off psychiatric drugs. Mental health first aid expansion; continue meeting people in the community. Train staff on improved understanding of how to work effectively with people with various cognitive abilities. More Occupational Therapists working in mental health. Currently only 2% of Occupational Therapists work in mental health and these specialists have a lot to offer. This work is not focused on diagnosis or labeling, and rather focuses on what people love and find interesting to build their skills, so it is very strengths-based. Language change to not use the term “mental illness.” Not using pathologizing language at a young age so that people don’t start seeing themselves and others in terms of mental illness. Shared decision making between provider and client as a practice change. “Nothing about us without us.” There seems to be a lot of contempt embedded in the system.
Parity and Stigma		Everyone has sufficient health care insurance People with money do have choices now, so we’re talking about all people having those choices. We all have neurodiversity, stop pathologizing people. If you are not neurotypical, school is not going to be fun for you, and your chances of being successful in life go down because of how others cast you. System free of class bias, gender bias, all of those things. Are there other countries we could model? Other states? The “Time to Change Wales” campaign. Hospitals take people from the community, not just the ED's. "If you can be kept safe at home, you don't need an inpatient bed." Maintaining connections while also finding the best care for more intensive MH services. Reducing mental health stigma. Improving access for people who are psychiatrically inpatient to access community resources while they are inpatient. Improvement in training in trauma-informed care, peer support, etc. Training for all service providers and for the community as a group to interact in a kind and non-stigmatizing way with people with mental health issues.
Structure		Allow time trade/barter for services. We have a lot of legacy contracts that don’t have accountability built into them. We don’t have the MH services in this county that we should have. 42 CFR Part 2 – Ohio changed all provider denominations to allow them to share info. a financial structure that supports diversity of services and complex mental health care • Greater information for providers and people using the services about what is available. A statewide resource guide available online. More information for people about how to identify and access services that exist. • Keeping the online resources and programs current. This is not helpful when the programs and providers listed are outdated. • Keeping technology user friendly so that it is easy for everyone to navigate. • More peer services, including more peer run crisis programs. • Greater access to transportation. • Greater access to affordable housing. More mobile housing and more tiny houses that people can live in. • More warm lines throughout the state, perhaps also with texting capability. Sometimes people just want the connection, or someone to check in with.

		• Mobile therapeutic units that can provide resources and connections, immediate access to counseling or crisis support. There is so much fear around liability and lawsuit, so this can really limit when an agency is able/willing to do. Insurance has really shaped the structure of healthcare and limiting how broad of a service can be provided. Services are now limited by what the specific scope is intended to be, and there is no room for a holistic or broad focus on wellness or treatment. When a need does not fit into a specific service or category that need is often not met. • ONHs should not exist. They do more harm than good, and they have the potential to do a great deal of harm. They are also totally toothless, but patients would not want them to have teeth. • Immigrant communities and folks seeking asylum need greater access to healthcare. This could be a statewide policy. • DMH could hold the DAs more accountable when they are not following through on meeting their contractual obligations or providing ineffective services. As an example, when a DA "shuts the door" on a patient there is not a lot of attention around how to work through the issue, support the person in continuing to access services, or observable oversight and accountability from DMH on this experience. This may require greater resources for the DAs to have a broader spectrum of what they can offer to clients. • Greater equity in resource availability statewide.
Funding	Crisis	Need regional psychiatric ER departments. Afraid this might be "othering" but ERs are worst place for people in MH crises. Alameda model. Need low-stim environments. Rapid response psychiatric services – not just screeners More pre-crisis support
	General	Everyone earns a truly livable wage (NOT $15/hour – more like $25) Strongly urging legislators to come to this. Have volunteers present to the legislators in a small chamber. Not just a report they file. No call/no show – payment options Better pay/benefits; more providers, but not necessarily high degree jobs; spousal benefits; aid in finding jobs for spouses; role of volunteers (voluntarism for consumers vs. employment); navigators are state positions within DMH (one per district who knows the local information), they get appropriate training, funding and support; trauma informed staff available in person or via phone/skype. More resources available to keep people in their communities. Being able to wrap and be with the person wherever they were. Providing transportation, helping people meet basic needs such as grocery shopping. Allowing people to stay in their community with supported housing rather than needing to leave their community. Resources may need to be focused in rural communities to augment services available in small towns or to help people easily get to larger towns/cities. Consider putting the resources where infrastructure already exists, such as hiring social workers at the local libraries or general stores in order to make mental health support visible and easily accessible. This service would not be tied to a mental health diagnosis or to insurance, but it would allow people to get their needs met. Find the community hubs.

	Staffing	Could we lower the cost of medical school so we can have more psychologists Grant program to pay for people who have a mental health history themselves to get a master's degree in psychotherapy. Get them into inpatient units. Student loan forgiveness for working in AHS Funding for navigators - perhaps not Medicaid, but another avenue.
	Flexibility	Allow flexibility. Flex dollars, flex time, flex locations. Flex criteria, roles, etc. It's about seeing individuals. Meet people where they are. Alternative therapies are reimbursed by Medicaid and Medicare. Registered psychotherapists but not licensed – for peers – some of them are excellent. A way of keeping it from being a free from all but provide peer services. Not paid for by Medicaid, but it can be. It would increase the diversity of psychotherapists available. Allow us to think more broadly to allow us to do real community level work. Goes back to funding streams. Trying to bridge between disciplines and such. If we neutralized funding streams that create misaligned incentives. Organization gets ability to prescribe and reimbursement is not based on individual eligibility. Being able to transition across services easily, longer funding cycles and bigger grants. Then housing and MH models that allow people to stay in place longer or however long they need to be at whatever level of care they need. People are not penalized for working by losing food stamps. Universal basic income. Remove funding restrictions. We're in a box now. Funding of services – prevention and wellness, when people aren't coming to appts to allow sustainability • Diversity for billing – payment reform expanded – providers to charge for half price for no/call no/show • Including transportation time for billing • Case management not billable for private therapists Flexible funding to help go around the barriers of insurance requirements.
Coercion		Have true informed consent. Wide variety of good modalities available so people really have a choice, know pros and cons of each. People would speak honestly and welcome full range of choices. Whole issue of coercion would not exist.[also above under person-centered] If there were more services available to people that they were interested in accessing they would be more likely to engage in treatment rather than being coerced into it. End all coercive treatment. It does not serve or help anyone. The money saved by not doing coercive treatment could be spent on other programs and supports.
Technology and data sharing		Need one electronic medical record. Need to get them together. Air Force – one medical record, and no matter where the person is in the world, their medical record is available. Technology could create no-wrong-door, deep collaboration – how does that play out with HIPAA and nothing about me than without me? Need to solve that one.

		State isn't going to have the money or resources to make this all real. But do have ability to take away barriers that prevent us from sharing data and information. Single health record. Stay out of the way. Technology as a tool; telepsych; statewide broadband; Apps to access services (211, DA's, providers, across the country too, not just in VT); transportation; kiosks at places to connect people with services/ providers; navigators; nationwide access to those providers willing to accept VT Medicaid - make reimbursement rates appealing Use the "tele-friend" model being piloted at Dartmouth. People receive tablets for 30-60 days, and the tablets offer daily check-ins as well as access to education. This could work well for follow-up from mental health treatment as well. Improved cell and internet service statewide so that people can access their providers, resources, and supports.
Judiciary, Law, Corrections, Police		All police are required to have 40 hours of crisis intervention training; social workers embedded in police force. Team Two expansion;

LOCATION: Burlington
System Needs

Category	Themes	Detail
Wellness	Provider Wellness	It is essential that the worker enjoys the job because that allows them to be there, be present, and be sincerely caring. Not being overworked (give staff ample time to get their work done and to meet with people). Keep staff from being pressed for time (example of a person who had to wait 4 months for an appointment and then when they had the appointment, it felt pressured and rushed). Ensure caregiver self-care Focus on integration of health and mental health. Stress leads to physical health issues as well as stress. Labels are not helpful. Also looking at the integration of education and mental health needs.
	Consumer Wellness	Vermont has access to beautiful nature for free and this is valuable to our mental health and health. Would like to see increased opportunities to access nature and natural resources
		Education and workforce: have more decentralized and technical training available throughout the state. Employment is a contributor to mental health.
	Community Wellness	UVM Wellness dorm – physical and mental health wellness (Dr. Hudziak) – encourage more of this and even earlier. a. Focus on wellness and mental health as part of your life; support to talk about eating, sleeping, getting help. In grade school and beyond. Destigmatizing getting counseling as part of coping with life. b. Change perceptions of this generation to be more open to MH supports. Understand trauma and address that. ACES Mental wellness in the community for all people Increasing a variety of community supports Creating community to increase feelings of worth and connectedness
		Decrease in suicide rate by focusing on societal and community issues rather than focusing on individuals specifically. Why does Vermont have such a high suicide rate? More focus on suicide prevention discussion in schools could be very useful.

Prevention	Preventative healthcare	Need to have knowledge of the population's needs and disparities Access to health care
Treatment	Early Childhood tx	Development- early intervention – childrens integrated services, success beyond six being into and embedded in the schools prior to treatment. Prevention models
		Prevention- primary prevention – regardless of age- this can occur across the lifespan- but having a system that is developmentally sensitive and trauma informed
		Early childhood- we get it right in doing it across environments. Throughout the lifespan how can we integrate more. Where early intervention and other things happen in other developmental stages across settings. Funding – what are the strategic priorities so we can target early intervention and prevention because there isn't enough money and this gets funneled to treatment.
		1) Intergenerational family support, noting that there seem to be a lot of grandparents raising children. Focus on trauma treatment for families facing fractured relationships.
Recovery	MH/ ADAP	The way Burlington is now dealing with the opioid crisis. Police chief's focus on the <u>person</u>. The hub and spoke system- no waiting list- peer coaches
Integration	Head Start/ Childcare	Need to create different ways for children to access care, especially children who are in need of services/supports but are not at a crisis level. Also need to provide supports to the parents. Need to develop better equality with pre-natal care – some areas of the state offer great pre-natal care and some do not. This is critical for the growth of the child and the parents.
	MH/Police/ incarceration	React to conflict with kindness DOJ civil rights division doesn't hear enough complaints from the MH population for a variety of reasons. They are doing more outreach to "find" the complaints (people sometimes don't know when they can/should complain or understand their rights). The DOJ office is in the same building as law enforcement and court- people don't want to go *there.* Forensic MH patients- give them a positive experience in a hospital vs. time in jail MH and incarcerated population – many people incarcerated and going undiagnosed and do not receive access to mental health services unless they ask. A disconnect between MH providers and law enforcement. Police officers needing to learn how to be more trauma informed and educated about mental health. There are a lot of struggles with law enforcement.

	MH/Dr. Office	Primary Care office does the linking to MH provider who is taking new clients. Ideal one-stop shopping where MH is at the same location as Primary Care provider. c. Community Health Center does this. But also want choice. d. MH provider in pediatrician's office, meets with everyone even. Normalizing access. e. Youth Peer groups.
		Use wrap around, wholistic approach to health. See the person as a whole being and not just treat a section of the person. (Example, person met with an oncologist and was told information about cancer but nothing else such as how it could bring about depression and how to handle all the other impacts on one's life that a cancer diagnosis and its treatment may bring.) a. Strategy: consider using the 8 dimensions of wellness for all services Focus on integration of health and mental health. Stress leads to physical health issues as well as stress. Labels are not helpful. Also looking at the integration of education and mental health needs.
		Education of physical care providers • including not only MH concerns, but more holistic view of their life circumstances. • Multi-cultural, cultural competency. • Include study of the brain.
		Practice changes – de-stigmatize MH by regular screenings at PCP. Screenings should also include trauma and addiction, domestic violence. Medical training needs to incorporate more info about mental health. Including dentistry.
	MH/ Schools	Change in the educational model to teach physical and mental health wellness in schools, including coping skills, mindfulness, etc.
	DMH DCF	DMH SOC is only one area of service to kids and families in particular- an area that deserves focus connection between DA/SSA and the DCF central. In mental health have the option of saying that when our shift is done we can go home and the child welfare system doesn't have that luxury so we need to figure out ways to partner more effectively with DCF based on their needs for having demands with no time constraint,. Support for foster families and not feeling like they are feeling supported- there needs to be more effective customer service and education and support for these folks in need.

	Community Partners	Most effective services exist where hospitals and designated agencies have a strong relationship and communicate well during care coordination
		Integrated care. No one should be protective of their turf Improved collaboration with community partners.
		Pay attention to the folks who would benefit from services who are outside of the CRT. Goes back to coordination and collaboration with private/public services. It would be good to have more care homes for adults like shared living provider in DS.
		Act 264 works really well. It would be great to see this as more of a preventative program than a crisis response program. Once someone starts to struggle it would be ideal to get in at the ground level and intervene early to prevent a situation from getting to a crisis level.
	AOE and MH	Schools are sharing mental health resources during times of crisis in the community and offering positive responses to the community.
		The system puts a lot of fear in parents when their children are not going to school. Truancy is a major issue. When you can't get kids to be in school then they are more isolated and they also miss out on needed supports. How can we help kids meet their basic needs so that they are available to learn and able to tolerate being in the classroom.
		Are there ways to build on the collaborations with other systems (education system, after school programs).
		The system puts a lot of fear in parents when their children are not going to school. Truancy is a major issue. When you can't get kids to be in school then they are more isolated and they also miss out on needed supports. How can we help kids meet their basic needs so that they are available to learn and able to tolerate being in the classroom.
	Legislature	Create a way to Bill for preventative MH – even if no diagnosis. Increase the focus of mental health as a health issue Change the law – talk/contact your legislator • mandate all large regional hospitals take involuntary and level 1

		• Wrap-around law – coordinate the services (system navigator). All services need to coordinated and available within the system of care. Gun control should be worked on to help reduce suicide (three of the participants lived in a county with high rate of death by suicide with a firearm) Making the Commissioner a non-appointed, more permanent position would make it easier for these things to be carried out. Feeling that direction changes every single time a new person is appointed.
	State Partnerships	Work with VDH about co-occurring MH and SUD needs. Need to break down silos. Vermont being smaller equals more opportunities De-siloing the different Vermont State departments – e.g. DAIL, DMH Pathologizing system. Too quick to translate into diagnosis. Want to make you feel better. Services that fit the person. Redesign program so they are not siloed by departments and programs. Interdisciplinary. Programs for folks who medication doesn't work or they do not want to take it. More holistic options (acupuncture). Vermont does have a lot of very good programs, and housing programs. Expanding the ones we have. Strength is work group in Chittenden looking at expanding private/public partnership to expand children's services (united Way). Less office based services more home base or meeting in the community. Suggest smaller case load sizes need to be smaller and case managers paid better. We have fragmented resources how do we organize or reconfigure it. Better opportunities to coordinate care through EHR, easier way to know who is working with whom. Treating the whole person. Providers having time to respond to everything they need. There is also so much coming from the state- initiatives and outcomes, documentation, QA ad QI and its just not as connected as a system of care and people are asking for so much and its adding to the stress of the organization. The "System" needs to align more and streamline their expectations.
Access	ED and Inpatient Beds	Figure out what needs to happen to increase access More training, follow all statutes and requirements to admit someone involuntarily. Decrease in wait times in the Emergency Rooms for inpatient treatment.

		Treatment at the Emergency Department. When go to ED, someone with MH background meets with person and family as soon as possible. Recommend another state hospital to address MH needs. Immediate access to care, not just in ED. More options of care, so that before get to crisis have other options for care. Drop in center. Crisis team comes out to home. Great communication between hospital and DA. Screeners are in hospital. ED docs have MH training. Just like law enforcement. Hospital hiring nurses with psychiatric training. Soothing, make feel comfortable Better ED waiting space, outside light. Peer support specialists at hospital and other settings. Beside person, with them. Can support and de-escalate. Paid peer support. Could begin as volunteer, but want to value that time & effort. Don't want to go to hospital for MH care! Living Room model. Place where people can go that is proactive, checks-in with people known to have some challenges or not known and there's number to call to talk with someone for support. Could outreach to you. Separate space where can have calming place. Using inpatient care for acute care only More inpatient psychiatric placements within each county. It can be traumatic and painful for folks to need to go out of county to get their mental health treatment. There are no Level 1 psychiatric beds in Chittenden County or northern Vermont. There are no children's mental health beds anywhere but Brattleboro. This is a hardship for families and a barrier to quality coordination of care and maintaining outpatient supports. Having all these treatment resources clustered in one place is very difficult for families who live far away. The number of level 1 beds decreased overall when the decentralized system of care was created, so there was a loss in treatment accessibility for individuals needing high acuity inpatient placements. There is a disconnect between the hospitals that have ERs (but no psych services) and the hospitals that can fully serve someone with mental health needs. How can we get people who don't need emergency services out of the hospital? We need an equitable distribution of access and resources. If there are no new resources, how can we be smarter? Are crisis screeners just automatically telling people to meet at the ER? Why not meet elsewhere to avoid pushing people to the ERs if they don't need that level of care.

	Communication	More communication between resources that are available in the community Many people in this position do not have the mental bandwidth to request a counselor or mentor. More focus on mental health Advance Directives. Make this part of the intake process, or a standard part of working with a client once the person is enrolled in services and has a little more of a relationship. Improve the clarity in our system of using and honoring Advance Directives. Having the family do this can lead to challenging dynamics. It will be less stigmatizing and more practical to have it done with a Designated Agency. Having a clearer mental health Advance Directive could help avoid the court process to get medications and the ensuing delay in treatment. This could also happen inpatient prior to someone's discharge. Having someone available for check ins. Collaboration was a huge part of the success of this and bridging the gap between services (e.g. was a clinician who worked with a client who on a Friday was struggling and the crisis service provided check ins over the weekend to provide support). Assertive support was offered, it wasn't passive. This was helpful because the client may not have reached out in need. It wasn't a formal referral; it was a discussion and a plan was created that was supportive and helpful to the client. Communication between parties. Be able to communicate with everyone involved in someone's treatment team or support network. Doctors don't always have time to be able to accomplish having the in-depth conversations that could really benefit everyone. Doctors need to be efficient and end up replicating things that have already been done if communication isn't happened. Hospitals have to weigh laws about privacy with what someone is asking for in the moment or needing in the moment. Community supports and peer supports work well in community settings because they require more time, how do we bring that into hospital settings? Need openness and honesty, don't approach with shame or blaming or telling people they aren't having the experience they are having. Received great customer service from Howard Center. Alternatives and options- not necessarily in crisis and don't necessarily need to be hospitalized- we deal with crisis and hospitalizations and people that are frequent users of the system….so many resources are put to the crisis. We want to help people not get to that point but its hard in a system that is crisis related. From a prevention perspective- we seem to be missing prevention for adult outpatient. Transition aged clients as they move into adulthood. Waiting for beds in the ER's and by the time the crisis is over there still aren't supports in place. Having services available to families- many of the children are the products of the environments they come from and we need to look at the whole family. Also helping families to feel less isolated

	Crisis Services	Call crisis – don't say go to ED Someone is there to check in for good days. Picks up on concerns and supports. Proactive. HC has START team that does this for short period of time. Want more of this. Expansion of crisis units and beds Overall strengths: programs that exist in the community that help individuals stay out of inpatient. Ideally, inpatient will be for acute care only. A cultural shift whereby people fundamentally believe that Mental Health emergencies are serious Knowing how to access services while in a crises is not easy to navigate Decrease in suicide rate by focusing on societal and community issues rather than focusing on individuals specifically. Why does Vermont have such a high suicide rate? More focus on suicide prevention discussion in schools could be very useful. Access to a safe space to have a mental health crisis. "I just need a safe space to be crazy." Emergency rooms do not feel like healing environments. Not much of a sub-acute system for kids. Kids receive services if they are in crisis or they're needs rise to a high enough level, otherwise they go on a waitlist. Need more preventative services, or lower lever support options to keep kids from escalating.
	infrastructure	*Infrastructure* - telemedicine capability. Universal access requires transportation. Affordable housing. Connectivity / wi-fi. Tele communication with other services, including attorneys. Option for community-based service. More outpatient supports / alternatives to ED and hospital. Organization within the system so consumers can get the help they need Improved access to services so that any Vermonter has access to needed mental health care. We need more residential programming for youth in-state so that children do not need to go out of state, where they are far away from their families. Improved access to services so that any Vermonter has access to needed mental health care. We need more residential programming for youth in-state so that children do not need to go out of state, where they are far away from their families.

		Reduce paperwork and have shared systems. Streamline! Streamline paperwork, especially for insurance and care documentation. IT system that is open and shared, help providers move away from being territorial. IT System that supports sharing across all members of a team.
	Transportation	Need to work on increasing access to transportation. Improved public transportation or transportation for low-income families so that they can attend necessary medical and mental health appointments.
	Basic needs	Increase in housing supports, especially for folks who are struggling with the intersection of housing instability, mental health issues, and addiction issues. Are we realistic in our poverty levels? A lot of families need more help than they are getting. People need stable housing and support systems. Ask people the questions about who and what they need. Simply ask the questions. Do they need skilled services at home, different living environment? Have a proactive conversation about needs. Mental health is not a standalone issue, treatment needs to be holistic. Increase in housing supports, especially for folks who are struggling with the intersection of housing instability, mental health issues, and addiction issues.
	Wait times	When call provider, they are responsive, are taking patients, have specialty need and can see you right away. f. Want a way to see list of people who are taking new patients. g. Website with openings, describe what specialty, insurance accepts. People can look it up. i. Psychology Today not as good – costs providers $. ii. OPR? h. It's about access. i. User-generated – Wiki type model? Getting additional staff to help those waiting – decrease waiting time. 24 hour access to help Streamlining services to make access easier Decrease in wait times in the Emergency Rooms for inpatient treatment

		Timely ability to have everyone available that was needed, coordinated care, heard from parents-- child got what they needed.
	Psychiatry	Centralized database for psychiatry that shows who has availability so that people do not have to call and wait 13 months to be seen.
	Counseling	Trauma expert- ask what can we do for you? what do you need? What's worked for you in the past? Vs. what traumatized you? Empathy for the people that are asking for help
	Service needs	Need to address basic needs A participant was not allowed to access Seneca because they smoke marijuana, multiple people agreed that preconditions for programs are largely unhelpful. We need to be able to help people more timely and have the resources
		If someone has a bad experience, seek to make sure that he is not retraumatized further by the mental health experience.
		More standardization of MH care. Right now not standardized
		Organizations can be buffer until crisis support shows up. Reach out to other people -case managers, mentor until crisis support is available. There is an arbitrary cliff in services and supports once you turn 18. We need more services and support for transition age youth. We know so much more than we used to about brain development. Kids take a long time to launch and we need more structured supports. With children's services, when things work well the family is involved. This is not a standard part of treatment for adults, even transition-age youth. Having enough funding to allow DA/ SSA systems to talk about more prevention and early intervention models- talking about wellness from a MH perspective. Especially around Trauma- the biggest low hanging fruit around wellness and prevention. Seeing this as an investment to offset physical healthcare dollars.
	Homeless Services	As parent, housing is essential. Mental Health with people who are homeless- first they need a place to live! Need to bring in housing. Need a positive community response to helping the homeless from police interactions to other community members

		Get rid of poverty
	Service Delivery	It is hard to be sent to many different people and have to tell your story over and over again before getting the help you need. a. Strategy: ensure that a person only has to tell their story once and that this person is the point person who can make the connections to needed services as needed. b. Strategy: maybe use an auto population process on the computer so that any additional forms or organizations that need that same information can have it without the person telling their story over and over. Attending to basic needs even in a medical setting/hospital (shower, housing) Identify point of contact opportunities b. Schools need to identify kids who may seem distressed; are their parents at home struggling? Offer help to the family system. Have school counselors available to talk with kids and provide education and training for school staff and students on mental health awareness. c. Access to trained mental health staff in schools who can screen for MH as well as health issues (hearing, etc.) More personal, see the problem from the persons point of view. Be flexible. Having several options with the choice to the consumer. Willingness to go beyond what's necessary. Not just checking the box. Customer Service. When considering better coordination thinking mostly on a local level. It's remarkable how hard communication is and how hard people are working. Perhaps same team follows throughout the whole system of care. Flexible dollars are helpful (payment reform) the fee for service approach likely led to some of the fragmentation. Small acts of kindness, focus on quality of service delivery, e.g. getting you a cup of water while you're waiting in the Emergency Room for treatment. Start with a greeting. Small visual and non-verbal cues to be welcoming and inviting, such as a rainbow flag on a name badge, or a color that may be connected to mental health. Seeking to have every experience fulfilled to the max. We need more options for people to get long-term help, including more psychiatrists and after-hours support. If someone has a bad experience, seek to make sure that he is not retraumatized further by the mental health experience.
		Wellness Coop and Spectrum and Outright Center – these offer ways to help you stay well as supports for when you need them. Soteria: it offers hospital prevention o Could do more but needs enhanced communication with the rest of the system. Maybe more contact with the screeners. Street Outreach helps

		○ Maybe offer more of this to find people BEFORE they need more intensive care/treatment Removal of diagnostic criteria Fund programs that prove to be successful Removal of duplicitous services so we can create new, needed services Would love to see more robust clinical street services. More SRO type of housing options. We have a lot of housing options but maybe the conversation goes back to other resources not related to designated agency. Change the protocol around treatment so that it isn't limited by imminence of danger. When this has been happening for a long period of time, it may not have to be a big and dramatic event to be really serious. This could involve statutory changes, changes in hospital admissions protocol, and flexibility/capacity of Emergency Rooms to meet urgent mental health needs. Howard Center crisis clinician once told a parent that they have to be careful how many folks with mental health concerns they send to the Emergency Room at one time. This is not helpful to be limited. We have some really solid mental health programs, such as My Pad in Burlington and Hilltop. Waitlists to get in can be a challenge. Collaborative care instead of treatment teams, everything is done together. Anyone the client wants involved is involved and it's not hierarchical. Starts with the questions: where is the client now? Where do we want to go? There are co-leaders who lead the conversation, but everyone is involved. No one is talking about the client when they aren't there (for the most part). Gives everyone participation and a voice. It take a lot of coordination. Very person centered. Decisions don't get made without the person being involved and in agreement.
	coercion	Need to change the mission of the department and take out the part where we need to have a system free from coercion.
Quality	Staff Training	Access to knowledgeable people who were willing to take time and apply it. Had authority to act on that knowledge appropriately. Sensitivity training for professionals and help professional to not bee they have to have all of the answers- should not feel they're expected to have the answers
		Change in the educational model to teach physical and mental health wellness in schools, including coping skills, mindfulness, etc.

		System supports providers to not be so high-stressed, limited resources. Knowledgeable. Education of MH providers may be relatively generic, not in depth. Funding mechanism allows specialists to exist. Structure supports some specialization. Respects the conditions' complexity to have specialists. Can speak about specialty with expertise with other parts of the system and consumers/family.
		Process of living with a disability requires different supports than treatment of disorder. Requires different way of thinking about a problem. Broader community is ready to support people with MH and neuro-dev disabilities in education, jobs. Beyond reasonable accommodations. What is truly necessary to have someone be successful in living in community. Better understanding of HIPAA, better understanding and outreach about what you can and cannot do, especially in the context of an emergency. This can be a barrier to continuity and quality of care. Providers should say that they can listen and receive information even if they cannot share information, and actually be available to receive this information. Family members also need education that this is something that they can do. DMH can improve the HIPAA explanation for everyone, families and providers alike.
		Realize limits of MH supports – maintaining quality of life requires access to satisfying lifestyle.
		Have change in professional boundaries- have more of an increased focus on human connection vs. a diagnosis focus Need a trauma informed system. Don't make assumptions even in a small town- you may not know what someone is going through even if you think you know them. Loan Forgiveness Parity in pay Value professions equally CEOs of DA/SSAs need to prioritize their workforce second only to client care Low employee turnover should be one of the highest goals and a thing by which we measure our success as an organization The use of co-reflection in team meetings provides more opportunity to process the emotional aspects of our work
	Staff needs/ capacity	Capacity Continuity in treatment team. Open Dialogue can be a great model, but it's hard to do with so much staff turnover. More focus on what changes can be made for the Open Dialogue treatment model to work better. Better payment for staff so that they do not stay at the Designated Agency to get licensed only to leave to work at a higher-paying place of employment.

		Scope of practice: each practitioner knows their scope. Collaboration is great, but if people work outside of their scope it won't deliver quality services. People need to be well trained and understand what their scope is.
	EBP's	Prisons need EBP MH services for all people in the prison system not just people with an identified mental illness Open dialogue is an amazing model that needs to be more present in our system. Housing first model is really useful in other program across the state. It helps create a foundational stability to have peoples needs met and be truly inclusive of getting peoples needs met.
Person-centered and Culturally Competent	Relationships with consumers	Effective communication: works differently for different people Understanding the need. You can't help someone get what they need without an understanding of what they need. Need more work with race and class Connecting as people, Recognizing need for help, not intense inquiry, acted to help with timeliness and no pressure. When someone expresses that they have a problem or noticing difficulty there is acknowledgement of the challenge and attention on it. Didn't had to ask, but someone was responsive to needs because they paid attention. Avoid assumptions and biases. Open to unfamiliar circumstances and conditions and the individual. Allows to have positive attitude, open, welcoming. Show empathy. Allow more time Control body language – welcoming Provide information beforehand so questions can be thought of in advance or person can approach the service knowing something versus nothing. Follow-through is essential. Do not drop the ball. Follow through builds much needed trust. Empathy Authenticity

		Customized approach The provider has to think of himself and be aware of his implicit biases. How to manage and not be affected by negative past experiences Look for opportunities for teaching moments (good supervision) by being allowed to openly communicate and acknowledge trigger, biases and not feel the need to be defensive. Need a strong system culture that allows for learning and growth (honesty) Non judgmental system- each person who has an addiction (issue) has a different story No shaming. Shame is so detrimental to both the person being shamed and the person doing the shaming Connections- acceptance and no judgement Human beings need connections- that needs to be the assumption. Forming relationships built on trust and respect, being told that you are worth the time and capable of achieving goals in life makes a huge difference in a person's life when setting up a life outside of prison Flattening of the hierarchy in mental health services, such as between doctor and patient. Focus on individuality of needs. Person-specific and person-centered treatment. Intergenerational family support, noting that there seem to be a lot of grandparents raising children. Focus on trauma treatment for families facing fractured relationships. Assume good intentions. Start with this perspective when people call to seek a service. Honor the person's story. Be respectful. Truly listen to the person's perspective without minimizing the experience or intensity of it. Hear and appreciate the uniqueness of this person's experience. This is especially important from crisis clinicians and Emergency Room providers. Using the Open Dialogue principle of using the person's language can be helpful. Recognize each experience as authentic without comparing it to others.

		Person-centered and compassionate care. Don't let federal guidelines get in the way of providing the care needed. Could be more interaction provided. Focusing on dignity, individual plans of care, what are the clients next steps, how can the client be supported. The support is individualized. It isn't completely medical model and is voluntary care. Quick and timely responsiveness. Return the person's call as soon as you can, even if you do not have an answer. Give the update that you might not have an answer but you're working on it, if that is the case. Involve the family / do not disregard the family. Ask the client, "Is there anyone in your family that we could talk to?" If so, have them sign a release so that the family can be involved. See the person as part of a family or part of a community. It would be ideal if this could be part of the protocol for intake. Once the release is signed, call the family back so that they know that they can be involved. Listen to the family's perspective. Understand the precipitating event, appreciate the full context. It's not helpful to hear "well, he seems fine now." When visiting a patient waiting for mental health treatment at UVMMC, there is a special security area where you need to sign paperwork, put your items in a special locker, get a special sticker, declare in hearing and sight distance of others in the waiting room that you do not have weapons, and then have a security escort bring you back to the waiting area. This feels stigmatizing and discriminatory, and this causes people visiting loved ones with mental health issues to be treated differently and to feel differently than other visitors. It's public, a violation of privacy, and embarrassing to have this experience. This process should be done in a way that affords people their dignity. Better quality of care in the Emergency Room. Provider has told a patient, "If you discharge and call First Call, you'll get treatment faster." Family then found their loved one standing outside of the Emergency Room an hour later. Plenty of notice (a month) when a transition was going to occur, planed transition to another person, there was no poor quality of care. Notice reduced any shock or surprise. Seamless transition. Showed respect about the advance notice. Showed empathy and awareness that our actions effect other people. Continuity of care is important. Clear, transparent communication. Empathy, positivity, relationship building. Listening, asking, "what can I do?" Focus on individuality of needs. Person-specific and person-centered treatment.
	Active listening	Listened to what we said we needed, didn't try to sell something else. Responded with options in response to identified needs. Good follow up to make sure it all worked. Focused on us as consumer; gave us trust that we knew what we wanted

		Small acts of kindness, focus on quality of service delivery, e.g. getting you a cup of water while you're waiting in the Emergency Room for treatment. Start with a greeting. Small visual and non-verbal cues to be welcoming and inviting, such as a rainbow flag on a name badge, or a color that may be connected to mental health. Seeking to have every experience fulfilled to the max.
	ESL	English not first language, didn't know how to explain needs, . asked what was primary language; connected to interpreter over phone so was able to express needs. Willing to help and very engaged. Felt comfortable expressing self and to go into detail of what needed. Provided materials in translated form in primary language to make sure comfortable. Felt like had her full attention and not pressured for time.
	Transparency	Transparency of the organization/system for staff to have. This would look like an organizational chart with the different programs being defined and contact information. It would help to know where my organization fits in within the bigger picture and what other resources are out there. There is so much but a lot is kept "secret" so being transparent about what exists would be beneficial. a. Strategy: Maybe a website that is a central hub for all this information. b. Strategy: Maybe a standardized and regularly updated resource book that can be given to all providers/organizations and is available online. Transparency for the client: Help the person to know what to expect beforehand. Review how the process/service will work. c. Strategy: Get to know the person and what they want and need before jumping right into doing whatever has to be done by the provider (forms etc.) Transparency for consumers and providers about how to navigate the mental health system. Communication about how to access services more easily and effectively. Transparency for consumers and providers about how to navigate the mental health system. Communication about how to access services more easily and effectively.
	Cultural Competency	Knowledge of cultural differences and of the culture of the persons served; understand cultural perspectives of mental health. Provider is culturally trained to take care of people from specific cultures. Some words to explain science behind MH are not easily translated. Use individuals from minority group who have some medical or educational background to help their communities. More comfortable to see/ work with provider from their own country; don't have to explain everything. a. Support/incentivize individuals from minority communities to become trained, credentialed. Want MH specialists from diverse backgrounds who speak different languages; don't want to always rely on translation services.

		Tie civil rights to mental health Address privilege and power Multi-cultural, cultural competency. A client left Brattleboro Retreat because they were Muslim and did not feel that their religion was being respected. This client left the state and found a program that provided them treatment and accommodated their religious practices. Cultural awareness b. Available translators c. Connections with cultural leaders d. Service providers increase cultural awareness and best approaches such as flexibility of working with many types of groups- some individually based, some family system-based, (different cultures have different preferences) Supervisors need to make it okay to talk in supervision in a safe way about biases (implicit bias) and personal trigger points Don't pathologize but understand social, societal problem. Don't "other" people; everyone is part of our community. No diagnosis-based root of solution- look at societal issues Flattening of the hierarchy in mental health services, such as between doctor and patient.
Stigma	Reducing stigma	MH practice with more of an attitude of public health. Don't wait until someone is sick. There is information in community – school, PCP, community – info out there for everyone about strategies can use if experiencing stress. j. NAMI trains people to tell story, give presentations in community to inform about mental health, break stigma about mental illness. k. Community needs to be aware of the resources. l. Public health communication strategies. VDH help get message out there related to mental health. where is discrimination happening (through bullying or in the employment world)? Public service announcements using well-known people- "come out of the shadows," share trauma experiences, prison experiences, etc. to decrease stigma and increase willingness to talk about it. "It might be part of your history but don't have to be ashamed of it being part of your history."

		Increase sharing of personal stories Stigma Reduction Lots of stigma has been lifted, but there is still work to be done there Decrease in stigma around mental health issues.
Peer Supports	Peer programs	• Vermont Support Line – a peer run hotline for people who need support when feeling like they are having a crisis. • Peer work in Vermont – the work of Alyssum, Pathways, Support Line, Soteria • There are a lot of free services now (Soteria, Pathways, Alyssum, Support Line, and other donated services (some yoga centers offer free vouchers, the sailing center offers free services, state parks offer free passes, some free transportation) – we did not get into details beyond this) • Soteria Program was mentioned again. • Amount of peer programs and services was mentioned again. Advertise Pathways more o Most people know about it at Howard Center but not everywhere. Need more Pathways (approach) More peer run places to bolster as sense of community Training mental health workers in Intentional Peer Support. Shifts the paradigm to everyone can be a peer with a change in mindset. Peer respites, more beds, but not in hospitals. Overall feeling that crisis and inpatient would be able to perform their job functions better if we increase our community programs. Potentially divert people to residential instead of inpatient. Forensic peer support Value peer support. People can give back after they've recovered and should be encouraged to get involved if they can.
Parity	Healthcare	Universal health insurance with universal access to MH and physical healthcare. *Policy changes* – parity law. Still don't have true parity. Medicare reimbursement is less for mental health. Reimbursement and access (prior authorization) is same for MH. Medical necessity – doesn't discriminate against alternative services, peer services.

		Flexibility in funding Parity in pay and student loan forgiveness for mental health providers Elimination of preconditions in order to engage in certain services

Longer thoughts worth noting:

What do you think the role of DMH is? Public safety? Treatment? There are some people that are dangerous. There is a small group who are dangerous. We have room for improvement with competency and holding people accountable. Nobody can make our community safe. Why would social workers be expected to do this. Gun lobby says its not the gun it's the mental health problem. Vermont is lacking big time, have held on to the belief that no one will need longtime protective custody. We are terrible at predicting things. Goes over to suicidal. When did it become the mental health professionals responsibility with saving me from making decisions about ending my life. We should dismantle the entire system. We are always looking for someone to blame for things that are really the persons free choice.

It can be challenging when all stakeholders who DMH invites into the conversation do not agree. This is what happened around discussions of replacing VSH prior to Tropical Storm Irene. Everyone could not agree so nothing happened. Then things had to happen suddenly. A positive outcome was the decentralized system of care and more money going into residential placements. This helped a bit, but now we are finding we still need more hospital beds. We need more long-term supported housing options such as My Pad. We need more step-down options for folks can discharge from the hospital sooner.

System Vision and Ideals: Burlington

Category	Themes	Detail
Wellness	Provider Wellness	Spaces to teach/guide people about navigating services and taking wellness steps to get help before there is a crisis. Preventative model. Teach the steps that can prevent having to go to the ER (as an example). This could happen online, in schools, primary care offices.
	Consumer Wellness	Using block-grant funding to allow for wellbeing/wellness/parent training
		Practice changes regarding wellness and that it isn't for severe mental illness but for everyone (the whole population) yoga, mindfulness, massage,
	Community Wellness	Care for the planet. Forest bathing. Cow cuddling.
		Inner Fire is an example of a meaningful, holistic, way to heal-make meals together, spend time in nature, decrease use of medication.
		Holistic focus on wellness and community support.
		Community integration – everyone is connected.
Prevention	Preventative healthcare	Preventable deaths don't occur. Suicide, substance misuse etc. root cause analysis and wipe them out.
		Ability to recognize signs and symptoms early on as early prevention as higher success rates
		ACES should shift timeframe and our knowledge about this. Interventions that you are providing is making impact later in life. We need to have patience to invest now and wait
		Global movement on sexuality identity – people identify their own sexuality. Yet we identify what others' states of mind are.

		Shift from crisis to prevention. There is a big gap between the initial onset of the need and crisis level. Focus on prevention and early intervention rather than waiting until we are at a crisis point. People often do not qualify for services or supports until they hit the crisis level. Seek to identify people who might have a family history of mental illness and living in environments that could exacerbate stress and offer early intervention and support so that they might not develop major mental illness.
		prevention would save huge buckets of money, then invest in sustainable cycle to provide services.
Treatment	Early Childhood tx	Universal pre-k 1 year Parent off for newborns
		Reach during pre-natal time with emotional intelligence. Part of pre-natal classes. Connect to resources re: post-partum depression; parenting with knowledge about MH to reduce stigma. o Similar for foster families.
		100% vaccination rate
		Re-evaluate foster family based care o Small group care; flexible licensing laws to allow more options – especially for teenager
	Lifespan	Work designed for short-term and intermittent but the reality is that the care needs to be long term – how do our services accommodate that and be sustainable across life spans and programs
		Behavioral education at the ages and stages framework model so people learn how to behave and manage their own experiences and needs.
Integration	HeadStart/ Childcare	For every early ed center, there is a parent or grandparent going in to help teachers, help kids thrive. Set up longitudinal relationships.
		Parent-child centers and other science-based Public Health strategies that work. Collaboration across health, MH, education for families with children.
	MH/Police	No militarized police force. People help one another.

		Strengthening relationships with law enforcement. Educate law enforcement about the MH system, become trauma informed, and know where and how to make referrals.
		Decreasing incarceration o Which includes not shipping our people out of state.
		Flyers for Police to have in cruisers to provide to families when MH crisis.
		More training opportunities, or ongoing training opportunities, for law enforcement, in supporting people with mental health issues.
	DOC	Every human being would have their basic human needs met when they leave prison. Employment training, MAT, housing when they are released from prison. Referred to the Burlington Wellness Department upon release. MH counseling and VR services are set up.
		Focus on restorative justice for incarcerated population – offer mentor trainings all over state – open training facilities statewide and offer online
	MH/Dr. Office	Build on Blueprint for Health work on prevention. UVMMC and Health Work working on this as well. Jim Hudziak's program.
		de-stigmatize MH by regular screenings at PCP. Screenings should also include trauma and addiction, domestic violence. Medical training needs to incorporate more info about mental health. Including dentistry.
		relationship between **primary care** and mental health. How to attach to expert MH services to primary care. All PCPs need to screen, and need to refer as needed. **Psychiatry consult** to support medication prescribing by PCPs. **Pediatricians** are seeing an increase in mental health and addiction needs.
		Integrated MH into primary care. If you go to PCP, get treated for physical and MH issues. People trained, additional MH professional in medical home for pediatrics and adults (incl elder care). Screening for MH part of annual checks. o Screening for MH of parent/perinatal partners during well-child visits and even in pre-natal. People w/ MH needs are supported to have children. System supports without stigma. Goal is thriving
		Medical specialists understand impact of disease on mental health. They feel responsible to heal the whole person.
	MH/ Schools	Schools and daycares need to be brought into the folds.

		Strengthen partnerships between schools and parents and MH providers. Proactive in finding resources and meeting needs. Bring services to people where they spend the majority of their time (work, schools etc.) Help identify barriers when people aren't accessing services.

		• MH and school systems better connected.
		  ○ Offer support for families.
		  ○ Offer earlier approaches to supporting ALL children across all schools with emotional and social supports (not just some schools but all with same high quality)
		  ▪ For example, attend to anxiety at an early age
		  ▪ Start with teachers and what they are learning and include families.
		  ○ Maybe require that parents check off on homework so the parents know what is being taught at school.
		  ○ Provide more affirmations for children and families.
		  ○ Provide more opportunities to teach or support families/parents through FREE groups
		  ○ When families are supported and knowledgeable they can offer wrap around supports to the child who is experiencing mental health challenges or illness. This is a much different experience for the child than the family/parents who are reactive.

	Community Connections	Communication between all people who touch a person with mental illness. Crisis doesn't know what street outreach does, etc. Police don't talk to anyone. Community-based communication hub.
		Incorporate community. Afterschool programs, social groups. Help people feel like they belong and matter. Help people identify their community and connect them to it. Help people retain their community or networks after a hospitalization or crisis or lifechanging event.
		One building in every city in Vermont that says, "navigator here" and anyone can walk in and ask for help about anything.

		Offer affordable childcare. Offer childcare on sight for employees.
		Continue to hold conversations around communities about MH, hear everyone's vision ongoing. Increase partnership with Pride Center; Out & About; as well as Outright VT. How can workspace be improved to feel safe being out and so clients can be served as well as possible.
		Community agreements about where someone would go if they are struggling, rather than going to a facility or hospital More connection with community.
		.Intermingling of **emergency response, police response** work with MH professionals. E.g. Social workers work with police. *At each point of contact, need a support system to access appropriate services*. *Interconnections*, e.g. **transportation**. **Schools.** Need to feel safe. (No wrong door.)
		coordination between DA's and community partners. NAMI, peer advocates, VT family network, rides. All of support systems to communicate and get the word out. Huge marketing campaign. Break down all barriers. Fun activities. Recognizing that mental health care is health care.
		Breaking down barriers and supporting conversation between people of diverse backgrounds, sharing information for people living in rural communities about what resources and supports are available. Helping people to expand their ideas and ways of viewing the world.
		Focus on loneliness. Building community so people are not lonely and isolated and therefore need to seek (intentionally or unintentionally) that connection in a hospital or in corrections.
		Strong community and outpatient supports so that inpatient treatment is less necessary.
	AOE and MH	Build partnership with education and look at funding system so that mental health is available in all schools in Vermont o Mindfulness is huge in schools and is making a difference; teaching coping skills; teacher education and infusing it into the school

		Develop more teaching positions – more teachers in schools. ○ Add a social and emotional specialist position who would only teach that subject. Make social and emotional skills a core subject in school. ○ Teach to children and include interpersonal and communication skills so people can be assertive and get their needs met in health ways. ○ Teaching this would ensure learning job readiness skills early. Provide more guidance counseling and do not have it focused only on college entry. Review the curriculum of all teachers to ensure the emotional/social intelligence piece is incorporated. Require that all teachers receive training in this topic area. Provide support and training to all teachers on self-care to allow them to bring their best self forward.
	SOC	reinvigorate system of care work – where systems would swap money and not be stuck by barriers of contracts so that it is not separate but more unified. Core funding as individual systems is small; how we relate to each other and how we work together is defined and makes it difficult for a good system of care and the outcomes each system pursues
		Access to resources without preconditions ○ Do not tell people the criteria they need to meet to engage
		System integrates private providers more. Unified billing structure so even if payers are different, feels like unified system. on-line interface. Listing people/providers. Resources for people setting up practices. Existing organizations have reasons to perpetuate what have done before; allow for other providers to have role. Eliminate no-compete agreements so people can have employment with provider and private practice. Foster development of practice community that is integrated and doesn't see each other as competition for resources.
		Focus on ages and stages and how to support people at various life stages. Start with a focus on education, then workforce support, then services and supports for seniors.
		nonprofit and private services needs to break down barriers to services. A give and take between providers. Multi provider plans. Between funding mechanisms
		Funding supports hiring child psychiatry in all regions.
		Public service funded through tax dollars, no diagnosis needed, walk-in and say how you're feeling, and someone is there to help you. Housing, therapy on the spot, psychiatrist available to prescribe - not based on diagnosis but based on presentation (no DSM). All same insurance – no stigma – no rate differentiation. No shaming, no economic class attached to insurance coverage.

	State Partnerships	DAIL and DMH work together and an AFC home. Dept of Transportation. Wouldn't be the dept of mental health. Dental and hearing everything included. Lifespan. Money comes into the dept of health and wellness. No grants. Systems competing with one another and push back on each system rather than understanding that we have limited resources and what is the avenue to have a space where those systems come together – All within AHS should work together rather than pick DMH to do this/DCF to do this/Education this.. etc. o Work collaboratively within AHS – renew system of care commitment o Cross training to understand what others' roles are and what's practical to expect from each system (understand barriers and abilities)
		Partnerships between MH and Developmental Disabilities are needed.
		Community-based providers partnership with DMH and VDH/ADAP.
Access	ED and Inpatient Beds	Kids have built in respite to provide that support but more readily available
		EDs: they are often the first place where people go in MH crisis or need. As they intake people, include them in the feedback loop of what is working and what isn't. Strengthen relationships between treatment teams, especially when there is someone who regularly uses hospital services.
		Another Jarrett House (crisis program for very young children) in southern Vermont so that families are not so far away from their children during these times. More in-state supports and services for children struggling with mental health needs, especially residential and in-home supports.
	Residential Beds	More residential options so that individuals with mental illness do not have to be at home because sometimes that is more of an unsafe space for them, or they are more likely to accrue legal charges by behaving violently toward family members.
	Geographical Concerns	Services are close to one another. Get people out of houses to interact.
		Welcoming, support, and mental and physical health integration in rural communities.

	Transportation	Transportation is not a problem
		Transportation: ○ Subsidize or reduce the cost of using transportation services or purchasing cars and maintaining vehicles. ○ Offer more free transportation ○ Increase public options for transportation ○ Develop new materials for paving the roads so it doesn't have to be done every year. ○ Offer more trains as form of transportation. ○ Provide gas vouchers. ○ Work to create less cars on the road.
		Transportation. Light rail system to major areas.
		Transportation to services and childcare services.
		Improvement in access to public transportation so that people can get to their appointments and maintain connections with their mental health providers.
	Services in the home	Instead of group homes, people with mental illness and live in a home with others. Shared provider system.
		Less hospital beds-more in-home services
	ED	Improved collaboration between inpatient and outpatient providers, especially around discharge planning. This might require more responsiveness from outpatient providers. Discharge might happen from the inpatient setting before these important conversations can happen due to limits on insurance.
		Community-based providers and hospital community partnerships are strong.
	Respite	More respite programs and services for families and individuals.
		Hundred Acre Farm another example of a program that is community-based More places like ASSIST, Jarrett house, hospital diversion More respite available (and peer respite)

	Eldercare	SASH network – wellness nurses are embedded in all the senior centers in the state.
		We need a psychiatric nursing home. People who are having mental health issues or substance use issues, in combination with physical health issues, are not accepted into nursing homes.
		Strengthen partnerships in the long-term care world. Nursing or residential care homes need to improve. Older adults are experiencing health issues, loss of family and friends. Expand more services to allow people to stay in their homes longer, if that's what they want. Older individuals are struggling with addiction, offer more coaching and supports specialized to people who are aging, help educate.
		Very old and frail need someone to come with them. Homebased services, paid a livable wage.
	Service needs	Lifespan services. Age in place.
		Focus on identifying the barriers to collaboration between providers and agencies – financial, regulations, legal statutes, insurance parameters, etc. – so that we can start breaking them down.
		Elders attached to infants and young children
		Bringing psychiatric Advance Directives into the treatment process earlier. This can help avoid delays in treatment later, allows people to make decisions when they are able to do so.
		Person who answers the phone can provide something of value. Has answers for those who call.
		Health system focused on life needs – housing, education, jobs, etc.
	Homeless/ Housing	Access to stable, supported housing-shared housing model with community. There is a lot of stigma around mental health supported living settings that would need to be addressed.
		Affordable housing that is warm, adequate, and safe is critical for health and mental health. ○ Policy idea: allow section 8 housing voucher recipients to have roommates because currently it is not allowed.
		Supported housing across generations (intergenerational?) – My Pad as good example.

		○ Elder care integrates medical & MH needs in one setting. ○ In attractive settings; integrated with other community facilities. ○ Co-housing child care & elder/long-term care addresses multiple needs. AI robotic animal pets for elders
	Service Delivery	Walk in anywhere and get all services – build on what we have on this now.
		We all experience mental health and have anxiety and it may not go away but can be more tolerable to function – How do I exist with this?
		More options for step-down, step-up care. More phased approaches. Community-based supports (housing until can be independent). Can readily transition from one level to another based on needs – responsive.
		COSA – Circles of Support & Accountability (for people being released from prison to connect and wrap in community) – proven to work – model may have relevance to MH. Volunteers, wraparound, recovery coaching. Gives support when you need it.
		More services coming to people rather than people having to go to the services
		Another level of care in the spectrum of care – more focus on crisis services, respite, residential supports to support intervention and hospital diversion, supporting the person and their family in a time of crisis.
		Parents have supports they need. One stop shopping. Kids have access to a trusted adult. Every person in Vermont has somebody to trust and rely on.
		If someone shows a need, they should be eligible to receive that service, and not be limited by diagnoses that they have or have not been given earlier in life.
		In 10 years the Vermont support line would be 24 hours and fully staffed. And a team of responders.
		Maintain excellent treatment and recovery services. Community response.
		Systems is more need based - Eligibility criteria is the same – definition between populations can seem grey ○ Where are they served better and why cant it be both – CSP, DS, TAY
		Access to skills and services and supports so children and families are supported holistically.
	Supported Employment	More opportunities for people to work, with less rigidity and more flexibility on developing ways for people to work and live with their mental health issues. People want to participate and be a member of the community. Work often gives meaning to people, and

		it is important for them to have this opportunity. Needing special accommodations is often such a barrier to accessing employment. We need more funding allocated for supported employment.
		Better incentives for employment when a person is on SSI and/or SSDI and that person returns to work.
		More opportunities for people to work in their community. It is so important for people's stability.
	Crisis Services	When there is a crisis, time is given before there is a diagnosis and prescription written. Crisis should mean you get immediate help. Not sent to ER and left to sit for weeks.
		Less time waiting for involuntary medication treatment so that so much time does not pass before the person can be treated and move forward. This would mean a legal change in the time period allowed before involuntary medication can be administered.
		Immediate help- say you need help and receive it without a wait- get assessed and immediate treatment. Whatever they may need they will receive and without a wait. Based on opiate treatment model – Chittenden Clinic. Need more clinicians – shortage right now – adequate pay for staff to retain good people and treat as valued career. How is access to services in more remote areas?
		More crisis beds. Mobile response services to reduce reliance on EDs.
		Pathways VT Support Line – make this 24/7
		Involuntary treatment is still available, but in the ideal system there would be less need for it. Involuntary treatment erodes an individual's trust in the system and has long-lasting effects. However, for a certain percentage of people with serious mental illness, this can be necessary. Potential for collateral damage of illness, accruing legal charges and spending time in prison, facing homelessness, etc. without involuntary treatment.
		Model in Italy - Torino – hospitals have drop in capacity and residential settings have 24/7 drop in without the bureaucratic process. Accessible and available easily. Don't need a crisis to go.
	Silos	Siloes come down
Quality	Staff Training	Peer educators. Community outreach by people with lived experience. soft skills primary. Basic human kindness and compassion. Not doing but being. Interpersonal relationship skills.

		Systemic training. Everyone follows protocol to make people feel safe, respected.
		Everyone who works with people (children, youth, adults, families) would be required to take WRAP training (wellness recovery action plan). Everyone needs to be trained and experienced in Intentional Peer Support. More peer support services are needed.
		Need more young people trained through affordable education process; agencies that can pay them to remain in positions/state so health for all is part of everyone's conversation.
		Mental Health first aid training.
		All people in charge have all gone through Intentional Peer Support. Person-centric training.
		Investment in staff training and time upfront; flexibility in work hours and schedules; people available to answer phones; being able to pay well for flexibility Increased peer support
	Workforce	We need more psychiatric and mental health providers. Need to triage and identify what roles we need most. How do we honor this field, support professionals so that they stay in their roles and communities? Do we need to alleviate educational costs for professionals in this field? How do we emotionally support our mental health providers so that they are able to keep doing the work?
		Don't offer training just for Drs. Expand MH training to other professionals – nurse practitioners; leverage diff kinds of providers in primary care setting. Accountability for organizations who aren't hiring people with expertise.
		Emphasis on recruiting people with specific knowledge/expertise. People with experience with specific minority communities, disabilities. Balance Human Resource infrastructure. When promoting services, make it clear what is expertise.
		MH system look inward to consider developing people as professionals (peers); partnership with MH agencies and universities to talk about what it takes to have truly inclusive programs that are affordable & successful.

		Looking at the workforce in community mental health. What makes people stay? Good supervision, payment, respect, feeling good about the work that they do, etc. It is beneficial to have reduced turnover and to have staff who stay long-term for improved continuity of care.
	EBP's	More training in Open Dialogue, including for medical providers and social workers.
Data Outcomes	Data Driven Decision Making	Paradigm shift move away from finances – instead of how much does it save us, what is happening when people are living healthy lives. Instead of Youth Risk Behavior Survey, how about the Youth Thriving Survey.
		satisfaction surveys across systems asked 100% of the time. Same survey with same language. Computer infrastructure.
Person-centered and Culturally Competent	General	– training: holistic approach, not a narrow lens. Psychology, sociology, the arts… Person-centeredness, part of a trauma-informed approach. Multi-cultural lens – focus on discrimination and unconscious bias. Need to understand impact of institutionalization. Include dentistry.
	Peer Networks	Everyone who has experience altered states has a peer support person. Every police department has a trained peer on staff. Recovery coaches who are peers are common. Have peer supports in place instead of rushing in with a diagnosis. Pathways support line # is broadly disseminated. Someone higher up talks up the service. Support the support line with funding and staff. People with lived experienced are the most important people to inform the next 10 years. They are the ones who know. It is a human rights issue. Right to live with respect, have decision making. Alyssum pilot – is there data on how successful that is? Yes. Another Way – drop in, peer run. Pathways. Also places with private spaces – lots of people don't want to go to a public hang-out place. NAMI and Vermont Psychiatric Survivors coming together to discuss collaboration and humanities to share their viewpoints.
		Increase peer support services and peer positions in Vermont.
		Provide Intentional Peer Support training to everyone.

		Embedding peers in the mental health system and creating space for peers to be part of the process as supports. This could also reduce stigma.
	Whole family tx	DULCE program. That is integration. What resources does a family need at this moment? Be able to get it.
		• Family support when a family member has gone through a psychiatric crisis. Support around family members with new and ongoing mental health issues. Families often feel helpless and do not know what to do to support their family member and navigate the mental health system.
		Parent education for new mothers. Often-times there is a multi-generational process of trauma, abuse, and neglect. New mothers often don't know how to meet their children's attachment and mental health needs if their own needs were never met.
	Diversity	Diversify workforce; tap into minority communities. Trainings available. Connect with VT Refugee Resettlement program. Have data about education level, who to reach out to. o There is a group - SBIRT Cultural Brokers – who does training to screen for MH & SUD within minority communities. Go into the home; not office-based; universal screening process. Refer to local supports. (Mercedes Avila). Look at gender/sexuality; inclusion of LGBTQ people in workforce; training of workforce in LGBTQ cultural issues. Choice of providers includes those from within LGBTQ community. Safe space to be out about identity.
		Culture need to have more acceptance of differences and understanding of individuals.
		Continue to hold conversations around communities about MH, hear everyone's vision ongoing Invite organizations within minority community to engage in conversations. Hold in the community – Old North End St Joseph's center – other pre-existing groups
Parity and Stigma	Diagnosis Stigma	No stigma. Mental illness is an acceptable variation in human experience Providers agree on what mental health and illness is. Don't give long-term prognoses based on a diagnosis. This is a whole person. Stop the DSM diagnoses. We are humans. How do we get the whole person into the picture.
		Positive person-centric language. Be activated instead of triggering. No more use of "legally sane" "legally insane." Sets a tone. Stigmatizing. State using those terms sets a tone and perpetuates the power dynamic. Change from "suffers from" to experiences or lives with.

		Stigma reduction o All health is mental health o DMH should do more radio and TV spot to normalize MH experiences Physicians and schools need stigma and mental health training. Particularly in rural areas these are the people who see members of their community the most often and have the most power to intervene.
		Open dialogue model advances destigmatizing people Power differential occurs and some professionals (psychiatrists e.g.) talk down to others. What is their buy in for reducing stigma? More peer support needed (Alameda, CA model was referenced) More folks outside of mental health are trained in MH information-such as that folks with a mental illness are more likely to be harmed, than to harm Increase spread of information – whether through workshops, groups, websites, public messaging campaign, webinars. o What making people aware of? o Internships from local university – good with technology can help with social media campaign. Front Porch Forum.
	Socioeconomic stigma	Everyone has a livable wage. No one has to worry about income housing or food. Universal basic income.
	Mental Health and Meds	Got to take down the federal role of this. Change the education and messaging of the pharmaceutical industry. Education about medication, increase in peers to assist in helping folks to make informed decisions about medications and different choices. Change the funding to medical schools.. no more pharmaceutical funding for research. Pharmacies would need to change what they do. People should get free things that aren't medication.. like state park admission
Infrastructure		Community centers – buildings where local people can meet
		telemedicine capability. Universal access requires transportation. Affordable housing. Connectivity / wi-fi. Tele communication with other services, including attorneys. Option for community-based service. More outpatient supports / alternatives to ED and hospital.
		Integrate telemedicine – virtual counseling may be better than no counseling when in crisis
Funding and payment	Provider Payment	Monetize health instead of illness
		People need a better understanding of funding structures. Presently, people feel as though they are not sure what route to take and what can be realistically changed because there is not enough education around the system generally.

		Prioritizing public funding for mental health support, education. Streamline resource allocation to minimize duplication of services and maximize impact of funding available
	Parity	Accessible services regardless of socio-economic status.
		Universal Healthcare was mentioned a number of times in almost all the groups
		Parity in funding and services available in all areas of the state.
		If you are involuntarily committed, you may leave with a bill. You don't have to pay when you're in jail. You shouldn't have to pay for your hospitalization, voluntary or involuntary.
		Break down economic barriers, seek equity in services and supports offered so that all kids and families and people can access what they need.
		True parity exists: DMH and Dept of Health need to come under one to change messaging. It so hard to explain to people what we do. Payment. Culture change around stigma.
		Greater parity in resources and opportunities, e.g. Mental Health Court or Drug Court, inpatient psychiatric treatment, and residential options, statewide. This might require an increase in taxation to generate more funding.
		Finally, the profit motive is completely removed from health care.
		Eligibility – proving services for Medicaid waiver – need to shift thinking and definition of these high level waiver services. Medicaid reimbursement – flexible with ebb and flow of services and hamper the services being offered and continue to be offered as people need and don't need services. Medicaid state plan to include more wellness activities ex. Mindfulness; yoga; o Benefits everyone not just mental health consumers o Alternative funds for this for DAs to provide
		Human services not in the health care budget trends. Real parity will never happen until the budgets are determined using the same methodologies.
		Insurance is not employment based

Technology and data sharing	Documentation and EHR	Easier sharing of information, collaboration, cooperation, and creation. So many agencies and groups hold a piece of the puzzle and we need easier ways for everyone to come together.
		Reduce paperwork and have shared systems. Streamline! Streamline paperwork, especially for insurance and care documentation. IT system that is open and shared, help providers move away from being territorial. IT System that supports sharing across all members of a team.
		san Diego platform(?). Healthcare information protection similar to Substance Abuse/HIV, but in a perfect world.. we wouldn't need that either! Conversation moved to Electronic Health record and how certain records are hidden. Why do we need to hide stuff. So many sides to the story. The answer is there is no judgement for whatever treatment you are getting. No more need to document
	Data and Outcomes	User friendly way to collect data, especially as more information is being asked since there is an increase in federal/state request for data – how to do the work and do the data. The tools are helpful for growth but the work with the individual is time intensive
		Look at data. What's the return on investment, do we have data to drive what we're asking the system to do, then measure it and adjust as needed. What data do we have to measure what we need.
		More data collection. Assess where the funds are going, what's being utilized and left on the table.
		we need to know what our outcome measure is going to be. Need points to aim toward. What do we want to change in the system, have an outcome and then be able to track progress. Outcomes based accountability
		Use data to tell stories of people and not performance of agencies - organize it differently - if we tell stories about people, it could affect funding
Judiciary, Law,	HIPAA and Privacy rules	HIPAA and 42 CFR ironed out. DMH guidance document that was HIPAA respectful but basically said that care team needs to get all consents signed. Very helpful.
		Fixing 42 CFR Part 2 (can't share SU info)

		change the gun lobby power. They run the message. Media messaging, education system and community members.
		Improved understanding around HIPAA. There is a great variation in understanding. More clarity around the constraints and what it does allow would be helpful, especially in the applicability to mental health care.
		Examine statues/laws, are they in line with what we want with regard to confidentiality, commitment process, requirements for professional requirements, no reciprocity with other states for degrees
	Disability determination	Examine disability determination process and criteria. Examine how long people can receive public assistance or benefits, encourage self sufficiency

LOCATION: Previous stakeholders: System Needs

- Notes from 12/17 DH/DA Community Meeting
- Washington County Mental health Taskforce Report November 1, 2017
- Data needs Subcommittee status report (noted as a reference)
- VCP and DMH workgroup on Wait times in ED Minutes 1/25/2017
- Recommendations form ALT to ED bed group AKA 23 Hour bed group LS 11/17/2017
- Memo from Dillon to Network
- ED utilization and Wait times meeting 11/29/2016
- Geropsychiatric subgroup meeting notes
- Mental Health workflow preliminary report to Al Gobeille
- Inpatient psychiatry barrier days analysis

Category	Themes	Detail
Prevention	Upstream	More money upstream
		We need more preventative services; needing more flow through services- front door and back door continuum of care
Treatment	Impacts to tx	Transitions. Transitions
		Service gaps between levels of care
		Use a public health model
		Smaller secure settings – intensive staffing, smaller settings, accept long term placement in every county
		Structure and supervision and various options to match the needs
Recovery		Impact of hx of individual returning to the community
		Personal choice at odds with system risks/ ethics- Service gaps between levels of care
Access	MH/Police	Increased coordination with law enforcement
		Collaboration with police has led to more complex cases in the ED'
	ED	ED is a poor setting to receive mental health care
		The living room model was discussed extensively – both a model in Delaware (Ellendale) and the Alameda model in California
		Long term care needs are filling up acute beds
		Limited OP tx capacities impact ability to avoids crises. Possible increase in number and acuity of clients presenting at ED and in community in Psychiatric crisis
		Lots of actions happening in communities- more acute situations are not getting to people as early as we used to. More and more people are coming to the ED's – numbers are spiking
		We need to stop telling people to go to the ED including DA staff- people go out of habit instead of looking for an alternative that is not available – often then are just looking for someone to talk to
		Increasing crowding and waiting in ED's
		More people are presenting at ED's experiencing a mental health crisis. Increased mobile crisis services ad collaboration with law enforcement may be resulting in identifying more people in need. Community providers are increasing referring to ED's for crisis services
	SUS/ ADAP	Drug and alcohol use is adding to the complexity/ acuity of people presenting with psychiatric crisis. Hospitals don't always screen for substances

	Need for integration	How to enhance fluidity in planning and providers
		Lack of integrated service delivery; lack of low barrier service strategy
		Would like to see Choices for Care partner with DA case managers to better manage individuals who have depression/ anxiety etc.
	Data	More consistent and accurate data on ED wait times that are assessed on a regular basis
	Community	Treatment in community of origin/ treat in communities
		More peer supports in the community
		The ACT teams going into homes to support individuals and families
		Mobile crisis teams that are trained to deescalate and medicate- Model used in Texas
		Coordination with community based treatment teams for children can be challenging
	Services	Expanding housing for outpatient to include evenings and weekends
	Inpatient Beds	Compare what works well for people using short hospital stay – what works
		How do we achieve timely discharge in decentralized system or mediate an agreeable discharge
		Need Forensic beds
		Societal factors and Kuligoski decision creating increased risk aversion. System- wide providers are acting to protect their own interest and lack incentives to share risk
		Looking at both voluntary and involuntary wait times for beds
		Client presentation impacts willingness of providers to accept patients into their inpatient unit/ crisis bed/ IRR/ nursing home. Presentation includes factors such as: medical need, geriatric population, opiate addiction, public safety concerns, catchment are of client, known from past level 1 admissions.
		VSH used to have individuals on inpatient units have passes to community settings such as prospective IRR settings- could be a prolonged visit.
		The idea of a 23 hour bed was discussed- but would require a change in law. Based on a similar program in Delaware and CA- possible consequences to Human Rights
		Hospitals wont accept people from ER's until they take meds
		Longer stays for some people in inpatient hospital settings is reducing availability to those who are waiting
		Inpatient units will refuse new admissions when units have too many people who are very acute
		Hospitals are concerned about placement of people who need step down facilities, because the process to get into a step down takes too long.

		BR expressed concern with accepting children that have high acuity or have complex medical issues such as diabetes or seizure disorders
		Hospitals hold beds for their own catchment areas and refuse people out of their area
	Resources	Lack of resources
		Lack of safety
		Capacity access
		Need leverage to have hospitals take patients who are labeled "too acute" "saving beds" for their own catchment area when hospital beds are available
	Diversion Beds/ crisis beds	Investment in greater ranger of stepdown and diversion beds
		Crisis beds wont accept homeless people, therefore they are sent to the ER
	Secure residentials	Important that a more secure residential program be created- we don't have adequate capacity right now
	Housing	More mypad models
		Lack of supported housing such as Mypad or clustered apartments
	Process barriers	How to build bridges back for those that may have burned them
		Complex systems
	Outpatient	Clinicians in the community are more risk averse
	Resources	We need more pre-crisis resources; "through put" options for discharge; is there enough capacity in system to accept routine psychiatric patient care?
	Services in the home	Smaller settings
	Wait times	Delay in people being able to discharge from hospitals to stepdown and community settings increases wait times at ED
	"Barrier Days"	UVMMC created a report on the increase in Barrier days- days that clients remined in the hospital due to lack of appropriate d/c options- both home with support and to step downs (see resource documents)
	Case Management	
	Residential beds	Intensive residential in each community
		Additional secure settings
		Lilypad model- people would not have to d/c from IRR's but could return as needed to maintain ongoing support
	Elderly	Aging population placements with medical needs regionally
		Geriatric mental health care in nursing homes
		Nursing homes and residential care are delaying acceptance- its hard to place elderly due to vulnerability and risk and the problem of a place to return to when nursing homes or families will not take them back

		Skilled nursing facilities (SNF) are not able to meet the needs of individuals with significant bx
		Healthcare staffing in nursing facilities continues to be a challenge
		Tele-psychiatry does not always include bx mgmt..
		MAT in skilled nursing facilities- tends to be people under 60 and in need of IV antibiotics.
		SNF are not feeling connected with the local designated agencies
		Individuals with bx needs are having to go Out of State for Skilled Nursing facility care- most individuals going out of state also have public guardian. This poses legal challenges due to the differences between states
		CMS regulations of SNF are a barrier- zero tolerance for staff to resident assaultive bx. Resident to resident assaultive bx is "more gray"; regulatory impact of medications is not great, but will affect 5-starr rating. It is okay if an individual arrives with a prescribed anti-psychotic with a gradual dose reduction plan
		CRT for the geriatric population is a barrier
		DAIL/DMH provider networks are "specialized"
	Psychiatry	Seek consistency and follow through with medication hearings
		Barrier- re-apps for changing dosages
		Invol. Meds in community (act 114)
		Psychiatric urgent care walk in clinic
		Psychiatric emergency rooms
	Crisis Response	24/7 drop in centers- could a crisis bed setting be used for this?
		Create free standing "Mini Psych Units" and expanding psychiatric beds in the state
		More mobile crisis services lead to encountering more people and "cant turn a blind eye"
Quality	Staff Training	Lack of role modality expectations
		Workforce issues have an impact on the problem. Factors include vacancies short staffing variation in staff experience undertrained DA and ED nursing staff and increased staff stress due to complexity of system
		Practices can be very inconsistent due to staff inexperience
		Crisis workers are more stressed- intensity of work may be related to complexity of the system/ process as much as acuity of clients
		Nursing staff in the ER's are undertrained
	Workforce	Eldercare vacancies prevent better partnering
		Crisis programs are understaffed

	legal	Legal system slow, laws set for population, not individual needs
Person-centered and Culturally Competent	Training	Teaching the value of relationships – flexibility
		Working on underlying trauma (trauma informed care)
Stigma	Client stigma	There is difficulty accessing inpatient care for people who have been labeled "level 1" or have used "level 1" beds in the past, even if they do not currently meet level 1 criteria
		Small number of people that have been "blacklisted" (BPD, hx of assaultive bx, med refusal)
Data	Data Analytics	No standard of truth; we have data on the supply side but we need better and more accurate data on the demand side, what is the demand?

System Vision and Ideals: Previous Stakeholders

Category	Themes	Detail
Treatment	Beds	Build additional forensic patient bed capacity/ facility, including for those not meeting level one criteria
		Should we have specially developed ED's for people with psychiatric needs waiting for beds
	Inpatient	Looking for ways to step people down from ER to crisis beds- could people wait in crisis beds for inpatient care instead of ER (statutory change)
	Hospitals	Make reoccurring tx easier instead of having to start from the beginning of the involuntary tx process
		Consider measure for incentivizing timely d/c to community service provider system
		Designated hospitals should be required to accept high acuity patients, as well as patients who are in ED's outside their catchment area
	Eldercare (geropsychiatric)	Better training and education for staff at SNF on working with clients that have mental illness
		Create more opportunities for workforce development for mental health staff that work with elderly population
		Increase community collaboration with DA/ SSA's so the SNF community feels more included
		Look more closely at provisional CRT enrollment for elder population while in SNF
		Look across provider networks for opportunities to partner- both "institutional" and HCBS
		Clarify CMS directives around assaultive bx
Recovery	Long term residential	Explore opportunities and resources to establish nursing and/or primary care staffing in designated agency long term residential care homes

Access	Right time, right place	Afterhours centralized phone access- Local response and knowledge of people is effective and worth looking into
		Creation of a stronger more compassionate system for people with mental illness who currently await hospitalization in ER or await d/c from inpatient settings.
	Case Management	Outpatient case management system – could each agency have a hospital tracking case manager or a point person at each agency
		Stepping up care management of people in ED's- add incentives to make it work
	Housing	Fund and expand existing and new housing programs to support clients/patients before ED/Hospitalization (diversion) and after ED/ Hospitalization (stepdown) and ensure flow is coordinated from ED/IP/Hospital to and from the community
	Living Room Model	A peer support program would provide another option in the existing continuum of care, reduce use of hospitals and reduce wait times for people by providing an alternative structure staffed setting with immediate access. "Hub" for connecting people with services Not a step down from hospitalization Can be adaptable for the unique needs of a rural state with scattered populations Provide trained staff to do outreach and provide support
	EE's	Further analysis needs to be done to evaluation the necessity of a possible alternative to conducting EE's
	releases	Finalize a universal release form for its programs to help endure access to all services
		Align federal requirements with state law to help break down barriers to admission
	Value based	Complete analysis of current system expenditure to move to value based care after examining strategies for payment reform that will enhance system-ness
		How can we create incentives for risk sharing so as to avoid protecting agency risk when not in the best interest of the person being served
Quality	Workforce	Offer state funded loan forgiveness for mental health professionals to address staff shortages
Person-centered and Culturally Competent	Training	Training ED staff and nurses/ security- create collaborative training
	Resources	Can crisis bed staff support people in the ER Community Cadre to work in ER (LCMHS)
Structure	Workforce	(DA) create administrative capacity to facilitate hospital discharge through care coordination and/or a resource and referral hub to assist individuals to access both community mental health and private counseling resources

	Considerations	Implementation of any new program of approach would have to take into account the needs of a specific community and local existing resources, so that services are not being duplicated and that services that people will not use are put into place
		(DMH) increase coordination and shared care management between Choices for Car and DA's
Funding	reimbursement	Raise reimbursement rated for the DA/SSA so that salaries are on par with state employees and other health professionals to reduce vacancies and turnover of staff at all levels of care
	Tiered rates	(DMH_ develop a tiered rate system that incentivizes nursing home and geropsych patients
	Incentives	(DA) consider measure for incentivizing timely acceptance form d/c hospital
Technology and data sharing	Data needs	Create a coordinated, data drive, multi-organizational statewide surge capacity plan
		Create a comprehensive data collection system to look at all facets of ED waits and psychiatric admissions- both voluntary and involuntary
		(DA) Designate meaningful outcome measurement related to timely discharge to ensure accountability, taking into consideration uncontrollable variables such as court processes, appropriate bed availability, individual choice, and public safety issues
		Expand tracking of individuals waiting placement to encompass both involuntary and voluntary patients
Judiciary, Law, Corrections, Police	Legal	Work with judicial system to enforce current involuntary process timeliness for involuntary administration of medications to reduce stays/ demands
		Provide or approve a secure facility for forensic patients
		Create a judicial system liaison to work with DMH legal, DOC, WCMH ES, CVMC ED to support enforcement of existing laws and meet with judge Grierson to improve interface with the judicial system

Category	Themes	Detail
Wellness	Provider Wellness	*Needs*- Awareness of compassion fatigue
	Public education	*Needs - RBA*- what are our results- a way forward is to include the community more and educate them- so they can create accountability for themselves. We don't spend enough resources on community based "Stuff" motivate people to move forward as a community. *Needs* - Education of the consumer about the resources they have at their doorstep. Try to help instill the culture of mental health being normalized. how to we expand that- what are the topics people do know about? Veterans or conversations that are already happening. Work with children and families to better understand their children. Allowing parents to come in for training and education.
Prevention	Building Flourishing Communities	*Needs*- Reach out to kids at a young age, so they have the tools to take care of themselves
Treatment		*Strengths* - VT has always been open to different modalities. Can we use traveling psychiatry across state to increase accessibility- it's a small enough state?" *Strengths* - Hub and Spoke, could model be replicated for Mental Health? *Strengths* - In Randolph area, would like IOP or PHP, as successful options in other areas of state. *Strengths* - Open dialogue model Vermont does a good job with severe and persistent mentally ill. Case Management, housing access to Psychiatry. Population health, social determinants. Getting folks into care and then getting them to the right place. We used to try to figure that out before accepting them into the door. There is no wrong door. State understands MH is a priority.
Recovery		*Needs* – to be Recovery focused, Getting support for families. Have Peer navigator.
Integration		*Strengths* - Having process in place to get input from everyone. Very inclusive, participation. Collaborate well *Needs* - Children's MH is suffering.
	MH/Police	*Strengths*-
	Community	*Strengths*- Project VISION in Rutland- a lot of subcommittees, transportation, safety, community collaborative. Accountable communities for health is similar transportation, housing- community partners- using the partners can reduce the burden of the DA's.
	Inpatient Beds	*Needs*- more beds
	Geographical Concerns	*Needs*- People don't have to go far to find services

	Process barriers	*Needs* - People have to repeat information to providers: this is a barrier for people who seek help *Needs* - Ease of access. Should not be confusing. Human on the other end? Knowing where to go for help. Collective information. Knowing how to ask the right questions. Needs to be answered by human being, not an automatic recording. Get help quick *Needs* - Removing archaic self imposed perceived barriers to treatment. Shifted away from initial phone intake and questions before treatment is possible.
	Resources	*Needs* - Our agency doesn't currently have a transition aged youth program; I work with youth and adults. These youth don't get the choice, its either one program or the other, very siloed. Who they engage with in therapy is a toss-up on whose available and what their specific specialties happen to be. Agency, vs youth, make choices of who they are exposed to. The ask is- for a transitional aged program, peer meetings/ age appropriate supports and providers.
		Needs- Collaboration to improve access - different programs provide temporary shelters/needs, which makes access difficult. *Needs*- more temporary shelter
	Eligibility	*Needs* - equal & good access to care; affordable insurance o Homeless population, which is susceptible to major mental illness, will have treatment o Lack of Medicare providers to satisfy needs for aging populations
Quality	How can you get a consistent experience in the MH SOC (wherever and with whomever you encounter)? Staff Training	*Needs* - Strong culture □ Provide good environment for people to heal □ Implement culture change in "pods" recognizing each "pod" has its own understanding of how to get the work done- build on the strengths/respecting each □ Awareness of compassion fatigue □ Provide and environment of support for everyone • Build in respite systems • Accommodate even if a person has used all of their benefit leave time • Sabbaticals without judgement • Program close for service for 2 weeks without being judged by state- trust that they are doing what they have to do to the best of their ability (program itself may need time off) • Provide childcare for staff at all organizations • Focus on the reasons people stay in a job i.e.- personal and professional development opportunities; quality supervision/co-supervision (it may be the person relieving you from your shift who is more closely aware of how you're doing than your supervisor who you don't see as often- everyone responsible for taking care of each other)

		How do we get there that if someone calls 100 times, staff never get frustrated. Staff member getting training and support. How is the staff supported and appreciated. Resilience building of staff member. Even front office support. Having someone to bounce tings off of. Getting support from other staff. Being inclusive of staff in ways of supporting staff. 1. Ease of access 2. Level of support 3. Time. Being able to research the problem. Time to understand the need, ask he right questions, set the tone. Not feel rushed. Team based care. Everyone helping. Integrated, coordinated, connected team. Could mean more staff is needed or just ensuring more staff are trained.
		Needs - Training of all staff ○ Everyone knows what their role is and how to do it well. ○ Attitude- community service angle- appreciate all that people bring to the table ○ Patience- a lot, a lot, a lot of patience ○ Self-awareness- feeling their reaction. Encourage staff to look to themselves to recognize what is going on that brought up feelings ○ How staff model attitude, caring, kindness, etc. How staff interact with and treat each other (don't judge for taking time off for wellness- trust each other is doing what it is they need to be well to do good work. Staff are dealing with major life issues not unlike those our clients face. "People (staff) are living with tough stories, too." ○ Have good workforce development efforts to retain qualified good people so you have the most experienced people working with the most challenged populations (currently it's the opposite- least experienced front-line staff at point of entry when people at most acute need/crisis- bad for everyone. Aside: even when being as creative as possible, still need $ resources to retain developed workforce) ○ Support for staff around really treating people well • I feel good when other people feel good. People don't like to feel arm-twisted • Staff wellness priority- good time off- good team- good system back-up • Help staff to feel they don't have to feel some degree of control. Be clear within parameters, what is it they *can* do? "I'm responsible for engaging with you." Permission for staff to be themselves. Supervision should support that autonomy • When staff feel good about themselves- think about what brings us our own mental health- leads to being able to bring that to others • Huge focus on staff wellness, good healthcare (including insurance), burnout prevention • Allowing for other people's truths. It doesn't matter what <u>we</u> (as staff) think is going on. Give validity and allowing for the truth in their experiences- decreases defensiveness • Admitting as an organization internally what the reality is of how much control we have (control is an illusion- [this is freeing for staff])

		• [Aside: Admit/realize that so much impacts what we do- concepts of culture of wellness, societal issues, what is the reality of creating a 10 year vision? It's daunting and overwhelming- trying to keep looking above that- then back to worrying how to bring people along…] • At Alyssum, the move to a Complete Collaborative Management approach with true culture of shared program responsibility, no hierarchy, making it everyone's where everyone knows they could have autonomy, decision-making power, autonomy, credit and trust drastically leading to better care and customer service • Concept of giving unlimited time off based on what staff need and still finding ways to get the work done and done well- where people are trusted to get the job done- productivity may go up. When people have a need they (the organization and the team) figure it out with each other. • It's hard work- you can't do it if you're burned out. Giving trust = big gain and return on investment. We talk about giving responsibility to clients served, do the same for staff • Understanding and appreciating generational differences is staff needs • Can't expect people to get well if staff are not well • there is a big issue with equality, being treated the same. Tiered system of care based on need rather than demographics or socioeconomic status
		Needs- Decrease competition amongst different organizations (for funding, grants, etc.) recognizing all do good work- how to be supportive of that? Increase collaboration. Expect collaboration between hospitals, crisis programs, community-based programs. Not thinking only one road gets you to another- decrease fighting for resources and increasing collaboration with the goal of making the best service situations for customers- could even be several organizations working together. Avoid replication of services. No fighting over staff (financial disparities leading to DAs losing staff to FQHCs, for example) o Go back to social work at its heart being more feministic vs paternalistic-type of administrating which is more disconnected from the purpose of the work. Feministic approach is more supportive of flexibility o Fund the system of care differently for additional innovations above and beyond the basic charges: here's funding for you to do what you think could work best/be creative and try vs. this is what we want, here's money, tell us how you will do it. Give more time for agencies to think/plan what to do when funds pop up o Don't let state/legislators lose sight of what is best for individual and community wellness because of money constraints (attitude of do we have to be the best? What can we do that's good enough? That thinking is lowering expectations and concerning). DAs have already resigned themselves to "working with the leftovers" o Universal health care for all or comparable health insurance for DAs as for state employees. Good health insurance = wellness o Centralized intakes – reduced pressure on the agency, on the people

		Strengths- A lot of organizations feel constrained and people just have to deal but this organization is saying no – we can treat them better.
		Strengths- Service working well- from Rutland- Evergreen services- started a coordinated entry- support and a warm handoff to close the gaps so the client won't fall through the cracks. *Strengths*- Strongest state in mental health" The fact we are having these conversations, knowing there are many deficits" "good access to health care"
	Workload	*Needs* - Being appropriately staffed to fully tend to current and waiting customers/ service user significant in building trust and relationship. People who are doing the direct care- don't have say over caseloads or what they can handle The system doesn't treat employees the way we treat our clients- this can be helped through teaming with their colleagues.
		Needs- Providers following up and closing loop of communication reduced anxiety of having to deal with difficult provider on the other end of referral. Example used regarded vaccination process and coordination with Dept of Health and RNs working with VT Public Nursing. Process was efficient, interaction didn't promote anxiety or set up roadblocks, and clearly identified next steps with specific paperwork. *Needs* - the automatic helping nature of response, to say yes (example- asked BGS to help her find her way in WSOC, could've easily shrugged shoulders but rather took time to bring her to correct location), ppl like to help." *Needs* -advocated for JOBS, YIT contract. Walk in psychiatry on Thursdays at Spectrum health clinic. However, there was a waitlist of 45 for counseling because of workforce issues and can't fill two therapy positions. A qualified applicant from CA couldn't' accept position because of 30 percent pay cut in moving to VT for this position.
		Strengths- Anyone who makes eye contact with me, or who smiles- you can tell when someone is genuine or going through the motions. Even if I don't like the individual, I can still tell if someone wants to help as a professional, despite personal feelings." These body language skills translate to mental health because they relate to good listening skills, vs "promising to fix things."
		Strengths- Blueprint nurses, hub and spoke
		Needs-

	DA	*Needs* - In order to support workforce, need quality directors. At DAs, accountability inconsistent. Need to put incentives in place. A lot of people don't stay because of supervisors, and systems in place or not. Opportunity is strengthening various agencies, being aware of vicarious trauma, and training. *Needs* - Request for term limits of board at DAs if not currently in place.
		Strengths-
Person-centered and Culturally Competent	Training	*Strengths*- Patients grow to trust that people are going to help them navigate through the process and providers feel confident
		Needs- Don't necessarily need immediate answer, helpful to have someone say "I'll look into it" or responding in some way. Early part of intervention. Empathetic response. *Needs* - Anyone should get the care and compassionate response regardless of who is calling. Assume honesty. Be Patient centered. What does that look like? We are here for our patients and what can we do? Getting response and follow through. Respect effect. Every engagement gets respect . Increase access to care More providers. Psychiatry, Child Psch. Right level of services.
		Strengths- "Choices for Care is very person centered, and allows for creativity"
	Lack of flexibility	*Needs*- wants to be trained to use diverse therapies, outside of DBT, etc. For example, while driving and not looking directly at each other in traditional setting. Flexibility in practice and approaches. Her nonprofit had insurance to cover driving, but other agencies don't cover unless case manager. *Needs* – flexible schedules for families - parents working shifts/several jobs.
	Lack of choice	*Needs*- Our agency doesn't currently have a transition aged youth program; I work with youth and adults. These youth don't get the choice, its either one program or the other, very siloed. Who they engage with in therapy is a toss-up on whose available and what their specific specialties happen to be. Agency, vs youth, make choices of who they are exposed to. The ask is- for a transitional aged program, peer meetings/ age appropriate supports and providers.[this is above, as well, under "Access."
	Basic needs	*Needs* – Provide for basic needs like food and housing first. Integrate provision of these – right now, different programs provide them.

Parity and Stigma	Funding	*Needs* - Similar positions pay more based on where those resources are coming from. The pay disparity is not logical (ex. Reach up to AOP). Identifying parallel systems that used to be different in the past- how to integrate, create parity- these are challenges when we have limited resources.
	Stigma	*Needs* - culture in community makes a difference, some will build Adult Family Care Homes, for example, others won't. *Needs*- make mental health care as ordinary as dental visits, etc.
Structure		*Needs* - Central Access Hub for info, if need to get someone connected to services. *Needs* - Develop a central development and training center. Want a central place for mental health professionals for recruitment, like School Spring for schools. Now use Indeed but takes you to out of state often. He calls graduate programs to put jobs on listserv. *Strengths* - Easy to spread information about major healthcare change due to small state/community • Opportunities for people to come and express opinions, accessible • Actively ask for areas of needs • Good at relationship/community building, good accountability • Flexibility to meet everyone where they are at • Ability to hire staff • Ability to have training/tuition reimbursement •
Funding and payment	Provider Payment	*Needs* - LCMHCs can't bill Medicare, creating shortage. CMC doesn't meet with any Medicare patients right now. Huge number of psychiatrists set to retire, need to invest in student loan relief, raise income to meet 30 percent loss. Loan forgiveness.
		Strengths - Moving away from a fee for service model- this is a foundational change that will allow higher quality of care. Change of mindset and a change of focus- how do we still provide quality of services
		Needs- Need to fix salaries, which in turn influence factors for people to stay in system
Technology and data sharing	Telehealth	*Needs*- internet access for all
Judiciary, Law, Corrections, Police	Complexity	*Needs* - Increased clarification around laws with privacy and support for clients who are in crisis.

System Vision and Ideals: Randolph

Category	Themes	Detail
Wellness	Workplace	Wellness in schools- start having a more systematize approach to things like mindfulness, emotional regulation. Democracy in systems- Dan Greenberg's model. Democracy is the school system- allowing people to have the same privileges in the community sense- treated with respect and their vote matters the same to foster a change about wellness and a sense of belonging. Healthy idolization- be a voice and an advocate for themselves. Promoting culture of wellness through taking and using vacation time, many folks don't feel they can do to cover and work load issues. Creating an ecosystem- whole health, mental health Focus more energy on young people to help them understand whole person wellness, How to provide wellness to young ages – MH working with schools- integration of mental health in a holistic way. Whole person approach- healthcare providers. ED's physicians, nurses- a lot of trauma- higher suicide rates. Wellness for all Community Education. Social Determinants Make sure everyone has food
	Mindfulness	Reducing stigma- teaching mindfulness, emotional regulation at a young age- AOE is not allowed to talk about mindfulness in schools or add it as part of the curriculum
Prevention	Education	Can't teach emotional intelligence, goes back to prevention with kids on interpersonal skills. Businesses should be supportive, help spread message Schools to wellness and solid accomplishment- we can do this by listening. Need a paradigm shift in how we treat out youngest citizens. Investment in education in the community- engage and educate. Little in prevention and education Emotional intelligence training for youth/kids System takes into account family centered approach. Focus on respite and community "neighbor" supports, social connections, eliminate social isolation, disconnection.
		Children are living within their own communities and should be learning to self govern in that way. Children's museums, afterschool programs are affordable Teaching and helping parents to parent children

		Promotion of prosocial skills at very young ages – in day care Universal Pre- k, Full day pre-k programs 2 year maternity leave Child care is on worksite. Basic needs are met
Treatment		Participants don't like that EDs are being used as crisis beds. "We need more people in EDs who are trained to support ED staff in these skills." More psychiatry providers for clients with specialized needs Less credentialed staff who can provide direct community support.
	Crisis	More beds in hospitals, not just in Brattleboro and Burlington
Recovery		Discharge planning from hospital is a huge issue, we need to partner well when people changing levels of care." Can we Embed PCP in school? DOC did film about Circles of Support/ COSA. Surrounding newly released with peers upon release.
Integration	Community	Project Vision in Rutland good model to replicate. Connection between mental health and health. Parity with health. Any door you open, you can get help. All services available where you are. How do we strengthen the partnerships?
		Housing, Education, Access to food, are all partnerships that need strengthened. Nutrition, transportation, benefits. OB and midwife and pediatric specific practices need enhanced partnerships, to engage family systems. After work programs to help families access food and a kitchen to cook food together. providers get to shadow others for a day to get a sense of what other organizations do for a day, in order to strengthen understanding and partnerships. Cross-training
	Medical practices	Build relationships between mental & medical health so people don't have to explain to things again and again Key to quality improvement

Access		- Crisis Text Line, for youth but also adults. Beef up text line to serve as intake, take next step in supporting and connecting access to services, vs having to do intake with new person over the phone. Or possibly add teletherapy. Option for youth, rural people. Choices for Care currently trialing 50 folks who get nightly call each evening from call center. Low energy/ low commitment from providers. Could D.A. have an office or diversion with clinicians prepared to respond to instant text messages. Addresses transport issues. Texting can help give young people time to process difficult interactions and response. - Setting funds aside for leadership and clinical leadership roles. - Hub and Spoke for mental health; how different than current system, asks Sarah? Jeff says little more guided by state and uniform. Some local DAs may have an IOP or PHP, or long list for psychiatrist, not under central management. - Addiction IOP in Bradford through CMC, but not mental health IOP locally. - If no capacity locally to sustain IOP, can we do telepsych IOP session, or have transportation options expanded. Transportation is no longer a barrier. - Tele or text shouldn't be an end goal, but a gateway.
		Anyone who has mental health issues should have access, regardless of ability to pay. No authorizations required.
		Issues of continuity of providers and services due to insurance/ in network changes.
		Beefing up EAP for mental health workers.
		Understand how federal regulations are affected with nursing homes- and tackle this issue a more equal distribution of wealth Nationalized care of our citizens- mental health and health are paid for Using fed and state dollars to contribute to accessibility for people to get their needs met without going into crisis. Eliminate fee for service. Nobody pays for services. Ability to pay is not a barrier.
	Case Management	Get legislature to make insurance companies work together, offer case management with private insurance and in home services.
	Childcare	Childcare while parents engaged in services.
	Transportation	Address need for transportation options
	Programs	Including Dept of Labor in more outreach though education.

Quality	Workforce	my best staff are those without college degrees but with lived experiences. They're able to deal with feedback, failure, and other issues." Quality- trained and supervised therapeutic foster placement- training and compensation for TFC and recruitment Debt forgiveness- as a SOC if you work for us is tuition forgiveness More staff Cooperative licensing. Once licensed, you are licensed everywhere. Combine mental health and substance use licenses. Simplify steps in getting licensure. Make it easier to move and practice in Vermont. Educational pipeline to work. Last year of college is more of a paid apprenticeship. Make college more affordable by incentivizing practice in Vermont
	consistency	Every provider is trauma-informed Educate all front line staff using screening tool.
Person-centered and Culturally Competent	Goals	Client-centered treatment instead of financially driven treatment (Single payer healthcare)
	Respect	
	Resources	Come to a place where we don't have the haves and have nots- having people know what they need. Options and opportunities- is really what its about. There are some cross sects of folks that are so apathetic- nothing motivates them to get better. Home becomes place of care. Affordable housing, simplify housing vouchers. Visiting Doctors and nurses.
	What is person-centered	More resources for people across the lifespan- supported housing models. Peer modeled programs' micro-residentials, hospitals
		More psychiatry providers for clients with specialized needs
		Create a hub for services for our aging population
Parity and Stigma	Public Awareness	PSAs, although no longer communications budget at DMH. using highway electronic click it or ticket signs for mental health Public Service Announcements. Mental health- reducing stigma and having the conversations at a young age- by making it just a normalized part of life
	Stigma	Look at the schools- helping children to develop resilience as well their academics. Helping children develop resiliency skills- it helps break down the stigma, Reducing stigma- teaching mindfulness, emotional regulation at a young age- AOE is not allowed to talk about mindfulness in schools or add it as part of the curriculum Elderly there is a huge stigma with elderly folks with a mental health condition. Engage with the elderly- combine them with young children. Allowing elderly the options for wellness plans- physical, emotional, spiritual, psychological.

		Creating an integrated setting- for elders that have mental illness- government agencies need to come together to help figure out how to get these people the help they need.
	Insurance coverage	Truly equal Can money neutralize the issue?
Structure	Workforce	Suggestion that role of guidance counselor could play role in better preparing students for reality of career paths in VT, if students like their job they do better and stay longer in VT, strengthening workforce and transitioned aged youth success overall. Potential partnerships with sending someone to school for further credentialing in exchange for x amount of years of service, through state, Designated Agency, other? Possibility of taking short trainings on Relyus web based training site,- could go to Office of Professional Regulations, and go to state colleges to see if will accept for credit to help offset cost of advanced training? -“no opportunities for young people to get feet wet in this field.” “ the above is true for older folks who want to be involved, as well.” Compulsory service- Pre-retirement- community work to get the social security Free appropriate public education for college- 6 years anytime in life to complete an education Assistance in finding a job And an acknowledgement that education may not be necessary to do your job Equity- Pay equity- women of Iceland went on strike and 2 weeks later there were laws MH industry is underpaid

	Housing	An expansion of the supportive housing models.
	Children	Children's museums, afterschool programs are affordable
	Coverage	Reimbursement for LCMHCs for Medicare, in light of aging population on Medicare.
		Anyone who has mental health issues should have access, regardless of ability to pay. Lawmakers should have public healthcare so they can see what they wanted Have enough funding to attract and retain staff Insurance pays for housing and employment services
Judiciary, Law, Corrections, Police		Teaching prisoners to farm and create something they can be proud of. – teaching folks in corrections to function and contribute- focus on rehabilitation Criminal justice reform Law enforcement trained • No one feels profiled • Winooski training: cross professional training requirement in the regions

LOCATION: Rutland

System Needs

Category	Themes	Detail
	Consumer Wellness	Need- More healthier living workshops – chronic health issues need attention, more learning on self-care; Evaluation of provider as well as patient. Provide feedback. Need- Wellness recovery action plans, developed by the person is helpful. Wishes and likes groups ; Outdoor time is healthy as part of hospital care.
Prevention	Preventative healthcare	Need- Thinking of the continuum can it be about prevention as part of the domain There is no other place that's going to look at this – it should be prevention all the way to the end even maintenance. Need - Promote, improve prevention
Treatment	Early Childhood tx	Need- Mental Health starts from day 1 – across the entire lifespan. It is hard to focus on the strengths. But I think that looking at the social detriments and what are the basic needs that have to be met.
		Birth to three time frame, emphasize education to parents about attachment attunement, and working with doctors and others to get an education. Children are depressed because parents are less attuned to needs and are kids are turning to technology.
Integration	HeadStart/ Childcare	Early intervention can be happening in pediatrician's office, example of getting a scribe so that they can implement a trauma-informed approach. This requires resources. This is tough because we want prevention.

	MH/Police	Need- Person embedded within police department Need- Person working with the police. Links people to services and diverts folks from hospitals. Need- Corrections need to work with mh and mh with housing. Need- Burlington police looking to get a mental health unit. MH getting imbedded more with police Integration of mh in law enforcement is happening in parts of the staff Need – integration of mental health and law enforcement Need- collaboration with crisis with the police. Strength - Embedded crisis worker in the police department- it created a whole different relationship with he police Need - Embedded social workers with police sometimes are very effective with the right person. (this is a crisis approach) system is geared too much toward crisis. Need - Should rethink how we staff things. Sheriffs were talking and engaging. Train them in MH. Have someone there available to talk and interact. Could be trained therapists, or others in community.
	MH/Dr. Office	Strength- Community Health Team approach seems to work Need- Integrated primary and mh care rather than competing with each other to meet the needs of people.
		Need - Increased integration in the primary care officer- CM and SW type positions. Increasing more psychiatry providers- that has helped. Embedded therapists in their community health center. In NH they are very embedded in Priamry Care offices—they are happening more in Vermont.
		Strength and need - Hospital is doing a great job of embedding sw in their outpatient clinics
	MH/ Schools	Needs - Schools- are pushing for therapists on site.
		Needs - Same thing happens in schools- risk aversive- a lot of them have RMHS but its not across the board and when they aren't involved when a crisis occurs the knee jerk reaction is to send them to the ER.
		Needs - A lot of money goes toward adults but kids are running into bottleneck issues. Job force in para education is dwindling
	MH/ DAIL	Needs- MH system work more with TBI and folks in DS that fall through the cracks. Needs- SASH coordinators and public housing. This works well in terms of prevention.

	Community Partners	Need - Attempts to collaborate- process where everyone came to the team meeting with the client. Too many people involved, the meeting falls apart. One person gets stuck and doesn't have time to do it all. One person who had a good team, but when stable, the team is no longer available.
		Needs- Collaboration among agencies Ongoing team support, not just when needs are high.
		Strength - FQHC pilot model as more of a systemic approach. When resources are flexible you can deliver services that people need at the right time.
		Need - Integrated care needs to be a system of back and forth and not used against the family, can be used to then judge them. Needs to be trauma informed. Need to know what can be shared. General education with the medical providers about information and sharing. *Need-* People who are embedded and bridging the gaps can be working well.
	AOE and MH	Strength to build on- Being embedded in schools to identify early on, behaviors or other things that might be indicative of a need for a family or a child. Most of our work is done outside (school, community, home, outside of the office).
		Need- More mental health counselors involved in school system – varies across states. Need- Schools are good access points for services.
		Need - Having integrated services in the school- kids HAVE to be at the school. Parents don't have to do a lot of things, but having integrated MH supports at the school that don't require the involvement of the parent (another POV at the table that does not support this idea). There is a missed opportunity where we hear and know that kids are going back to homes where there is addiction etc. Example of lack of supports in the schools after a child has a MH crisis.
	Restorative Justice Centers	Need- Diverting people from the traditional criminal justice Tamarack Program in Rutland. Quicker access to treatment programs. More mental health diversion programs. Restorative Justice councils may have different names.
	State Partnerships	See where we might collaborate better Need - Lack of engagement in the system.

Access	ED and Inpatient Beds	Need- Residential Care- some are more intensive some are less, there aren't enough but having that step down choice is important. I think we need to do what we are doing but need to multiply it. Need- Shared decision-making model; Inpatient setting can improve. More input into their own recovery and treatment plan. Move away from involuntary treatment. Need - Need - When people are hospitalized at an acute level there seems to be minimal to non-existent integration with those ongoing providers that folks will be working with when back in the community. This could be homelessness, SUT, aftercare planning.
		Need bridgers. Shouldn't be day of discharge. Should be available for transition and build relationship. Know resources, help with appointments, Need - Example of state response to specific need of a child. Limitation of system around residential. Transparency around numbers of individuals sent out and cost of this
	Eldercare	Need - Meeting the needs of Vermont's aging population requires connection of MH/PH, this may not be hospital level of care. Someone home-bound may not be able to be in a hospital
	Geographical Concerns	Both- Cities have good opportunities, Better access in smaller counties Need- we need to customize services based on the needs of the state. Need- While I like pathways there is so much disparity between locations- we need ot look at the best practices but provide the same range of services across the state.
	Transportation	Need- Transportation access in rural state is very important. No transportation no service Need - Rutland County does not have transportation and in low SES areas
	Services in the home	Strength - What is working. Really compassionate providers who care about parents and kids. Flexible about meeting with people in their home. Sometimes pick up the child and talk while driving side by side. Need - Home based treatment and IFBS- its small and they need more support.

	Wait times	Need- Time to access- getting people to services in a manner that meets the person's need. Need - More funding for community options- instead of so much emphasis on hospitalization. Need- Bx health has open access – have walk in hours instead of making an appointment. Need - Have been efforts around wait times/follow up after hospitalization but lack of connection in terms of expectations of discharge and reality of being at home.
	Crisis	Need- Access to crisis services is okay, but can we get ahead of crisis? Need - A calm mediator position could be helpful in these situations. Response teams that do not look like police officers. Not loud for autistic individuals. Strength – crisis text line Strength - Idea of a text service. Strength- pathways warm line Strength- DMH seems better with communication- reaching out regularly with Cindy and Ally- reaching out with really tough cases. Crisis teams feel much more supported. Need - Crisis team approach that allows people access to someone to talk whenever they feel in crisis and not just when the provider thinks they are in crisis. Need - Connection that people can turn to in crisis. If you are on disability for MH reasons, you should have a case manager, therapist, PCP, etc, at the DA and not be put on a wait list.
	Case Management	Both- Pilot for case-management through community FQHC. VCIL gets referrals and does collaboration with that organization. Doing case management for folks that sometimes fall through the cracks like folks with a TBI. VCIL doesn't do the TBI case management. Need - Case management services in the home is working. VA diverting veterans with serious mental health issues from hospital. Relationship building and more of the picture of a person in their home environment. Strength - Case management at the Planned Parenthood through CSAC

		Need- System of case manager within the DAs, but if you haven't gone through the right steps, you don't have a case manager.
		Need- Want to have case management/more ability to know the services and know how to refer (information and referral hub)
	Choice	Need- The DA system of care makes it harder to get care elsewhere because it eliminates choice. Where choice is available people do better because everyone is different.
	Service needs	Need- People get the right care at the right time in the right place- Some places do have the transitional care. We want transitions from one level of care to another
		Need- Alternative treatment modalities. Focus on recovery than medical models
		Need - Education and access for folks in the community to know who to access and how. Need - Educating the community about what we do.
	Homeless Services	Need- Public housing desire for case management. Preventing evictions, homelessness, visits to ER. Strength- The work at Pathways- having housing is a basic need and the supported employment. Need- Interested in l living in the Ven diagram of housing/mental health Stable Housing and benefits, and employment
	Service Delivery	Strength - Warm lines seem to be helpful Strength- 211 provides some referral and there is a local listing Needs- Community based/regional approach- developing relationships and trust with partners- this does work well and is a strengths based model that helps to build better outcomes. Need- Address some of the barriers to access within the DA system. Need- Integrating supported employment. Promote social connectedness Need - Community-based and person focused services More time for human relationship. Strength and Need- Value in this state that people should live in their communities and get the supports they need to be successful in them. Need - Having imbedded workers (peers, decision making, treatment planning) in schools, hospitals, ED's, Law enforcement Need - Wanting a more streamlined approach to getting the services that are needed.

		Need - people in housing who are unconnected to services- the system does not support these individual, the system is cumbersome. Need - Therapy as a standalone treatment modality should be available to anyone who wants it.
		Strength- Eldercare clinician is working very well- going into peoples homes. Not necessarily clinical. Trying to work through life issues.
	Eligibility	Need- More accessible Appeal process and clear notification process; resources for challenging these limitations
	Mobil Services	Needs- Someone with significant issues/obstacles. Clinician was not tied to an office. Did a lot of home visits and was able to support the individual. The primary care office was able to rely on this clinician to support the individual.
Quality	Staff Training	Need- More staff, eliminate wait lists, quicker access Need- More workforce training opportunities and better sustaining those initiatives.
		Needs - Funding to hire and support the system of care Needs- Staff development and training, evidence-based practices that work
		Need- Would like to see it simpler for people doing direct services. Need information on how to get Master's in Counseling.
		Need -More training. More diversity on who is serving on boards, be on intake, etc. No idea of what my experiences have been and the cultural diversity that I have seen.
		Need - Workforce development, increase in pay, job training and support. Need - Notion that "anyone" can help someone with MH condition- why is it acceptable to have janitors/sheriffs talking to us in the ED.
	Relationships with provider and consumer	Need- Language and forms needs to be updated. More training – IPS – fosters communication between two people as peers. One is not dependent on the other in the relationship. Not infantilism.

		Need - Get rid of the bigotry of low expectations
	EBP's	Need- Develop ways to support and sustain evidence-based practices
	Overall Quality	Need- Improving the overall quality of services across the state. Need- Frustrated with current system. Scared of DMH. Trauma reactive rather than Trauma informed. Need - Tx. plans should be collaborative. Non-directive, no finite number of goals. More time needs to be spent in assessing need and with you determine goals, revisit often and keep on track or wasting time. Need - Intake process should not take an 1-1 ½ hours. Deterrent to just needing someone to talk to. Having to come to the clinic is a barrier. Services need to be available where they are needed. Should not have a wait list for up to month.
	Trauma Informed Care	Need- We do some trauma informed care, but it is not a lot. People mostly think about things in this way and use it in their work. Need- ACES- see more ACES being embedded in how we work- having work be trauma informed. Learn about how parents are passing things down to their own children. This can help with prison system too. Need- Training for staff to be trauma-informed in their care and approaching
	Data Driven Decision Making	Needs- Standardized ways of determining needs and progress. Using one now for kids (CANS) and working toward one with adults. Being able to demonstrate what is working, how people are making progress. Need - Less Paperwork, new CANS we've incorporated, bureaucracy stops me from going to homes.
Person-centered and Culturally Competent	Reactivity	
	Community driven care	Need- Community-based focus of care is important to keep. Community focus on this responsibility is important. Need - Support community resources, not just inpatient.

Parity and Stigma	Diagnosis Stigma	Need- Have the voice of the consumer, people in our positions we need to allow people to to not just sit at the table but participate and break down barriers, addressing stigma. I would love to see a commissioner be out about their own issues with mental health or homelessness- people with lived experience. We need to support people in leadership to be out about their own experiences, I think that can be helpful. Need- All of us that have been there and done that and share what we have been through. Not feeling alone, community, compassion. Non-judgmental- we are in it together. Need- Promote education to help move people into different levels of care and avoid stereotyping – nursing home placement from psych hospitalization Need- Build on programs that decrease stigma
		Needs: Diversity of experience in the administrative world. Stigma and being open about experiences We aren't asking or talking about people being out. DMH needs to do way more with a leader who is taking about the full range of experiences. They are not advocates for individuals they are advocated for a system and we lose sight of people in the way its articulated and presented. Need- Discrimination of housing, access, employment, association and the DMH perpetuated the discrimination as it talks about this 1 person. This one thing- in meetings and in legislature or whatever this 1 person is who needs hospitals…or whatever. Need- Decrease media negative profiling of mental illness.
	Socioeconomic stigma	Doesn't mean just color; also includes culture. Often easier thinking you know a problem, but really don't.
Structure	SOC	Strength - Our system- we are so community based, it is not like this everywhere. If you look at a centralized system… Vermont is in the communities and responding in the communities.

		Need- Undo silo-mentality, better communication, awareness of the partner's work, programs, etc.
Funding and payment	Provider Payment	Strength and need - Medicaid covers a large number of people in Vermont. Everyone is covered, hospital is paid.
	Funding	Need - Clear appeals process for entitlements
Coercion	Coercion	Legislature has decreed that we need to work toward a system without coercion Respect, caring, and non-coercive intervention Recovery and resiliency expectation for mental illness
Technology and data sharing	Documentation and EHR	Need- Better technology Need - Infrastructure/ telecommunications – cell service issues, transportation issues
Judiciary, Law, Corrections, Police	HIPAA and Privacy rules	Need - to find ways to include family members in treatment. Health care providers need to be open to hearing from families and not just exclusion under HIPAA.
Peer networks and models	Models that work	Strength- a clubhouse and people were really get stuck in that program. We worked on helping them transition through the system it can be really scary- we get them working but they need a place to go where they feel accepted. People with low self esteem, stigma of having low self esteem, and needing to be accepted. We created a stage and we saved our bottles and got a sound system and microphones and now we have talent shows 2x a year and now we are opening it up to the community and when you see there self esteem go up, they are feeling better. Feeling connected is a big piece Strength and need: I think peer support groups is really important and people with lived experience Strength and need- Pathways is trying to replicate services in different areas- Pathways provides choice and I think that's important in any system of care- for people to have different choices in their local community is really important
	Peer support	Strength- I think peer support groups is really important and people with lived experience Need- Seeing more robust peer and advocacy community intentional peer supports Need- Consumer advisory councils at hospitals – increasing capacity – funding, training, and people Need- Building off the strengths of certain programs like peer run support programs.

		Need- Programs like Mypad are really helpful with supports. Need- More use of peers to connect with other veterans is very helpful and relatively new at VA.
	Relationships with peers	Some agencies have been burnt by peers an then they make the changes to not allow peers it depends on the DA's We have been in meetings and the peers have bashed the whole agencies and then it becomes an us versus them- if we were to switch that how would it look? If its integrated from the start this wouldn't be the issue. Pathways- practice a peer approach so its not an us and them.
	Respite and peer run agencies	Need- Respite centers/peer run agencies have put together a plan of peer respite that is statewide. Ability to address issues without hospitalization. 2-3 beds on site would be physically separate from the crisis center. Need- Regular place to go and get support without going to the ER. White Paper would be a good add-on to this section.
	Recovery community	Need- People in recovery community, trained as recovery coaches. Need - CHT example- this really helps the people that come together get to know each other. This helps folks to get to know what other resources are available. Time spent with the team is not always well spent in terms of the outcomes.

Location: Rutland

Visioning Notes

Category	Themes	Detail
Wellness	Provider Wellness	gym memberships, wellness in the workplace
	Alternative therapies	Supports other than medication (yoga, meditation, Zumba); Non-traditional alternatives are available to be natural supports rather than ascribed ones. Outside of traditional settings also need to be available.
Prevention	Preventative care-Care	how do we teach parents to be good parents no matter what income is. Where do those skills get taught. How do we create a system to teach parents to reach their full potential. Schools help make better parents
		So much preventative care that we don't need mental health at all.
		Working with parents and children about emotional intelligence.
		A lot of preventative care- creating a standard of living that is healthy for people. Creating a good life that is healthy for folks.
	Education	People would think about MH differently- it wouldn't be abnormal; or broken and need to be fixed---normalized- get help- like physical health. Teaching kids that its not normal to want to lay in bed for two weeks. Make sure teachers understand mental health and how to help kids in their classroom. Destigmatizing mental health. Understanding suicidal ideation- educating people about suicide and understanding emotions in general and people can sometimes feel very distressed. Different mental illnesses come along with intrusive thoughts.
		teaching kids about eating habits, health, self esteem, self acceptance can go a long way in staving off. Helping them to not develop unhealthy thought patterns. Education about on-line behaviors- including safety in the health curriculum. Healthy emotions. DBT e Empowering youth and leadership training Normalizing leadership and self empowerment and self- care into the school day and the curriculum. Parenting skills into home , adulting classes.
Integration	Childhood	We often talk about the individual, but the point of the family system is huge. For a child, this is often a symptom of a family. Treating the child is a reaction that doesn't address the need. Civil death penalty- heart break. Child is also not thriving- vision is support for the family and separation is a last resort.

		Make therapy available for children to try EMDR, meditation, possible trying different modalities of therapies before a crisis happens, Expand yoga and mindfulness and other therapies before you're a parents to expand opportunities.
		Educate kids before they become parents on skills to help them with parenting readiness. Voc Rehab supports and investments Sexual education, early education of children, basic education to have the basic skills needed.
		Parents need to be involved in treatment, completely accessible for parents as well. No harm by parents seeking support – penalize them at times.
	MH/Police	**Project Vision**- collaboration between a number of community agencies and Law enforcement where they talk about challenges in the community. Integrated community – started with police through opiate epidemic. Creating something like this across the state.
	MH/Dr. Office	Example of treatment for PH but not MH. No coalition of support, or outreach to people in traumatizing scenarios. Training of Physicians that people need support in how they feel about their PH.
		Every doctors office should be assessing mental health – at every visit. Opening the door for people to talk about mental health issues.
		Access- imagine if people had full access to help- with like walk in or call in to get any available help
	Schools	Break down the barriers -early intervention in schools between school and mental health
		Peer based counseling in schools integrated into the school system and have connection with parents in ways that are non-threatening. Funding available to support this. Opioid epidemic needs to be considered. Role would be normalized in the environment. Shouldn't be just to put out fires. Part of basic teacher education in preparation for teaching experience and be prepared. Work collaboratively with therapist so each can do their job. Integrated into the community. Foundation of knowledge in all disciplines.
	Medical/ mental Health	Mental health is health care- equal
		Breaking down the siloes of the two systems. If I need something for my MH, I know where to go, I can be honest about because we recognize the whole person and the need and we can be honest with each other.

	General integration	Standardizing the expectation Diversifying integration (schools, primary care, law enforcement) No Department of Mental Health- becomes department of health, there is not second class system of health care. Reeducation and training of doctors is done. Care is appropriate, not harmful, Focus on prevention, early intervention maintenance Get rid of the MH system- get rid of siloes- create a shared lens. Go beyond Dx and the immediate view of the problem. Ideal system would have inclusion- everyone would feel they have something to contribute as value. For people who are determined to be disabled is profoundly alienating and condemned to a future of poverty and 15 hours a day of lack of meaning
	Community	Great collaboration, teamwork, no loop holes
		Community Centers- finding your communities
		Community commitment so that all are accountable (this supports depression/anxiety) More social activities available and easier to access for people of all abilities
		Community inclusion and needs are met in the community free of oppression and discrimination.
		Decreasing social isolation- learning to be more self reflective about how we isolate ourselves from the community. Self reflect on our own racism and how we are not a part of the village. Taking steps to get out of our comfort zones.
	Incentivizing wellness	Creating a system that supports folks on their path to recovery without penalizing them monetarily. That incentivizes recovery and mental wellness. A system that is local and accessible and allows options.
		helping people feel connected with their community. People benefitted from having people around—drop in centers. Volunteering and community service. – community connectedness with the elderly populations- longeveity is related to community involvement- doing things with your community to keep people lively and young. Helping with generational connectedness.
		10 years from now- start teaching kids young to appreciate their community and get involved. Validating non traditional connections but also encouraging face to face interactions with people. Healthy balance.

Access	ED and Inpatient	Hospital is exception
	Inpatient Beds	Hospitalization overhauls
	Accessibility for services	Need to be able to streamline supports and delivery flexibly where and when needed. Call-in options for support, all get chance to be heard, don't have to have a mental illness label, using technology that meets the generational need.
	Housing	Plenty of affordable, accessible housing
		No homelessness, no poverty
	Geographical Concerns	More available services statewide
	Process barriers	Information about services and resources is easily accessible.
	Elderly	Supports for elderly with MH and health issues- creating community programs- SASH programs, connecting to community so its not isolating. In the future- cooperative ways of funding or having communities fund transitional living homes by valuing the elderly.
	Transition through tx	Transitions through life are seamless
	Wait times	Easy to navigate, less stress, available, no waiting
	Vocational	Don't do enough job shares to create purposeful job opportunities for people with all strengths. Assist people to support in finding meaningful work. Reducing discrimination by expecting employers to provide equal opportunities.
	Psychiatry	Decreased needs for meds
	Crisis Response	We invest a lot in the crisis- we have to invest in things that seem long term.
		Increase a more home like environment to decrease agitation and depression for people already hospitalized.

		Immediate de-escalation of a crisis and in the moment making a determination of the best steps
Quality	Staff Training	Living wages, more staffing, better training, awareness Care would always be good quality, trained, well-compensated
		Providing competitive wages for mental health professionals it would reduce turnover- we would have to figure out the resource gap story or increased valuing of the appropriate resources.
		Compensating peers and increasing wages for professionals.
		More staffing for all transition points. Full continuum of care.
		Staff to assist family with behavioral issues. Have continuum of care but criteria for each level is significant barrier. Usually barriers are higher up, not community.
	Human Services	Being supported
	Service Delivery	Always some foundation of support, teaming as a foundation
		Systems that don't dehumanize is ideal. Make system see people as individuals. No bureaucracy. More collaborative effort that impacts lives.
	Workforce	Workforce that is sufficient to meet the needs, more people who do this as a career
		More case managers, lower caseload
	Education and training	Greater understanding of brain development. The way we're treating children we're creating more MH challenges. Experiment with cherry blossoms and how MH trauma is carried on and so that we can get past the generational MH problems.
Person-centered and Culturally Competent	Training	State paying for licensure. Do away with licensure tests. Invest in workforce that is meaningful. Livable wages.
	Trauma informed	Care is trauma-informed

	Peers	Getting support from peoples lived experience- peer support groups, as case managers, clinicians
		People with lived experience being embedded in everything with mental health
Parity and Stigma	Diagnosis Stigma	No Stigma Reducing stigma across the board (for staff/providers as well) Vision is not just for kids, it is true for adults. When someone has a MH Dx, there is no way to get out from under the MH challenge. There is not a way to get out. System does not the address the MH challenges of having a MH Dx.
	stigma	Everybody is understanding each other, places people can go for help without stigma or labels.
		Get rid of words- stigma and behavioral health in the future. We care about the actions and potential discrimination. People with MH are in society and not invisible.
		Anxiety in brown kids can't be seen without context of diversity and cultural awareness. Parenting and mental health education before having children – aware of trauma and ACES so children can be raised more healthy and becomes part of culture. Parent classes.
		Having the community be more accepting of mental health. Building awareness of mental health so that it would reduce stigma through education, ,mentoring, allowing safe spaces for people to share their experiences.
		Having someone in a position of power that is out with their mental illness or ownership of their mental health
	Coersion	A lot of community options with no coercion, no stigma and everyone has opportunities
		Self-direction and self-determination need to drive treatment choices. Facilities need to respect these choices. Choices made together.
	Parity	Parity for health and wellness- everyone should have access – being paid for by insurance companies- prescriptions for wellness.

Structure	Healthcare	Universal healthcare Your healthcare goes with you, wherever you go- benefits and supports are portable. Don't have limitations of location codes for insurance benefit coverage. Health insurance for everyone. Able to access services where and as needed.
Funding and payment	Provider Payment	Free access
Peer	Peer services	Using peer support specialists to assess
		Anytime you can have people with lived experience be a part of the decision making it will always be a better part.
		More community settings- more alyssums, more connection to loving and non judgmental people.
	Data Sharing	Technology used more as a tool deliver services and improve access, preventive measures
		Transparency with the data and tracking it Asking the right questions? Getting to the right data points

LOCATION: St. Johnsbury

System Needs

Category	Themes	Detail
Wellness	Provider Wellness	*Needs*- Why is it that this is mental health agency, but the staff do not feel that their mental health is taken care of? Wellness/Prevention – plenty of funding for public service announcements, makes a difference really does make a difference really does make a difference.
Prevention	Building Flourishing Communities	*Needs*- More work asked about building flourishing communities – lack of staff time and money around moving it forward
Integration	Headstart	Derby and Newport headstart are combining.
	MH/Police	*Strengths*- PETER Group – partnership with police in Newport, a few areas in the State are trying to have a more supportive community response to challenging police situations
	MH/Dr. Office	*Strengths*- Therapist through the doctor's offices, shared (great resource)
		Needs- Therapist through the doctor's offices, not enough of them
		Needs- Lack of integration around communication (integration between the two system)
		Needs- No easy way for nursing staff to communication with mental health staff, lack of support, real lack of integration.
		Strengths- Primary care doctors don't always know what the issues are, so when they find out what they issue is they then offer the family a resource.
		Needs Lack of training in medical schools (nursing) around supporting people with mental health challenges
		Strengths- More behavioral health in primary care settings – integrated, new laws about youth being able to access health care on their own.
	Schools	*Strengths* - Schools trying to do suicide prevention work for 5-12 year old age range
	Integration and coordination	*Needs* - Lack of integrated care in the community around substance abuse, example of an individual being discharged into the community with no discharge plan within any support.
		Needs- Coordination of care between private therapist (Didn't have any information about crisis text line)

	Data	*Needs*- More data needed – more information about integration possibilities between health care and mental health care
	Community	*Strengths*- A strong community, in the northern NEK that is really trying to make things better. The hospitals pull things together to see how they can make things better. Mental health is talked about work is constantly being done.
		Strengths- Small area, everyone knows each other so they try to work together to be perspective and reduce the potential issue for kids as they get older. Lots of collaborating happens.
		Strengths- Headstart and early headstart families, have been able to do some great things. Community activities around empowering families
		Needs- Wish there was more embedded workers crisis the community
	Transition Aged Youth	Todays teenagers are making a lot of progress over where we were, gender fluidity is just normal. Building youth leadership – how do adults in our community, how do we continue to support that.
	MH/Womens' empowerment	*Strengths*- Recently had a private counselor call and just ask to do a women's group, around empowering women.
Access	ED and Inpatient Beds for kids	*Needs* - Not enough facilities, a lot of families who have had their child in the emergency room because there are not enough beds in the state. Suicidal issues, sitting in the ER for several days, families are asking questions not getting enough answers. Last parent working with, son was 18 so mother was getting any answers, child was dealing with it on his own. No beds open, other child had medicals issues. Was sitting in the ER waiting and that seems to be an ongoing issue. Recently had someone waiting in the ER. Other people have kids waiting on the floor after having medical issues, so they wait on the floor, but still waiting.
	Inpatient Beds	*Needs*- More beds, people stay in the ED's for weeks and weeks (people would be able to move forward throughout the system and not have to sit in the ED due to a lack of bed availability).
	MH for kids	*Needs*- The support for adults is much more significant. There's only one psychiatrist for children at NKHS
		Needs- Huge lack of services for children in general – those who are there are very over worked

		Needs- There was a 6 months wait for a daughter, didn't want to take into an emergency room (would have potentially waited for up to weeks). Was able to get someone to take daughter on that didn't usually work with adolescents.
		Needs- WRAP program, something modified for youth- policies around modifying it for youth.
	Rehab Beds	*Needs* - Lack of rehab beds in Vermont
	Geographical Concerns	*Needs* - High needs in the area.
	Process barriers	*Needs* - Bureaucratic issues, gate keeping (urine tests) around accessing services for clients.
	Chronic Health	*Needs*- Teenage daughter who has chronic health and mental health, there is no support group in the area for chronic health issues. There is a NAMI group in the area, but the chronic health group is only men in their 40. The teenagers talk amongst themselves, but chronic health issues play into the issue.
	Resources	*Needs* - Bigger state wide list of available resources
		Needs - Centralized contact information – lack of resources and people who know how to contact.
	Services in the home	*Needs* - Clients who need someone coming in their home, won't go into the agency, but would take someone coming into their home.
	Wait times	*Needs* - Lots of young people who have died by suicide, lack of access to resources. Took a long time to get into treatment, then treatment is very short. Aware that some people can sign themselves out of treatment (that can be part of the problem).
	Case Management	*Needs* - More case management for people receiving food stamps and social security
	Counseling	*Needs* - BAART – Hub for substance abuse, where people go and get treatment. Throughout the state. Needs more counseling, do substance abuse counseling but don't get into the root.
		Needs- Heard over and over again there are not enough counselors

	Eligibility	*Needs* - For Head start, they can only accept people with such low income, people who make minimum wage with one child they are to high income. Enrollment in so low, they are going to close the program. Contributes to the lack of understand and cycle in the community.
		Needs - Reality of the benefits cliff
		Needs - BAART – Hub for substance abuse, where people go and get treatment. Waiting list (get pregnant), bill Medicaid
	Psychiatry	*Needs*- Have had a hard time replacing psychiatrics in the community, they have seen people who have had a wide spectrum of experiences.
	Crisis Response	*Strengths*- NEKHS- crisis response is […] very responsive
		Needs- NEKHS- crisis response - they don't have enough people, capacity issue
Quality	Staff Training	*Needs* - People have very intense needs, and there just isn't counselors who are trained enough to do work with kids with the intense enough needs. Counselors are doing the best that the can, but they just aren't well enough trained.
		Needs - […] then the clients are saying that services are not sufficient because the staff are not skilled. The lower paid staff don't stick around.
		Needs- […] didn't get the feeling that the training was the same with all the same people.
		Strengths- Recovery center – Newport, Morrisville lots of people who have been trained and employed through the recovery center
		Strengths- NEKHS- crisis response is strong […]
	Human Services	*Needs*- Daughter […], was once admitted to the hospital. Person from human services come to screen her (had other cases to deal with at the same, would come and deal and then leave for 30 minutes). Didn't seem to have training on how to deal with person who was suicidal. Some other people from human services were awesome.

		Strengths- Daughter […], was once admitted to the hospital. Person from human services come to screen her […] Some other people from human services were awesome.
	Police Staff	*Strengths*- Supportive experience with the police in NKHS, had had some experience with training around supporting people with challenges.
	Emergency Department	*Needs*- PSOP (patient safety observer position)- sitting in the emergency department, serious lack of communication around the process with people moving out of the emergency department into an inpatient program.
	Workload	*Needs* - Case Loads are huge, if someone goes on maternity leave or someone leaves
		Needs- Not enough people for the case loads
		Strengths- Case manager at NKHS is very strong […]
		Strengths- Case manager at NKHS is […] over worker
		Needs- Generally people at the NKHS […] maybe overworked.
	DA	*Strengths*- Generally people at the NKHS has been a strong provider, passionate, caring […].
		Strengths- Daughters therapist is awesome
Person-centered and Culturally Competent	Training	*Strengths*- Comes down to people who are well trained, […] Expectations from the top down.
		Needs- Reaching a trainee who didn't have the information and wasn't able to answer the questions about what the parent needed.
		Strengths- Experiences with providers have mostly been positive
	Lack of flexibility	*Needs*- Families feel like they experience certain things due to protocol, or agency says that it must be a certain way.
	Lack of choice	*Needs*- people are saying "things are not in the best interested of the client" large barrier to the client
Parity and Stigma	Diagnosis Stigma	*Needs* - Clients who are being referred to services, went through the assessment, 10 years ago client had substance abuse issues, DA wanted substance abuse treatment even though not relevant. Stigma that carries over.

	Youth stigma	*Strengths*- Students are working and want to support each other – NKHS, trained students on Zero Suicide training so they can help each other.
		Strengths- Crisis text line – kids sharing information and cards with peers
Funding and payment	Provider Payment	*Needs* - People are not getting paid enough professionally, hard to find a highly paid person to work with the kid with the complex trauma.
		Needs - The DA employees seem to be underpaid, mostly the counselors.
		Needs- The state of Vermont is pushing for $15.00 minimum wage, what is going to happen for people who are being paid that now.
		Strengths- The state of Vermont is pushing for $15.00 minimum wage,
		Needs- [for person-centered and respectful care] people who are well trained are expecting a higher wage. Can be a lack of resources around paying providers.
	Funding	*Strengths*- Were able to organize the first every walk Out of Darkness walk Middle School Walk and raised 4,000 dollars.
		Needs- Schools trying to do suicide prevention work for 5-12 year old age range (was able to do that work as part of a internship, otherwise schools wouldn't have been able to do that work).
Technology and data sharing	Telehealth	*Needs*- Lack of broadband internet (even in Danville, Hardwick, Etc..) so telehealth internet won't work in much of the area – regardless of the policy recommendation around telehealth being an option
	Data Analytics	Blueprint 2017 data takes two years to come back – could we get a similar model for the agencies. DA's are not used to using the data in the same way.
	Data Sharing	*Needs*- Challenges around specific systems such as the pain clinic, but more generally – how do we support people with sharing information.
		Needs- Signed released are not being honored

		Strengths- One of the strengths with mental health providers is that they protect their patients confidentially.
		Needs- But there needs to be a system that providers can all have a system where they can communicate system.
Judiciary, Law, Corrections, Police	Complexity	*Needs*- Increased clarification around laws with privacy and support for clients who are in crisis.

System Vision and Ideals

Category	Themes	Detail
Wellness	Workplace	In order for any of us to function in the world we all have to be able to function internally, we all have to be able to have wellness. I think a lot of workplaces offer that type of workplace wellness. Ability to work to the full capacity. In order to be able to do the jobs that we are doing, and for our kids to be able to do things well. It would ne nice, if schools integrated wellness. Requiring wellness breaks at work Requirement for wellness breaks and guidelines for what that means for people Opportunities for physical activity (w/out referrals to get PT and other physical activities that benefit wellness and mental health) Acupuncture is part of your health plan and massage neurofeedback and biofeedback for health and mental health Moms and dads have a year of paid home leave and they all have a social worker that comes to their door, regardless of income, coverage, etc.
	Mindfulness	Mindfulness. Schools, starting earlier making it more of the normal culture, modeling it. Furry things to pet Forest bathing, beach bathing mountain bathing- more connection with the natural world. Spending 20 minutes in the woods, your brain changes. Gym at Dr offices or hospitals – not the medical model like PT or OT but just gyms with knowledgeable trainers. Spirituality- for people that are spiritual Mindfulness training, ACE scores, giving people opportunities to learn, psychoeducation, increasing resiliency Integrated services in the mental health system, regularly include yoga, meditation services (located in the Burlington area), group sessions in the middle of it all. Physical therapy, occupational therapy, all in one session.

Prevention	Education	Free accessible cradle to grave education for everyone, that would create solutions for many of our problems around childcare. Preventative efforts to support people of all ages. Stop making it so challenging to accessing your education. Quality of food being held responsible for resulting health conditions o Ex reduction of sugar/trans fats Health class involves emotional health and self-esteem classes in school Reducing ACES scores Every provider is trauma informed After school care is available.
		Sex education being done earlier
		Classes for adults- how can they be better parents, have better coping skills, having reasonable or reduced costs.
		Continued education
Treatment		Youth and adult mental health first aid should be offered to everyone – offer it to church groups, organizations, schools curriculum, employee trainings Trauma informed Involving stakeholders more often in the conversation regarding community/state needs Being able to talk about mental health with employers about mental health
	Across the lifespan	Aging – do not want to be a burden to family- they need to live their lives and not my life. If not of sound mind, need to have help and an environment that can support folks that are not of sound minds. De-stigmatize congregate living. It is not an evil thing, but how you enact it can be difficult. It could be used as a way to support folks who are aging and not of sound mind. Would like to have a support for folks who are leaving foster care environments. Think about congregate living as a way to support these kids. And really planning for transitions and ways to support kids outside of a foster care environment. Maternal wellness system is overhauled. How we care for the mother is changed, let the father and mother stay home

	Wholistic	Wholistic perspective/approach – More trauma informed Treatment that is remote – in person is ideal Maintenance of health – don't end counseling because progress is made o Doing check ups periodically Different approach to psychiatric stays - bed availability – o Stabilizing and returning to the community o Mental health hospitals – less traumatic, more welcoming environment that feels more therapeutic rather then sterile When leaving hospitals – re-integration process – slower to integrate for more success Capitalize on the high rates of participation in well-child visits that are occurring prior to school enrollment. Is there an opportunity to ask parents about their MH when they are at the pediatric visit. Is there an opportunity to ask about kids when the parent is accessing services.
Recovery	Recovery	Psychosocial determinants of health don't exist o no barriers; no drugs needed because you are happy; housing/food stabilizing
		Open dialogue for a year- recover and no meds.
		Redefining – ongoing health maintenance like disease management o What skills/tools Recovery house for men/women – substance use/mental health issues/pregnancy Empowering recovery – it is possible Supports within treatment to assist in recovery – in all aspects of life, care, healthcare, etc
Integration	Community	We want people to be involved in their communities, that incredibly important to their mental health.
		multigenerational relationships in the household – parents/grandparents/children all in the home caring for one another o grandparents in grandchildren's lives positively o financial support for the entire family with the entire family contributing

		Community based teams – neighbors, families, kids everyone is struggling with trying to make that work Indigenous counsel groups, parker palmer, circles, good grief, death café- there would be more informal ways togethers, neighborhoods- cultural change
	Law Enforcement	Well trained professionals and partnerships with the police.
	Mental/ Physical Health	Mental health physical – seeing a psychologist/therapist to check in on your mental health once a year as you do with a PCP seamless interaction between mental health and physical health ○ communication, treatment, etc ○ not a cookie cutter thing – integrate medical and therapeutic model Integrating mental/behavioral health into health settings (more pediatric and geriatric) Think about mental health as broader than traditional MH diagnoses. Think instead about the mental health affects of diabetes or COPD Pediatrician verbalizing wanting to see kids until they start collage, we would like to have pediatric services continue until people are 25 if they want to.
	MH/SU	Coordinating with the hub of treatment, to make sure there is an expectation and to make sure that someone is getting supported with both areas. Held accountable across environments. Really need counselors that are able to support clients with both issues. Staffed peer drop in centers, should be accessible at every school. No bullying No social media Reduce marketing to kids for adult products More family involvement in schools and their education – home/school parent partnership Having mental health in the schools- educate people on brain health (mental health). Includes how you can take care of yourself. How you can help your peers who may be in need. How you understand the process by which you begin to feel anxious, depressed, etc., we are not training people to give their own diagnoses, but just how to recognize and appreciate. The purpose is to destigmatize and normalize mental health.

		We would staff schools with MH professionals for as long as kids are in the school building.
	Inclusion	Involves all aspects of the healthcare team.
		Everyone has a person-centered care team – including all the loved ones that care for you. Currently we're individuals not working all together.
		Until we understand what each other does, we can't integrate because our last of trust and misunderstandings get in the way.
		real true collaboration, The services aren't siloed. Recognize the other portions. This happens in MH and Schools and everywhere.
Access	Right time, right place	Community resource coordinators (primary role is enrolling people in health insurance – 2012), want to make more of that position. Looking at ways to physically meet people where they are at. everyone's got something they want to do and have the access to do it When I call to get an appointment I am able to get in to the provider that can prescribe me meds if I need it and set me up with therapy the day I want it.
		points of access everywhere – in the school, workplace ○ a staff that is there ○ more availability for home visits to come to your place Acupuncture is part of your health plan and massage neurofeedback and biofeedback for health and mental health
		One stop shopping, so families would be able to access all their needs within one door. An auto referral to someone just like primary mental health care not an after thought

		need a centralized intake system for people, Access- no wrong door, its going to coordinated and holistic
		Everyone has access to the services that they need in a timely manner ex: if you break you leg you want someone to reset your leg quickly. On demand, immediate help. Services would be wherever it is convenient.
		any door is correct.
		No limitations based on insurance – verbal medical appts available Treatment at access points in various locations within the community where people are (schools, drs office) More community workers refer to mental health clinicians
	Case Management	Increase in case management availability for people, for various conditions. Case management for all
		Case managers would be able to be mobile. Case managers would need to be coordinated, should have someone.
	Eldercare	Dementia friendly America – integrating those who struggle to access the community can access it in a welcoming manner accepted by the community
	ED	Crisis- a warm environment that help ease anxiety, mindfulness and yoga- dim lights, staff will be nice, nurses and psychiatrist and peers are there to help, health coaches with a full range of alternative approaches. Looking at folks stuck in the hospital. We have ability of finding folks at risk of being stuck and modeling and doing prevention to keep folks out in the first place. Trying to get upstream, not just more beds.
	Choice	In an ideal world you would have a variety of people who are qualified to work within whatever treatment is best for that disorder.

	Children's Inpatient	More capacity – or a mental health unit, we would want units in local hospitals or another hospital in Vermont to support kids so they didn't have to
	Childcare	free childcare being done in the community
	Transportation	Transportation, resources accessibility needs to truly accessible.
		We'd have access to reliable transportation. We would use technology so that folks can access MH supports from home. Having more video connections for communication. Group supports that are available online. Does not replace physical contact. But can be a support.
		really accessing transportation for people,
	Infrastructure	sidewalks – walkable, safe community
	Programs	Continue creating more programs, around mentoring (big-brothers etc..) Increasing flexibility when it comes to making programs successful.
		prioritizing those programs that are not just medical in models.
	EBP's	Mental health tx approached- the range of approaches is celebrated instead of a huge focus on evidence based practices. More inclusive of different people having different needs. The relationship between provider and consumer is being undermined- by prescribing how many sessions someone needs. The relationship between the provider and consumer creates the threshold for care. Who is a mental health PCP?- whoever someone identifies as being their safe person and is identified in their WRAP plan Children are given a wrap plan in their classroom every year Non violent communication- a model for communicating in a way that's connecting instead of escalating a disconnecting people in a crisis
Quality	Workforce	Early good qualified, skilled case managers for people. Adequate pay for staff/ tuition reimbursement More availability for masters level clinicians to work under license – BA or licensed clinician – masters level working underneath them – Masters level clinician continues to get support of supervisors If not licensed, providing services with specific requirements for education to still qualify services

		Trust in other providers to do the best work Staff wouldn't have student loans- US Dept. of Ed makes good on promises. Days off- people get days off. Don't call it anything- just let it happen (pers., sick kids, annual, etc.) Vicarious trauma- we spend a lot of time thinking about kids having resources to learn, having a network in place to support the care takers. There would be MH professionals for the adults and professionals too. Embedded MH care- is this only for students, or is it for staff? This about something bigger, make it available for staff as well. Dental, physical, mental health. Minimum standards for training – Vermont would have to decide what model they would want for training, always evaluating and assessing whether that was appropriate. Trauma informed trainings for staff minimum standards – reduce the lack of compassion for staff members among professionals. In a perfect world this job wouldn't be so painful.
	consistency	What is waiting o the other side is help that is helpful. A Consistent response
Person-centered and Culturally Competent	Goals	More patient centered goals, what would make you feel less stressed. The atmosphere of healthcare- someone can come in and design a spa like atmosphere instead of a sterile looking environment. Focus on customer service.
	Respect	Respect what the client wants and needs, not putting them in a category not forcing them into a treatment category due to a history of treatment.
	Resources	Be realistic about giving people the tools to do what they need to be successful.
		Flexibility in care,

	What is person-centered	and compassionate care.
		Person centered, maybe you can see with your professional hat that someone might need medication, but you absolutely start where they are. Seamless integration between community partners (technology – secure, regionalized records/group chat) Involvement of client's in own plan of care – shared decision plans (crisis plans before crisis); identify strengths, needs, story – to set the tone of treatment Employer meets you where you are at – rate your strength rather than deficits
	Peer Services	More community centers, multigenerational – wellness and staff to run them Meeting where an advocate/representative from each organization to have discussion regarding themes in mental health so that they can collaborate and make changes More community centers, multigenerational – wellness and staff to run them Peers- a stronger role for peers- a greater percentage of emergency work should involve peers. "the ER workers took control of the process and the Peers took care of the presence" Pathways and Alyssum need to have more of a presence NAMI – in our own voice program- 2 peers and they each tell their story- to help elicit conversations and Q&A and its really inspiring. Peers in recovery inspiring other people Emotional health and wellness- stigma- getting rid of timelines. Peers talking, how to we help people become more resilient.
Parity and Stigma	Public Awareness	Pictured a place where somewhere went when they were troubled, it wasn't a separate place. In an ideal world everyone would have the knowledge of how to interact with people who have been in a crisis or are in a crisis.
	Stigma	No fear

		The word illness is banned forever and its called emotional health or wellness and we never use Mental Illness again. society when we talk about mental health without stigma – where we can discuss it without shame as it would be normalized absence of stigma will assist us in accomplishing mental health goals. As long as mental health is seen as a weakness, it will be difficult to treat." "It is important to look at psychosocial and other factors that play into mental health." "Equity rather than equality" – no cookie cutter
	Parity	Some organization have structure regarding this but others do not Recognizing services for men and women and that they are offered for more Sick/vacation time – not all people's family are equal – a difference where some people get more days off a year based on their situation – advanced FMLA Mental Health is a part of health. There is parity in resources, you are screening for all, you are not sent to different place for different needs.
		Swedish model/northern models are a question of taxation and ensuring the social supports are in place for all generations. Vermont after school supports youth voice and uses the Finnish government model, but in Finland this is done with government funding.
		Universal health care- if folks don't have to worry about health care costs then they are happier. He had a plan that required 20 percent payment, then had HAS and premiums went up and employee share went up. Would like to see a system that would pay for everyone regardless of background. The funds would have to come from somewhere.
		If there is one mental health system and one source of funding, then we have apples and apples, but if we have more than one mental health systems and more than one funder, then we might not get so much done.
		The monetary barriers have been eliminated Single payer healthcare system like Finland

	Housing	Supportive housing, especially people with significant mental health issues.
		Subsidized housing would exist, but with less restrictions. Right now it is impossible to get into them.
Funding	Disability	Sometimes we work people onto disability benefits.
		Support for people on SSI
	Not enough	More money more resources.
	Coverage	Make some of these things a health care cost (etc.. make going to the gym a health care cost based on level of commitment)
		If we have universal health care, payment is not an issue.
Technology and data sharing	Transfer	In an ideal world electronically documentation and information would be able to get transferred you wouldn't have to start all over when you needed support, moving from one are of the other to the other.
	Data	Improved data tracking of MH in collaboration with clients Measure level of happiness as a measure of success. Keep the person at the center and don't do one sized treatment. Collaborative documentation (so that we don't lose folks related to documentation). Changing to have clients being a part of the paper work can help the documentation be more meaningful. Common understanding of populations that we need to prioritize. We need to have common understanding of how you measure healthy children. Think about how we reinvest healthcare savings. Parity plays a part here. Unifying screening tools that are used across the state so that there is standardization across school areas.
	Supportive	Share information in a way that was supportive and would reduce recidivisms within the community. The gaps that often happen is different EMR's so universal EMR's. Easier access to information HIPPA more conversations about how to support people in different ways. Smooth transitions around the care continuum

	Technology	Role of virtual reality in treatment of mental health. We have VR technology may have real opportunity on retraining the brain. If we have an individual with SUD. If we want someone to be able to get off of the drugs, there is a fear of what is going to happen when you get off of the medication. Can we use VR to help people experience what they would go through in withdrawal without actually having the effects of it. Think about social media- how could this be a positive force for mental health? It is being abused so terribly now- what does it look like? Troll farms are gone, no cyber bullying. Social media is an added layer of tension for youth.

LOCATION:

System Needs

Category	Themes	Detail
Wellness	Provider Wellness	*Needs*- Thinking about the patient and about the provider- how are we supporting them to have a work environment that is supportive. If we don't care for the provider, then we don't care for the client and the client doesn't stay. We could approach this with training, pay, holistic environments that have wellness programs for their employees. Having physical movement classes in the environment. Having staff meetings for supporting each other.
	Consumer Wellness	*Strength*- St. Johnsbury school feeding children for free makes a big difference. Would wish that all schools would have this programming. It is not always the glamourous and fun work that makes a difference. It might be the nitty gritty stuff.
		Need-Training doctors on how more alternative medicine practitioners can partner (not all scary). Think about funding- yoga, massage, preventative care and wellness- none of this is covered by insurance. Think about better connections between them. Think about interest and trust among providers- bias toward post-acute care. Health actually happens in the post-acute environment, not in the acute care environment. To be recognized as a provider of health, not just mental health or physical health would change the discourse a bit.
	Community Wellness	*Needs*- Wells River community forum to discuss opiate issues (this was prior to vaping). Recognize issue in locality- we decided to do something about it. In last 6 months to year there are new issues such as the sale of cannabis oil, vaping targeted at young kids. Our group may need to step back a little bit and create some awareness that we really do have some mental health issues in Vermont. Instance of murder suicides in families, and yet some folks think we don't need to think about guns in relation to mental illness.
Prevention	Preventative healthcare	*Strength and Need*- Preventative care- Vermont is doing well compared to other states, but still see need. We have better insurance than many other states when thinking about coverage.
Treatment	Early Childhood tx	*Need*- Issue of early childhood and MH and trying to get upstream. Looking at early childhood MH consultation, such as from a DA in childcare settings. Requires doing this not attached to Dx. Don't have funding to provide the consultation because of requirement for Dx.

		Opportunity -Idea- if child reaching level of need to access services. Child is disruptive or not doing well, may not reach level of MH Dx or need. The amount of turnover in these facilities is very high. Concern in not having the qualified professionals that would be needed.
		Need- Want longer pre-k hours and expansion of universal prek. Quality of child care centers would improve through universal pre-k, staff longevity
		Need- Child care centers and public schools- seeing more trauma in young children 3,4,5, having impacts on early learning, the teachers and the classroom- goes above and beyond the academic needs of children.
	Transition Aged Youth	*Strength*- Movement in transition age youth. Conversation about transition age youth and opportunity through payment reform to work on this more.
Recovery	MH/ ADAP	*Need*-The opioid epidemic has reaching impacts on kids.
		Need- SA assessments are all self report and there is a need to have a more comprehensive evaluation. (NKHS)
		Need- We need embedded in EDs, police, schools, more professions in schools, Addiction tx, prevention, early intervention, choices, alternatives to MAT programs.
Integration	HeadStart/ Childcare	*Strength* Pre-K- going well- connections between schools and pre-K providers is very good, *Need*- but turn-over is very high and creates impact.
		Need- Did have the preschool development expansion grant, but easier through the public schools. Grant is gone this year and anticipating challenges related to this.
		Needs- Pre-K screenings- educators, spec, ed, but if we pulled in MH, pediatrician, that would be amazing. If we could have it at locations more than the public school, that would be amazing as well. With the advent of the teaching strategies Gold Assessment system there is less duplication. Childcare providers are very able to come together to work.
	MH/Police	

	MH/Dr. Office	*Wish*- Integration of pediatrics with schools. Can get universal screening on ACES and resilience's. Building concrete supports and social support
		Strength- we have good measures around well-child visits- how is this connected to DMH measures. The models- we are better off if we are working on the whole person approach.
		Primary care doctors don't get the training re: MH issues or DS.
		Need- I wish for medical primary care/pediatrics that the outcome measurements were different (more social determinants of health).
		We are on the cusp of looking at integrated mental and physical health. Doctors are not talking with psychiatry. They don't work together. They don't have parody. Private insurance doesn't pay for case worker – they work with ones that have Medicaid.
		Need-Would love to see the funding silos breakdown so that we can work in a more integrated way around wellness.
		Strength- Dulce program social worker that works with a family from 0-6 months that can support the family and create. Build on strength of first year well-child visits and percentage of families that are connecting
		*Streng*th- NVRH has committed two community health workers that are supporting families as above, such as applying to Medicaid, getting a referral to a specialist, Dentist, MH. They will come to the childcare center, the home and other places. They help with any need.
		Need- talking with the local hospital, primary care, integrating across our physical spaces. Seeking to have physical health provider on the same site to alleviate transportation and other needs. Starting small for number of days that physical health provider (integrative medicine). This is about access to care, not about building a physical health practice as a new identity. Also building two pharmacies in their facilities. 95% of kids seen in first year of life- is this an opportunity for connecting on the MH of families and kids. Digestion starts with your mouth- look at the self-image of the kid that comes to school when their teeth are rotten.
	MH/ Schools	*Strength* - capitalizing on SB6 budget works really well in terms of the contract with the DAs. Leveraging the dollars is a great advantage to schools. The DA in that area is in 90ish % of schools in their area.

		Need - ACES- conversation about the impact on children in infancy whose cries are not met. Schools are more relied on than ever before to meet the need because we are seeing the kids for a large amount of the day. Concern that AOE budget is not increasing because of the "fewer children" argument. But no recognition of need.
		Needs- Themes- be nice today, be positive today, kids are enjoying the school time, but when folks get home, where kids are getting poked fun at on social media, we don't have a place in that. School board partnering with doctor's office and having mh professionals coming into the school. Realizing the guidance counselor is not enough.
		Even when the family network doesn't deliver, if you have a safety net in the school, then it almost doesn't matter what happens at home.
	Community Partners	*Strength*- There has been a nice shift in terms of collaboration with DMH and community partners. Ability to screen in different ways and using data to impact that is more important. Flexibility is working well. Sense of collective impact that is changing. Less "my kid" "your kid" and moving toward collaboration on improvement.
		Need- Our system requires focus on one kid at a time, but we are starting to shift toward more population health approaches.
		Needs- There is a need for stronger collaboration between all service agencies because there are a lot of service needs we are working in silos- trying to get everyone on the same page is an issue.
		Needs- Working through Faith services- they are the last stop since they are free. But clients need to have exhausted all their resources prior to seeing me at the church. The system has let them down or they don't understand it enough to use it—the stories can be large and complication. – If they sign releases they can access help.
	AOE and MH	*Needs*- On the ground, we are building partnership, but there is a disconnect between AOE and DMH leadership that are confusing. SB6 example- requirements to break out between "special ed" and "general ed". This seems like AOE going through its own payment reform.
		Needs- What about the ideas of fewer children and higher need? In st. J there are not fewer children- This district has a higher number of children. Invitation to have someone watch the public classroom for one hour and to observe the social-emotional needs of the kids.

		Needs- There is a disconnect between CDD and AOE that doubles the work.
		Needs- Our biggest opportunity is with our kids. We have to work with adults, but biggest chance is reaching out and working in schools. Not instantaneous, but we should seize the opportunity to work with kids in the schools now. Please please please invest in schools.
	State Partnerships	*Strengths*- working with Department of Mental health is a strong and positive relationship. Complex process with payment reform- very strong, positive and collaborative relationship with DMH. This goes to the leadership and at all levels across the state agency.
Access	ED and Inpatient Beds	*Needs*- When working the hospital field there was a breakdown of communication and coordination- very silo'd The Brattleboro retreat discharges- the psychiatrist only see's a handwritten note prior to seeing the client. Families sometimes bring in the sheet. Questions about what are the expectations when a child is discharged.
		Ad Hoc with our system and that doesn't work, we need a structured way of looking at our system. We need to strike the right balance with acute level of care.
		Do we have enough facilities to treat and keep people safe. We have ACT 248 group but that is DAIL. Then we have the most intensive patients that are being held in the hospital.
		Needs- Wait times for IDDS and children when they need a more intensive level of care- there is a substantial wait time issue.
	Rehab Beds	
	Geographical Concerns	*Need*- Transportation challenges for access to care. If working well we would have more public transportation and ride shares or something along those lines. Right now folks might get to appointments 1.5 hours early, in the winter that might not work.
		NKHS office should be downtown. With the hospital so it is on one campus. Waitlist for therapist in Newport bc the agency was so far away. It is more isolated building. The building is lovely but how do we bring all treatment together so it's not separate.

	Process barriers	
	Transportation	A big problem in a rural area is transportation. It is a problem to be in a rural area. Sometimes it is a decision to live in Montpelier or Burlington. To have access to services then an address is needed before services can be accessed. This is an issue. Get rid of all these pockets of criteria
		NKHS office should be downtown. With the hospital so it is on one campus. Waitlist for therapist in Newport bc the agency was so far away. It is more isolated building. The building is lovely but how do we bring all treatment together so it's not separate.
	Wait times	*Need*- Families that can make appointments during the school day and access through the school day have much more access than those that are only accessing after school. St. J has about 60-65% of kids on free/reduced lunch and eligible. We have school-based counselors and are talking more and more about school-based services are we seeing the needs rise more and more.
		People have to wait – They change their minds. Need services immediately.
	Service needs	*Needs*- housing- impact on mental health as well as reduction of mental illness or improvement in how people feel when they have it. This with transportation is high in the hierarchy of needs.
		Needs- There is a lack of services for specialty populations like - LGBTQ services, a group at church because there is not and specialized resourced for them and there were A lot of suicide in this region with that population and there isn't the resources to provide those services.
		There are problems with the number of children in foster care, high ACES scores, we have so many young children experiencing trauma. Opioid dependence kids – high MH children services. There are a lot of mental health kids. We need to do upstream work.
	Homeless Services	*Needs*- Homeless folks living under the bridge and cannot get services- no great outreach programs for these folks NKHS partners with the warming shelter and a day shelter for homeless folks. Youth services through VCRYP- they have a shelter at youth services. The don't serve youth under the age of 18.
	Service Delivery	*Needs*- Allow the MH providers to be less restricted in how we deliver the services and how we use the revenues/profit margins that we have. We should allow DAs to have a contribution margin- look at investment into the community rather than recouping. Evaluate what the contribution is
		Needs- LIT team- children leaving the retreat and coming back to the community- schools are ill equipped to accept the Childrens back. Aftercare plans are not written until after the child returns

		If NKHS or other agencies are more clear about our resources and recommendations The LIT and CSP process- CSP's aren't to get services- there are coordinated meetings to create a service plan- There needs to be louder and stronger communication that our goal is to keep people in our communities and not send them away when they are struggling. LIT has a good group of participants – the local DA with HIPAA doesn't share information so it can be coordinated to wrap services. If there was better collaboration it would work better as a local system
Quality	Staff Training	*Need*- Access to care depends on the type of service. Challenges are driven by recruitment efforts. There is drive to recruit. There is a lack of talent available in the marketplace and at times we rob Peter to pay Paul. We may be competing for resources. Access to care is driven by vacancies that we could fill if we had the right talent
		Opportunities- when Melissa and Frank were here- thinking about recruiting across borders. It all depends on services provided- pediatric services are very challenging and CRT because of the level of care that people provide.
		Needs- Turnover Turnover Turnover of staff in all social service areas
		Needs- Vermont leads the nation in terms of the ratio of nurses to school students. We have very ideal numbers (207is to 1). Contrary to that is the fact that we are way behind in terms of the numbers of psychologists, counselors, social workers.
		Needs- Hiring and retaining employees is a huge – only one Child and adolescent services clinician at NKHS right now The turnover is problematic- providing the services and effect for families
	Workload	*Needs*- a lot of areas where people need services. People know where to go, but the need/demand exceeds the capacity.
	EBP's	*Needs*- There can be improvements in the types of evidence based services for youth and families. Not a lot of DBT. PCC, Assessments for youth with sexually reactive.
	Data Driven Decision Making	*Needs*- When quality is tied to data, that is something that ties to effectiveness. Good supervision and oversight. Data helps people to know what we are doing, what is most important, what do we need to work on, what do we need to change. It is hard if we are all measuring different pieces but not pulling it together.

Person-centered and Culturally Competent	Reactivity	*Needs*- Sometimes the system is reactive. There are many open channels for groups and children, but there are probably better ways.
	Peer Networks	*Needs*- VFN- peer to peer work can be helpful here. We struggle to build this
	Whole family tx	*Needs*- Professional learning community- parent nights for outdoor science education. Offered families a stipend for attendance. 25-30 people for 2 hour sessions. Had a great diversity of socio-economic backgrounds. Having stipends helped.
Parity and Stigma	Diagnosis Stigma	*Needs*- Kids with Autism, attention deficit, stigma is very difficult, learning profiles are created that are very stigmatizing. IMD is an issue. We need parody. It would never happen in the cardiac unit.
		Needs- Definition of "at risk" and who is "at risk"- everyone is "at risk" from the day you are born to when you die, at any moment you are at risk from breakups to job loss to other changes.
	Socioeconomic stigma	*Needs*- De-stigmatizing mental health through these types of conversations is helpful. In this room, where folks have higher education and income, less stigmatized, as you have less income or resources, the topic becomes more taboo. We need to continue this conversation so that people can say "I'm a little depressed" and we can do more to support people other than saying "buck-up, you'll be okay". De-stigmatizing is one of the largest parts. Needs- MH doesn't discriminate. Services are not equitable to all populations, such as folks that have private insurance that
	Health and Mental Health	*Needs* thinking about MH as health of the brain. If we think about brain health, this is not stigmatized, whereas mental health is. If we start talking about mental health as brain health, would this make a difference in how we feel about them? A stroke is also brain health. If we talk about these as diseases of the brain or conditions of the brain, would this help to normalize? Look at HIV- there was a large effort to destigmatize HIV and to change the dialogue around that.
Technology and data sharing	Documentation and EHR	*Needs*- To continue improving patient care we need to spend more time with the patient instead of documenting the care. The documentation is not read. The EHR are not designed to facilitate anything. It is just the linkage of all of the required documents. This takes away from patient centered care and doesn't have as much value. Reduce data, reports, etc. Hours of documentation are in place of treatment or working with the person.

		Schools err on the side of voluminous documentation. Once you learn this, you are going to continue because it is all that you know. More is not necessarily better because it is not read and can be misconstrued.
Judiciary, Law, Corrections, Police	HIPAA and Privacy rules	*Need*- Refusal to disclose information and lack of information can lead to concerns for clients with SA issues. *Need*- 42 CFR handcuffs people to be able to appropriately collaborate and communicate. HIPPA and 42 CFR-creates SILO's